Michigan Department of Health and Human Services

SFY 2025 External Quality Review Compliance Review Report *for* Prepaid Inpatient Health Plans

Region 2—Northern Michigan Regional Entity

September 2025

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Overview

Background

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

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

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

Description of the External Quality Review Compliance Review

MDHHS requires its PIHPs to undergo periodic compliance reviews to ensure that an assessment is conducted to meet federal requirements. State fiscal year (SFY) 2025 was Year Two of the three-year cycle of compliance reviews for the Behavioral Health Managed Care Program. The reviews focus on standards identified in 42 CFR §438.358(b)(1)(iii) and applicable state-specific contract requirements. The compliance reviews for the Michigan PIHPs consist of 13 program areas referred to as standards. Table 1-1 outlines the standards that will be reviewed over the three-year review cycle for **Northern Michigan Regional Entity** (**NMRE**).

[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/sites/default/files/2023-03/2023-eqr-protocols.pdf. Accessed on: July 25, 2025.

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

Standard	Associated Federal Citation[1,2]		Year One (SFY 2024)	Year Two (SFY 2025)	Year Three (SFY 2026)
	Medicaid	CHIP			
Standard I—Member Rights and Member Information	§438.10 §438.100	§457.1207 §457.1220	✓		No compliance review required
Standard II—Emergency and Poststabilization Services[3]	§438.114	§457.1228		✓	
Standard III—Availability of Services	§438.206	§457.1230(a)	✓		
Standard IV—Assurances of Adequate Capacity and Services	§438.207	§457.1230(b) §457.1218	✓		
Standard V—Coordination and Continuity of Care	§438.208	§457.1230(c)	✓		
Standard VI—Coverage and Authorization of Services	§438.210	§457.1230(d)	✓		
Standard VII—Provider Selection	§438.214	§457.1233(a)		✓	
Standard VIII—Confidentiality	§438.224	§457.1233(e)		✓	
Standard IX—Grievance and Appeal Systems	§438.228	§457.1260		✓	
Standard X—Subcontractual Relationships and Delegation	§438.230	§457.1233(b)		✓	
Standard XI—Practice Guidelines	§438.236	§457.1233(c)		✓	
Standard XII—Health Information Systems[4]	§438.242	§457.1233(d)		✓	
Standard XIII—Quality Assessment and Performance Improvement Program	§438.330	§457.1240		✓	

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

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

[3] MDHHS requested that the review of the Emergency and Poststabilization Services standard be delayed until SFY 2025 to give MDHHS time to provide further guidance to the PIHPs regarding the applicability of the requirements.

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

Summary of Findings

Review of the Standards

Table 1-2 presents an overview of the results of the standards reviewed during the SFY 2025 compliance review for **NMRE**. HSAG assigned a score of *Met* or *Not Met* to each of the individual elements it reviewed based on a scoring methodology, which is detailed in Section 2. If a requirement was not applicable to **NMRE** during the period covered by the review, HSAG used a *Not Applicable* (*NA*) designation. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all eight standards. Refer to Appendix A for a detailed description of the findings.

Table 1-2—Summary of Standard Compliance Scores

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard II—Emergency and Poststabilization Services	13	13	12	1	0	**92%**
Standard VII—Provider Selection	25	25	21	4	0	**84%**
Standard VIII—Confidentiality	22	22	16	6	0	**73%**
Standard IX—Grievance and Appeal Systems	39	39	28	11	0	**72%**
Standard X—Subcontractual Relationships and Delegation	6	6	6	0	0	**100%**
Standard XI—Practice Guidelines	7	7	6	1	0	**86%**
Standard XII—Health Information Systems	9	9	7	2	0	**78%**
Standard XIII—Quality Assessment and Performance Improvement Program	24	24	23	1	0	**96%**
Total	**145**	**145**	**119**	**26**	**0**	**82%**

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

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

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

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

NMRE achieved an overall compliance score of 82 percent, indicating adherence to many of the reviewed federal and State requirements. However, opportunities for improvement were identified in the areas of *Provider Selection*, *Confidentiality*, *Grievance and Appeal Systems*, *Practice Guidelines*, and *Health Information Systems* as these program areas received performance scores below 90 percent. Detailed findings, including recommendations for program enhancements, are documented in Appendix A.

Corrective Action Process

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

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

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

2. Methodology

Activity Objectives

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

MDHHS requires its PIHPs to undergo periodic compliance reviews to ensure that an assessment is conducted to meet federal requirements. The reviews focus on standards identified in 42 CFR §438.358(b)(1)(iii) and applicable state-specific contract requirements. The compliance reviews for the Michigan PIHPs consist of 13 program areas referred to as standards, with the current three-year cycle of compliance reviews spanning from SFY 2024 through SFY 2026. MDHHS requested that HSAG conduct a review of the first half of the standards (with the exception of Standard II) in Year One (SFY 2024) and a review of the remaining half of the standards (and Standard II) in Year Two (SFY 2025). For SFY 2026, MDHHS elected not to conduct a compliance review activity. However, monitoring of the CAPs will occur through the annual EQR technical report process and/or State monitoring activities. Table 2-1 outlines the standards that will be reviewed over the three-year review cycle.

Table 2-1—Compliance Review Standards

Standards	Associated Federal Citation[1,2]		Year One (SFY 2024)	Year Two (SFY 2025)	Year Three (SFY 2026)
	Medicaid	CHIP			
Standard I—Member Rights and Member Information	§438.10 §438.100	§457.1207 §457.1220	✓		No compliance review required
Standard II—Emergency and Poststabilization Services[3]	§438.114	§457.1228		✓	
Standard III—Availability of Services	§438.206	§457.1230(a)	✓		
Standard IV—Assurances of Adequate Capacity and Services	§438.207	§457.1230(b) §457.1218	✓		
Standard V—Coordination and Continuity of Care	§438.208	§457.1230(c)	✓		
Standard VI—Coverage and Authorization of Services	§438.210	§457.1230(d)	✓		
Standard VII—Provider Selection	§438.214	§457.1233(a)		✓	
Standard VIII—Confidentiality	§438.224	§457.1233(e)		✓	

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

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

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

[3] MDHHS requested that the review of the Emergency and Poststabilization Services standard be delayed until SFY 2025 to give MDHHS time to provide further guidance to the PIHPs regarding the applicability of the requirements.

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

This report presents the results of the SFY 2025 review period. MDHHS and the individual PIHPs use the information and findings from the compliance reviews to:

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

Review of Standards

Technical Methods of Data Collection and Analysis

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

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

Pre-Site Review Activities:

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

Site Review Activities:

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

Post-Site Review Activities:

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

Data Aggregation and Analysis:

HSAG used scores of *Met* and *Not Met* to indicate the degree to which the PIHP's performance complied with the requirements. A designation of *NA* was used when a requirement was not applicable

to the PIHP during the period covered by HSAG's review. This scoring methodology is consistent with CMS EQR Protocol 3. The protocol describes the scoring as follows:

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

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

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

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

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

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

HSAG conducted file reviews of the PIHP's records for grievances, appeals, practitioner credentialing, organizational credentialing, and delegation to verify that the PIHP had implemented what the PIHP had documented in its policy. HSAG selected five each for grievances, appeals, practitioner credentialing, and organizational credentialing, and three delegation records from the full universe of records provided by the PIHP. The file reviews were not intended to be a statistically significant representation of all the PIHP's files. Rather, the file reviews highlighted instances in which practices described in policy were not followed by the PIHP staff members. Based on the results of the file reviews, the PIHP must determine whether any area found to be out of compliance was the result of an anomaly or if a more

serious breach in policy occurred. Findings from the file reviews and the universe files were documented within the applicable standard and element in the compliance review tool.

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

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

Description of Data Obtained

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

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

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

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

Data Obtained	Time Period to Which the Data Applied
Documentation submitted for HSAG's desk review and additional documentation available to HSAG during or after the site review	January 1, 2024, through December 31, 2024
Information obtained from a review of a sample of practitioner initial credentialing and recredentialing case files	April 1, 2024, through September 30, 2024

Data Obtained	Time Period to Which the Data Applied
Information obtained from a review of a sample of organizational initial credentialing and recredentialing case files	April 1, 2024, through September 30, 2024
Information obtained from a review of a sample of grievance and appeal files	April 1, 2024, through September 30, 2024
Information obtained from a review of a sample of delegation files	January 1, 2024, through December 31, 2024
Information obtained through interviews	May 23, 2025

Standard II—Emergency and Poststabilization Services

Standard II—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
Definitions		
1. The PIHP defines "emergency medical condition" as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: a. Placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy. b. Serious impairment to bodily functions. c. Serious dysfunction of any bodily organ or part. Note: "Emergency medical condition" applies to the scope of services the PIHP is responsible for (e.g., emergency behavioral health condition). 42 CFR §438.114(a) 42 CFR §457.1228	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual **Evidence as Submitted by the PIHP:** • SII_E1 ES and Children's Diagnostic Policy 5135_pages 2,3 • SII_E1_ Emergency Service Procedure_1 • SII_E1_Access to Care Program_page 2 • SII_E1_Crisis Intervention Program Plan 25_page 1 • SII_E1_Crisis Services member materials_page 1 • SII_E1_Crisis-Services-Trifold_page 2 • SII_E1_Emergency Crisis Intervention Policy_pages 2,3 • SII_E1_Emergency Systems Program Plan_page 1 • SII_E1_Guide_to_Services_FY25_pages 9, 10 (3,4) • SII_E1_NMRE_Access to Care Program_pages 6,7,10,11 • SII_E1_Services Suited to Condition_page 2 • SII_E1_WV Alternatives to Hospitalization_page 1 • SII_E1_WV ES Module 5_page 2 • SII_E1-E3-E4-E5-E6-E7-E8-E9_Member	☒ 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		

Standard II—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
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: HSAG has determined that the PIHP met the requirements for this element. However, refer to Element 13 for related findings. **Recommendations:** Refer to Element 13 for related recommendations.		
Required Actions: None.		
2. The PIHP defines "emergency services" as covered inpatient and outpatient services that are as follows: a. Furnished by a provider that is qualified to furnish these services under Title 42. b. Needed to evaluate or stabilize an emergency medical condition. 42 CFR §438.114(a) 42 CFR §457.1228	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual • A list of services considered to be emergency services to evaluate or stabilize an emergency medical condition (emergency services cannot require a prior authorization) **Evidence as Submitted by the PIHP:** • SII_E2 Children's Diag_pages1,2,3 • SII_E2 Crisis_pages1,2,3 • SII_E2 Emergency Systems Procedure_page 1 • SII_E2_Crisis Intervention Program Plan 25_pages 1,2,3 • SII_E2_Emergency Crisis Intervention Policy_pages 2,3,4 • SII_E2_NMRE_page9,10,11,28,40,44 • SII_E2_WV ES Procedure Manual_page 4 • SII_E2-E3-E8-E9-E10-E11-E12	☒ 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		

Standard II—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
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: HSAG has determined that the PIHP met the requirements for this element. However, refer to Element 13 for related findings. **Recommendations:** Refer to Element 13 for related recommendations.		
Required Actions: None.		
3. The PIHP defines "poststabilization care services" as covered services, related to an emergency medical condition that are provided after a member is stabilized to maintain the stabilized condition, or, under the circumstances described in 42 CFR §438.114(e), to improve or resolve the member's condition. 42 CFR §438.114(a) 42 CFR §438.114(e) 42 CFR §457.1228 Contract Schedule C—Definitions/Explanation of Terms	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual • Examples of services considered to be poststabilization care services related to an emergency medical condition that are provided after a member is stabilized to maintain the stabilized condition **Evidence as Submitted by the PIHP:** • SII_E1-E3-E4-E5-E6-E7-E8-E9_Member • SII_E2-E3-E8-E9-E10-E11-E12 • SII_E3_ Hospital Liaison Procedure_pages1,2 • SII_E3_Access to Care Program • SII_E3_Access_page_6 • SII_E3_Guide_pages10,44 • SII_E3_Intensive Crisis Stabilization • SII_E3_Member Handbook_page5 • SII_E3_NL flyer_pages1-6 • SII_E3_Provider Manual_pages11,12,13,16	☒ Met ☐ Not Met ☐ NA

Standard II—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
PIHP Description of Process: PIHP and it's 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: HSAG has determined that the PIHP met the requirements for this element. However, refer to Element 13 for related findings. **Recommendations:** Refer to Element 13 for related recommendations.		
Required Actions: None.		
Coverage and Payment		
4. The PIHP covers and pays for emergency services regardless of whether the provider that furnishes the services has a contract with the PIHP. 42 CFR §438.114(c)(1)(i) 42 CFR §438.114(b)(1) 42 CFR §457.1228	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual • Claim payment algorithm for emergency services, with the place of service and/or other code(s) that identifies emergency services • Three case examples of a provider submitted claim for emergency services with screenshots of the adjudicated claim (one example must be from an out-of-network provider) **Evidence as Submitted by the PIHP:** • SII_E1-E3-E4-E5-E6-E7-E8-E9_Member • SII_E4 through E9_Adjudicated Claim example 5 • SII_E4_adjudicated Claim_Example 4 • SII_E4_CWN out of network_page 1 • SII_E4_Doctors Behavioral Hospital SCA	☒ Met ☐ Not Met ☐ NA

Standard II—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
	• SII_E4_E5_E6_E7_WV Inpatient Claim example 1 • SII_E4_E5_E6_E7_WV Inpatient Claim example 2 • SII_E4_E5_E6_E7_WV Inpt Claim_Example 3 • SII_E4_Guide_pages3,11,17,27,39,40 • SII_E4_NMRE.CWN_page28 • SII_E4_NMRE.CWN_page38 • SII_E4_OutofNet_page1,2 • SII_E4-E9_Case example- Single case- 1 • SII_E4-E9-E11_Case Example-Single Case- 2 • SII_E4-E9_E11_Case example- Single case 3 • SII_E4-E9-E11_ Out of Network Providers • SII_E4-E9-E11 Purchase of Service Contracting	
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: HSAG has determined that the PIHP met the requirements for this element. However, refer to Element 13 for related findings. **Recommendations:** Refer to Element 13 for related recommendations.		
Required Actions: None.		
5. The PIHP does not deny payment for treatment obtained under either of the following circumstances: a. A member had an emergency medical condition, including cases in which the absence of immediate medical attention	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual • Claim payment algorithm for emergency services	☒ Met ☐ Not Met ☐ NA

Standard II—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
would not have had the outcomes as specified in the definition of "emergency medical condition." b. A representative of the PIHP instructs the member to seek emergency services. 42 CFR §438.114(a) 42 CFR §438.114(c)(1)(ii) 42 CFR §457.1228 Contract Schedule A—1(C)(3)(f)	• Process to track when a PIHP representative instructs a member to seek emergency services (e.g., member services, care management) • Three case examples of a provider submitted claim for emergency services with screenshots of the adjudicated claim (one example must be from an out-of-network provider) **Evidence as Submitted by the PIHP:** • SII_E1-E3-E4-E5-E6-E7-E8-E9_Member • SII_E4 through E9_Adjudicated Claim_Example 5 • SII_E4_E5_E6_E7_WV Inpatient Claim example 1 • SII_E4_E5_E6_E7_WV Inpatient Claim example 2 • SII_E4_E5_E6_E7_WV Inpt Claim_Example 3 • SII_E4-E9_Case example- Single case- 1 • SII_E4-E9-E11_Case Example-Single Case- 2 • SII_E4-E9_E11_Case example- Single case 3 • SII_E4-E9-E11_ Out of Network Providers • SII_E4-E9-E11 Purchase of Service Contracting • SII_E5_Access Procedure_Pg3 • SII_E5_Crisis_page 2 • SII_E5_Example 3- referred to ED 2 • SII_E5_Fee Assessment Policy • SII_E5_GS_FY25_pages9,11,17,12,44 • SII_E5_Member Handbook_page7 • SII_E5_NCCMH_page2,3 • SII_E5_Wellvance_page3 • SII_E5_WellvanceBrochure_page 2 • SII_E5 through E13_CWN_page6,19,20	

Standard II—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
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: HSAG has determined that the PIHP met the requirements for this element. However, refer to Element 13 for related findings. **Recommendations:** Refer to Element 13 for related recommendations.		
Required Actions: None.		
Additional Rules for Emergency Services		
6. The PIHP does not: a. Limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. b. Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider, the PIHP, or MDHHS of the member's screening and treatment within 10 calendar days of presentation for emergency services. 42 CFR §438.114(d)(1) 42 CFR §457.1228	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual • Claim payment algorithm for emergency services • Three case examples of a provider submitted claim for emergency services with screenshots of the adjudicated claim (one example must be from an out-of-network provider) **Evidence as Submitted by the PIHP:** • SII_E1-E3-E4-E5-E6-E7-E8-E9_Member • SII_E4 through E9_Adjudicated Claim_Example 5 • SII_E4_E5_E6_E7_WV Inpatient Claim example 1 • SII_E4_E5_E6_E7_WV Inpatient Claim example 2 • SII_E4_E5_E6_E7_WV Inpt Claim_Example 3 • SII_E4-E9_Case example- Single case- 1 • SII_E4-E9-E11_Case Example-Single Case- 2	☒ Met ☐ Not Met ☐ NA

Standard II—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
	• SII_E4-E9_E11_Case example- Single case 3 • SII_E4-E9-E11_ Out of Network Providers • SII_E4-E9-E11 Purchase of Service Contracting • SII_E6_ Adjudicated Claim out of Network • SII_E6_ Emergency Service Procedure • SII_E6_adjudicated Claim In network • SII_E6_Emergency Crisis Intervention Policy • SII_E6_Emergency Crisis Intervention Policy_pages 2 • SII_E6_Guide_page11 • SII_E5 through E13_CWN_page6,19,20	
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: HSAG has determined that the PIHP met the requirements for this element. However, refer to Element 13 for related findings. **Recommendations:** Refer to Element 13 for related recommendations.		
Required Actions: None.		
7. A member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the member. 42 CFR §438.114(d)(2) 42 CFR §457.1228 Contract Schedule A—1(C)(3)(g)	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual • Claim payment algorithm for emergency and poststabilization services	☒ Met ☐ Not Met ☐ NA

Standard II—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
	• Three case examples of a provider submitted claim for emergency services with screenshots of the adjudicated claim (one example must be from an out-of-network provider)	
	Evidence as Submitted by the PIHP: • SII_E1-E3-E4-E5-E6-E7-E8-E9_Member • SII_E4 through E9_Adjudicated Claim_Example 5 • SII_E4_E5_E6_E7_WV Inpatient Claim example 1 • SII_E4_E5_E6_E7_WV Inpatient Claim example 2 • SII_E4_E5_E6_E7_WV Inpt Claim_Example 3 • SII_E4-E9_Case example- Single case- 1 • SII_E4-E9-E11_Case Example-Single Case- 2 • SII_E4-E9_E11_Case example- Single case 3 • SII_E4-E9-E11_ Out of Network Providers • SII_E4-E9-E11 Purchase of Service Contracting • SII_E7 through E13 Guide_ page_9,10,11 • SII_E7_Crisis Services_page1 • SII_E7_E9_CWN_page3 • SII_E7_Fee Assessment Policy • SII_E7_page1 • SII_E7_Service Priority_page1 • SII_E7_Services2,3 • SII_E7_Utilization Management_page1 • SII_E5 through E13_CWN_page6,19,20	
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		

Standard II—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
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: HSAG has determined that the PIHP met the requirements for this element. However, refer to Element 13 for related findings. **Recommendations:** Refer to Element 13 for related recommendations.		
Required Actions: None.		
8. The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the PIHP. 42 CFR §438.114(d)(3) 42 CFR §457.1228 Contract Schedule A—1(C)(3)(f)	**HSAG Required Evidence:** • Policies and procedures • Provider materials, such as the provider manual • Three case examples of a peer-to-peer discussion between the PIHP and emergency provider pertaining to emergency services **Evidence as Submitted by the PIHP:** • SII_E1-E3-E4-E5-E6-E7-E8-E9_Member • SII_E2-E3-E8-E9-E10-E11-E12 • SII_E4 through E9_Adjudicated Claim_Example 5 • SII_E4-E9_Case example- Single case- 1 • SII_E4-E9-E11_Case Example-Single Case- 2 • SII_E4-E9_E11_Case example- Single case 3 • SII_E4-E9-E11_ Out of Network Providers • SII_E4-E9-E11 Purchase of Service Contracting • SII_E7 through E13 Guide_ page_9,10,11 • SII_E8_Continuing Stay Review • SII_E8_ES screen with consultation • SII_E8_ES screen with consultation-DC • SII_E8_guide_page11 • SII_E8_E13_page12_Example 1 • SII_E8_Stay Review_Example 2	☒ Met ☐ Not Met ☐ NA

Standard II—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
	• SII_E8_WV Adult_example 3 • SII_E8_WV Adult_example_4 • SII_E8_WV Second Opinion_Example 5 • SII_E5 through E13_CWN_page6,19,20	
PIHP Description of Process: PIHP and it 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: HSAG has determined that the PIHP met the requirements for this element. However, refer to Element 13 for related findings. **Recommendations:** Refer to Element 13 for related recommendations.		
Required Actions: None.		
Coverage and Payment of Poststabilization Care Services		
9. The PIHP is financially responsible for poststabilization care services obtained within or outside the PIHP that are pre-approved by a plan provider or other PIHP representative. 42 CFR §422.113(c)(2)(i) 42 CFR §438.114(e) 42 CFR §457.1228 Contract Schedule A—1(C)(3)(c)	**HSAG Required Evidence:** • Policies and procedures • Provider materials, such as the provider manual • Workflow for claims review process for poststabilization care services • Three case examples of a provider submitted claim for poststabilization care services with screenshots of the adjudicated claim (one example must be from an out-of-network provider) **Evidence as Submitted by the PIHP:** • SII_E1-E3-E4-E5-E6-E7-E8-E9_Member • SII_E2-E3-E8-E9-E10-E11-E12	☒ Met ☐ Not Met ☐ NA

Standard II—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
	• SII_E4 through E9_Adjudicated Claim_Example 5 • SII_E4-E9_Case example- Single case- 1 • SII_E4-E9-E11_Case Example-Single Case- 2 • SII_E4-E9_E11_Case example- Single case3 • SII_E4-E9-E11_ Out of Network Providers • SII_E4-E9-E11 Purchase of Service Contracting • SII_E7 through E13 Guide_ page_9,10,11 • SII_E7_E9_CWN_page3 • SII_E9_Adjuicated Claim • SII_E9_E10_E11_WV DC digital log • SII_E9_E10_E11_WV NMRE Discharge Log • SII_E9_E12_WV Claim Out of Network example 4 • SII_E9_E12_WV PostStabilization Claim example 1 • SII_E9_E12_WV PostStabilization Claim example 3 • SII_E9_Post Stabilization Service Claim • SII_E9_SCA Bay City CRU • SII_E9_Single Case agreement • SII_E5 through E13_CWN_page6,19,20	
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: HSAG has determined that the PIHP met the requirements for this element. However, refer to Element 13 for related findings. **Recommendations:** Refer to Element 13 for related recommendations.		
Required Actions: None.		

Standard II—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
10. The PIHP is financially responsible for poststabilization care services obtained within or outside the PIHP that are not pre-approved by a plan provider or other PIHP representative, but administered to maintain the member's stabilized condition within one hour of a request to the PIHP for pre-approval of further poststabilization care services. 42 CFR §422.113(c)(2)(ii) 42 CFR §438.114(e) 42 CFR §457.1228	**HSAG Required Evidence:** • Policies and procedures • Provider materials, such as the provider manual • Workflow for claims review process for poststabilization care services **Evidence as Submitted by the PIHP:** • SII_E2-E3-E8-E9-E10-E11-E12 • SII_E9_E10_E11_WV DC digital log • SII_E9_E10_E11_WV NMRE Discharge Log • SII_E10_E11_E12_WV Provider Claims Management Policy • SII_E10_E12 Claims Review • 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: HSAG has determined that the PIHP met the requirements for this element. However, refer to Element 13 for related findings. **Recommendations:** Refer to Element 13 for related recommendations.		
Required Actions: None.		
11. The PIHP is financially responsible for poststabilization care services obtained within or outside the PIHP that are not pre-approved by a plan provider or PIHP representative, but administered to maintain, improve, or resolve the member's stabilized condition if:	**HSAG Required Evidence:** • Policies and procedures • Provider materials, such as the provider manual • Workflow for claims review process for poststabilization care services	☒ Met ☐ Not Met ☐ NA

Standard II—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
a. The PIHP does not respond to a request for pre-approval within one hour. b. The PIHP cannot be contacted. c. The PIHP representative and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation. In this situation, the PIHP must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the patient until a plan physician is reached or one of the criteria in 42 CFR §422.113(c)(3) is met. 42 CFR §422.113(c)(2)(iii) 42 CFR §422.113(c)(3) 42 CFR §438.114(e) 42 CFR §457.1228 Contract Schedule A—1(C)(3)(d) DHHS-BPHASA-Memo-Poststabilization Timeframe Clarification 9.26.24	• Process to track requests for pre-approval of poststabilization care services and timeliness of the PIHP's response • One case example of a peer-to-peer discussion between the PIHP and the treating provider pertaining to poststabilization care services **Evidence as Submitted by the PIHP:** • SII_E2-E3-E8-E9-E10-E11-E12 • SII_E9_E10_E11_WV DC digital log • SII_E9_E10_E11_WV NMRE Discharge Log • SII_E10_E11_E12_WV Provider Claims Management Policy • SII_E4-E9_E11_Case example- Single case 3 • SII_E4-E9-E11_ Out of Network Providers • SII_E4-E9-E11_Case Example-Single Case- 2 • SII_E4-E9-E11_Purchase of Service Contracting • SII_E5 through E13_CWN_page6,19,20 • SII_E11.Q2 PIHP PI Report • SII_E11_PBIP FUH • SII_E11_Provider Manual • SII_E11_Provider Manual_78-85 • SII_E11_WV Post-stabilization services discussion example • 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_E11_Single case_Example4	
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		

Standard II—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
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: HSAG has determined that the PIHP met the requirements for this element. However, refer to Element 13 for related findings. **Recommendations:** Refer to Element 13 for related recommendations.		
Required Actions: None.		
12. The PIHP limits charges to members for poststabilization care services to an amount no greater than what the PIHP would charge the member if he or she had obtained the services through the PIHP. For purposes of cost-sharing, poststabilization care services begin upon inpatient admission. 42 CFR §422.113(c)(2)(iv) 42 CFR §438.114(e) 42 CFR §457.1228	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Workflow for claims review process for poststabilization care services • Three case examples of a provider submitted claim for poststabilization care services with screenshots of the adjudicated claim (one example must be from an out-of-network provider) **Evidence as Submitted by the PIHP:** • SII_E2-E3-E8-E9-E10-E11-E12 • SII_E5 through E13_CWN_page6,19,20 • SII_E7 through E13 Guide_ page_9,10,11 • SII_E9_E12_WV Claim Out of Network example 4 • SII_E9_E12_WV PostStabilization Claim example 1 • SII_E9_E12_WV PostStabilization Claim example 3 • SII_E10_E11_E12_WV Provider Claims Management Policy • SII_E10_E12 Claims Review • SII_E11-E12-E13_P.P. NLCMHA UM Plan	☒ Met ☐ Not Met ☐ NA

Standard II—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
	• 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_E12_Access Policy • SII_E12_Access Policy2 • SII_E12_Access_Page 3 • SII_E12_Adjudicated Claim_Example 1 • SII_E12_Adjudicated Claim_Example 2	
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: HSAG has determined that the PIHP met the requirements for this element. However, refer to Element 13 for related findings. **Recommendations:** Refer to Element 13 for related recommendations.		
Required Actions: None.		
End of the PIHP's Financial Responsibility		
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.	**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	☐ Met ☒ Not Met ☐ NA

Standard II—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
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	• 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	

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.

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.

Standard II—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
• 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.		

Standard II—Emergency and Poststabilization Services						
Met	=	12	X	1	=	12
Not Met	=	1	X	0	=	0
Not Applicable	=	0				
Total Applicable	=	13	**Total Score**		=	12
Total Score ÷ Total Applicable					=	92%

Standard VII—Provider Selection

Standard VII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
General Rules		
1. The PIHP implements written policies and procedures for selection and retention of network providers and those policies and procedures, at a minimum, meet the requirements of 42 CFR §438.214. *The PIHPs written credentialing policy reflects the scope, criteria, timeliness, and process for credentialing and re-credentialing organizational providers and individual practitioners. The policy is approved by the PIHPs governing body, and:* a. *Identifies the PIHP administrative staff member and/or entity (e.g., credentialing committee) responsible for oversight and implementation of the process and delineate their role.* b. *Describes any use of participating providers or practitioners in making credentialing decisions.* c. *Describes the methodology to be used by PIHP staff members or designees to provide documentation that each credentialing or re-credentialing file was complete and reviewed prior to presentation to the credentialing committee for evaluation.* d. *Describes how the findings of the PIHP's Quality Assessment Performance Improvement Program (QAPIP) are incorporated into the re-credentialing process.* 42 CFR §438.214(a) 42 CFR §438.214(e) 42 CFR §457.1233(a) Contract Schedule A—1(O)(1)(a) Credentialing and Re-Credentialing Processes—B(1) Credentialing and Re-Credentialing Processes—B(5)	**HSAG Required Evidence:** • Policies and procedures **Evidence as Submitted by the PIHP:** • S7_E1_Credentialing Policy and Procedure; scope, criteria, timeliness throughout entire document • S7_E1_FY24 QAPIP PLAN; Page 5, #11. Credentialing and Recredentilaing • S7_E1_1_10_25 CMH Training Agenda; Page 1 "Contract process, "Organizational Credentialing"	☒ Met ☐ Not Met ☐ NA

Standard VII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
PIHP Description of Process: The NMRE Contract and Provider Network Manager is the point person at the PIHP for contract activities and maintains a close network of contract managers at the regional CMHSPs responsible for these functions. The policies and procedures related to the provider network are monitored by this individual, including those of the CMHSP providers. at the Provider These functions are subject to regular monthly discussion Network Managers committee (comprised of those same individuals), and are also the subjects of routine educational sessions, such as a January 2025 training held with organizational credentialing as a topic. Main focuses are MDHHS requirements, state and federal laws, best practices, and opportunities to increase efficiency and implement reciprocity. Credentialing operational improvements and applicable contractual improvement is a part of the NMRE QAIPIP plan, also included as evidence.		
HSAG Findings: HSAG has determined that the PIHP has met the requirements for this element.		
Required Actions: None.		
2. The PIHP follows a documented process for credentialing and recredentialing of network providers that meets MDHHS' requirements for each of the following provider types *and health care professionals:* a. Acute. b. Primary. c. Mental health. d. Substance use disorders (SUD). e. Long-term Services and Supports (LTSS) providers. f. *Physicians (Doctor of Medicine [MDs] and Doctor of Osteopathic Medicine [DOs]).* g. *Physician's Assistants (PAs).* h. *Psychologists (Licensed, Limited License, and Temporary License).* i. *Licensed Master's Social Workers (LMSWs).* j. *Licensed Bachelor's Social Workers (LBSWs).* k. *Limited License Social Workers (LLSWs).* l. *Registered Social Service Technicians (RSSTs).* m. *Licensed Professional Counselors (LPCs).*	**HSAG Required Evidence:** • Policies and procedures **Evidence as Submitted by the PIHP:** • Credentialing Policy and Procedure: Page 3 of 7, Section A. 1 • FY2024_NMRE.CWN_AGREEMENT: Page 6, IV.B	☒ Met ☐ Not Met ☐ NA

Standard VII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
n. *Nurse Practitioners (NPs).* o. *Registered Nurses (RNs).* p. *Licensed Practical Nurses (LPNs).* q. *Occupational Therapists (OTs).* r. *Occupational Therapist Assistants.* s. *Physical Therapists (PTs).* t. *Physical Therapist Assistants (PTAs).* u. *Speech Pathologists (SLPs).* v. *Board Certified Behavior Analysts (BCBAs).* w. *Licensed Family and Marriage Therapists (LFMTs).* x. *Other behavioral healthcare specialists licensed, certified, or registered by the State, as appropriate.* 42 CFR §438.214(b) 42 CFR §438.214(e) 42 CFR §457.1233(a) Credentialing and Re-Credentialing Processes—C(1)		
PIHP Description of Process: The NMRE policy and procedure reflects the health care professionals identified in the MDHHS master contract by incorporating the Credentialing and Credentialing processes of the MDHHS into our policy and procedure by reference, and into the contracts we hold with our CMHSPs by reference.		
HSAG Findings: HSAG has determined that the PIHP has met the requirements for this element.		
Required Actions: None.		

Standard VII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
Nondiscrimination		
3. The PIHP network provider selection policies and procedures do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment, consistent with 42 CFR §438.12. 42 CFR §438.214(c) 42 CFR §438.12 42 CFR §457.1233(a) Contract Schedule A—1(F)(6)(a)(iii) Credentialing and Re-Credentialing Processes—B(2)(a)(ii)	**HSAG Required Evidence:** • Policies and procedures • Nondiscrimination statement for credentialing committee members • Mechanism for monitoring for discriminatory practices **Evidence as Submitted by the PIHP:** • Credentialing Policy and Procedure: Page 2, Section B 2 • CMHSP_Delegated_Managed_Care_Tool,, Row 335 • FY25 SUD Treatment Application Scoring: (just note that cost of service type is not a consideration when selecting provider) • Closed Panel Application: Page 1 • Wellvance AV Credentialing Procedure: Page 1, #2 • NLCMH Credentialing Individuals Policy: Page 2 • NLCMH Initial Credentialing Org Provider Policy: Page 2 • NEMCMH Credentialing Policy: Page 1, "Policy" • NCCMH Credentialing_Procedure: Page 1, "Application" • CWN Credentialing Recredentialing Policy: Page 3, IV, 2	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The NMRE and all 5 of our CMHSPs hold policies that bar discrimination for high risk or costly services, this is evidenced in our uploaded policies. The NMRE monitors this in policies annually; we review the CMHSP policies as well as ensure that each CMHSPs local process for selection does not consider costliness of service as a barrier for legally and contractually required services. We have uploaded an copy of a provider application used by the PIHP directly as evidence that we are looking at gaps in coverage and service need, not risk of additional expenditure. As further evidence we have uploaded our internal committee review form which looks at quality, network need, and qualifications and high risk or costliness of service is not a consideration.		
HSAG Findings: HSAG has determined that the PIHP has met the requirements for this element.		

Standard VII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
Recommendations: HSAG recommends that the PIHP have its credentialing committee members sign off on a nondiscrimination attestation to ensure an understanding of nondiscriminatory practices.		
Required Actions: None.		
4. The PIHP may not discriminate in the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. a. If the PIHP declines to include individual or groups of providers in its provider network, it gives the affected providers written notice of the reason for its decision. b. In all contracts with network providers, the PIHP complies with the requirements specified in 42 CFR §438.214. 42 CFR §438.12(a) 42 CFR §438.214 42 CFR §457.1233(a) Contract Schedule A—1(F)(6)(a)(i–ii) Credentialing and Re-Credentialing Processes—B(2)(a)(i)	**HSAG Required Evidence:** • Policies and procedures • Provider notice template(s) for adverse credentialing and/or contracting decisions • Examples of one individual and one organizational executed provider contracts • Nondiscrimination statement for credentialing committee members • Mechanism for monitoring for discriminatory practices • 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 2, Section B 1; Page 3 of 7, A.2 • FY2024 NMRE.CWN Agreement, Page 30 of PDF (27 of contract), Section XII Part A • CMHSP_Delegated_Managed_Care_Tool,, Row 335 • Wellvance AV Credentialing Procedure: Page 1, #2 • NLCMH Credentialing Individuals Policy: Page 2 • NLCMH Initial Credentialing Org Provider Policy: Page 2 • NEMCMH Credentialing Policy: Page 1, “Policy” • NCCMH Credentialing_Procedure: Page 1, “Application” • CWN Credentialing Recredentialing Policy: Page 3, IV, 2	☒ Met ☐ Not Met ☐ NA

Standard VII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
	• 2024_CMHSP_Organizational_Provider_Credentialing monitoring tool: Page 2, 2nd row from bottom • 2024_CMHSP_Staff_Cred ReCred Monitoring Tool: Page 7, third row from top • LUCIDO, MICHAEL Contract: Page 14, XIX. A • CORNERSTONE_I_INC._NCCMH Contract: Page 14, XIX. A • 1_10_25 CMH Training Agenda: 1:30-2:30 timeslot, part of this included a deep dive of the below bullet evidence • MDHHS Credentialing Guideline markup: Page 1, B. Was specifically covered in training with CFR citation (shows from Jan 9th)	
PIHP Description of Process: The NMRE and all 5 of our CMHSPs hold policies that bar discrimination complaint with the standard, as evidenced in our uploaded policies. The NMRE monitors these policies annually; as well as ensure that each CMHSPs local process for selection does not discriminate individuals by scope of practice, basis of license, etc. We have uploaded a copy of a provider application used by the PIHP directly as evidence that we are looking at gaps in coverage and service need, not risk of additional expenditure. As further evidence we have uploaded our internal committee review form which looks at quality, network need, and qualifications and high risk or costliness of service is not a consideration. NMRE directly monitors to activities of subcontracted CMHSPs with relation to anti-discriminatory practices during site review where we look at their 1) policy and procedures, and 2) during the sample pulls which require access the CMHSP's internal credentialing records. This was also included specifically in a training on January 9, 2025 (yes, out of time range of review but directly applicable). We covered the MDHHS standard in entirety and also relayed the CFR citation included in this standard to our CMH contract managers.		
HSAG Findings: HSAG has determined that the PIHP has met the requirements for this element.		
Required Actions: None.		

Standard VII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
Excluded Providers		
5. The PIHP may not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act. 42 CFR §438.214(d)(1) 42 CFR §457.1233(a) 42 CFR §1002.3 Contract Schedule A—1(F)(6)(a)(iii) Credentialing and Re-Credentialing Processes—B(2)(b)	**HSAG Required Evidence:** • Policies and procedures • List of required sources the PIHP uses to screen for sanctions/exclusions (e.g., Office of the Inspector General Vendor: Valenz Health.[OIG], State-specific sanctions) • Name of vendor or application used by the PIHP to perform screenings, including confirmation of the sources used to screen for sanctions/exclusions • List of delegates responsible for screening for sanctions/exclusions of employees and/or providers • Written agreement with delegated entity(ies) responsible for the initial and ongoing monitoring of sanctions/exclusions • Three consecutive monthly examples of documentation supporting the routine screening of employees for sanctions/exclusions (proof of screening sources must be included) • Three consecutive monthly examples of documentation supporting the routine screening of providers for sanctions/exclusions (proof of screening sources must be included) • HSAG will also use the results of the Practitioner and Organizational Credentialing and Recredentialing File Reviews **Evidence as Submitted by the PIHP:** • Vendor Name: Valenz Health; confirmation of sources is listed on below report summaries	☒ Met ☐ Not Met ☐ NA

Standard VII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
	• Responsible Delegates: Ausable Valley CMH dba Wellvance, Centra Wellness Network, Northern Lakes CMH, North Country CMH, Northeast Michigan CMH • Credentialing Policy and Procedure: Page 3 of PDF, A.3; Page 7, Section H. Reporting; Page 7, E. #3, • S7_E5 Excluded Provider Screening • FY2024 NMRE.CWN Agreement: Page 9 of PDF, IV.B; Page 30, XII C; Page 45, XIX, A.2; • Board and Employee EPS Summary for September 2024 (sources used on page 2 and 3) • Board and Employee EPS Summary for August 2024(sources used on page 2 and 3) • Board and Employee EPS Summary for July 2024(sources used on page 2 and 3) • S7_E5_NMRE and SUD Entities EPS CLEARED List for February 2024 • S7_E5_NMRE and SUD Entities EPS Summary for February 2024 • S7_E5_NMRE and SUD Entities EPS Summary for March 2024 • S7_E5_NMRE and SUD Entities EPS Summary for April 2024	
PIHP Description of Process: The NMRE and all five of our CMHSP partners use a third party vendor Valenz to run our excluded provider lists. The five CMHSPs of the NMRE are Ausable Valley CMHA dba Wellvance, Manistee Benzie Community Mental Health Organization dba Centra Wellness Network, Northern Lakes CMHA, Northeast Michigan CMHA, and North County CMHA. The NMRE passes through the requirements of the MDHHS contract and provider credentialing guidelines in our agreement with or 5 CMH agencies, and monitors their exclusions in case samples during annual review; we also monitor their policies which contain this language.		
HSAG Findings: HSAG has determined that the PIHP has met the requirements for this element.		

Standard VII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
Required Actions: None.		
Practitioner Verification of Credentials		
6. *For credentialing and recredentialing, the PIHP primary source verifies that the practitioner has a current and valid license or certification.* 42 CFR §438.214(e) Credentialing and Re-Credentialing Processes—C(3)(a)	**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.4.a; Page 6, E.1; Page 6, C.3a; Page 6, D3 • 2024_CMHSP_Staff_Cred ReCred Monitoring Tool: Bottom page 1/top of 2; Page 4 • 2024_CMHSP_Delegated_Managed_Care_Tool:Row 363, Row 384 • S7_E6_NMRE Site Review Corrective Action Plan NLCMH: Page 9, 12.16	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The NMRE policy and procedure reflects the MDHHS requirements related to primary source verification. The NMRE also monitors our CMHSPs policies and procedures during monitoring. During monitoring, the NMRE reviews this in the policies of our CMHSPs, and also selects case samples to review findings. If the NMRE finds that the required elements are not primary sourced (such as having a hard copy on file only), we require the corrective action to primary source documents. It is also a standard recommendation to use a browser that supports dates on the primary sourced documents. One example of this has been uploaded as evidence.		
HSAG Findings: HSAG has determined that the PIHP has met the requirements for this element.		
Required Actions: None.		

Standard VII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
7. *For credentialing and recredentialing, the PIHP primary source verifies:* a. *Board certification, or highest level of credentials attained, if applicable, or completion of any required internships/residency programs, or other postgraduate training.* 42 CFR §438.214(e) Credentialing and Re-Credentialing Processes—C(3)(b)	**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.4.b; Page 6, E.1; Page 6, C.3.b; Page 6, D1 • 2024_CMHSP_Staff_Cred ReCred Monitoring Tool: Bottom page 1/top of 2; Page 4 • 2024_CMHSP_Delegated_Managed_Care_Tool:Row 363, Row 384	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: NMRE policy requires primary source verification of board certification; 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.		
HSAG Findings: HSAG has determined that the PIHP has met the requirements for this element.		
Required Actions: None.		
8. *For credentialing, the PIHP primary source verifies:* a. *Official transcript of graduation from an accredited school and/or the Michigan Department of Licensing and Regulatory Affairs (LARA) license.* 42 CFR §438.214(e) Credentialing and Re-Credentialing Processes—C(3)(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 5 of PDF, B.4.a and c; Page 6, E.1; Page 6, C.3.c; Page 6, D1 • 2024_CMHSP_Staff_Cred ReCred Monitoring Tool: Bottom page 1/top of 2; Page 4 • 2024_CMHSP_Delegated_Managed_Care_Tool:Row 365, 366, 385	☒ Met ☐ Not Met ☐ NA

Standard VII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
PIHP Description of Process: NMRE policy requires primary source verification of official graduation transcript; this requirement flows from the PIHP to our CMHSPs via our provider network agreement with them. The NMRE also recognizes the National Student Clearinghouse, which is used by the NMREs CMHSPs. We also review this when we pull samples during CMHSP monitoring.		
HSAG Findings: HSAG has determined that the PIHP has met the requirements for this element. **Recommendations:** For one practitioner record (Sample 4), it was unclear what date the educational transcripts were verified and whether PSV was conducted. The PIHP staff members stated during the site review that the transcripts were originally submitted prior to the credentialing date; however, implementation of a new electronic human resources (HR) system, caused documents to become lost during the transition. HSAG strongly recommends that the PIHP ensure records are adequately maintained during system transitions. Further, HSAG recommends that the PIHP conduct a review of its credentialing files to determine the volume of missing credentialing documents and take steps to ensure the records are updated appropriately. If the PIHP does not demonstrate adequate implementation of HSAG's recommendations during future compliance reviews, the PIHP may receive a *Not Met* score.		
Required Actions: None.		
9. *For credentialing and recredentialing, if the individual practitioner undergoing credentialing is a physician, then physician profile information obtained from the American Medical Association (AMA) or American Osteopathic Association (AOA) may be used to satisfy the primary source requirements of Elements 6, 7, and 8.* 42 CFR §438.214(e) Credentialing and Re-Credentialing Processes—C(3)(e)	**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 5 of PDF, B. 4. e • 2024_CMHSP_Staff_Cred ReCred Monitoring Tool: Bottom page 2, top page 5 • 2024_CMHSP_Delegated_Managed_Care_Tool: Row 390	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: NMRE policy requires physician profile information obtained from the American Medical Association (AMA) or American Osteopathic Association (AOA); 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.		
HSAG Findings: HSAG has determined that the PIHP has met the requirements for this element.		
Required Actions: None.		

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**
11. *For credentialing, the PIHP verifies the practitioner's work history (minimum of the most recent five years of work history).* a. *If a gap in employment exceeds six months or more, the practitioner clarifies the gap in writing.* 42 CFR §438.214(e) Credentialing and Re-Credentialing Processes—C(2)	**HSAG Required Evidence:** • Policies and procedures • HSAG will also use the results of the Practitioner Credentialing File Reviews **Evidence as Submitted by the PIHP:** • Credentialing Policy and Procedure: Definitions; Page 5 of PDF, B.3, Page 6, C.2 • 2024_CMHSP_Staff_Cred ReCred Monitoring Tool: Page 1, top page 4 • 2024_CMHSP_Delegated_Managed_Care_Tool:Row 361, 380	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: NMRE policy requires verification of practitioner work history; this requirement flows from the PIHP to our CMHSPs via our provider network agreement with them. We review this when we pull samples during CMHSP monitoring.		
HSAG Findings: HSAG has determined that the PIHP has met the requirements for this element. **Recommendations:** Although the PIHP's credentialing checklist included work history information, HSAG recommends that the PIHP develop a field to document the date when work history was verified.		
Required Actions: None.		
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

Standard VII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
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.		
Practitioner Credentialing Application/Attestation		
13. *For credentialing and recredentialing, the written application is completed, signed, and dated by the individual practitioner and attests to the following elements:* a. *Lack of present illegal drug use.* b. *History of loss of license, registration, certification, and/or felony convictions.* c. *Any history of loss or limitation of privileges or disciplinary action.* d. *Attestation by the applicant of the correctness and completeness of the application.* e. *Attestation by the applicant that they are able to perform the essential functions of the position with or without accommodation.* 42 CFR §438.214(e) Credentialing and Re-Credentialing Processes—C(1)	**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.1a-d, Page 5, C.1.a-d • 2024_CMHSP_Staff_Cred ReCred Monitoring Tool: Bottom page 1, top of page 6 • 2024_CMHSP_Delegated_Managed_Care_Tool:Row 356-362 and 374-379	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The NMRE Credentialing policy and procedure requires an application that contains the above attestations. This flows to CMHSPs through our provider network agreement; the NMRE monitors this in our CMHSPs' policies and in case samples at the time of monitoring.		
HSAG Findings: HSAG has determined that the PIHP has met the requirements for this element.		

Standard VII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
Recommendations: While attestations were included in the case files, HSAG recommends that the PIHP update its credentialing policy to specifically identify all requirements of this element. If the PIHP does not demonstrate adequate implementation of HSAG's recommendations during future compliance reviews, the PIHP may receive a *Not Met* score.		
Required Actions: None.		
Organizational Verification of Credentials		
14. *For credentialing and recredentialing, the PIHP confirms the provider completed the current credentialing application.* 42 CFR §438.214(e) Credentialing and Re-Credentialing Processes—D(1)(a)	**HSAG Required Evidence:** • Policies and procedures • List of organizational provider types and corresponding licensing body in the State • 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 4 of PDF, B.1a-d; Page 6 E1 • Providers and Types (excel doc)	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The NMRE Credentialing policy and procedure requires an application that contains a current credentialing application. This flows to CMHSPs through our provider network agreement; the NMRE monitors this in our CMHSPs' policies and in case samples at the time of monitoring. After FY2025, regional plans are for these to be in the CRM (for applicable organizations and staff).		
HSAG Findings: HSAG has determined that the PIHP has met the requirements for this element.		
Required Actions: None.		
15. *For credentialing and recredentialing, the PIHP confirms that the provider licensed or certified and in good standing with State and federal regulatory bodies.* 42 CFR §438.214(e) Credentialing and Re-Credentialing Processes—D(1)(b)	**HSAG Required Evidence:** • Policies and procedures • List of organizational provider types and corresponding licensing body in the State • HSAG will also use the results of the Organizational Credentialing and Recredentialing File Reviews	☒ Met ☐ Not Met ☐ NA

Standard VII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
	Evidence as Submitted by the PIHP: • Credentialing Policy and Procedure: Page 4 of PDF, B.2; Page 6 of PDF, D.3; Page 4, E.3 • 2024_CMHSP_Staff_Cred ReCred Monitoring Tool: Top of page 2; top of page 4 • 2024_CMHSP_Delegated_Managed_Care_Tool:Row 394	
PIHP Description of Process: The NMRE Credentialing policy and procedure require provider licensure or appropriate certification to be in good standing with the State and federal regulatory bodies. This requirement flows to CMHSPs through our provider network agreement; the NMRE monitors this in our CMHSPs' policies and in case samples at the time of monitoring.		
HSAG Findings: HSAG has determined that the PIHP has met the requirements for this element.		
Required Actions: None.		
16. *For credentialing and recredentialing, the PIHP confirms that the provider has been approved by an accrediting body.* a. *If the provider is not accredited, the PIHP performs an onsite quality assessment.* b. *For solely community-based providers (e.g., applied behavioral analysis [ABA] or community living supports [CLS] in private residences), an onsite review is not required, and an alternative quality assessment is acceptable.* 42 CFR §438.214(e) Credentialing and Re-Credentialing Processes—D(1)(c) Credentialing and Re-Credentialing Processes—D(1)(h)	**HSAG Required Evidence:** • Policies and procedures • Onsite assessment review tool/template • Requirements for an alternative quality assessment • HSAG will also use the results of the Organizational Credentialing and Recredentialing File Reviews **Evidence as Submitted by the PIHP:** • 2024_CMHSP_Organizational_Provider_Credentialing monitoring tool: Bottom page 1 • S7_E16_FY2023 SUD Provider Review Tool_NMRE: Row 15 • Credentialing Policy and Procedure: Page 2 of PDF, Policy, C • Contract Provider Review TEMPLATE CWN • CLS Monitoring Template NEMCMH	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The NMRE Credentialing policy and procedure require provider accreditation, or onsite quality assessment in lieu of accreditation. For solely community-based providers that may only provide services in a home, the NMRE accepts A) the results of provisional HCBS visits		

Standard VII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
(conducted directly by the NMRE Regional CMH or CMH from another region), B) LARA licensure/licensure survey approval evidence, C) Compliance Reviews (included are samples from Centra Wellness Network and Northeast MI CMH—these are used as quality review on community based providers. This has been reviewed with the CMHSPs in trainings, as well as discussed in the monthly Provider Network Committee Meetings. This requirement flows to CMHSPs through our provider network agreement; the NMRE monitors this in our CMHSPs' policies and in case samples at the time of monitoring.		
HSAG Findings: HSAG has determined that the PIHP has met the requirements for this element. **Recommendations:** While the *Organizational Provider Credentialing Monitoring Tool* had a review element to confirm the delegate validated provider accreditation status or conducted an onsite quality assessment, HSAG strongly recommends that the PIHP update its credentialing policy to clearly identify all requirements of this element and expand on its process for conducting and/or verifying alternative quality assessments. If the PIHP does not demonstrate adequate implementation of HSAG's recommendations during future compliance reviews, the PIHP may receive a *Not Met* score.		
Required Actions: None.		
17. *For credentialing and recredentialing, the PIHP confirms the provider has no malpractice lawsuits that resulted in conviction of criminal neglect or misconduct, settlements, and/or judgements within the last five years.* 42 CFR §438.214(e) Credentialing and Re-Credentialing Processes—D(1)(d)	**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 4 of PDF, B.4.D.i • ENTITY DOO Template FY2025: Page 3, #1 • Scholl Practitioner Credentialing Application: Page 1, D, F, G • Application_FY24 25_Trinity Health St. Mary's: Page 4, #3 • FY2024_NMRE.CWN_AGREEMENT: Page 6/7, IV.B; Page 28, XIII. B-E • Excluded Provider Screening Policy and Procedure: Page 3, 3.B	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The NMRE's credentialing policy requires either an NPDB verification, or in lieu or NPDB verification, a minimum five year history of professional liability claims resulting in judgement or settlement. This requirement flows from the MDHHS agreement to our regional CMHSPs through our provider network contract and is also monitored in the policies and practices of our CMHSPs. The NMRE and its CMHs also run exclusions verifications on owners, managing employees, control interests, and subcontractors of our providers (via Valenz and PSV as needed), disclosures		

Standard VII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
of ownership forms, as well as attestations on credentialing applications. The new Universal Credentialing CRM also lists these attestations as a required field for providers.		
HSAG Findings: HSAG has determined that the PIHP has met the requirements for this element. **Recommendations:** This element has been a challenge for all PIHPs to implement as demonstrated through the 2025 Compliance Review. Therefore, all PIHPs received a *Met* score to allow time for the PIHPs to obtain guidance from MDHHS regarding this requirement. As such, HSAG strongly recommends that the PIHP consult with MDHHS on the appropriate mechanism to use to verify the provider has no malpractice lawsuits that resulted in conviction of criminal neglect or misconduct, settlements, and/or judgments within the last five years. HSAG further recommends that the PIHP develop and implement a clear policy and procedure to reflect the guidance provided 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: None.		
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		

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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.		
19. *For credentialing and recredentialing, current insurance coverage meeting contractual expectations is on file with the PIHP.* 42 CFR §438.214(e) Credentialing and Re-Credentialing Processes—D(1)(g)	**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:** • FY2024 NMRE.CWN Agreement, Page 65 of PDF (62 of contract), Section XXVI, D. • NLCMH Initial Credentialing Org Provider Policy: Page 2 • FY2024 SUD Boilerplate Treatment: Page 45, XXVII A-D • FY2023 SUD Provider Review Tool_NMRE: Row 20 • CLS Monitoring Template NEMCMH: Page 3, insurance coverage • Contract_FY24_Mercy Health: Page 16, XXV	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The NMRE collects copies of current insurance coverage for our SUD Treatment providers and CMHs, a requirement in both of our provider agreement boilerplates. We monitor this during our site visits to both SUD providers and CMHSP providers. We also pass the MDHHS credentialing requirements along to our CMHSPs to ensure they are collecting these from providers and monitoring; as evidence in their monitoring tools and their subcontracts.		
HSAG Findings: HSAG has determined that the PIHP has met the requirements for this element.		
Required Actions: None.		

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Requirement	**Supporting Documentation**	**Score**
20. *The contract between the PIHP and any organizational provider specifies the requirement that the organizational provider must credential and recredential their direct employees, as well as subcontracted service providers and individual practitioners in accordance with the PIHPs credentialing/re-credentialing policies and procedures (which must conform to MDHHS credentialing process).* 42 CFR §438.214(e) Credentialing and Re-Credentialing Processes—D(1)(i)	**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:** • FY2024 NMRE.CWN Agreement: Page 28 of contract, XIII. B-D; Page 31 of PDF (28 of contract), Section XIII. E • Credentialing Policy and Procedure: Page 1, Definitions, "Network Provider"; Page 1, Policy • FY2024 SUD Boilerplate Treatment: Page 5, IV.A and B; Page 6, IV.E; Page 27, XV.C;	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The NMRE's contracts with our 5 regional CMHSPs require that the CMHSP's professional and nonprofessional staff, and that of their subcontractors professional and nonprofessional staff meet our competency standards under the service agreement, including Medicaid Managed Supports and Services under the PIHP's master contract. It also requires that the CMHs shall make available for Payor review, notice of primary verification that the Provider's staff professionals, their subcontractors and subcontractor staff professionals have obtained and maintain all approvals, accreditations, certifications and licenses required by federal, State, and local laws, ordinances, rules, and regulations to practice their professions in the State of Michigan and to perform Medicaid Managed Supports and Services Program activities. The NMRE's credentialing policy applies to all network providers; any provider receiving Medicaid funding directly or indirectly to order, refer, or render covered services as a result of the stat's contract with the NMRE, our CMHSPs, and/or SUD panel.		
HSAG Findings: HSAG has determined that the PIHP has met the requirements for this element.		
Required Actions: None.		

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Requirement	**Supporting Documentation**	**Score**
Time Frames		
21. *The PIHP ensures that the initial credentialing of all individual practitioners and organizational providers applying for inclusion in the PIHP network must be completed within 90 calendar days of application submission.* a. *The start time begins when the PIHP has received a completed signed and dated credentialing application from the provider.* b. *Completion time is indicated when written communication is sent to the provider notifying them of the PIHP's decision.* 42 CFR §438.214(e) Credentialing and Re-Credentialing Processes—C(4) Credentialing and Re-Credentialing Processes—D(2)	**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 4 of PDF (2 of policy), 5, compliance with MDHHS-PIHP contract E21_2024_CMHSP_Organizational_Provider_Credentialing monitoring tool: Page 2, "Timing" • Page 3, 3rd row from top • 2024_CMHSP_Staff_Cred ReCred Monitoring Tool: Page 3, third row from top • 1_10_25 CMH Training Agenda: Page 1 "Contract process, "Organizational Credentialing" • Wellvance Practitioner Credentialing Log • Wellvance Organizations Credentialing checklist • NCCMH Practitioner Application date tracking • NCCMH Organizational Provider checklist	☒ Met ☐ Not Met ☐ NA
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 credentialers on the MDHHS timeliness standards, 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.		

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Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the PIHP has met the requirements for this element. **Recommendations:** All providers initially credentialed were completed within the 90 calendar day time frame. However, the PIHP's documentation included inconsistent time frames. HSAG recommends that all credentialing policies and monitoring tools accurately reflect the 90 calendar day time frame standard for completing initial credentialing decisions. If the PIHP does not demonstrate adequate implementation of HSAG's recommendations during future compliance reviews, the PIHP may receive a *Not Met* score.		
Required Actions: None.		
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. • 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	☐ Met ☒ Not Met ☐ NA
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		

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Requirement	**Supporting Documentation**	**Score**
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.		
Provider Monitoring		
23. *The PIHP conducted ongoing monitoring, and intervention, if appropriate, of organizational providers and/or individual practitioners as it relates to sanctions, complaints, and quality issues. This process includes, at a minimum, review of:* a. *Monthly Medicare/Medicaid sanction checks.* b. *Monthly State sanction checks.* c. *Any limitations on licensure, registration, or certification.* d. *Member concerns which include appeals and grievances (complaints) information.* e. *Noted quality issues at the PIHP level.* 42 CFR §438.214(e) Credentialing and Re-Credentialing Processes—B(7)	**HSAG Required Evidence:** • Policies and procedures • Provider monitoring tracking forms • Credentialing committee meeting minutes • Three consecutive months (October, November, and December 2024) of provider monitoring of sanction (must include evidence for all sub-elements) **Evidence as Submitted by the PIHP:** • Credentialing Policy and Procedure: Page 4 of PDF (2 of policy), B.2; Page 5 of PDF, B.4.7; Page 6 of PDF, D.5; Page 6 D.4 • Excluded Provider Screening: Page 2of PDF, Policy, 2; Page 4 of PDF, A.1.c; Page 4 of PDF, A.2 • 2024_CMHSP_Organizational_Provider_Credentialing monitoring tool: Page 2, near top • 2024_CMHSP_Staff_Cred ReCred Monitoring Tool: throughout document • NMRE and SUD Entities EPS List Overview for October 2024 • NMRE and SUD Entities EPS CLEARED List for October 2024 • NMRE and SUD Entities EPS List Overview for November 2024	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
	• NMRE and SUD Entities CLEARED EPS List for November 2024 • NMRE and SUD Entities EPS List Overview for December 2024	
PIHP Description of Process: The NMRE conducts full, comprehensive reviews of the credentialing processes of our CMHSPs and SUD providers biennially. We identify noncompliant practices, policies, and samples from the comprehensive review and require corrective action plans from our providers (which we either approve or require changes to their plans to ensure compliance). The following year, we review evidence of the corrective action plans in practice and collect new samples as needed. Monitoring includes review of the policies and procedures of our providers as well as evidence in samples that initial and monthly exclusions checks occur, that there is a way for appeal and grievance and quality issues to influence the credentialing decision. As a note, all 5 of the NMREs 5 CMHSPs use Valenz as their third-party verification vendor; Velenz verifications are monthly verifications. As a note, the Valenz verifications use an automated system to flag "potential hits", which the CMH must review to clear. In some cases there may be potential hits listed but the CMHs verify the name, state, SS#, or other identification data does not match the NMRE/CMH provider. One note on this standard and evidence provided for c, d, and e, "Any limitations on licensure, registration, or certification, Member concerns which include appeals and grievances (complaints) information, and noted quality issues at the PIHP level" are not monthly verifications the way exclusions are. They are part of the MDHHS credentialing 2/3 year timeline and would be seen in polices, contracts, and case samples (though they exists in day to day operations).		
HSAG Findings: HSAG has determined that the PIHP has met the requirements for this element.		
Required Actions: None.		
Adverse Credentialing Decisions		
24. *The PIHP has a written appeal process that is available when credentialing or recredentialing is denied, suspended, or terminated for any reason other than lack of need.* a. *The written appeal process is consistent with applicable federal and State requirements.* b. *The appeal process is included as part of an adverse credentialing decision notification letter.* c. *An individual practitioner or organizational provider that is denied credentialing or recredentialing by the PIHP is*	**HSAG Required Evidence:** • Policies and procedures • One case example of an adverse credentialing decision, including the notice to the provider • 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 7 of PDF, F, and G. Appeal Process	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
informed of the reasons for the adverse credentialing decision in writing by the PIHP within 30 days of the decision. 42 CFR §438.214(e) Credentialing and Re-Credentialing Processes—F–G	• CWN Credentialing Recredentialing Policy: Page 6, V. G • NEMCMH Credentialing Policy: Page 3, 7.2 • NCCMH Credentialing_Procedure: Page 2, Procedure, 7 • Wellvance AV Credentialing Procedure: Page 3, #6 • NLCMH Credentialing Individuals Policy: Page 4, yellow highlighted • WV Adverse Credentialing Letter template • NCCMH Credentialing Denial Letter template • NEMCMH Credentialing Appeal Hearing Form • NEMCMH Appeals Process • NEMCMH Credentialing Appeal Hearing Form	
PIHP Description of Process: The PIHP has appeal processes for adversely credentialed providers written into policy; an individual practitioner or organizational provider that is denied credentialing/re-credentialing by a Network Provider will be informed of the reasons for the adverse decision in writing by the Network Provider. In the event a credentialing/re-credentialing application is denied, or a provider is suspended or terminated for any reason other than need, the provider may appeal the decision by submitting a letter of appeal to the Network Provider's Chief Executive Officer CEO) for which participation was denied within ten (10) business days of the date of the determination notice. The letter will concisely state the basis for the appeal and will include any supporting documentation. All appeals will be reviewed, and a decision made within fourteen (14) business days of receipt of the appeal letter. The decision issued by the Network Provider's CEO will be final and binding. This appeal process will apply to providers employed and/or directly contracted with the NMRE when the NMRE denies, suspends, or terminates a Provider for any reason other than for lack of need. The NMRE's 5 regional CMHSPs have appeal processes written into policy as well; Centra Wellness Network has adopted the language of the NMRE. The NMRE and its CMHSPs does not have examples of adverse credentialing decisions for the review period; however, the NMRE has shared samples of adverse credentialing templates (which the region shares amongst each other).		
HSAG Findings: HSAG has determined that the PIHP has met the requirements for this element. **Recommendations:** While the PIHP reported it had no adverse credentialing decisions during the time period of review, HSAG recommends that the PIHP clearly delineate all requirements of this element in its credentialing policy. Additionally, HSAG recommends that the PIHP develop an adverse credentialing letter template and ensure its CMHSPs also have a template available and meet the requirements of this element.		
Required Actions: None.		

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Requirement	**Supporting Documentation**	**Score**
25. *The PIHP reports improper known organizational provider or individual practitioner conduct which could result in suspension or termination from the PIHP's provider network to appropriate authorities (i.e., MDHHS, the provider's regulatory board or agency, the Attorney General, etc.).* 42 CFR §438.214(e) Credentialing and Re-Credentialing Processes—H	**HSAG Required Evidence:** • Policies and procedures • One case example of improper conduct of a provider, including reporting to appropriate authorities • 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 7 of PDF, H. Reporting • NEMCMH Credentialing Policy: Page 3, 7.2 • NMRE.CWN_AGREEMENT:Page 57, H. Reporting Events, J. Regulatory Agency; Page 64, XXVII. A Oversight	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The NMRE did not have any examples of improper organizational or individual provider conduct that resulted in termination from the PIHP network or network of our CMHSPs. The NMRE's policies and the MDHHS requirements (and that of federal and state law) are required elements of the CMHSP contract for their agencies and subcontractors, as noted in the oversight portion of our agreement.		
HSAG Findings: HSAG has determined that the PIHP has met the requirements for this element.		
Required Actions: None.		

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Met	=	21	X	1	=	21
Not Met	=	4	X	0	=	0
Not Applicable	=	0				
Total Applicable	=	25	Total Score		=	21
Total Score ÷ Total Applicable					=	84%

Standard VIII—Confidentiality

Standard VIII—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
General Rule and Administrative Requirements		
1. For medical records and any other health and enrollment information that identifies a particular member, the PIHP uses and discloses such individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E, to the extent that these requirements are applicable. a. The PIHP designates a privacy official who is responsible for the development and implementation of the policies and procedures of the PIHP. b. The PIHP designates a contact person or office who is responsible for receiving privacy-related complaints and who is able to provide further information about matters covered by the notice required by 45 CFR §164.520. c. The PIHP trains all members of its workforce on the policies and procedures with respect to protected health information as necessary and appropriate for the members of the workforce to carry out their functions within the PIHP as outlined in 45 CFR §164.530. d. The PIHP has appropriate administrative, technical, and physical safeguards to protect the privacy of protected health information (PHI). e. The PIHP has written policies and procedures for maintaining the confidentiality of data, including medical records, member information, and appointment records. 42 CFR §438.224	**HSAG Required Evidence:** • Policies and procedures (should address all components of 45 CFR part 164 subpart E) • Workflow for adhering to Michigan State law for addressing confidentiality of information about minors, privacy of minors, and substance use disorder records • Provider materials, such as provider contract and provider manual, requiring providers to have mechanisms to guard against unauthorized or inadvertent disclosure of confidential information • Employee-facing materials • Organizational chart that includes the PIHP's privacy official(s) • Staff training materials **Evidence as Submitted by the PIHP:** • NMRE.CWN_AGREEMENT_FY24: Page 2, Definitions, HIPAA, Page 17, J.1.A-1; Page 44, XVII, E.1, Page 48, XIX. A.11; Page 58, XXII. A; Page 59, XXII. B	☒ Met ☐ Not Met ☐ NA

Standard VIII—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
42 CFR §457.1110 45 CFR §164.520 45 CFR §164.530 45 CFR Parts 160 and 164, Subparts A and E 42 CFR Part 2 Contract Schedule A—1(R)(4) Contract Schedule A—1(R)(9)(a–d) Contract Schedule A—1(R)(9)(h–i)		
PIHP Description of Process: The elements of 42 CFR 164 are incorporated in the NMRE CMHSP contract in a number of places, specifically under Confidentiality/Records/Retention/Release/Confidentiality under "Beneficiary Record", defined as an element of HIPAA in the NMRE definitions and is further incorporated into the agreement(s) throughout the agreement under all HIPAA requirements.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** Although the PIHP explained that most Health Insurance Portability and Accountability Act of 1996 (HIPAA)-related incidents and member rights requests under the HIPAA Privacy Rule are handled through delegated entities, since these are the entities primarily serving members, HSAG continues to strongly recommend that the PIHP have detailed and comprehensive HIPAA-related policies, procedures, and training materials in place to support awareness of all confidentiality-related requirements under the HIPAA Privacy Rule and Michigan Mental Health Code, and ensure that the policies, procedures, and training materials outline the responsibilities of both the PIHP and its entities delegated to manage privacy and security incidents and member rights requests. Additionally, HSAG recommends that the PIHP enhance both its *SUD Provider Review Tool NMRE* and *CMHSP Delegated Managed Care Tool* to incorporate the PIHP's mechanisms to ensure all staff and delegated entities are adhering to member privacy rights under the HIPAA Privacy Rule. Lastly, although the PIHP discussed expectations and monitoring processes for staff training, both upon hire and annually, HSAG strongly recommends that the PIHP document and track staff training as completed (e.g., obtaining signed attestations, storing certifications). Of note, some of the recommendations listed in this Standard are similar recommendations from the prior compliance review that still apply to the PIHP. If the PIHP does not demonstrate adequate implementation of HSAG's recommendations during future compliance reviews, the PIHP may receive a *Not Met* score.		
Required Actions: None.		

Standard VIII—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
Uses and Disclosures of PHI		
2. The PIHP and its business associates may not use or disclose PHI except as permitted or required by 45 CFR §164.502 or by 45 CFR §160 subpart C. The PIHP is permitted to use or disclose PHI as follows: a. To the individual. b. For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR §164.506. c. Incident to a use or disclosure otherwise permitted or required by 45 CFR §164.502, provided that the PIHP has complied with the applicable requirements of 45 CFR §§164.502(b), 164.514(d), and 164.530(c). d. Except for uses and disclosures prohibited under 45 CFR §164.502(a)(5)(i), pursuant to and in compliance with a valid authorization under 45 CFR §164.508. e. Pursuant to an agreement under, or as otherwise permitted by 45 CFR §164.510. f. As permitted by and in compliance with 45 CFR §164.512, §164.514(e), (f), or (g). 45 CFR §164.502(a)(1) 45 CFR §164.502(a)(5)(i) 45 CFR §164.502(b) 45 CFR §164.506 45 CFR §164.508 45 CFR §164.510 45 CFR §164.512 45 CFR §164.514(d–g) 45 CFR §164.530(c)(2)(ii)	**HSAG Required Evidence:** • Policies and procedures • Business associate agreement template • One example of an executed business associate agreement • Staff training materials **Evidence as Submitted by the PIHP:** • Gogolin_NMRE_BAA_DRAFT_2_13_24 • BAA Boilerplate: Page 1, #1.Definitions, D., E.; Page 2, 3.6, Page 2, 4.d; Page 3, 5.A-D	☒ Met ☐ Not Met ☐ NA

Standard VIII—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
42 CFR §457.1110(a–b) 45 CFR §160 Subpart C Contract Schedule A—1(R)(9)		
PIHP Description of Process: The NMRE's BAA contains sections throughout that apply to and comply with this element, which have been provided.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
3. The PIHP, and its business associate as permitted or required by its business associate contract, is required to disclose PHI: a. To an individual, when requested under, and required by 45 CFR §164.524 or §164.528. b. When required by the Secretary to investigate or determine the PIHP's compliance with 45 CFR §160 subpart C. 45 CFR §164.502(a)(2–4) 45 CFR §164.524 45 CFR §164.528 42 CFR §457.1110(d) 45 CFR §160 Subpart C Contract Schedule A—1(R)(9)	**HSAG Required Evidence:** • Policies and procedures • Business associate agreement template • One example of an executed business associate agreement • Staff training materials **Evidence as Submitted by the PIHP:** • Gogolin_NMRE_BAA_DRAFT_2_13_24 • BAA Boilerplate: Page 1, Definitions, 1., Page 2, 4.h, Page 3, #4 I.; Page 4, #4., f, g, j	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The NMRE's BAA contains a few sections that apply to this element, which have been provided, namely in its "Responsibilities of the Business Associate with Regard to Protected health Information" section.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		

Standard VIII—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
Minimum Necessary		
4. When using or disclosing PHI or when requesting PHI from another covered entity or business associate, the PIHP makes reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request. 45 CFR §164.502(b) 42 CFR §457.1110 Contract Schedule A—1(R)(9)(c)	**HSAG Required Evidence:** • Policies and procedures • Three examples of requests for PHI from another covered entity (e.g., member's previous PIHP, dental benefits administrator, provider) • Staff training materials **Evidence as Submitted by the PIHP:** • S8_E4_Care Coordination_page 5 • S8_E4_CPS Request_Example 1 • S8_E4_Disclosure Example 1 • S8_E4_Provider Request_Example 2 • S8_E4_Records Request Example 3 • S8_E4_Disclosure of Records Example 3 • S8_E4_Training_2024_Slides 18-23	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The PIHP uses the minimum necessary PHI to accomplish the intended purpose of the use, disclosure, or request when fulfilling a request or requesting PHI.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
5. Minimum necessary does not apply to: a. Disclosures to or requests by a health care provider for treatment. b. Uses or disclosures made to the individual. c. Uses or disclosures made pursuant to an authorization under 42 CFR §164.508.	**HSAG Required Evidence:** • Policies and procedures • Staff training materials **Evidence as Submitted by the PIHP:** • S8_E5_Medical Records Process • S8_E5_Clinical Record Process	☒ Met ☐ Not Met ☐ NA

Standard VIII—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
d. Disclosures made to the Secretary regarding compliance and investigations under 45 CFR Part 160. e. Uses or disclosures that are required by law as described in 45 CFR §164.512(a). f. Uses or disclosures that are required for compliance with applicable requirements of 45 CFR §164.502. 45 CFR §164.502(b)(2) 45 CFR §164.508 45 CFR §164.512(a) 45 CFR Part 160 42 CFR §457.1110		
PIHP Description of Process:		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** Although the PIHP was able to explain how its practices for uses and disclosures comply with the minimum necessary rule and do not limit the disclosure of PHI when permitted under federal rule, HSAG continues to strongly recommend that the PIHP's policies and procedures be updated to specifically include the exceptions that apply to the minimum necessary requirement under the HIPAA Privacy Rule. If the PIHP does not demonstrate adequate implementation of HSAG's recommendations during future compliance reviews, the PIHP may receive a *Not Met* score.		
Required Actions: None.		
Uses and Disclosures Requiring Authorizations		
6. Except as otherwise permitted or required by 45 CFR Part 164 Subpart E, a covered entity may not use or disclose PHI without a valid authorization. When a covered entity obtains or receives a valid authorization for its use or disclosure of PHI such use or disclosure must be consistent with such authorization. a. If a covered entity seeks an authorization from an individual for a use or disclosure of PHI, the covered entity provides the individual with a copy of the signed authorization.	**HSAG Required Evidence:** • Policies and procedures • Authorization for use and disclosure form template • Two examples of signed authorizations for the purposes outlined in 45 CFR §164.508 • Staff training materials **Evidence as Submitted by the PIHP:**	☒ Met ☐ Not Met ☐ NA

Standard VIII—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
45 CFR §164.508 45 CFR Part 164 Subpart E 42 CFR §457.1110	• S8_E6_Consent to Share Inormation_page 2 • S8_E6_Notice of Privacy Practices_page 4 • S8_E6 Auth to Realease Info Ex. 1 • S8_E6_Completed Consent to Share Ex.2 • S8_E6_Compliance Training_18	
PIHP Description of Process: The NMRE does not disclose PHI without a signed authorization from the beneficiary, unless the disclosure is permitted by 45 CFR part 164, Subpart E. The NMRE also provides the individual with a copy of the signed disclosure authorization.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** Although the PIHP required the use of the MDHHS-5515 Consent to Share Behavioral Health Information form, which included a section for members to confirm whether they received or declined a copy of the form, should the PIHP (or its delegates) obtain consent for disclosing PHI for reasons outlined in 45 CFR §164.508, HSAG strongly recommends that the PIHP (or its delegates) ensure it has an appropriate HIPAA authorization form available as well as a process outlined in a policy or procedure to further demonstrate that members are provided a copy of the signed authorization form as required under 45 CFR §164.508(c)(4). Additionally, HSAG continues to strongly recommend that the PIHP ensure its oversight process of its delegates include a component to evaluate the procedures for providing each member with a copy of any signed authorization or consent form to ensure compliance with the requirements under this element (e.g., enhance both its *SUD Provider Review Tool NMRE* and *CMHSP Delegated Managed Care Tool).* If the PIHP does not demonstrate adequate implementation of HSAG's recommendations during future compliance reviews, the PIHP may receive a *Not Met* score.		
Required Actions: None.		
Privacy Rights		
7. The PIHP complies with the member's right to request privacy protection for PHI and the requirements under 45 CFR §164.522. 45 CFR §164.522 42 CFR §457.1110	**HSAG Required Evidence:** • Policies and procedures • Process workflow • Member request forms for privacy protection • Two examples of member's request for privacy protection, including documentation of the request and evidence to support completion of the privacy protection request • Staff training materials	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
	Evidence as Submitted by the PIHP: • S8_E7 Clinical Record Procedure • S8_E7_Client Request Ex. 1 • S8_E7_Request Ex. 2 • S8_E7_E8_E9_Guide to Services page 9	
PIHP Description of Process: The NMRE provides privacy protection for the beneficiary's PHI when requested.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** Although the PIHP confirmed that most privacy rights requests are managed by the contracted CMHSPs, it is important that the PIHP have policies and procedures in place to detail the delineation of responsibilities between the PIHP and its CMHSPs and to ensure that procedures are in place should the PIHP receive a request directly from a member. The PIHP's Notice of Privacy Practices informed members of their privacy rights; however, HSAG continues to strongly recommend that the PIHP develop detailed policies and procedures that outline the requirements, steps, and procedures the PIHP takes (or requires its CMHSPs to take) to ensure compliance with member rights requests under the HIPAA Privacy Rule. At a minimum, the written documentation should include the procedures for intaking the request from the member (e.g., use of a template to be completed by the member, field in the system to note the request staff responsible for intaking the request and staff responsible for responding to the request, etc.); the system(s) and fields used to document the privacy rights request; tracking mechanism(s) for monitoring completion of the request to ensure time frame compliance (when applicable); steps taken to update the health information system to notate any implemented requests (e.g., alerts, record modifications); internal notification requirements to obtain information as necessary and to ensure the appropriate individuals (e.g., staff members, providers) are informed of the right(s) exercised by the member; location of the system where copies of information provided to members (when required) are maintained; and the method for providing the member with confirmation of completion of the rights request (e.g., mailed notices, copies of documentation requested when appropriate). The PIHP should also consider developing request forms (as applicable) and notification template letters specific to each privacy right request. Further, the PIHP's formal oversight process of its delegated entities should include a component for assessing each entity's procedures for complying with members' requests for exercising their privacy rights under the HIPAA Privacy Rule (e.g., enhance both its *SUD Provider Review Tool NMRE* and *CMHSP Delegated Managed Care Tool*). Of note, these recommendations apply to all member rights requests outlined in elements 7–10. If the PIHP does not demonstrate adequate implementation of HSAG's recommendations during future compliance reviews, the PIHP may receive a *Not Met* score.		
Required Actions: None.		

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Requirement	**Supporting Documentation**	**Score**
8. The PIHP complies with the member's right to access PHI and the requirements under 45 CFR §164.524. a. The PIHP acts on a request for access no later than 30 days after receipt of the request. b. The PIHP provides the member with access to the PHI in the form and format requested by the member, if it is readily producible in such form and format, or if not, in a readable hard copy form or such other form and format as agreed to by the PIHP and member. 45 CFR §164.524 42 CFR §457.1110	**HSAG Required Evidence:** • Policies and procedures • Process workflow • Member request form to access PHI • Two examples of member's request to access PHI, including documentation of the request and evidence to support timely completion of the PHI access request • Staff training materials **Evidence as Submitted by the PIHP:** • S8_E8_Notice of Privacy Practices _page 2 • S8_E8_Client Records Ex. 1 • S8_E8_Info Disclosure Consumer Ex. 2 • S8_E7_E8_E9_Guide to Services page 9 • S8__E8_E9_Use and Disclosure page 5	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: When a request for PHI is received from the beneficiary, the NMRE fulfills the request within 30 days of the request, and provides the PHI in the format requested by the beneficiary, if possible.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
9. The PIHP complies with the member's right to have the PIHP amend PHI or a record about the member in a designated record set for as long as the PHI is maintained in the designated record set. The PIHP complies with the requirements under 45 CFR §164.526. a. The PIHP acts on the member's request for an amendment no later than 60 days after receipt of such a request.	**HSAG Required Evidence:** • Policies and procedures • Process workflow • Member request form to amend PHI • Two examples of member's request to amend PHI, including documentation of the request and evidence to support timely completion of the amendment request	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
45 CFR §164.526 42 CFR §457.1110(e)	• One example of a denial of an amendment and notification to the member • Staff training materials **Evidence as Submitted by the PIHP:** • S8__E8_E9_Use and Disclosure page 5	
PIHP Description of Process:		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
10. The PIHP complies with the member's right to receive an accounting of disclosures of PHI made by the PIHP in the six years prior to the date on which the accounting is requested, in compliance with the requirements under 45 CFR §164.528. a. The PIHP acts on the member's request for an accounting, no later than 60 days after receipt of such a request. b. The PIHP documents the accounting of disclosures and retains the documentation as required by 45 CFR §164.530(j). 45 CFR §164.528 45 CFR §164.530(j) 42 CFR §457.1110	**HSAG Required Evidence:** • Policies and procedures • Process workflow • Member request form for an accounting of disclosures of PHI • Mechanism to track disclosures (e.g. where reports to Adult Protective Services are documented within the system for retrieval for the accounting of disclosure) • Two examples of member's request for an accounting of disclosures, including documentation of the request and evidence to support timely completion of the accounting of disclosure request • Documentation to demonstrate how the record of the accounting of disclosures is retained • Staff training materials **Evidence as Submitted by the PIHP:** • S8_E10_Notice of Privacy Practice page 2 • S8_E10_Document Disclosure Log ex. 1 • S8_E10_Client Accounting Request Ex. 2 • S8_E10_Compliance Training_slide 23	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
PIHP Description of Process: NMRE complies with requests by beneficiaries for a list of disclosures for up to 6 years prior to the request. The request for disclosures are provided within 60 days.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
Breach of Unsecured PHI		
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]).		

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Requirement	**Supporting Documentation**	**Score**
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.		
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.		
12. The PIHP has a policy and procedure to immediately report to MDHHS any suspected or confirmed unauthorized use or disclosure of protected health data and information that falls under the Health Insurance Portability and Accountability Act (HIPAA) requirements of which the PIHP becomes aware. a. The PIHP will work with MDHHS to mitigate the breach and will provide assurances to MDHHS of corrective actions to prevent further unauthorized uses or disclosures. Contract Schedule A—1(R)(9)(e)	**HSAG Required Evidence:** • Policies and procedures **Evidence as Submitted by the PIHP:** • S8_E12_Breach Notification Policy page 4 • S8_E12_E13_E14_Breach Notification page 2 of 10	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: When the NMRE suspects or confirms an unauthorized disclosure of information that falls under HIPAA, the NMRE immediately reports the information to MDHHS. MDHHS then assists the NMRE with moving forward.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** Although the requirements for this element were discussed during the site review, HSAG strongly recommends that the PIHP have a process to ensure immediate notification of any suspected or confirmed unauthorized use or disclosure of PHI to MDHHS as outlined in the Contract. Additionally, the PIHP should confirm reporting expectations with MDHHS and update its policies and procedures accordingly. If the PIHP does not demonstrate adequate implementation of HSAG's recommendations during future compliance reviews, the PIHP may receive a *Not Met* score.		
Required Actions: None.		

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Requirement	**Supporting Documentation**	**Score**
13. The PIHP for the purposes of 45 CFR §164.404(a)(1), 45 CFR §164.406(a), and 45 CFR §164.408(a), a breach is treated as discovered by the PIHP as of the first day on which such breach is known to the PIHP, or, by exercising reasonable diligence would have been known to the PIHP. a. The PIHP shall be deemed to have knowledge of a breach if such breach is known, or by exercising reasonable diligence would have been known, to any person, other than the person committing the breach, who is a workforce member or agent of the PIHP. 45 CFR §164.404(a) 45 CFR §164.406(a) 45 CFR §164.408(a)	**HSAG Required Evidence:** • Policies and procedures • 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 **Evidence as Submitted by the PIHP:** • S8_E12_E13_E14_Breach Notification page 2 of 10 • S8_E11_E13_E20_Breach Tracking	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The NMRE treats the discovery of the breach as the first day in which the NMRE became aware if the breach. The NMRE then performs all due diligence according to the discovery of the breach.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
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

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Requirement	**Supporting Documentation**	**Score**
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 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.		
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.	**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	☐ Met ☒ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
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)	• S8_E14_E15_Breach Notification Example 3	
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, 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.		

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Requirement	**Supporting Documentation**	**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.		
16. The notification must be provided in the following form: a. Written notice by first-class mail to the individual at the last known address of the individual or, if the individual agrees to electronic notice and such agreement has not been withdrawn, by electronic mail. b. If the PIHP knows the individual is deceased and has the address of the next of kin or personal representative of the individual, written notification by first-class mail to either the next of kin or personal representative of the individual. c. The notification may be provided in one or more mailings as information is available. 45 CFR §164.404(d)(1)	**HSAG Required Evidence:** • Policies and procedures • Confirmation of first-class mailing **Evidence as Submitted by the PIHP:** • S8_E16_Breach Notification page 5 of 10	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: When the NMRE notifies a beneficiary of a breach of data, the NMRE sends written notice by first class mail to the last known address of the beneficiary; however this information will be sent electronically if the beneficiary agrees. If the NMRE discovers that the beneficiary involved in the breach is deceased, then the NMRE will send notification to the next of kin or personal representative. The NMRE also mails updated mailings as necessary.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		

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Requirement	**Supporting Documentation**	**Score**
Required Actions: None.		
17. In the case in which there is insufficient or out-of-date contact information that precludes written notification to the individual, a substitute form of notice reasonably calculated to reach the individual must be provided. a. If there is insufficient or out-of-date contact information for fewer than 10 individuals, then such notice may be provided by an alternative form of written notice, telephone, or other means. b. If there is insufficient or out-of-date contact information for 10 or more individuals, then such substitute notice must: i. Be in the form of either a conspicuous posting for a period of 90 days on the home page of the PIHP's website, or conspicuous notice in major print or broadcast media in geographic areas where the individuals affected by the breach likely reside. ii. Include a toll-free phone number that remains active for at least 90 days where an individual can learn whether the individual's unsecured PHI may be included in the breach. c. Substitute notice need not be provided in the case in which there is insufficient or out-of-date contact information that precludes written notification to the next of kin or personal representative of the individual under 45 CFR §164.404(d)(1)(ii). 45 CFR §164.404(d)(1)(ii) 45 CFR §164.404(d)(2)	**HSAG Required Evidence:** • Policies and procedures • One example of a substitute notice for when there was insufficient or out-of-date contact information for fewer than 10 members, if applicable during the review period • One example of a substitute notice for when there was insufficient or out-of-date contact information for more than 10 members, if applicable during the review period **Evidence as Submitted by the PIHP:** • S8_E17_Breach Notification page 6 of 10	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
PIHP Description of Process: When the NMRE discovers and out of date address for the beneficiary to be notified, a substitute communication is attempted. The substitute notice includes a conspicuous posting of the breach for 90 days via NMRE.org or a conspicuous notice via printed or broadcasted media. The notice includes contact information so the beneficiary may contact the NMRE for further information.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
18. In any case deemed by the PIHP to require urgency because of possible imminent misuse of unsecured PHI, the covered entity may provide information to individuals by telephone or other means, as appropriate, in addition to notice provided under 45 CFR §164.404(d)(1). 45 CFR §164.404(d)(1) 45 CFR §164.404(d)(3)	**HSAG Required Evidence:** • Policies and procedures • One example of notice provided to members for an urgent situation, if applicable during the review period **Evidence as Submitted by the PIHP:** • S8_E18_Breach of Notification_page 6_of_10	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The NMRE may use alternative forms of communication to report the misuse of PHI in urgent situations, before a written notice is sent.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
19. For a breach of unsecured PHI involving more than 500 residents of a State or jurisdiction, the PIHP must, following the discovery of the breach, notify prominent media outlets serving the State or jurisdiction, without unreasonable delay and in no case later than 60 calendar days after discovery of the breach. 45 CFR §164.406(a–b) 45 CFR §164.404(c)	**HSAG Required Evidence:** • Policies and procedures • One example of breach of unsecured PHI involving more the 500 members, including the date of discovery and date of notification to media outlets, if applicable during the review period **Evidence as Submitted by the PIHP:** • S8_E19_E20 Breach Notification page 6 of 10	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
PIHP Description of Process: When a breach of PHI occurs involving more than 500 residents, the NMRE notifies media outlets serving the area no later than 60 days from discovery of the breach, or as soon as possible.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
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		

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Requirement	**Supporting Documentation**	**Score**
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." **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.		
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 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	**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 **Evidence as Submitted by the PIHP:** • BAA Boilerplate: Page 2, 4.c and d • Gogolin_NMRE_BAA_DRAFT_2_13_24	☐ Met ☒ Not Met ☐ NA

Standard VIII—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
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		
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, 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.		

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Requirement	**Supporting Documentation**	**Score**
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.		
Notice of Privacy Practices		
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

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Requirement	**Supporting Documentation**	**Score**
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 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		

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Requirement	**Supporting Documentation**	**Score**
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).		

Standard VIII—Confidentiality						
Met	=	16	X	1	=	16
Not Met	=	6	X	0	=	6
Not Applicable	=	0				
Total Applicable	=	22	**Total Score**		=	16
Total Score ÷ Total Applicable					=	73%

Standard IX—Grievance and Appeal Systems

Standard IX—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Grievance System General Requirements		
1. The PIHP defines a grievance as an expression of dissatisfaction about any matter other than an adverse benefit determination (ABD). Grievances may include, but are not limited to the quality of care or services provided; aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. Grievance includes a member's right to dispute an extension of time proposed by the PIHP to make an authorization decision. 42 CFR §438.228 42 CFR §438.400(b) 42 CFR §457.1260(a)(2)(ii) Appeal and Grievance Resolution Processes Technical Requirement—II	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook **Evidence as Submitted by the PIHP:** • S9_E1_Grievance and Appeals procedure_page 2 • S9_E1_Guide to Services_page 15_16_35	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: In both policy and procedure, along with guide to services (member handbook), a grievance as an expression of dissatisfaction about any matter other than an adverse benefit determination (ABD). Grievances may include but are not limited to the quality of care or services provided; aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. Grievance includes a member's right to dispute an extension of time proposed by the PIHP to make an authorization decision.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** HSAG noted that the universe file did not include any grievances for SUD providers. During the site review, the PIHP staff members explained that the resolution of grievances is delegated to its SUD providers, but SUD-related grievances have been underreported. The PIHP staff members further explained that the PIHP has remediated this issue, which has increased the volume of reported grievances. Documentation submitted by the PIHP also suggested that there was an informal resolution process prior to the formal grievance process. However, if the PIHP is delegating grievance functions to its CMHSPs and SUD providers, all complaints meet the definition of a grievance (i.e., expression of dissatisfaction). HSAG recommends that the PIHP conduct ongoing education with its CMHSPs and SUD providers to ensure grievances are appropriately being reported, investigated, and resolved. Additionally, HSAG recommends that the PIHP enhance oversight and monitoring activities over delegated grievance functions. This must include a random sample of grievance records to determine if the CMHSPs and SUD providers are following State and federal grievance processing guidelines. Additionally, HSAG is concerned		

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that, across the entire behavioral health system, grievances related to member rights complaints are not being consistently identified, tracked, reported, or resolved as a grievance and instead are handled by the Office of Recipient Rights (ORR). However, grievances related to member rights complaints meet the definition of a grievance and should follow the PIHP's grievance resolution process. HSAG has recommended that MDHHS review the delineation of responsibilities between the PIHP's grievance process and the ORR and provide guidance to the PIHPs on MDHHS' expectations for how grievances related to member rights complaints must be handled. HSAG recommends that the PIHP implement any future guidance issued by MDHHS. HSAG recommends that the PIHP implement any future guidance issued 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: None.		
2. A member may file a grievance with the PIHP at any time. a. With the written consent of the member, a provider or an authorized representative may file a grievance on behalf of a member. 42 CFR §438.228 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

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Requirement	**Supporting Documentation**	**Score**
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 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.		
3. The member may file a grievance either orally or in writing. 42 CFR §438.228 42 CFR §438.402(c)(3)(i) 42 CFR §457.1260(b)(1) 42 CFR §438.46 (a) Contract Schedule A—M(1)(d)	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • System screenshot of the field where the filing mode is documented (i.e., orally or in writing) • HSAG will also use the results of the system demonstration	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
	Evidence as Submitted by the PIHP: • S9_E3_Grievance and Appeals procedure_page 2 • S9_E3_Guide to Services_page 15 • S9_E3_Screenshot_Filing mode	
PIHP Description of Process: The PIHP will accept grievances in written form or orally from the beneficiary.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
Handling of Grievances		
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

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Requirement	**Supporting Documentation**	**Score**
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 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 the acknowledgement time frame standard.		
5. The PIHP ensures that the individuals who make decisions on grievances are individuals: a. Who are not involved in any previous level of review or decision-making, nor a subordinate of any such individual. b. Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease: i. A grievance regarding denial of expedited resolution of an appeal.	**HSAG Required Evidence:** • Policies and procedures • Organizational chart of grievance staff members, including credentials • System screenshot of the field where the decision-maker (name and credentials) on grievances is documented • System screenshot of the field where the results of the review are documented • HSAG will also use the results of the Grievances File Review	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
ii. A grievance that involves clinical issues. c. Who take into account all comments, documents, records, and other information submitted by the member or their representative. 42 CFR §438.228 42 CFR §438.406(b)(2) 42 CFR §457.1260(d) Contract Schedule A—M(2)(f) Appeal And Grievance Resolution Processes Technical Requirement—VIII(C)(4)	**Evidence as Submitted by the PIHP:** • S9_E5_Document Results • S9_E5_Grievance and Appeals procedure_page6 • S9_E5_Org Chart • S9_E5_Screenshot_decision maker	
PIHP Description of Process: The PIHP ensures that individuals making decisions about grievances are not involved in previous level or review or decision making and ensuring that the reviewer has the appropriate expertise. The reviewer typically is the Grievance and Appeals Coordinator as they are removed from any decision making. Furthermore, all reviewers will take into consideration any documentation or information that the beneficiary would like reviewed.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** While the system screenshots confirmed that the PIHP's system had a dedicated field to document the name and credentials of involved staff, HSAG recommends that the PIHP ensure that its delegates have this same functionality. Additionally, since more than one involved staff may be part of the grievance review process and as individuals who make decisions on clinical grievances must have the appropriate clinical expertise, HSAG recommends that the PIHP enhance its system to include confirmation of who the decision-maker is. Of note, this was also a recommendation made by HSAG during the SFY 2022 compliance review. If the PIHP does not demonstrate adequate implementation of HSAG's recommendations during future compliance reviews, the PIHP may receive a *Not Met* score.		
Required Actions: None.		
Timely Resolution and Notification of Grievances		
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.	**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	☐ Met ☒ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
42 CFR §438.228 42 CFR §438.408(a) 42 CFR §438.408(b)(1) 42 CFR §457.1260(e)(12) Contract Schedule A—M(1)(e)(v) Appeal and Grievance Resolution Processes Technical Requirement—VIII(D)(1)	• 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	
	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

Standard IX—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
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.		
7. The PIHP may extend the time frame for resolving grievances by up to 14 calendar days if: a. The member requests the extension; or b. The PIHP shows (to the satisfaction of MDHHS upon its request) that there is need for additional information and how the delay is in the member's interest. 42 CFR §438.228 42 CFR §438.408(c)(1) 42 CFR §457.1260(e)(1) Contract Schedule A—M(1)(e)(ix) Appeal and Grievance Resolution Processes Technical Requirement—VIII(D)(2)	**HSAG Required Evidence:** • Policies and procedures • Tracking and reporting mechanisms • System screenshot of the field where the date and time of receipt of the grievance 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 case examples of a grievance with an extension applied, including the date of receipt of the grievance and the date the extension was applied • 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 **Evidence as Submitted by the PIHP:** • S9_E7_E8_Screenshot_Grievance Extension • S9_E7_Grievance and Appeals Policy_page 7_8 • S9_E7_Screenshot_Date Grievance Received • S9_E4_E6_E7_Grievance Tracking and Reporting	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
PIHP Description of Process: The PIHP may extend the grievance 14 days if it is in the best interest of the beneficiary or if the PIHP can prove to MDHHS that additional information is necessary.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. Of note, the PIHP reported it had no grievance resolution time frame extensions during the time period of review. **Recommendations:** The PIHP's system did not have a dedicated reportable field to track extensions and could only document an extension 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: None.		
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.		
9. *The notice of grievance resolution includes:* a. *The results of the grievance process.* b. *The date the grievance process was concluded.* 42 CFR §438.10(c)(1) Appeal and Grievance Resolution Processes Technical Requirement—VIII(D)(3)	**HSAG Required Evidence:** • Policies and procedures • Grievance extension template letter • HSAG will also use the results of the Grievances File Review **Evidence as Submitted by the PIHP:** • S9_E9_Grievance and Appeals Policy_page 8	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The PIHP ensure that the grievance resolution includes the results of the grievance process and the date that the grievance process concludes.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		

Standard IX—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Appeals General Requirements		
10. The PIHP defines an appeal as a review by the PIHP of ABD. 42 CFR §438.228 42 CFR §438.400(b) 42 CFR §457.1260(a)(2)(ii) Appeal and Grievance Resolution Processes Technical Requirement—II	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual **Evidence as Submitted by the PIHP:** • S9_E10_Grievance and Appeals Policy_page 2 • S9_E10_Member Handbook_review_page32 • S9_E10_NMRE-SUD-Provider-Manual_page 9	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The PIHP policy and procedure along with the guide to services, states that an appeal is a review by the PIHP of and ABD.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
11. The PIHP has only one level of appeal for members. 42 CFR §438.228 42 CFR §438.402(b) 42 CFR §457.1260(b)(1) Contract Schedule A—1(M)(e)(iii) Appeal and Grievance Resolution Processes Technical Requirement—VII(A)	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual **Evidence as Submitted by the PIHP:** • S9_E11_Grievance and Appeals Policy_page 5 (2) • S9_E11_Grievance and Appeals Policy_page 5 • S9_E11_Member Handbook_one level appeal_page 16_17	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The PIHP ensures there is only one level of appeal at the PIHP (local) level.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		

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Requirement	**Supporting Documentation**	**Score**
12. The PIHP establishes and maintains an expedited review process for appeals, when the PIHP determines (for a request from the member) or the provider indicates (in making the request on the member's behalf or supporting the member's request) that taking the time for a standard resolution could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function. a. The PIHP ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal. 42 CFR §438.228 42 CFR §438.410(a–b) 42 CFR §457.1260(f) Contract Schedule A—1(M)(8)(a) Contract Schedule A—1(M)(8)(b)(vi) Appeal and Grievance Resolution Processes Technical Requirement—VII(C)(2)	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual **Evidence as Submitted by the PIHP:** • S9_E12_Grievance and Appeals Policy_page 9 • S9_E12_Member Handbook_oexpeditedappeal_page 16 • S9_E12_NMRE-SUD-Provider-Manual_page 9	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: In the case of a request for an expedited appeal, the PIHP maintains an expedited review process for when it is determined that the timing of a standard appeal could seriously jeopardize the beneficiary's life, physical or mental health, or ability to attain, maintain, or regain maximum function. The PIHP also ensures that there is no punitive action against a provider who requests and supports a beneficiary's expedited appeal.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** HSAG recommends that the PIHP inform providers that punitive action will not be taken for supporting a member's appeal in provider-facing materials such as the provider manual and/or provider contract. If the PIHP does not demonstrate adequate implementation of HSAG's recommendations during future compliance reviews, the PIHP will automatically receive a *Not Met* score.		
Required Actions: None.		

Standard IX—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
13. Following receipt of a notification of an ABD by the PIHP, the member has 60 calendar days from the date on the ABD notice in which to file a request for an appeal to the PIHP. 42 CFR §438.228 42 CFR §438.402(c)(2)(ii) 42 CFR §457.1260(b)(1) Contract Schedule A—1(M)(2)(c) Contract Schedule A—1(M)(8)(b)(ii) Appeal and Grievance Resolution Processes Technical Requirement—VII(A)(1)	**HSAG Required Evidence:** • Policies and procedures • Tracking mechanisms • Member materials, such as the member handbook • ABD notice template • Provider materials, such as the provider manual • System screenshot of the field where the mailing date of the ABD is documented • System screenshot of the field where the date of receipt of the appeal is documented **Evidence as Submitted by the PIHP:** • S9_E13_E16_E21_E22_E23_E25_Appeal Tracking and Reporting • S9_E13_Grievance and Appeals Policy_page 6 • S9_E13_Member Handbook_page 16 • S9_E13_NMRE-SUD-Provider-Manual_page 32 • S9_E13_Screenshot Date of Receipt Appeal • S9_E13_Screenshot_ABD Mailing Date • S9_E13_Screenshot_ABD Mailing Date_Paper	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: In policy, procedure and guide to services, the PIHP outlines that a beneficiary has 60 calendar days from the date of an ABD notice to file an appeal.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		

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Requirement	**Supporting Documentation**	**Score**
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 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		

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Requirement	**Supporting Documentation**	**Score**
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.		
Handling of Appeals		
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.	**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	☐ Met ☒ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
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)	• 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	
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.		
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.		

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Requirement	**Supporting Documentation**	**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.		
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.		

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Requirement	**Supporting Documentation**	**Score**
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 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.		
17. The PIHP ensures that the individuals who made decisions on appeals are individuals: a. Who are not involved in any previous level of review or decision-making, nor a subordinate of any such individual. b. Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the MDHHS, in treating the member's condition or disease: i. An appeal of a denial that is based on lack of medical necessity. ii. An appeal that involves clinical issues. c. Who take into account all comments, documents, records, and other information submitted by the member or their representative without	**HSAG Required Evidence:** • Policies and procedures • Organizational chart of appeal staff members, including credentials • System screenshot of the field where the decision-maker (name and credentials) on appeals is documented • System screenshot of the field where the results of the review are documented • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the PIHP:** • S9_E17_Grievance and Appeals Procedure page 2	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
regard to whether such information was submitted or considered in the initial ABD. 42 CFR §438.228 42 CFR §438.406(b)(2) 42 CFR §457.1260(d) Contract Schedule A—1(M)(2)(f) Appeal and Grievance Resolution Processes Technical Requirement—VII(B)(4)	• S9_E17_OrganizationalChartWithCredentials • S9_E17_Screenshot_Credentials • S9_E17_Screenshot_Results of review	
PIHP Description of Process: The PIHP ensures that the appeal reviewer is not a person who was involved in any previous decision making or a subordinate of the decision making individual, the person has the appropriate clinical expertise and will take into account any and all documentation or information submitted by the beneficiary or representative that was not considered in the initial decision.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** While HSAG was able to identify the decision-maker on the appeal case files (e.g., narrative notes, appeal worksheet), HSAG recommends that the PIHP enhance its system to include a dedicated field to document the decision-maker's name and credentials. Of note, this was also a recommendation made by HSAG during the SFY 2022 compliance review activity. If the PIHP does not demonstrate adequate implementation of HSAG's recommendations during future compliance reviews, the PIHP may receive a *Not Met* score.		
Required Actions: None.		
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) Appeal and Grievance Resolution Processes Technical Requirement—VII(A)(2)	**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 • S9_E18_Guide to Services_page 15	☐ Met ☒ Not Met ☐ NA
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		

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Requirement	**Supporting Documentation**	**Score**
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.		
19. The PIHP provides the member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. a. The PIHP informs the member of the limited time available for this sufficiently in advance of the resolution time frame for appeals as specified in 42 CFR §438.408(b) and (c) in the case of expedited resolution. 42 CFR §438.228 42 CFR §438.406(b)(4) 42 CFR §438.408(b-c) 42 CFR §457.1260(d) Contract Schedule A—1(M)(2)(h) Appeal and Grievance Resolution Processes Technical Requirement—VII(B)(5)	**HSAG Required Evidence:** • Policies and procedures • Member communications, such as ABD notice template, member acknowledgment template, and/or call script • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the PIHP:** • S9_E19_ Grievance and Appeals Procedure_page 2 • S9_E19_ABD_Evidence Review_page 2	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The PIHP will provide the beneficiary with a reasonable opportunity, either in writing or in person, to present evidence and testimony that supports legal and factual arguments. The PIHP must inform the beneficiary of the limited time available, in advance of the resolution time frame for both standard and expedited appeals.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** MDHHS' ABD model notice that was applicable during the time period of review for the case files notified members of their right to be provided additional information to support their appeal but did not inform members of the limited time to do so. However, MDHHS' model ABD notice		

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effective October 1, 2024, was updated and included a statement informing members of the limited time to provide information for expedited appeals. HSAG has recommended that MDHHS update this template to include a statement informing the member that information may be presented in person or in writing. HSAG recommends that the PIHP implement any future guidance or policy changes issued 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: None.		
20. The PIHP provides the member and his or her representative the member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the PIHP (or at the direction of the PIHP) in connection with the appeal of the ABD. a. This information is provided free of charge and sufficiently in advance of the resolution time frame for appeals as specified in 42 CFR §438.408(b) and (c). 42 CFR §438.228 42 CFR §438.406(b)(5) 42 CFR §438.408(b-c) 42 CFR §457.1260(d) Contract Schedule A—1(M)(2)(i) Appeal and Grievance Resolution Processes Technical Requirement—VII(B)(6)	**HSAG Required Evidence:** • Policies and procedures • Member communications, such as ABD notice template, member acknowledgment template, and/or call script • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the PIHP:** • S9_E20_ABD_Access Records_page 3 • S9_E20_E20a_Grievance and Appeals Procedure page 2	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The PIHP will provide the beneficiary or their representative, the beneficiary's case file, including medical records, documents, other records and any new or additional evidence considered, relied upon or generated by the PIHP in connection with the appeal, and this information is provided free of charge and sufficiently in advance of the resolution time frame.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		

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Requirement	**Supporting Documentation**	**Score**
Resolution and Notification of Appeals		
21. The PIHP resolves standard appeals and sends notice to the affected parties as expeditiously as the member's health condition requires, but *no later than 30 calendar days from the day the PIHP receives the appeal.* 42 CFR §438.228 42 CFR §438.408(a) 42 CFR §438.408(b)(2) 42 CFR §457.1260(e)(1–2) Contract Schedule A—1(M)(1)(e)(iv) Appeal and Grievance Resolution Processes Technical Requirement—VII(C)(1)	**HSAG Required Evidence:** • Policies and procedures • Tracking and reporting mechanisms • System screenshot of the field where the type of appeal request is documented (i.e., standard appeal) • System screenshot of the field where the date of receipt of the appeal is documented • System screenshot of the field where the date of the mailing of the resolution notice is documented • 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_E13_E16_E21_E22_E23_E25_Appeal Tracking and Reporting • S9_E21_Grievance and Appeals Procedure_page 3 • S9_E21_Screenshot_Appeal Type_Date of Receipt • S9_E21_Screenshot_Date of Mailing	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The PIHP resolves standard appeals and sends notices accordingly, as expeditiously as the beneficiary's health condition requires, which is no later than 30 calendar days from the receipt of the appeal.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** The universe file identified one appeal that was not resolved timely. It was not resolved until day 44 and the case was not reported with an extension on the universe. However, the PIHP submitted this appeal as an example of an appeal extension under Elements 23 and 24. Therefore, the case appeared to be untimely when it was not. HSAG recommends that the PIHP enhance mechanisms to ensure accurate data are being reported. If the PIHP does not demonstrate adequate implementation of HSAG's recommendations during future compliance reviews, the PIHP may receive a *Not Met* score.		
Required Actions: None.		

Standard IX—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
22. The PIHP resolves expedited appeals and sends notice to the affected parties no later than 72 hours after the PIHP receives the expedited appeal. 42 CFR §438.228 42 CFR §438.408(b)(3) 42 CFR §457.1260(e)(1) Contract Schedule A—1(M)(8)(b)(iii) Appeal and Grievance Resolution Processes Technical Requirement—VII(C)(2)(d)	**HSAG Required Evidence:** • Policies and procedures • Tracking and reporting mechanisms • System screenshot of the field where the type of appeal request is documented (i.e., expedited appeal) • System screenshot of the field where the date and time of receipt of the appeal is documented • System screenshot of the field where the date and time of the mailing of the resolution notice is documented • 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_E13_E16_E21_E22_E23_E25_Appeal Tracking and Reporting • S9_E22_Grievance and Appeals Procedure_page 3 • S9_E22_Screenshot Resolution Mailed Date • S9_E22_Screenshot_Appeal type • S9_E22_Screenshot_Date of Appeal	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The PIHP resolves expedited appeals and sends the notice to parties no later than 72 hours after the receipt of the expedited appeal.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. Of note, the PIHP reported no expedited appeals during the time period of review.		
Required Actions: None.		

Standard IX—Grievance and Appeal Systems		
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

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Requirement	**Supporting Documentation**	**Score**
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.		
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.		
24. If the PIHP extends the standard or expedited appeal resolution time frames 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. c. Resolves the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires. 42 CFR §438.228 42 CFR §438.408(c)(2) 42 CFR §457.1260(e)(1–2) Contract Schedule A—1(M)(1)(e)(vi) Appeal and Grievance Resolution Processes Technical Requirement—VII(C)(3)(a)	**HSAG Required Evidence:** • Policies and procedures • Three examples of appeals with extended time frame • Appeal 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 an appeal with an extension applied, including the oral and written notice of the extension • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the PIHP:** • 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.	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
	• S9_E23_E24_NOR - Appeal Ext. • S9_E24_Extension Letter Example 1 • S9_E24_Screenshot_Extension Information • S9_E24abc_ Grievance and Appeals Procedure page_3	
PIHP Description of Process: When the PIHP applies an appeal extension that is not at the request of the beneficiary, the PIHP makes a reasonable effort to give the member prompt oral notice, and follows up within two calendar days in writing, but also resolves the appeal as expeditiously as the beneficiary's health condition requires.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** The extension letter included double punctuation, missing punctuation, and acronyms not spelled out with first use. As such, HSAG recommends that the PIHP enhance its process to ensure extension notices are free from errors and written in plain language. If the PIHP does not demonstrate adequate implementation of HSAG's recommendations during future compliance reviews, the PIHP may receive a *Not Met* score.		
Required Actions: None.		
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) 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 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 • 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	☐ Met ☒ Not Met ☐ NA

Standard IX—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
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.		
26. For all appeals, the PIHP provides written notice of the appeal resolution that includes: a. The results of the resolution process and the date it was completed. b. For appeals not resolved wholly in favor of the member: i. The right to request a SFH, and how to do so. ii. The right to request and receive benefits while the hearing is pending, and how to make the request. iii. That the member may, consistent with MDHHS policy, be held liable for the cost of those benefits if the hearing decision upholds the PIHP's ABD related to the appeal. 42 CFR §438.228 42 CFR §438.408(d)(2)(i) 42 CFR §438.408(e)(1–2) 42 CFR §457.1260(e)(1) 42 CFR §457.1260(e)(4) Contract Schedule A—1(M)(2)(k) Contract Schedule A—1(M)(8)(b)(iv) Appeal and Grievance Resolution Processes Technical Requirement—VII(C)(5)	**HSAG Required Evidence:** • Policies and procedures • Appeal resolution notice template • System screenshot of the field where the appeal resolution notice is maintained • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the PIHP:** • S9_E26_Appeal Resolution Notice – Approval • S9_E26_Appeal Resolution Notice – Denial • S9_E26_Appeal Resolution Notice Template • S9_E26_Screenshot_Appeal Notice • S9_E26ab_Grievance and Appeals Procedure_page 4	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
PIHP Description of Process: The PIHP ensures that the written notice of appeal resolution includes the resolution process and date of completion, the right for the beneficiary to request a SFH and explains to the beneficiary how to file the SFH, the right to continue to receive services during the SFH process, and also inform the beneficiary that MDHHS policy states the beneficiary may be held liable for the cost of benefits that continue during the SFH process if the SFH upholds the original ABD related to the local appeal.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. Of note, MDHHS' appeal resolution denial model notice that was applicable during the time period of review for the case files did not include a statement that the member may be liable for the cost of continued benefits if the decision upholds the PIHP's ABD related to the appeal. Therefore, the requirements of sub-element (b)(iii) were considered NA for this review. MDHHS' model notice effective October 1, 2024, was updated to include this provision and remediates this finding.		
Required Actions: None.		
27. For notice of an expedited appeal resolution, the PIHP makes reasonable efforts to provide oral notice. 42 CFR §438.228 42 CFR §438.408(d)(2)(ii) 42 CFR §457.1260(e)(1) Contract Schedule A—1(M)(8)(b)(iv)(1) Appeal and Grievance Resolution Processes Technical Requirement—VII(C)(4)	**HSAG Required Evidence:** • Policies and procedures • System screenshot of field where oral notice of an expedited appeal resolution is documented • Three case examples of an expedited appeal, including the oral notice of the appeal resolution • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the PIHP:** • S9_E27_Grievance and Appeals Procedure_page 4 • S9_E27_Screenshot _Expedited Appeal Resolution	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The PIHP will make reasonable efforts to provide oral notice of an expedited appeal resolution.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. Of note, the PIHP reported no expedited appeals during the time period of review.		
Required Actions: None.		

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Requirement	**Supporting Documentation**	**Score**
State Fair Hearings and State External Review		
28. The member may request a SFH only after receiving notice that the PIHP is upholding the ABD related to the appeal. a. With the written consent of the member, a provider or an authorized representative may request a SFH on behalf of the member. 42 CFR §438.228 42 CFR §438.402(c)(1)(ii) 42 CFR §438.408(f)(1)(i) 42 CFR §457.1260(e)(5) Contract Schedule A—1(M)(8)(b)(iv) Appeal and Grievance Resolution Processes Technical Requirement—III Appeal and Grievance Resolution Processes Technical Requirement—IX(A)(1)	**HSAG Required Evidence:** • Policies and procedures • Appeal resolution notice template • Member materials, such as the member handbook and/or ABD notice • System screenshot of field indicating that a SFH was requested and documentation of the PIHP's participation **Evidence as Submitted by the PIHP:** • S9_E28_Appeal Resolution Notice – Denial • S9_E28_Appeal Resolution Notice Template • S9_E28_E29_Guide to Services_page 17 • S9_E28_Grievance and Appeals Procedure_page 4 • S9_E28_Screenshot_FH Documentation • S9_E28a_Grievance and Appeals Procedure_page 1	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The PIHP ensures beneficiary may request a SFH only after receiving a notice that the PIHP is upholding the ABD. The PIHP also informs the beneficiary that with written consent, someone other than the beneficiary may request a SFH on their behalf.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
29. The member has no more than 120 calendar days from the date of the PIHP's notice of appeal resolution to request a SFH. 42 CFR §438.228 42 CFR §438.408(f)(2) 42 CFR §457.1260(e)(5)	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook and/or ABD notice • Appeal resolution notice template • HSAG will also use the results of the Appeal File Review	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
Contract Schedule A—1(M)(7)(d) Appeal and Grievance Resolution Processes Technical Requirement—IX(D)	**Evidence as Submitted by the PIHP:** • S9_E28_E29_Guide to Services_page 17 • S9_E29 Grievance and Appeals Procedure_page 4 • S9_E29_Appeal Resolution Notice Template	
PIHP Description of Process: The PIHP ensures that the beneficiary has no more than 120 calendar days from the date of the appeal resolution to request a SFH.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
Continuation of Benefits		
30. The PIHP continues the member's benefits if all of the following occur: a. The member files the request for an appeal timely (within 60 calendar days from the date on the ABD notice). b. The appeal involves the termination, suspension, or reduction of previously authorized services. c. The services were ordered by an authorized provider. d. The period covered by the original authorization has not expired. e. The member timely files for continuation of benefits. *Timely files* means on or before the later of the following: within 10 calendar days of the PIHP sending the notice of ABD, or the intended effective date of the PIHP's proposed ABD. 42 CFR §438.228 42 CFR §438.420(a–b) Contract Schedule A—1(M)(5)(h) Appeal and Grievance Resolution Processes Technical Requirement—VI(A)	**HSAG Required Evidence:** • Policies and procedures • ABD notice template • Appeal resolution notice template • System screenshot of the field where documentation of continuation of benefits is applied • Three case examples of an appeal in which benefits were continued • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the PIHP:** • S9_E30_ABD_60 days_page 1 • S9_E30_ABD_Continuation of Services_page 1 • S9_E30_Grievance and Appeals Procedure_page 1 • S9_E30_Screenshot Continuation of benefits	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
PIHP Description of Process: The PIHP continues the services that were terminated, suspended or reduced as long as the member files timely for a continuation of benefits, the services were ordered by an authorized provider, the original authorization has not expired, during the appeal process		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** While the PIHP's system had a dedicated field to document whether benefits were continued (i.e., Yes, No, or NA) and the service(s) in question, HSAG recommends that the PIHP ensure that evidence of continued benefits is documented for each appeal, as applicable (e.g., active authorization during the appeal). If the PIHP does not demonstrate adequate implementation of HSAG's recommendations during future compliance reviews, the PIHP may receive a *Not Met* score.		
Required Actions: None.		
31. If, at the member's request, the PIHP continues or reinstates the member's benefits while the appeal or SFH is pending, the benefits must be continued until one of the following occurs: a. The member withdraws the appeal or request for SFH. b. The member fails to request a SFH and continuation of benefits within 10 calendar days after the PIHP sends the notice of an adverse resolution to the member's appeal. c. A SFH office issues a hearing decision adverse to the member. d. *The authorization expires or authorization service limits are met.* 42 CFR §438.228 42 CFR §438.420(c) Contract Schedule A—1(M)(5)(i) Appeal and Grievance Resolution Processes Technical Requirement—VI(B)	**HSAG Required Evidence:** • Policies and procedures • ABD notice template • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the PIHP:** • S9_E31_ABD_Continuation of Services SFH_page 3 • S9_E31_Grievance and Appeals Procedure page 5	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: When the PIHP continues or reinstates beneficiary's services while the appeal or SFH is pending, the PIHP ensures that the benefits be continued until the member withdraws the appeal, the member fails to request a SFH continuation of benefits with 10 calendar days of the local appeal, the SFH office issues a decision, or the authorization expires or the limits are met.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		

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Requirement	**Supporting Documentation**	**Score**
Recommendations: HSAG recommends that the PIHP update its policy to include requirements of sub-element (d). Of note, this was also a recommendation made by HSAG during the 2022 compliance review activity. If the PIHP does not demonstrate adequate implementation of HSAG's recommendations during future compliance reviews, the PIHP may receive a *Not Met* score.		
Required Actions: None.		
32. If the final resolution of the appeal or SFH is adverse to the member, that is, upholds the PIHP's ABD, the PIHP may, consistent with the state's usual policy on recoveries under 42 CFR §431.230(b) and as specified in the PIHP's contract, recover the cost of services furnished to the member while the appeal and SFH was pending, to the extent that they were furnished solely because of the requirements under 42 CFR §438.420. 42 CFR §438.228 42 CFR §438.420(d) Contract Schedule A—1(M)(6)(d) Appeal and Grievance Resolution Processes Technical Requirement—VI(C)	**HSAG Required Evidence:** • Policies and procedures • ABD notice template • Appeal resolution notice template • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the PIHP:** • S9_E32_ABD Notice Example • S9_E32_Appeal Resolution Notice Template • S9_E32_Grievance and Appeals Procedure_page 7	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The PIHP may recover the cost of services provided to the beneficiary while the appeal/SFH was pending, if the appeal/SFH upholds the original ABD decision, but only if the services were furnished because of certain requirements.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
33. If the PIHP or the SFH officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the PIHP must pay for those services, in accordance with State policy and regulations. 42 CFR §438.228 42 CFR §438.424(b) Contract Schedule A—1(M)(5)(k) Appeal and Grievance Resolution Processes Technical Requirement—VI(E)	**HSAG Required Evidence:** • Policies and procedures • Three case examples of an overturned appeal/SFH in which services were continued, including evidence that the continued services were paid for **Evidence as Submitted by the PIHP:** • S9_E33_Grievance and Appeals Procedure_page 7 • S9_E33_Proof of Payment Sample 1	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
PIHP Description of Process: The PIHP will pay for services that the membered received while the appeal/SFH are disputed, if the decision is to deny an authorization of services.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
Reinstatement of Services		
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		

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Requirement	**Supporting Documentation**	**Score**
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.		
Grievances, Appeals, and State Fair Hearings		
35. In handling grievances and appeals, the PIHP gives members any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate Teletypewriter and Telecommunications Device for the Deaf (TTY/TDD) and interpreter capability. 42 CFR §438.228 42 CFR §438.406(a) 42 CFR §457.1260(d) Contract Schedule A—1(M)(2)(d) Appeal and Grievance Resolution Processes Technical Requirement—VII(B)(1) Appeal and Grievance Resolution Processes Technical Requirement—VIII(C)(1)	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook **Evidence as Submitted by the PIHP:** • S9_E35_Grievance and Appeals Procedure_page 2 • S9_E35_Guide to SVCS_page 15_16	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The PIHP assists beneficiary's with explaining the grievance and appeal process, filling out the forms needed, and general assistance as needed.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		

Standard IX—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
36. The PIHP provides written notice of the grievance and appeal resolution in a format and language that, at a minimum, meets the requirements in accordance with 42 CFR §438.10. 42 CFR §438.10 42 CFR §438.228 42 CFR §438.408(d)(1) 42 CFR §438.408(d)(2)(i) 42 CFR §457.1260(e)(1)	**HSAG Required Evidence:** • Policies and procedures • Mechanisms to assess reading grade level of member notices • Grievance and appeal resolution templates, including taglines • HSAG will also use the results of the Grievance and Appeal File Reviews **Evidence as Submitted by the PIHP:** • S9_E36 Grievance and Appeals Procedure page 3 • S9_E36_NMRE-SUD-Provider-Manual_page 30_33 • S9_E36_Screenshot Accessibility • S9_E36_Screenshot Readability • S9_E36_Screenshot_Reading Grade Level	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The PIHP provides the written notice of the grievance and appeal resolution at a 6.9 grade reading level, as much as possible.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** Not all grievance and appeal resolution notices were written at or below the 6.9 reading grade level. HSAG recommends that the PIHP require that each grievance and appeal resolution notice be assessed for reading grade level prior to mailing. The reading grade level must be written at or below the 6.9 reading grade level. The reading grade level of the notice and efforts to reduce the reading grade level, when applicable, should be documented within the member's record. If notices are consistently written at or below 6.9, the PIHP could then determine whether the reading grade level should continue to be assessed for each notice, or whether the reading grade level could be evaluated during the PIHP's routine monitoring of grievance and appeal resolution notices. Of note, HSAG also made a similar recommendation during the 2022 compliance review. Additionally, HSAG recommends that the PIHP continue quality assurance (QA) processes to ensure that all member written communications (i.e., grievance and appeal acknowledgement and resolution notices) are professional, grammatically correct, free of errors, have abbreviations spelled out with first use, and are written to 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: None.		

Standard IX—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
37. The PIHP provides information specified in 42 CFR §438.10(g)(2)(xi) about the grievance and appeal system to all providers and subcontractors at the time they enter into a contract. 42 CFR §438.10(g)(2)(xi) 42 CFR §438.228 42 CFR §438.414 42 CFR §457.1260(g)	**HSAG Required Evidence:** • Policies and procedures • Provider manual • Provider contract • Subcontractor/delegation agreement template **Evidence as Submitted by the PIHP:** • S9_E37_Grievance and Appeals Procedure page 2 • S9_E37_NMRE.CWN_AGREEMENT_FY24 page 55-56 • S9_E37_Provider Manual, Contract and Agreement page 59	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The PIHP ensures that providers receive information on appeals and grievances at the time of contract.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** The *Provider Manual, Contract and Agreement* and SUD provider contract did not include all information under 42 CFR §438.10(g)(2)(xi). After the site review, the PIHP provided an annual training presentation of grievances and appeals; therefore, the PIHP received a *Met* score for this element. However, HSAG recommends that the PIHP include a standard contract provision in all provider contracts and written delegation arrangements that contains a reference to the PIHP's grievance and appeal policies and where to locate it, a reference to the MDHHS' grievance and appeal technical requirements with a link of where to locate it, and/or the grievance and appeal federal rule under 42 CFR 438 Subpart F. Of note, HSAG also made a similar recommendation during the SFY 2022 compliance review. If the PIHP does not demonstrate adequate implementation of HSAG's recommendations during future compliance reviews, the PIHP may receive a *Not Met* score.		
Required Actions: None.		
38. The PIHP includes as parties to the appeal and SFH: a. The member and his or her representative. b. The legal representative of a deceased member's estate. c. For SFH, the PIHP. 42 CFR §438.228 42 CFR §438.406(b)(6) 42 CFR §438.408(f)(3)	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook and/or notice templates **Evidence as Submitted by the PIHP:** • S9_E38_MOAHR Notice of Appeals	☒ Met ☐ Not Met ☐ NA

Standard IX—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
42 CFR §457.1260(e)(5) Contract Schedule A—1(M)(2)(j) Contract Schedule A—1(M)(7)(b) Appeal And Grievance Resolution Processes Technical Requirement—VII(B)(7) Appeal And Grievance Resolution Processes Technical Requirement—IX(G)		
PIHP Description of Process: The PIHP ensures that the beneficiary, beneficiary representative, the legal representative of a deceased member's estate in the appeal and SFH process.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** While the PIHP's policy included parties to an appeal, it did not include reference to parties to a SFH. As such, HSAG recommends that the PIHP update policy accordingly. Of note, HSAG also made this recommendation during the SFY 2022 compliance review. If the PIHP does not demonstrate adequate implementation of HSAG's recommendations during future compliance reviews, the PIHP may receive a *Not Met* score.		
Required Actions: None.		
Recordkeeping Requirements		
39. Grievance and appeal records are accurately maintained in a manner accessible to MDHHS and available upon request to CMS, and contain, at a minimum, all of the following information: a. A general description of the reason for the appeal or grievance. b. The date received. c. The date of each review or, if applicable, review meeting. d. Resolution at each level of the appeal or grievance, if applicable. e. Date of resolution at each level, if applicable. f. Name of the member for whom the appeal or grievance was filed. 42 CFR §438.228 42 CFR § 438.416(b–c) 42 CFR §457.1260(h) Contract Schedule A—1(M)(9)(a–b) Appeal And Grievance Resolution Processes Technical Requirement—IV	**HSAG Required Evidence:** • Policies and procedures • HSAG will also use the results of the Appeals and Grievances File Reviews and the system demonstration **Evidence as Submitted by the PIHP:** • S9_E39_Grievance and Appeals Procedure_Page 5	☒ Met ☐ Not Met ☐ NA

Standard IX—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
PIHP Description of Process: Grievance and appeals records are accurately maintained and accessible to MDHHS upon request to CMS, and include general description of the grievance or appeal, the date received, the date of each review, resolution at each level of the appeal, date of resolution at each level, name of the beneficiary who the appeal or grievance regards.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		

Standard IX—Grievance and Appeal Systems						
Met	=	28	X	1	=	28
Not Met	=	11	X	0	=	0
Not Applicable	=	0				
Total Applicable	=	39	Total Score		=	28
Total Score ÷ Total Applicable					=	72%

Standard X—Subcontractual Relationships and Delegation

Standard X—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
General Rule		
1. Notwithstanding any relationship(s) that the PIHP may have with any delegate (i.e., subcontractor), PIHP maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with MDHHS. 42 CFR §438.230(b)(1) 42 CFR §457.1233(b) Contract Schedule A—2(2.7)(E)	**HSAG Required Evidence:** • Policies and procedures **Evidence as Submitted by the PIHP:** • NMRE.CWN_AGREEMENT_FY24: Page 6, IV. A; Page 67, XXVIII. A • DELEGATION POLICY: Page 1, "Policy"	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The NMRE, in its contract with the MDHHS agrees and understands that it is responsible for all terms of the contract with regard to Contractor responsibility. This includes the managed care functions contractually obligated to our 5 Regional CMHSPs. These obligations are identified within the exhibits of our CMH/PIHP contracts; the NMRE monitors the CMHs on these functions and assigns corrective actions as necessary. Exhibit D lists the activities, reporting, monitoring, and corrective actions associated with these activities. The purpose of these reviews, their recommendations, and corrective actions is to assure compliance with the NMRE contractually obligated, delegated managed care activities as in the PIHP MDHHS contract.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** The PIHP submitted its *Delegation Policy*; however, the policy included a watermark indicating that the policy was obsolete. HSAG recommends that the PIHP develop a policy or procedural document that describes its delegation oversight process. Additionally, through the site review discussions, it appeared that there were managed care functions delegated to SUD providers (e.g., grievances). However, SUD providers were not documented on the PIHP's list of delegated entities. Therefore, HSAG recommends that the PIHP evaluate the managed care functions being delegated to its contracted SUD providers, add all SUD providers performing managed care obligations to its delegated entities list, and ensure that all delegation oversight requirements and monitoring expectations are occurring with its contracted SUD providers as required (e.g., formal audits). If the PIHP does not demonstrate adequate implementation of HSAG's recommendations during future compliance reviews, the PIHP may receive a *Not Met* score.		
Required Actions: None.		

Standard X—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
Contract or Written Arrangement		
2. Each contract or written arrangement with a delegate must specify: a. The delegated activities or obligations, and related reporting responsibilities, are specified in the contract or written agreement. b. The delegate agrees to perform the delegated activities and reporting responsibilities specified in compliance with the PIHPs contract obligations. c. The contract or written arrangement must either provide for revocation of the delegation of activities or obligations or specify other remedies in instances where MDHHS or the PIHP determine that the delegate has not performed satisfactorily. 42 CFR §438.230(c)(1) 42 CFR §438.230(b)(2) 42 CFR §457.1233(b) Contract Schedule A—2(2.7)(G)	**HSAG Required Evidence:** • Delegation agreement/contract template • HSAG will also use the results from the Delegation File Review **Evidence as Submitted by the PIHP:** • NMRE.CWN_AGREEMENT_FY24: Page 73, Exhibit D, Section A page 74, Section B page 77, Section C page 76, Section D page 77, Section E page 80 (each section contains reporting criteria, reporting requirements, and sanctions or corrective action)	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The managed care functions contractually delegated to our 5 participating CMHSPs are listed specifically in Exhibit D of all such contracts. The exhibit is written loosely in an outline format; we describe the activity delegated, performance and reporting criteria, specific reports, monitoring processes, and corrective actions or sanctions for unsatisfactory performance.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		

Standard X—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
3. The contract or written arrangement indicates that the delegate agrees to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions. 42 CFR §438.230(c)(2) 42 CFR §457.1233(b) Contract Schedule A—2(2.7)(C)	**HSAG Required Evidence:** • Delegation agreement/contract template • HSAG will also use the results from the Delegation File Review **Evidence as Submitted by the PIHP:** • NMRE.CWN_AGREEMENT_FY24: Page 10, IX, A and B.7.o; Page 17, I; Page 21, Q. Behavioral Health Home Services, 5th paragraph; Page 22, X.C, Page 28, XIII., A and B; Page 34, H, 2nd paragraph; Page 37, P.' **Page 45, A.1, Page 50, 14.**, Page 52, 18; Page 53, number 24; **Page 54, 27**.;	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: NMRE's CMHSP/PIHP contract has multiple sections that reference Medicaid laws and regulations. Page 45's "Section XIX. Compliance in General", Section A. Law of the contract contains many references to applicable Medicaid law. Our evidence indicates the most notable portions of this section are part 1. Title XIX of the Social Security Act, 18. Special Waiver Provisions for Michigan Specialty Supports and Services Programs, 24. Approved Medicaid Waivers (sections 1915(c)/(i) and 1115 Demonstration Waivers, 27. The Michigan Medicaid Manual		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
4. The contract or written arrangement indicates, and the delegate agrees that: a. MDHHS, the Centers for Medicare & Medicaid Services (CMS), the Health and Human Services (HHS) Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the delegate, or of the delegate's subcontractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the PIHPs contract with the MDHHS.	**HSAG Required Evidence:** • Delegation agreement/contract template • HSAG will also use the results from the Delegation File Review **Evidence as Submitted by the PIHP:** • NMRE.CWN_AGREEMENT_FY24: Page 43, XVIII. A and B	☒ Met ☐ Not Met ☐ NA

Standard X—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
b. The delegate will make available, for purposes of an audit, evaluation, or inspection, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid members. c. The delegate agrees that the right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. d. If MDHHS, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the MDHHS, CMS, or the HHS Inspector General may inspect, evaluate, and audit the delegate at any time. 42 CFR §438.230(c)(3) 42 CFR §457.1233(b) Contract Schedule A—2(2.7)(O)		
PIHP Description of Process: The CMHSP/NMRE contract template ensures this requirement passes from the NMRE to our partner CMHSPs and their subcontractor; the primary vehicle for this language is XVIII. A and B.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** The *Record Access/Investigation/Onsight Review* section of the delegation agreements included language indicating that "the State of Michigan, the Centers for Medicare and Medicaid Services (CMS), the Office of the Inspector General (OIG), the Comptroller General, or designated representatives, at any time, shall be allowed to inspect, review, copy, and/or audit any records or documents of the Provider or its Subcontractors, and may, at any time, inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted." Because the language indicates "at any time," the element was scored as *Met*. However, HSAG recommends that the PIHP update its delegation agreement templates and specifically include the language under sub-element (d) pertaining to the right to audit when there is a reasonable possibility of fraud or similar risk. If the PIHP does not demonstrate adequate implementation of HSAG's recommendation during future compliance reviews, the PIHP may receive a *Not Met* score.		
Required Actions: None.		

Standard X—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
Monitoring and Auditing		
5. *The PIHP audits and monitors the delegates' performance, data, and data submission, including evaluation of prospective delegates' abilities prior to contracting with the subcontractor to perform services, collection of performance and financial data to monitor performance on an ongoing basis and conducting formal, periodic, and random reviews.* 42 CFR §438.230 42 CFR §457.1233(b) Contract Schedule A—2(2.7)(H)	**HSAG Required Evidence:** • Delegation agreement/contract template • HSAG will also use the results from the Delegation File Review **Evidence as Submitted by the PIHP:** NMRE.CWN_AGREEMENT_FY24: Page 15, F.g; Page 44, E 1-4; Page 51, XIX A.15; Page 72, Exhibit D, A. 4, Page 75, Exhibit D, B.3; Page 77, Exhibit D, C.4; Page 80 Exhibit D, D.4; Page 82, Exhibit D, E.4	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The NMRE conducts audits onsite of our partner CMHSPs to ensure performance of these managed care functions is compliant; we use both onsite and remote methodologies in practice. The contract language for this review is in the Site Review section of the agreement, in XVIII. Record Access/Investigation/onsite review in E. Site Reviews. In Exhibit D of the agreement, we further describe the monitoring, reporting, and corrective action for each of the contracted functions.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
6. *If the PIHP identifies deficiencies or areas for improvement, the PIHP and the delegate must take corrective action, including when appropriate, revoking delegation or imposing other sanctions if the delegate's performance is inadequate.* a. *If the PIHP determines revocation of a delegation to a delegated entity is appropriate, the PIHP provides notice of such action to MDHHS 10 business days in advance of issuing such notice to the delegate.* 42 CFR §438.230 42 CFR §457.1233(b) Contract Schedule A—2(2.7)(G)(1–2)	**HSAG Required Evidence:** • Delegation agreement/contract template • HSAG will also use the results from the Delegation File Review **Evidence as Submitted by the PIHP:** • NMRE.CWN_AGREEMENT_FY24: Page 74, Exhibit D, A. 5; Page 75, Exhibit D, B.4; Page 77, Exhibit D, C.5, Page 80, Exhibit D, D.5; Page 83, Exhibit D, E.5 • Delegated_Managed_Care_Monitoring_CWN F2023 FINAL • Program_Specific_Monitoring_CWN FY2023 FINAL • NMRE Site Review Corrective Action Plan CWN FY2023 • Centra Wellness FY 2023 NMRE Site Review Summary	☒ Met ☐ Not Met ☐ NA

Standard X—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
	• FY 2023 CWN Results Summary Final • Approved Site Review Corrective Action Plan CWN FY2024	
PIHP Description of Process: The NMRE, in its contract with its CMHSPs, in Exhibit D (contractually obligated managed care activities) states that the NMRE has the right to review and extend corrective action to the CMH for any unsatisfactory performance. The NMRE audits the delegated functions of our partner CMHSPs and reviews corrective actions from the prior year's review. These reviews include record reviews for the CMHSP array of services, credentialing/recredentialing, program specific functions, and Delegated Managed Care functions. For the Delegated Managed Care function review, the NMRE reviews policies, looks for evidence of the practice of the functions. Where corrective action is necessary, the review response notes this, along with the specifics of the unsatisfactory performance. For this element we have included a copy of the review tool from FY2023 for delegated and program specific activities for Centra Wellness Network, the corrective action plan document from that year, and site review summary from FY2023. We have also included the CMH's approved Corrective Action Plan for review during FY2024 (which is still in final stages for FY2024). This details the problems found in FY2023, the provider's planned Corrections, and the approval form the NMRE prior to the review of those actions in FY2024.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** The PIHP confirmed that it had not revoked delegation for poor performance during the time period under review, but indicated that the PIHP's Chief Executive Officer would provide this notification to MDHHS if necessary. Therefore, the PIHP received a *Met* score for this element. However, as the reporting requirement was not documented within a policy or procedural document, HSAG strongly recommends that the PIHP include the 10-day advance notice to MDHHS reporting requirement in a policy and/or procedural document to ensure staff members are aware that MDHHS must be notified 10 business days in advance of issuing a notice of revocation to its delegate(s). If the PIHP does not demonstrate adequate implementation of HSAG's recommendation during future compliance reviews, the PIHP may receive a *Not Met* score.		
Required Actions: None.		

Standard X—Subcontractual Relationships and Delegation						
Met	=	6	X	1	=	6
Not Met	=	0	X	0	=	0
Not Applicable	=	0				
Total Applicable	=	6	**Total Score**		=	6
Total Score ÷ Total Applicable					=	100%

Standard XI—Practice Guidelines

Standard XI—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
Adoption of Practice Guidelines		
1. The PIHP adopts practice guidelines that are based on valid and reliable clinical evidence or a consensus of providers in the particular field. a. *The Quality Assessment and Performance Improvement Program (QAPIP) describes the process for the adoption, development, implementation, and continuous monitoring and evaluation of practice guidelines when there are nationally accepted or mutually agreed-upon (by MDHHS and the PIHPs) clinical standards, evidence-based practices, practice-based evidence, and promising practices that are relevant to the individuals served.* 42 CFR §438.236(b)(1) 42 CFR §457.1233(c) QAPIPs for Specialty PIHPs—XI Contract Schedule A—1(L)(2)	**HSAG Required Evidence:** • Policies and procedures • QAPIP description • List of adopted practice guidelines • PIHP-specific meeting minutes documenting committee review and approval **Evidence as Submitted by the PIHP:** • SXI_E1_E2_E4_PG • SXI_E1_E2_E4_QOC Adoption_page 4 • SXI_E1_E2_requestqoc • SXI_E1_E3_Practice Guidelines • SXI_E1_FY24QAPIP_page_5 • SXI_E1_FY24QAPIPEval_page11 • SXI_E1_ongoing • SXI_E1_UM Program	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The NMRE has adopted practice guidelines that are based on valid and reliable clinical evidence or a consensus of providers of mental health, intellectual/developmental disabilities, and/or substance use disorder services. The NMRE and its CMHSPs have adopted practice guidelines from the American Psychiatric Association (APA), other practice guidelines reviewed and made available by the APA (e.g., VA/DoD, ASAM, American Academy of Child and Adolescent Psychiatry - AACAP), and MDHHS practice guidelines, and region-specific practice guidelines. Adopted practice guidelines consider the needs of its members, and are adopted in consultation with its network providers. Also, the NMRE and its five CMHSP's have purchased and are using the online version of MCG (Industry-Leading Evidence-Based Care Guidelines).		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		

Standard XI—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
2. The PIHP adopts practice guidelines that consider the needs of the PIHP's members. 42 CFR §438.236(b)(2) 42 CFR §457.1233(c)	**HSAG Required Evidence:** • Policies and procedures • List of adopted practice guidelines • PIHP-specific meeting minutes documenting committee review and approval • List of practice guidelines selected for adoption that are unique to the PIHP's program **Evidence as Submitted by the PIHP:** • SXI_E1_E2_E4_PG • SXI_E1_E2_E4_QOC Adoption_page 4 • SXI_E1_E2_requestqoc • SXI_E2_ACT Practice Guidelines • SXI_E2_FPE Practice Guidelines • SXI_E2_Home-Based PG • SXI_E2_IDDT Practice Guidelines • SXI_E2_PMTO Practice Guidelines • SXI_E2_Practice Guidelines	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The NMRE and its five CMHSP's have purchased and are using the online version of MCG. Next steps are to incorporate into EHR's but with Person Centered Planning driving the assessment and authorization process post-acute most of the care guidelines have only been used for acute hospitalizations. LOCUS is and has been used by the NMRE five CMHSPs since 2014. NMRE's five CMHSPs use the DECA, CAFAS and PECFAS functional assessment scales. NMRE is not using these for developing ranges of service or authorizations, as the PCP process is used to drive the assessment process and individual needs of the beneficiary based on medical necessity.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		

Standard XI—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
3. The PIHP adopts practice guidelines that are adopted in consultation with network providers. 42 CFR §438.236(b)(3) 42 CFR §457.1233(c)	**HSAG Required Evidence:** • Policies and procedures • List of adopted practice guidelines • PIHP-specific meeting minutes documenting committee review and approval • Evidence of consultation with network providers **Evidence as Submitted by the PIHP:** • SXI_E1_E3_Practice Guidelines • SXI_E3_Adopt_clinical • SXI_E3_ongoingconsult _page 1 • SXI_E3_request	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process:		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
4. The PIHP adopts practice guidelines that are reviewed and updated periodically as appropriate. 42 CFR §438.236(b)(4) 42 CFR §457.1233(c)	**HSAG Required Evidence:** • Policies and procedures • List of adopted practice guidelines • PIHP-specific meeting minutes documenting committee review and approval • Schedule for periodic review of adopted practice guidelines **Evidence as Submitted by the MCO:** • SXI_E1_E2_E4_PG • SXI_E1_E2_E4_QOC Adoption_page 4 • SXI_E4_E5_Practice G_pg3 • SXI_E4_FY24QAPIPEval_page11 • SXI_E4_Practice Guidelines	☒ Met ☐ Not Met ☐ NA

Standard XI—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
PIHP Description of Process: The NMRE has adopted practice guidelines that are based on valid and reliable clinical evidence or a consensus of providers of mental health, intellectual/developmental disabilities, and/or substance use disorder services. The NMRE and its CMHSPs have adopted practice guidelines from the American Psychiatric Association (APA), other practice guidelines reviewed and made available by the APA (e.g., VA/DoD, ASAM, American Academy of Child and Adolescent Psychiatry - AACAP), and MDHHS practice guidelines, and region-specific practice guidelines. Adopted practice guidelines consider the needs of its members, and are adopted in consultation with its network providers. Also, the NMRE and its five CMHSP's have purchased and are using the online version of MCG (Industry-Leading Evidence-Based Care Guidelines).Practice guidelines are reviewed annually by clinical directors for the region as well and Quality and Compliance leadership.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations**: The PIHP's Quality & Compliance Oversight Committee included representation from all its contracted CMHSPs. However, HSAG strongly recommends that the PIHP also add SUD providers to its committee to ensure that SUD providers have input into all discussions pertaining to clinical practice guidelines. Alternatively, or in addition to, the PIHP should ensure that its meeting minutes from the Quality & Compliance Oversight Committee include any discussions pertaining to clinical practice guidelines that occur through other SUD-related committees or discussion forums.		
Required Actions: None.		
Dissemination of Guidelines		
5. The PIHP disseminates the guidelines to: a. All affected providers. b. Members and potential members, upon request. 42 CFR §438.236(c) 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

Standard XI—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
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.		
6. *The PIHP assures services are planned and delivered in a manner that reflects the values and expectations contained in the:* a. *Inclusion Practice Guideline.* b. *Housing Practice Guideline.* c. *Consumerism Practice Guideline.* d. *Personal Care in Non-Specialized Residential Settings Technical Requirement.* e. *Family-Driven and Youth-Guided Policy and Practice Guideline.* f. *Employment Works! Policy.* 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) • Staff training materials • Provider training materials **Evidence as Submitted by the PIHP:** • SXI_E5_E6_NMREtraining • SXI_E6 Screenshot Practice Guidelines • SXI_E6_Clinical • SXI_E6_E7_pages11,12,13 • SXI_E6_E7_pgs24,33,54,108,109,110 • SXI_E6_Guide_to_Services_page18,19 • SXI_E6_Orientation Checklist • SXI_E6_pages 1,2 • SXI_E6_PGNECMH	☒ Met ☐ Not Met ☐ NA

Standard XI—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
	• SXI_E6_Practice Guidelines • SXI_E6_QI Plan Procedure Attachment D • SXI_E6_Quality_page 4 • SXI_E6_WV Child_page1 • SXI_E6_WV Consumerism • SXI_E6_WV Family Driven • SXI_E6_WV Housing • SXI_E6_WV Inclusion Practice Guideline reviewed 03.2023	
PIHP Description of Process: The NMRE reviews its provider network as necessary, but at least annually, to ensure practice guidelines are being followed appropriately.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
Application of Guidelines		
7. Decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. 42 CFR §438.236(d) 42 CFR §457.1233(c) Contract Schedule A—1(L)(5)	**HSAG Required Evidence:** • Policies and procedures • Hierarchy of coverage criteria • Member educational guidance (i.e., disease management) • Member materials (i.e., member handbook, member newsletters) • Three examples of coverage decisions, including the service, decision, and associated practice guideline **Evidence as Submitted by the PIHP:** • SXI_E6_E7_pages11,12,13 • SXI_E6_E7_pgs24,33,54,108,109,110 • SXI_E7 Denial_pages6,18 • SXI_E7_NMRE UR_page 5 • SXI_E7_Program Eligibility-Pages3,50	☒ Met ☐ Not Met ☐ NA

Standard XI—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
	• SXI_E7_UM minutes_pages2,3 • SXI_E7_WV_Homebased_17_Example 1a • SXI_E7_WV HB IPOS_Example 1b • SXI_E7_WV Home Based_Example 1c • SXI_E7_Example2_pg1,19 • SXI_E7_Access.Denial.Adult_Example 4 • SXI_E7_Access.Denial.Child-Example 3	
PIHP Description of Process: The NMRE and its five CMHSP's have purchased and are using the online version of MCG. Next steps are to incorporate into EHR's but with Person Centered Planning driving the assessment and authorization process post-acute most of the care guidelines have only been used for acute hospitalizations. LOCUS is and has been used by the NMRE five CMHSPs since 2014. NMRE's five CMHSPs use the DECA, CAFAS and PECFAS functional assessment scales. NMRE is not using these for developing ranges of service or authorizations, as the PCP process is used to drive the assessment process and individual needs of the beneficiary based on medical necessity. One of NMREs CMHSPs piloted Michicans to assist MDHHS in the development.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		

Standard XI—Practice Guidelines						
Met	=	6	X	1	=	6
Not Met	=	1	X	0	=	0
Not Applicable	=	0				
Total Applicable	=	7	**Total Score**		=	6
Total Score ÷ Total Applicable					=	86%

Standard XII—Health Information Systems

Standard XII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
General Rule		
1. The PIHP maintains a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of Medicaid managed care requirements. The systems provide information on areas including, but not limited to: a. Utilization. b. Claims. c. Grievances and appeals. d. Disenrollments for other than loss of Medicaid eligibility. 42 CFR §438.242(a) 42 CFR §457.1233(d) Contract Schedule A—1(P)(2)	**HSAG Required Evidence:** • Policies, procedures, and workflows • Systems integration mapping documentation • Most current completed Information Systems Capabilities Assessment Tool (ISCAT) through recent EQR activities (i.e., performance measure validation [PMV], encounter data validation [EDV]) • Technical manual(s) • List of disenrollment codes (i.e., reasons for disenrollment) provided by MDHHS • Screenshot of disenrollment codes available in the disenrollment system • HSAG will use the results from the information systems demonstration, including reporting capabilities • HSAG will use the results from the systems demonstrations included as part of the Disenrollment Requirements and Limitations Standard, Coverage and Authorization of Services Standard, and the Grievance and Appeal Systems Standard **Evidence as Submitted by the PIHP:** • R2 NMRE ISCAT PMV NAV SFY2024.zip • R2_NMRE_EDV_SFY2025.zip	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process:		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		

Standard XII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
Recommendations: Across all PIHPs, HSAG received conflicting information regarding whether disenrollment reasons/codes are provided to the PIHPs from MDHHS. HSAG recommends that all PIHPs consult with MDHHS regarding the disenrollment data being shared. If MDHHS is providing disenrollment reasons to the PIHPs, HSAG strongly recommends that the PIHP ensure that its information system has the capability to store these disenrollment reasons/codes. If the PIHP does not demonstrate adequate implementation of HSAG's recommendations during future compliance reviews, the PIHP will automatically receive a *Not Met* score.		
Required Actions: None.		
Basic Elements of a Health Information System		
2. The PIHP collects data on member and provider characteristics as specified by MDHHS and on all services furnished to members through an encounter data system or other method as may be specified by MDHHS. 42 CFR §438.242(b)(2) 42 CFR §457.1233(d) Contract Schedule A—1(P)(2)(a)(ii) Contract Schedule E—Contractor Financial Reporting Requirements	**HSAG Required Evidence:** • Policies, procedures, and workflows • Claims data collection and processing guidelines • Encounter data collection and submission guidelines • HSAG will use the completed ISCAT and results from the information systems demonstration, including reporting capabilities **Evidence as Submitted by the PIHP:** • R2 NMRE ISCAT PMV NAV SFY2024.zip • R2_NMRE_EDV_SFY2025.zip	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process:		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
3. The PIHP ensures that data received from providers is accurate and complete by: a. Verifying the accuracy and timeliness of reported data, including data from network providers the PIHP is compensating on the basis of capitation payments. b. Screening the data for completeness, logic, and consistency.	**HSAG Required Evidence:** • Policies, procedures, and workflows • Claims submission requirements document • Claims data collection and processing guidelines • Claim validation processes • Claim timeliness reports	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
c. Collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for MDHHS quality improvement and care coordination efforts. 42 CFR §438.242(b)(3) 42 CFR §457.1233(d) Contract Schedule A—1(P)(2)(a)(iii) Contract Schedule E—Contractor Financial Reporting Requirements	• Process to collect services rendered by providers or subcontractors through a capitated arrangement (e.g., collection through encounter data, claims with a zero-dollar payment) • HSAG will use the completed ISCAT and results from the information systems demonstration, including reporting capabilities **Evidence as Submitted by the PIHP:** • R2 NMRE ISCAT PMV NAV SFY2024.zip • R2_NMRE_EDV_SFY2025.zip	
PIHP Description of Process:		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
4. The PIHP makes all collected data available to MDHHS and upon request to CMS. 42 CFR § 438.242(b)(4) 42 CFR §457.1233(d) Contract Schedule A—1(P)(2)(a)(iv) Contract Schedule E—Contractor Financial Reporting Requirements	**HSAG Required Evidence:** • Policies, procedures, and workflows • HSAG will use the completed ISCAT and results from the information systems demonstration, including reporting capabilities **Evidence as Submitted by the PIHP:** • R2 NMRE ISCAT PMV NAV SFY2024.zip • R2_NMRE_EDV_SFY2025.zip	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process:		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		

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Requirement	**Supporting Documentation**	**Score**
Claims Processing		
5. The PIHP complies with section 6504(a) of the Affordable Care Act and ensures its claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by MDHHS to meet the requirements of section 1903(r)(1)(F) of the Act (electronic claims submission). 42 CFR §438.242(b)(1) 42 CFR §457.1233(d) Affordable Care Act, Section 6504(a) Affordable Care Act, Section 1903(r)(1)(F) Contract Schedule A—1(P)(2)(a)(i) Contract Schedule A—1(S)(13)(a)(xii) Contract Schedule E—Contractor Financial Reporting Requirements	**HSAG Required Evidence:** • Policies, procedures, and workflows • Claims data collection and processing guidelines • Provider manual • HSAG will use the completed ISCAT and results from the information systems demonstration, including reporting capabilities **Evidence as Submitted by the PIHP:** • R2 NMRE ISCAT PMV NAV SFY2024.zip • R2_NMRE_EDV_SFY2025.zip	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process:		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
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	**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)	☐ Met ☒ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
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 42 CFR §457.1233(d) 45 CFR §170.213 Contract Schedule A—1(R)(18)	• 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	
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		

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Requirement	**Supporting Documentation**	**Score**
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.		
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)	**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	☐ Met ☒ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
42 CFR §431.70 42 CFR §438.10(h)(1–2) 42 CFR §457.1233(d)	• 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 • 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		

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Requirement	**Supporting Documentation**	**Score**
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 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).		
Member Encounter Data		
8. The PIHP collects and maintains sufficient member encounter data to identify the provider who delivers any item(s) or service(s) to members. 42 CFR §438.242(c)(1) 42 CFR §457.1233(d) Contract Schedule A—1(P)(2)(b)(i)	**HSAG Required Evidence:** • Policies, procedures, and workflows • Encounter data collection requirements • Two samples/screenshots of encounter data with rendering provider and item/service data fields (one sample must include encounter data from a sub-capitated source) • HSAG will use the completed ISCAT and results from the information systems demonstration, including reporting capabilities **Evidence as Submitted by the PIHP:** • R2 NMRE ISCAT PMV NAV SFY2024.zip • R2_NMRE_EDV_SFY2025.zip	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process:		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		

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Requirement	**Supporting Documentation**	**Score**
9. The PIHP submits member encounter data to MDHHS at a frequency and level of detail specified by CMS and the State, based on program administration, oversight, and program integrity needs. a. The member encounter data includes all MDHHS-specific requirements for encounter data submissions, including allowed amount and paid amount, that MDHHS is required to report to CMS under 42 CFR §438.818. b. The member encounter data is submitted to MDHHS in standardized ASC X12N 837 and NCPDP formats, and the ASC X12N 835 format as appropriate. 42 CFR §438.242(c)(2–4) 42 CFR §438.818 42 CFR §457.1233(d) Contract Schedule A—1(P)(2)(b)(i–ii) Contract Schedule E—Contractor Financial Reporting Requirements	**HSAG Required Evidence:** • Policies, procedures, and workflows • Encounter data submission requirements • Encounter data submission timeliness reports • Three concurrent months of submission compliance (acceptance/rejection reports) • Two samples/screenshots of encounter data with allowed amount and paid amount fields (one sample must include encounter data from a sub-capitated source) • HSAG will use the completed ISCAT and results from the information systems demonstration, including reporting capabilities **Evidence as Submitted by the PIHP:** • R2 NMRE ISCAT PMV NAV SFY2024.zip • R2_NMRE_EDV_SFY2025.zip	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process:		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		

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Met	=	7	X	1	=	7
Not Met	=	2	X	0	=	0
Not Applicable	=	0				0
Total Applicable	=	9	Total Score		=	7
Total Score ÷ Total Applicable					=	78%

Standard XIII—Quality Assessment and Performance Improvement Program

Standard XIII—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
General Rules		
1. The PIHP establishes and implements an ongoing comprehensive quality assessment and performance improvement (QAPI) program (*referred to as the Quality Assessment and Performance Improvement Program [QAPIP] in Michigan)* for the services it furnishes to its members. 42 CFR §438.330(a)(1) 42 CFR §457.1240(b) Contract Schedule A—1(L)(2)(a) QAPIPs for Specialty PIHPs	**HSAG Required Evidence:** • Policies and procedures • QAPI program description • QAPI work plan **Evidence as Submitted by the PIHP:** • SXIII_E1_Charter_page2 • SXIII_E1_E10_E11_E22_E23_E24_Eval • SXIII_E1_E10_E11_QAPIP PLAN	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The responsibilities and duties of the Compliance and Quality Oversight Committee shall include the following: i Advise the NMRE Chief Compliance and Quality Officer on matters related to Compliance program plan and the QAPIP. ii Assist in the review of, and compliance with, contractual requirements related to program integrity, compliance, quality, HIPAA, and 42 CFR 438.608. iii Assist in developing reporting procedures consistent with the NMRE, federal, and state requirements. iv Assist in developing and reviewing data/reports consistent with contractual requirements. v Assist with the development, implementation, and operation of the NMRE's Compliance program and QAPIP Plan. vi Review and update, as necessary, NMRE policies and procedures related to the Compliance program and QAPIP plan. vii Evaluate the effectiveness of the Compliance program and QAPIP plan. viii Determine the appropriate strategy/approach to promote compliance and detect potential violations and areas of risk as well as areas of focus. ix Develop, implement, and monitor internal systems and controls to carry out the Compliance Program and QAPIP plan, and develop supporting policies as part of daily operations. x Review compliance related audit results and corrective action plans and make recommendations when appropriate		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		

Standard XIII—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
Recommendations: Although the PIHP enhanced the QAPIP work plan from the prior compliance review, HSAG recommends that the PIHP add additional details to the work plan, including goals and/or objectives for each of the associated QAPIP activities within the work plan (e.g., Consumer Experience Assessments, Quality Measures (HEDIS measures), Utilization Management and Authorization of Services) that will support the PIHP in evaluating whether its QAPIP efforts over time are successful or whether interventions or initiatives need to be revised or added to support improvement.		
Required Actions: None.		
2. *The PIHP has a written description of its QAPIP which specifies:* a. *An adequate organizational structure which allows for clear and appropriate administration and evaluation of the QAPIP.* b. *The components and activities of the QAPIP including those as required by the QAPIP Technical Requirement.* c. *The role for recipients of service in the QAPIP.* d. *The mechanisms or procedures to be used for adopting and communicating process and outcome improvement.* Contract Schedule A—1(L)(2)(a) QAPIPs for Specialty PIHPs—I	**HSAG Required Evidence:** • QAPI program description **Evidence as Submitted by the PIHP:** • SXIII_E2abd_Charter_page1-3 • SXIII_E2c_FY24 QAPIP_page2 •	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The responsibilities and duties of the Compliance and Quality Oversight Committee shall include the following: i Advise the NMRE Chief Compliance and Quality Officer on matters related to Compliance program plan and the QAPIP. ii Assist in the review of, and compliance with, contractual requirements related to program integrity, compliance, quality, HIPAA, and 42 CFR 438.608. iii Assist in developing reporting procedures consistent with the NMRE, federal, and state requirements. iv Assist in developing and reviewing data/reports consistent with contractual requirements. v Assist with the development, implementation, and operation of the NMRE's Compliance program and QAPIP Plan. vi Review and update, as necessary, NMRE policies and procedures related to the Compliance program and QAPIP plan. vii Evaluate the effectiveness of the Compliance program and QAPIP plan. viii Determine the appropriate strategy/approach to promote compliance and detect potential violations and areas of risk as well as areas of focus. ix Develop, implement, and monitor internal systems and controls to carry out the Compliance Program and QAPIP plan, and develop supporting policies as part of daily operations. x Review compliance related audit results and corrective action plans and make recommendations when appropriate		

Standard XIII—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** The PIHP provided a QAPIP plan that included a description of QAPIP activities, but did not have a separate QAPIP description and QAPIP work plan as expected. HSAG recommends that the PIHP develop both a QAPIP description, which includes a high-level overview of all QAPIP activities, and a QAPIP work plan, which includes more detailed information (e.g., goals, objectives, due dates, responsible department or person for each activity, etc.) and have a process to track progress for each QAPIP activity goal and objective over a period of time. Additionally, although the QAPIP plan included some information about the member's role in the QAPIP, HSAG recommends that the PIHP include more detailed information about the member's role in the QAPIP, including how the PIHP obtains member input into QAPIP activities.		
Required Actions: None.		
3. *The PIHP submits the updated QAPIP description and associated work plan to MDHHS annually by February 28. The report will include a list of the members of the Governing Body.* Contract Schedule A—1(L)(2)(a) QAPIPs for Specialty PIHPs—I QAPIPs for Specialty PIHPs—II(d)	**HSAG Required Evidence:** • QAPI program description • QAPI work plan • Evidence of submission of the QAPIP documents **Evidence as Submitted by the PIHP:** • SXIII_E3_BOARD_page_2,5,6 • SXIII_E3_QAPIP submission R2 •	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
4. *The QAPIP is accountable to a Governing Body that is a PIHP Regional Entity. Responsibilities of the Governing Body for monitoring, evaluating, and making improvements to care include:*	**HSAG Required Evidence:** • QAPI program description • Governing Body charter • Minutes from Governing Body demonstrating approval of the QAPIP and quality improvement plan • Examples of concurrent QAPIP progress reports	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
a. *Oversight of QAPIP—There is documentation that the Governing Body has approved the overall QAPIP and an annual Quality Improvement (QI) plan.* b. *QAPIP progress reports—The Governing Body routinely receives written reports from the QAPIP describing performance improvement projects undertaken, the actions taken, and the results of those actions.* c. *Annual QAPIP review—The Governing Body formally reviews on a periodic basis (but no less frequently than annually) a written report on the operation of the QAPIP.* Contract Schedule A—1(L)(2)(a) QAPIPs for Specialty PIHPs—II(a–c)	• Minutes from Governing Body demonstrating review of QAPIP progress reports and the annual QAPIP review **Evidence as Submitted by the PIHP:** • SXIII_E4_BOARD_page_2,5,6 • SXIII_E4_BYLAWS • SXIII_E4a_FEB_BOARD_pg61,71 • SXIII_E4b_FY24 QAPIP_page5 • SXIII_E4b_surveyboard_pg7 • SXIII_E4b_update_page129-138 • SXIII_E4c_FEB_BOARD_pg61,71	
PIHP Description of Process:		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
5. *There is a designated senior official responsible for the QAPIP implementation.* Contract Schedule A—1(L)(2)(a) QAPIPs for Specialty PIHPs—III	**HSAG Required Evidence:** • QAPI program description • Job description **Evidence as Submitted by the PIHP:** • SXIII_E5_Charter • SXIII_E5Quality Manager JD NMRE	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		

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Requirement	**Supporting Documentation**	**Score**
6. *There is active participation of providers and individuals in the QAPIP processes.* Contract Schedule A—1(L)(2)(a) QAPIPs for Specialty PIHPs—IV	**HSAG Required Evidence:** • Policies, procedures, and workflows • QAPI program description • Meeting minutes demonstrating active participation of providers and PIHP members in the QAPIP processes **Evidence as Submitted by the PIHP:** • SXIII_E6_Charter_sectionB • SXIII_E6_minutes_pg4,5 • SXIII_E6_pages 4,7 • SXIII_E6_participation	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** The PIHP provided *REP Meeting Minutes* to demonstrate that there is active participation of individuals in the PIHP's QAPIP processes. The meeting agenda also included *NMRE QAPIP* as a topic for discussion. However, as there were minimal individuals attending the meeting, HSAG recommends that the PIHP continue initiatives to increase the number of members participating in the Recovery Education Planning (REP) meetings.		
Required Actions: None.		
Basic Elements of QAPI Programs		
7. The QAPI program includes mechanisms to assess both underutilization and overutilization of services. 42 CFR §438.330(b)(3) 42 CFR §457.1240(b) Contract Schedule A—1(L)(2)(a) Contract Schedule A—1(L)(4)(a) QAPIPs for Specialty PIHPs—XIV(B)	**HSAG Required Evidence:** • Policies and procedures • QAPI program description • QAPI program work plan • QAPI program evaluation • Evidence demonstrating assessment of underutilization and overutilization of services (e.g., committee meeting minutes, reports)	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
	• Evidence demonstrating assessment of overutilization of services (e.g., committee meeting minutes, reports)	
	Evidence as Submitted by the PIHP: • SXIII_E7 Clubhouse • SXIII_E7 Quality Improvement (QI) • SXIII_E7 Respite • SXIII_E7 UM_Min August 24 • SXIII_E7_E9_FY24 QAPIP_page_6 • SXIII_E7_E9_FY24 QAPIPEval_pg13 • SXIII_E7_Program Capacity Review Example • SXIII_E7_QI_Program_Plan • SXIII_E7_QIP Snapshot • SXIII_E7_QOC_page5 • SXIII_E7_UM_pg4,7 • SXIII_E7_UR MINUTES_pg3,4 • SXIII_E7_Utilization Report • SXIII_E7_Utilization Report_pg6 • SXIII_E7_WV Consult 2024 • SXIII_E7_WV consult • SXIII_E7_WV Peer Chart Review 2 • SXIII_E7pg3,10,11,12,15-216	
PIHP Description of Process: The NMRE and it's CMHSPs use QOC meeting as a platform for utilization discussions, as well as UR Committee.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** While the PIHP demonstrated many efforts were in place to trend for over- and underutilization of services, HSAG recommends that the PIHP update its QAPIP plan and evaluation to include more detailed information about the specific metrics it uses to monitor for over- and underutilization and ensure it includes the results of these activities in the annual QAPIP evaluation.		
Required Actions: None.		

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Requirement	**Supporting Documentation**	**Score**
8. The QAPI program includes mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs, as defined by MDHHS in the quality strategy. 42 CFR §438.330(b)(4) 42 CFR §457.1240(b) Contract Schedule A—1(L)(2)(a)	**HSAG Required Evidence:** • Policies and procedures • QAPI program description • QAPI work plan • QAPI program evaluation • Definition of members with special health care needs • Assessment tools • Clinical guidance/criteria • Metrics/performance measures to assess special health care needs **Evidence as Submitted by the PIHP:** • SXIII_E8 2024 Quality Assurance • SXIII_E8 LTSS Assessment Tool Sept 2024 • SXIII_E8_ E9_WV RN assessment example • SXIII_E8_ QAPIPEval_pg5-7 • SXIII_E8_9_PATH Nursing Care Plan example • SXIII_E8_Access_page2,3,10 • SXIII_E8_Data_All_Region_2 • SXIII_E8_draft • SXIII_E8_E_9_WV Blank RN Assessment • SXIII_E8_E9 Monitoring • SXIII_E8_E9_ Assessments • SXIII_E8_E9_LTSS Assessment • SXIII_E8_E9_MCPAR_ • SXIII_E8_E9_Michicans • SXIII_E8_E9_Monitoring_Tool3291 • SXIII_E8_E9_PATH Master Nursing Care Plan Template • SXIII_E8_E9_WV Nursing Care Plan example	☒ Met ☐ Not Met ☐ NA

Standard XIII—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
	• SXIII_E8_E17_FY24 QAPIP • SXIII_E8_FY25 QAPIP_page2,3 • SXIII_E8_FY24_MCPAR_ • SXIII_E8_LTSS Assessment • SXIII_E8_NMRE QOC_pages4,6 • SXIII_E8_NMRE_page • SXIII_E8_Quality Improvement Plan • SXIII_E8_Satisfaction Surveys • SXIII_E8_Um Plan • SXIII_E8_UR_Page 3 • SXIII_E8_UR_Page 5,6 • SXIII_E8_WV_RN_Review	
PIHP Description of Process: Assessment of quality is an ongoing process, but formally completed via regular, scheduled, site visits.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
9. The QAPI program includes mechanisms to assess the quality and appropriateness of care furnished to members using long-term services and supports (LTSS), including: a. Assessment of care between care settings. b. Comparison of services and supports received with those set forth in the member's treatment/service plan, if applicable. c. *Identify ongoing special conditions of the member that require a course of treatment or regular care monitoring.* 42 CFR §438.330(b)(5)(i) 42 CFR §457.1240(b) Contract Schedule A—1(L)(2)(a)	**HSAG Required Evidence:** • Policies and procedures • QAPI program description • QAPI program work plan • QAPI program evaluation • Assessment tools • Clinical guidance/criteria • Metrics/performance measures to assess LTSS • Medical record audit tools and results **Evidence as Submitted by the PIHP:** • SXIII_E8_E_9_WV Blank RN Assessment • SXIII_E8_E9 Monitoring	☒ Met ☐ Not Met ☐ NA

Standard XIII—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
Contract Schedule A—1(L)(2)(c)	• SXIII_E8_E9_ Assessments • SXIII_E8_E9_LTSS Assessment • SXIII_E8_E9_MCPAR • SXIII_E8_E9_Michicans • SXIII_E8_E9_Monitoring_Tool3291 • SXIII_E8_E9_PATH Master Nursing Care Plan Template • SXIII_E8_E9_WV Nursing Care Plan example • SXIII_E9_clinical • SXIII_E9_page 2 • SXIII_E9_Program Eligibility Determination Policy • SXIII_E7_E9_FY24 QAPIP_page_6 • SXIII_E7_E9_FY24 QAPIPEval_pg13	
PIHP Description of Process: Assessment of quality is an ongoing process, but formally completed via regular, scheduled, site visits.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** The PIHP had minimal information in its QAPIP work plan and evaluation that addressed mechanisms to assess the quality and appropriateness of care furnished to members using LTSS and the outcomes. As such, HSAG strongly recommends that the PIHP enhance both its work plan and its evaluation to include more robust information pertaining to the PIHP's assessment of the quality and appropriateness of care furnished to members using LTSS.		
Required Actions: None.		
Performance Measurement		
10. The QAPI program includes the collection and submission of performance measurement data. The PIHP annually: a. Measures and reports to MDHHS on its performance, using the standard measures required by MDHHS;	**HSAG Required Evidence:** • Policies and procedures • QAPI program description • QAPI work plan • QAPI program evaluation • Performance measures reports	☒ Met ☐ Not Met ☐ NA

Standard XIII—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
b. Submits to MDHHS data, specified by MDHHS, which enables MDHHS to calculate the PIHP's performance using the standard measures identified by MDHHS; or c. Performs a combination of the activities described in sub-elements (a) and (b). 42 CFR §438.330(b)(2) 42 CFR §438.330(c)(2) 42 CFR §457.1240(b) Contract Schedule A—1(L)(2)(a) QAPIPs for Specialty PIHPs—V Contract Schedule E—Contractor Non-Financial Reporting Requirements	• Evidence of submission of performance measurement reports to MDHHS **Evidence as Submitted by the PIHP:** • SXIII_E1_E10_E11_E22_E23_E24_Eval • SXIII_E1_E10_E11_QAPIP PLAN • SXIII_E10 PIs • SXIII_E10_BHH to MDHHS • SXIII_E10_Children's Joint Care • SXIII_E10_E11 • SXIII_E10_E11_E12_BHH PIP • SXIII_E10_E11_E12_OHH PIP • SXIII_E10_MMBPIS NMRE Submission Proof • SXIII_E10_NMRE FY24 PBIP Draft • SXIII_E10_NMRE QOC_pg4-8 • SXIII_E10_NMRE R2 PBIP Narrative • SXIII_E10_NMRE SUD_page3-6 • SXIII_E10_PI board page_33 • SXIII_E10_PI FY24 • SXIII_E10_QOC	
PIHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		

Standard XIII—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
Performance Improvement Projects		
11. The QAPI program includes performance improvement projects (PIPs). a. The PIHP conducts PIPs that focus on both clinical and nonclinical areas, *and engages in at least two projects during the waiver renewal period.* i. *Clinical areas would include, but not be limited to, high-volume services, high-risk services, and continuity and coordination of care.* ii. *Nonclinical areas would include, but not be limited to, appeals, grievances, trends, and patterns of substantiated Recipient Rights complaints as well as access to, and availability of, services.* iii. *Project topics should be selected in a manner which takes into account the prevalence of a condition among, or need for a specific service by, the organization's individuals; consumer demographic characteristics and health risks; and the interest of individuals in the aspect of service to be addressed.* 42 CFR §438.330(b)(1) 42 CFR §438.330(d)(1) 42 CFR §457.1240(b) Contract Schedule A—1(L)(2)(a) QAPIPs for Specialty PIHPs—VII(A-B) QAPIPs for Specialty PIHPs—VII(E)	**HSAG Required Evidence:** • Policies and procedures • QAPI program description • QAPI work plan • QAPI program evaluation • List of all active PIPs, including which PIPs are considered clinical or non-clinical • PIP documentation for all active PIPs (excluding HSAG-validated PIPs) **Evidence as Submitted by the PIHP:** • SXIII_E1_E10_E11_E22_E23_E24_Eval • SXIII_E1_E10_E11_QAPIP PLAN • SXIII_E10_E11 • SXIII_E10_E11_E12_BHH PIP • SXIII_E10_E11_E12_OHH PIP • SXIII_E11_ FY24 QAPIPEval_pg1-4 • SXIII_E11_E12_NMRE Clinical PIP • SXIII_E11_NMRE QOC_pg4,5 • SXIII_E11_pg3,4	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The NMRE is currently working on 3 PIPs regionally, OHH, BHH, and newly started- clinical PI 3.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		

Standard XIII—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
12. Each PIP is designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction, and includes the following elements: a. Measurement of performance using objective quality indicators. b. Implementation of interventions to achieve improvement in the access to and quality of care. c. Evaluation of the effectiveness of the interventions based on the performance measures required by MDHHS. d. Planning and initiation of activities for increasing or sustaining improvement. 42 CFR §438.330(d)(2) 42 CFR §457.1240(b) QAPIPs for Specialty PIHPs—VII QAPIPs for Specialty PIHPs—VII(F) Contract Schedule A—1(L)(2)(a)	**HSAG Required Evidence:** • QAPI program description • QAPI work plan • QAPI program evaluation • Policies and procedures • PIP documentation for all active PIPs **Evidence as Submitted by the PIHP:** • SXIII_E12_ FY24 QAPIPEval_1-4 • SXIII_E11_E12_NMRE Clinical PIP • SXIII_E10_E11_E12_BHH PIP • SXIII_E10_E11_E12_OHH PIP •	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The NMRE team and it's CMHSPs review outcomes and potential improvements on an ongoing basis.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
13. The PIHP reports the status and results of each PIP to MDHHS as requested, but not less than once per year. 42 CFR §438.330(d)(3) 42 CFR §457.1240(b)	**HSAG Required Evidence:** • Policies and procedures • Evidence of annual submission of all PIPs to MDHHS **Evidence as Submitted by the PIHP:** • SXIII_E13 • SXIII_E13_E15_SE CI policy CWN • SXIII_E13_E24_QAPIP submission • SXIII_E13_E24_SubmissionFY24toMDHHS_1-4	☒ Met ☐ Not Met ☐ NA

Standard XIII—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
PIHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
Sentinel Events and Critical Incidents		
14. The QAPI program includes participation in efforts by MDHHS to prevent, detect, and remediate critical incidents (consistent with assuring beneficiary health and welfare per 42 CFR §441.302 and §441.730(a) that are based, at a minimum, on the requirements for home and community-based waiver programs per 42 CFR §441.302(h). a. *The QAPIP describes, and the PIHP implements or delegates, the process of the review and follow-up of sentinel events and other critical incidents and events that put individuals at risk of harm.* 42 CFR §438.330(b)(5)(ii) 42 CFR §441.302 42 CFR §441.302(h) 42 CFR §441.730(a) 42 CFR §457.1240(b) Contract Schedule A—1(L)(2)(a) Contract Schedule A—1(O)(12) QAPIPs for Specialty PIHPs—VIII	**HSAG Required Evidence:** • Policies and procedures • QAPI program description • QAPI program work plan • QAPI program evaluation • Three examples of sentinel event/critical incident reports • Committee meeting minutes • Provider remediation plan template(s) **Evidence as Submitted by the PIHP:** • SXIII_E14 104.102 • SXIII_E14 policy • SXIII_E14 • SXIII_E14 Critical incident example 1 • SXIII_E14_Critical Example 2 • SXIII_E14_Critical Example 3 • SXIII_E14 Sentinel example 1 • SXIII_E14_Sentinel example 2 • SXIII_E14_Inc and Rem • SXIII_E14_Inc and rem 2 • SXIII_E14_Incidents_Summary • SXIII_E14_IncidentsHCBSreport • SXIII_E14-21_CISE Reporting • SXIII_E14-E20_pg2,3,5,9,15,20,27	☒ Met ☐ Not Met ☐ NA

Standard XIII—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
PIHP Description of Process: The NMRE and its 5 CMHSPs developed and implemented a new tracking system for better accuracy and reporting.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
15. *At a minimum, sentinel events as defined in the MDHHS contract 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	☐ Met ☒ Not Met ☐ NA

Standard XIII—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
	• SXIII_E15_FY2025 • SXIII_E15_Incident QIP Log • SXIII_E15_reporting NMRE system • 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.		
16. *Individuals involved in the review of sentinel events have the appropriate credentials to review the scope of care. For example, sentinel events that involve client death, or other serious medical conditions, involve a physician or nurse.* Contract Schedule A—1(L)(2)(a) QAPIPs for Specialty PIHPs—VIII(B)	**HSAG Required Evidence:** • Policies and procedures • QAPI program description • Job description • Three examples of the review of critical incidents/sentinel events (credentials of the review staff must be provided) **Evidence as Submitted by the PIHP:** • SXIII_E14-21_CISE Reporting • SXIII_E14-E20_pg2,3,5,9,15,20,27	☒ Met ☐ Not Met ☐ NA

Standard XIII—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
	• SXIII_E16 Cummins_MD_ job description • SXIII_E16_Director of Health Services_JD • SXIII_E16_WV JD Chief Clinical Officer • SXIII_E16_WV JD Chief Quality Officer_pg2 • 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_E16_E17_Unexpected Example C	
PIHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
17. *All unexpected deaths of Medicaid members, who at the time of their deaths were receiving specialty supports and services, are reviewed and include:* a. *Screens of individual deaths with standard information (e.g., coroner's report, death certificate).* b. *Involvement of medical personnel in the mortality reviews.* c. *Documentation of the mortality review process, findings, and recommendations.* d. *Use of mortality information to address quality of care.* e. *Aggregation of mortality data over time to identify possible trends.*	**HSAG Required Evidence:** • Policies and procedures • QAPI program description • Tracking and reporting mechanisms • Three examples of the review of critical incidents/sentinel events involving deaths **Evidence as Submitted by the PIHP:** • SXIII_E14-E20_pg2,3,5,9,15,20,27 • SXIII_E14-21_CISE Reporting • SXIII_E8_E17_FY24 QAPIP • SXIII_E15_E16_E17_WV Root Cause Analysis Notes Example A	☒ Met ☐ Not Met ☐ NA

Standard XIII—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
Note: "Unexpected deaths" include those that resulted from suicide, homicide, an undiagnosed condition, were accidental, or were suspicious for possible abuse or neglect. Contract Schedule A—1(L)(2)(a) Contract Schedule A—1(O)(12) QAPIPs for Specialty PIHPs—VIII(C)	• SXIII_E15_E16_E17_WV Root Cause Analysis 1-18-24 Example B • SXIII_E17_E18 • SXIII_E17_tracking reporting • SXIII_E16_E17_Unexpected Example C	
PIHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
18. *Following immediate event notification to MDHHS, the PIHP submits information on relevant events through the Critical Incident Reporting System.* Contract Schedule A—1(O)(12) Contract Schedule A—1(L)(2)(a) Contract Schedule A—1(O)(12)(b–c) QAPIPs for Specialty PIHPs—VIII(D) Critical Incident, Event Notification, and SUD Sentinel Event Reporting Requirements	**HSAG Required Evidence:** • Policies, procedures, and workflows • QAPI program description • Critical Incident Reporting System oversight and reporting demonstration **Evidence as Submitted by the PIHP:** • SXIII_E14-E20_pg2,3,5,9,15,20,27 • SXIII_E14-21_CISE Reporting • SXIII_E17_E18 • SXIII_E18_E19_ FY24 QAPIPEval_pg4,5 • SXIII_E18-E21_ Sentinel Events Process •	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		

Standard XIII—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
19. *The PIHP reports the following five specific reportable events through the Critical Incident Reporting System:* a. *Suicide* b. *Non-suicide death* c. *Emergency medical treatment due to injury or medication error* d. *Hospitalization due to injury or medication error* e. *Arrest of the individual* Contract Schedule A—1(L)(2)(a) Contract Schedule A—1(O)(12)(b–c) QAPIPs for Specialty PIHPs—VIII(E) Contract Schedule E—Contractor Non-Financial Reporting Requirements Critical Incident, Event Notification, and SUD Sentinel Event Reporting Requirements	**HSAG Required Evidence:** • Policies, procedures, and workflows • QAPI program description • Critical Incident Reporting System oversight and reporting demonstration **Evidence as Submitted by the PIHP:** • SXIII_E14-E20_pg2,3,5,9,15,20,27 • SXIII_E14-21_CISE Reporting • SXIII_E18_E19_ FY24 QAPIPEval_pg4,5 • SXIII_E18-E21_ Sentinel Events Process • SXIII_E19_E_20_E21_24_Incidents_Summary • SXIII_E19_E29_E21_25_Incidents_Summary • SXIII_E19_page 1,2 •	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
20. *The QAPI describes how the PIHP will analyze, at least quarterly, the critical incidents, sentinel events, and risk events to determine what action needs to be taken to remediate the problem or situation and to prevent the occurrence of additional events and incidents.* Contract Schedule A—1(L)(2)(a) QAPIPs for Specialty PIHPs—VIII(E)	**HSAG Required Evidence:** • Policies, procedures, and workflows • QAPI program description • Tracking and reporting mechanisms • Three examples of quarterly analysis of critical incidents, sentinel events, and risk events **Evidence as Submitted by the PIHP:** • SXIII_E14-E20_pg2,3,5,9,15,20,27 • SXIII_E14-21_CISE Reporting	☒ Met ☐ Not Met ☐ NA

Standard XIII—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
	• SXIII_E18-E21_ Sentinel Events Process • SXIII_E19_E20_E21_24_Incidents_Summary • SXIII_E19_E20_E21_25_Incidents_Summary • SXIII_E20_21_Q2_Example 1 • SXIII_E20_21_Q2_Example2 • SXIII_E20_21_Q2_Example3 • SXIII_E20_WV Risk Management Policy	
PIHP Description of Process: FY24 was the year of new process development, testing, and implementation. In FY 25 we are able to trend reports/ data and will be able to review these trends further.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
21. *The PIHP's QAPIP has a process for analyzing additional critical incidents that put individuals at risk of harm. This analysis should be used to determine what action needs to be taken to remediate the problem or situation and to prevent the occurrence of additional events and incidents. These events minimally include:* a. *Actions taken by individuals who receive services that cause harm to themselves.* b. *Actions taken by individuals who receive services that cause harm to others.* c. *Two or more unscheduled admissions to a medical hospital (not due to planned surgery or the natural course of a chronic illness, such as when an individual has a terminal illness) within a 12-month period.* Contract Schedule A—1(L)(2)(a) QAPIPs for Specialty PIHPs—VIII(F)	**HSAG Required Evidence:** • Policies, procedures, and workflows • QAPI program description • Three examples of the analysis of critical incidents that put individuals at risk of harm **Evidence as Submitted by the PIHP:** • SXIII_E14-21_CISE Reporting • SXIII_E18-E21_ Sentinel Events Process • SXIII_E19_E_20_E21_24_Incidents_Summary2024 • SXIII_E19_E20_E21_25_Incidents_Summary • SXIII_E21_CI SE RE Decision Tree and Process • SXIII_E21_new process • SXIII_E20_21_Q2_Example 1 • SXIII_E20_21_Q2_Example2 • SXIII_E20_21_Q2_Example3 • SXIII_E21_WV IR Example4	☒ Met ☐ Not Met ☐ NA

Standard XIII—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
	• SXIII_E21_WV IR Example5 • SXIII_E21_IR Example6 • SXIII_E21_WV IR Risk Example7 • SXIII_E21_Wellvance IR Example8	
PIHP Description of Process: FY24 was the year of new process development, testing, and implementation. In FY 25 we are able to trend reports/ data and will be able to review these trends further.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
QAPI Program Reviews, Analysis, and Evaluation		
22. The PIHP develops a process to evaluate the impact and effectiveness of its QAPI Program. The QAPI program evaluation includes: a. The performance on the measures on which it is required to report. b. The outcomes and trended results of each PIP. c. The results of any efforts to support community integration for members using LTSS. d. *The annual effectiveness review includes analysis of whether there have been improvements in the quality of health care and services for members as a result of QAPI activities and interventions carried out by the PIHP.* e. *The analysis should take into consideration trends in service delivery and health outcomes over time and include monitoring of progress on performance goals and objectives.* 42 CFR §438.330(e) 42 CFR §457.1240(b) Contract Schedule A—1(L)(3)(a)	**HSAG Required Evidence:** • QAPI program evaluation • Committee meeting minutes (with discussion of QAPI evaluation) **Evidence as Submitted by the PIHP:** • SXIII_E22,E23 • SXIII_E1_E10_E11_E22_E23_E24_Eval	☒ Met ☐ Not Met ☐ NA

Standard XIII—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
PIHP Description of Process: Evaluation of QAPI is ongoing. QOC meets at least 10 times a year with the goal of reviewing all of the items.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** The PIHP demonstrated significant improvement in the level of detail included in the evaluation from the prior compliance review. However, HSAG still recommends including more robust and measurable goals and objectives for each of the QAPIP activities and include detailed data about how the activities support whether there have been improvements in the quality of healthcare and services for members. The PIHP could also consider adding a summary paragraph within the evaluation that includes the PIHP's overall assessment of how services and health outcomes were impacted during the year, as well as year over year, and include any significant barriers to care identified that prevented positive health outcomes, as well as any interventions that were implemented that resulted in improved health outcomes.		
Required Actions: None.		
23. *Information on the effectiveness of the PIHP's QAPIP are provided annually to network providers and to members upon request.* Contract Schedule A—1(L)(3)	**HSAG Required Evidence:** • Policies, procedures, and workflows • Annual effectiveness review submitted to providers/members **Evidence as Submitted by the PIHP:** • SXIII_E22,E23 • SXIII_E1_E10_E11_E22_E23_E24_Eval	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: Available upon request, on NMREs website, and beneficiaries were informed via mailer.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
24. *Annually, by February 28 each calendar year, the PIHP provides information on the effectiveness of its QAPIP to MDHHS.* Contract Schedule A—1(L)(3)	**HSAG Required Evidence:** • QAPI program evaluation • Evidence of QAPI program evaluation annual submission to MDHHS **Evidence as Submitted by the PIHP:** • SXIII_E1_E10_E11_E22_E23_E24_Eval • SXIII_E19_E20_E21_24_Incidents_Summary • SXIII_E13_E24_SubmissionFY24toMDHHS_1-4	☒ Met ☐ Not Met ☐ NA

Standard XIII—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
PIHP Description of Process: Completed.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		

Standard XIII—Quality Assessment and Performance Improvement Program						
Met	=	23	X	1	=	23
Not Met	=	1	X	0	=	0
Not Applicable	=	0				
Total Applicable	=	24	Total Score		=	23
Total Score ÷ Total Applicable					=	96%

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		

Standard II—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
(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. **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:		

Standard II—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
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:		

Standard VIII—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
MDHHS/HSAG Response:	☐ Accepted ☐ 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.		

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Requirement	**Supporting Documentation**	**Score**
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 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

Standard VIII—Confidentiality		
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,		

Standard VIII—Confidentiality		
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):		

Standard VIII—Confidentiality		
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

Standard IX—Grievance and Appeal Systems		
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.		

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
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.		

Standard IX—Grievance and Appeal Systems		
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	

Standard IX—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
14. The member may file an appeal orally or in writing. a. With the written consent of the member, a provider or an authorized representative may request an appeal on behalf of the member. 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		

Standard IX—Grievance and Appeal Systems		
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:		

Standard IX—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
MDHHS/HSAG Response:	☐ Accepted ☐ 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.		

Standard IX—Grievance and Appeal Systems		
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	

Standard IX—Grievance and Appeal Systems		
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		

Standard IX—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
report was provided which could be used to monitor timely acknowledgements, it is unclear whether the PIHP is actively monitoring adherence to 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)	**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:**	☐ Met ☒ Not Met ☐ NA

Standard IX—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Contract Schedule A—1(M)(2)(g) Appeal and Grievance Resolution Processes Technical Requirement—VII(A)(2)	• S9_E18_ Grievance and Appeals Procedure page 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	

Standard IX—Grievance and Appeal Systems		
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.		

Standard IX—Grievance and Appeal Systems		
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

Standard IX—Grievance and Appeal Systems		
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 42 CFR §457.1233(d) 45 CFR §170.213 Contract Schedule A—1(R)(18)	**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		
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.		
PIHP Corrective Action Plan		
Root Cause Analysis:		

Standard XII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
Application Programming Interface		
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 • 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		

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 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).

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	

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	