Michigan Department of Health and Human Services

SFY 2023 External Quality Review Compliance Review Report *for* Prepaid Inpatient Health Plans

Region 7—Detroit Wayne Integrated Health Network

October 20, 2023

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

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 and technical report described in 42 CFR §438.350 and §438.364. One of the four mandatory activities required by the Centers for Medicare & Medicaid Services (CMS) is:

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

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

Description of the External Quality Review Compliance Review

The state fiscal year (SFY) 2023 compliance review is the third year of the three-year cycle of compliance reviews that commenced in SFY 2021. The review focuses on standards identified in 42 CFR §438.358(b)(1)(iii) and applicable state-specific contract requirements. The compliance reviews for Michigan PIHPs consist of 13 program areas referred to as standards. MDHHS requested that HSAG conduct a review of the first six standards in Year One (SFY 2021) and a review of the remaining seven standards in Year Two (SFY 2022). This SFY 2023 (Year Three) review consisted of a review of the standards and elements that required a corrective action plan (CAP) during the SFY 2021 (Year One)

[1-1] 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/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Apr 6, 2023.

and SFY 2022 (Year Two) compliance review activities. Table 1-1 outlines the standards reviewed over the three-year review cycle.

Table 1-1—Compliance Review Standards

Standard	Associated Federal Citation[1,2]	Year One (SFY 2021)	Year Two (SFY 2022)	Year Three (SFY 2023)
Standard I—Member Rights and Member Information	§438.100	✓		Comprehensive review of each element scored as *Not Met* during the SFY 2021 and SFY 2022 compliance reviews
Standard II—Emergency and Poststabilization Services	§438.114	✓		
Standard III—Availability of Services	§438.206	✓		
Standard IV—Assurances of Adequate Capacity and Services	§438.207	✓		
Standard V—Coordination and Continuity of Care	§438.208	✓		
Standard VI—Coverage and Authorization of Services	§438.210	✓		
Standard VII—Provider Selection	§438.214		✓	
Standard VIII—Confidentiality	§438.224		✓	
Standard IX—Grievance and Appeal Systems	§438.228		✓	
Standard X—Subcontractual Relationships and Delegation	§438.230		✓	
Standard XI—Practice Guidelines	§438.236		✓	
Standard XII—Health Information Systems[3]	§438.242		✓	
Standard XIII—Quality Assessment and Performance Improvement Program	§438.330		✓	

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

Summary of Findings

Review of Standards

Table 1-2 presents an overview of the results of the SFY 2021 and SFY 2022 compliance reviews for **Detroit Wayne Integrated Health Network**. 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 **Detroit Wayne Integrated Health Network** 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 13 standards.

Table 1-2—Summary of Standard Compliance Scores

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard I—Member Rights and Member Information	19	19	16	3	0	**84%**
Standard II—Emergency and Poststabilization Services[1]	10	10	10	0	0	**100%**
Standard III—Availability of Services	7	7	6	1	0	**86%**
Standard IV—Assurances of Adequate Capacity and Services	4	4	0	4	0	**0%**
Standard V—Coordination and Continuity of Care	14	14	11	3	0	**79%**
Standard VI—Coverage and Authorization of Services	11	11	7	4	0	**64%**
Standard VII—Provider Selection	16	16	12	4	0	**75%**
Standard VIII—Confidentiality[1]	11	11	10	1	0	**91%**
Standard IX—Grievance and Appeal Systems	38	38	32	6	0	**84%**
Standard X—Subcontractual Relationships and Delegation	5	5	4	1	0	**80%**
Standard XI—Practice Guidelines	7	7	6	1	0	**86%**
Standard XII—Health Information Systems[2]	12	11	9	2	1	**82%**
Standard XIII—Quality Assessment and Performance Improvement Program	30	30	25	5	0	**83%**
Total	**184**	**183**	**148**	**35**	**1**	**81%**

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.

[1] Performance in this standard should be interpreted with caution as there were noted opportunities for the PIHP to enhance written documentation supporting the federal requirements; therefore, full compliance in this program area is not considered a strength within this compliance review. The PIHP's progress in implementing HSAG's recommendations will be further assessed for continued compliance in future reviews.

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

Review of Corrective Action Plan Implementation

Based on the findings of the SFY 2021 and SFY 2022 compliance review activities, **Detroit Wayne Integrated Health Network** was required to develop and submit a CAP for each element assigned a score of *Not Met*. MDHHS and HSAG reviewed the CAP for sufficiency, and **Detroit Wayne Integrated Health Network** was responsible for implementing each action plan in a timely manner. Table 1-3 presents an overview of the results of the SFY 2023 compliance review for **Detroit Wayne Integrated Health Network**, which consisted of a comprehensive review of the PIHP's implementation of each action plan. HSAG assigned a score of *Complete* or *Not Complete* to each of the individual elements that required a CAP based on a scoring methodology, which is detailed in Section 2.

Table 1-3—Summary of CAP Implementation

Standard	Total CAP Elements	# of CAP Elements *Complete*	# of CAP Elements *Not Complete*
Standard I—Member Rights and Member Information	3	3	**0**
Standard III—Availability of Services	1	1	**0**
Standard IV—Assurances of Adequate Capacity and Services	4	4	**0**
Standard V—Coordination and Continuity of Care	3	3	**0**
Standard VI—Coverage and Authorization of Services	4	4	**0**
Standard VII—Provider Selection	4	4	**0**
Standard VIII—Confidentiality	1	1	**0**
Standard IX—Grievance and Appeal Systems	6	6	**0**
Standard X—Subcontractual Relationships and Delegation	1	1	**0**
Standard XI—Practice Guidelines	1	1	**0**
Standard XII—Health Information Systems[1]	2	0	**2**
Standard XIII—Quality Assessment and Performance Improvement Program	5	5	**0**
Total	**35**	**33**	**2**

Total CAP Elements: The total number of elements within each standard that required a CAP during the SFY 2021 and SFY 2022 compliance review activities.

# of CAP Elements *Complete*: The total number of CAP elements within each standard that were fully remediated at the time of the site review and demonstrated compliance with the requirement under review.

# of CAP Elements *Not Complete*: The total number of CAP elements within each standard that were not fully remediated at the time of the site review and/or did not demonstrate compliance with the requirement under review.

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

Detroit Wayne Integrated Health Network demonstrated that it successfully remediated 33 of 35 elements, indicating the necessary policies, procedures, and initiatives were implemented and demonstrated compliance with the requirements under review. However, two elements were scored as *Not Complete*, indicating that **Detroit Wayne Integrated Health Network** had not fully remediated all

CAP elements at the time of the site review and/or the PIHP's remediation plan, including submitted documentation, did not demonstrate compliance with the requirement under review. Refer to Appendix A for a detailed description of the findings.

Technical Assistance

For any CAP elements scored as *Not Complete*, **Detroit Wayne Integrated Health Network** is required to participate in a mandatory technical assistance meeting with MDHHS and HSAG (unless otherwise noted in the CAP compliance review tool) to further discuss the requirement(s), expectations, and appropriate action plans to bring the element(s) into compliance. **Detroit Wayne Integrated Health Network** will be required to update its existing CAP(s) and applicable action plans to align with the expectations addressed during the technical assistance meeting, and subsequently follow MDHHS' and HSAG's direction and implement timely interventions to fully remediate the remaining action plans. HSAG will review **Detroit Wayne Integrated Health Network**'s implementation of the remaining action plans and level of compliance during the next three-year cycle of compliance reviews.

2. Methodology

Activity Objectives

According to 42 CFR §438.358, a state or its EQRO must conduct a review within a three-year period to determine the PIHPs' compliance with standards set forth in 42 CFR §438—Managed Care Subpart D, the disenrollment requirements and limitations described in §438.56, the enrollee rights requirements described in §438.100, the emergency and post-stabilization services requirements described in §438.114, and the quality assessment and performance improvement requirements described in §438.330. To complete this requirement, HSAG, through its EQRO contract with MDHHS, performed compliance reviews of the 10 PIHPs contracted with MDHHS to deliver services to Michigan 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 SFY 2023 compliance review is the third year of the three-year cycle of compliance reviews that commenced in SFY 2021. The review focuses 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. MDHHS requested that HSAG conduct a review of the first six standards in Year One (SFY 2021), and a review of the remaining seven standards in Year Two (SFY 2022). This SFY 2023 (Year Three) review consisted of a review of the standards and elements that required a CAP during the SFY 2021 (Year One) and SFY 2022 (Year Two) compliance review activities. Table 2-1 outlines the standards reviewed over the three-year review cycle.

Table 2-1—Compliance Review Standards

Standard	Associated Federal Citation[1,2]	Year One (SFY 2021)	Year Two (SFY 2022)	Year Three (SFY 2023)
Standard I—Member Rights and Member Information	§438.10 §438.100	✓		Comprehensive review of each element scored as *Not Met* during the SFY 2021 and SFY 2022 compliance reviews
Standard II—Emergency and Poststabilization Services	§438.114	✓		
Standard III—Availability of Services	§438.206	✓		
Standard IV—Assurances of Adequate Capacity and Services	§438.207	✓		
Standard V—Coordination and Continuity of Care	§438.208	✓		
Standard VI—Coverage and Authorization of Services	§438.210	✓		
Standard VII—Provider Selection	§438.214		✓	

Standard	Associated Federal Citation[1,2]	Year One (SFY 2021)	Year Two (SFY 2022)	Year Three (SFY 2023)
Standard VIII—Confidentiality	§438.224		✓	
Standard IX—Grievance and Appeal Systems	§438.228		✓	
Standard X—Subcontractual Relationships and Delegation	§438.230		✓	
Standard XI—Practice Guidelines	§438.236		✓	
Standard XII—Health Information Systems[3]	§438.242		✓	
Standard XIII—Quality Assessment and Performance Improvement Program	§438.330		✓	

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

This report presents the results of the SFY 2023 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.

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 compliance review tools was selected based on applicable federal and State regulations and laws, and the requirements set forth in the contract between MDHHS and the PIHPs as they related to the scope of the review, which included a review of the PIHP's implementation of its CAP for each element that received a deficiency during the SFY 2021 and SFY 2022 compliance reviews. The review processes used by HSAG to evaluate the PIHPs' compliance were consistent with CMS EQR Protocol 3.

For each of the PIHPs, HSAG's desk review consisted of the following activities:

Pre-Site Review Activities:

- Collaborated with MDHHS to develop the scope of work, compliance review methodology, and compliance review tools (i.e., CAP review tool).
- Prepared and forwarded to the PIHP a detailed timeline, description of the compliance review process, pre-site review information packet, a submission requirements checklist, and a post-site review document tracker.
- Scheduled the site review with the PIHP.
- Hosted a pre-site review preparation session with all PIHPs.
- Conducted a desk review of supporting documentation 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 half-day site review interview sessions 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 an IS review of the data systems that the PIHP used in its operations, applicable to the standards 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 *Complete* and *Not Complete* (as described below in the Data Aggregation and Analysis section) within the compliance review tool.
- Prepared a PIHP-specific report detailing the findings of HSAG's review.
- Conducted a mandatory technical assistance meeting with the PIHP to review any CAP element that received a score of *Not Complete* (unless otherwise noted in the CAP compliance review tool).

Data Aggregation and Analysis:

HSAG used scores of *Complete* and *Not Complete* to indicate the degree to which the PIHP's performance complied with the requirements. The scoring methodology is outlined below:

Complete 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 documentation, and IS reviews confirm implementation of the requirement.

Not Complete 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 documentation, and IS reviews do 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 Complete* would result in an overall provision finding of noncompliance, regardless of the findings noted for the remaining components.

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 element that required a CAP.
- The total number of *Complete* CAPs and *Not Complete* CAPs for each standard.
- The overall number of *Complete* CAPs and *Not Complete* CAPs calculated across the standards.
- Whether the PIHP was required to participate in a mandatory technical assistance meeting.
- 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:

- CAP workplans and timelines.
- Documentation supporting implementation of the CAPs (e.g., 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).
- Examples of case file documentation for the applicable program areas and elements that required a CAP (e.g., care management, service authorization denials, grievances, appeals, credentialing, and/or delegated entities).
- IS review of the data systems that the PIHP used in its operations applicable to the CAP elements under review.

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 and after the site review	Documentation effective as of the PIHP's site review date (i.e., August 18, 2023)
Information obtained through interviews	August 18, 2023

Appendix A. SFY 2023 CAP Compliance Review Tool for Detroit Wayne Integrated Health Network

Standard I—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
Language and Format		
6. The PIHP makes its written materials that are critical to obtaining services, including, at a minimum, provider directories, member handbooks, appeal and grievance notices, and denial and termination notices, available in the prevalent non-English languages in its particular service area. a. Written materials that are critical to obtaining services must also be made available in alternative formats upon request of the potential member or member at no cost, include taglines in the prevalent non-English languages in the State and in a conspicuously visible font size explaining the availability of written translation or oral interpretation to understand the information provided, information on how to request auxiliary aids and services, and include the toll-free and TTY/TDY telephone number of the PIHP's member/customer service unit. b. Auxiliary aids and services must also be made available upon request of the potential member or member at no cost. *42 CFR §438.10(d)(3)* *Contract Schedule A–1(M)(2)(b)*	**HSAG Required Evidence:** • Member handbook with taglines • Provider directory with taglines • Appeal resolution notice with taglines • Grievance resolution notice with taglines • Adverse benefit determination (ABD) notice with taglines **Evidence as Submitted by the PIHP:** • 2023-2024 Member Handbook -English–Taglines pages 20,21 Snapshot • 2023-2024 Member Handbook- Arabic-Taglines pages 20,21- Snapshot • 2023-2024 Member Handbook –Spanish- Taglines pages 20,21-Snapshot • 2023-2024 Member Handbook –CEO update, Page 1, English, Spanish and Arabic version • 2023-2024 Provider Directory- English Tag Lines Page 4, Snapshot Due Process: • Notice of Appeal Approval Taglines page 2,3 • Final Response to Grievance Taglines page 3 • Adverse Benefit Determination –Taglines page 3,4	☒ Complete ☐ Not Complete

Standard I—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Technical Assistance Required: ☐ Yes ☒ No		
Information for All Members With PIHP—General Requirements		
10. The PIHP must make a good faith effort to give written notice of termination of a contracted provider to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider. a. Notice to the member must be provided by the later of 30 calendar days prior to the effective date of the termination, or 15 calendar days after receipt or issuance of the termination notice. *42 CFR §438.10(f)(1)* *Contract Schedule A–1(M)(2)(b)(ii)(3)*	**HSAG Required Evidence:** • Policies and procedures • One example of a provider termination after implementation of remediation plan, including the effective date of the termination or date of issuance of the termination and the notice sent to affected members **Evidence as Submitted by the PIHP:** • Network Monitoring and Management Policy Page 4,5 Standard #40 • Service Provider Change Procedure Page 3- Procedure 3b • Example-: o Close out Plan – Everest Inc, Melbourne- Page 5 o Letter to Member 4-26-2023 o Mailing Postage- Everest Inc, Melbourne o Member Choice Letter for Melbourne Home o Sample of Provider Closure Tracking Log	☒ Complete ☐ Not Complete
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Technical Assistance Required: ☐ Yes ☒ No		

Standard I—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
Information for All Members of PIHP—Provider Directory		
16. The PIHP must make available in paper form upon request and electronic form, information about its network providers—Refer to the Provider Directory Checklist. *42 CFR §438.10(h)(1)(i-viii)* *Contract Schedule A–1(M)(1)*	**HSAG Required Evidence:** • Provider directory • Link to online provider directory **Evidence as Submitted by the PIHP:** • Provider Directory • Link to on-line Directory https://dwihn.org/members/Provider_Directory_Booklet.pdf (2023-2024 version, revised June r 2023) • Link to Provider E directory https://dwihn.org/find-a-provider	☒ Complete ☐ Not Complete
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Technical Assistance Required: ☐ Yes ☒ No		

Standard I—Member Rights and Member Information		
Complete	**=**	**3**
Not Complete	**=**	**0**

Standard III—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
Timely Access		
5. The PIHP must do the following: a. Meet and require its network providers to meet MDHHS standards for timely access to care and services, taking into account the urgency of the need for services. b. Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid FFS, if the provider serves only Medicaid members. c. Make services included in the contract available 24 hours a day, 7 days a week, when medically necessary. d. Establish mechanisms to ensure compliance by network providers. e. Monitor network providers regularly to determine compliance. f. Take corrective action if there is a failure to comply by a network provider. *42 CFR §438.206(c)(1)(i-vi)* *Contract Schedule A–1(E)(7)(a)*	**HSAG Required Evidence:** • Policies and procedures • Provider contract template • Monitoring reports for appointment standards (according to MDHHS' Access Standards policy) **Evidence as Submitted by the PIHP:** • Policies and Procedures o Access Policy, pages 2-3, Standard 3a and 3b. o Time Frames and Procedural Steps for Priority Populations Management (Entire Document). ▪ Reference to timeframes o Methodology – Provider Calendar Availability Monitoring and Reporting o Network Monitoring and Management Policy, Page 3 standard #22-23 and page 5, standard #42-43 o Monitoring for Appointment Standards: ▪ Call Center Procedure – how to schedule appts • Information and Reports related to Monitoring for appointment standards (according to MDHHS) o Access Committee Meeting Notes and Agendas (4/20/2022, 9/21/22, 2/15/23) o QISC Meeting Notes and Agenda April 2023, page 3 #6 o ACC 30-45 day intake calendar meeting notes 4.18.2022	☒ Complete ☐ Not Complete

Standard III—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
	○ TGC 30-45 day intake calendar meeting notes 6.27.22 ○ Access Call Center Silent Monitoring Procedure ▪ Clinical Silent Monitoring Form pg. 2 • Provider Contract Template ○ 2022 Clinical Outpatient Agreement Second Amendment ○ 2022 Clinical Residential Agreement Amendment	

HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.

Recommendations: While the PIHP submitted a DWIHN [Detroit Wayne Integrated Health Network] Access Call Center SUD [Substance Use Disorder] Urgent Appointments/Priority Population report that captured urgent level of care, referral date, intake appointment date, and compliance with the 24-hour time frame, HSAG strongly recommends that the PIHP develop processes to capture and report on performance metrics for the SUD priority population admission standards by collecting numerators and denominators and calculating a percentage of compliance for each standard. As an example, for Pregnant Injecting Drug Users, the PIHP would report on three measure indicators:

- Percentage of members who were screened and referred within 24 hours.
- Percentage of members who were offered detoxification, methadone, or residential services within 24 business hours.
- Percentage of members who were offered other levels of care within 48 hours.

The PIHP would follow a similar process for reporting outcomes for the remaining SUD priority populations. The PIHP should use the member-level data to identify cases that are out of compliance, initiate a case review, and implement interventions for improvement, as indicated. Additionally, MDHHS requires the PIHP's network adequacy plan to include timely appointments; therefore, the results of the SUD priority population admission standards (i.e., performance metrics and analysis of results) should be incorporated and evaluated within the PIHP's annual network adequacy analysis. The PIHP's implementation of HSAG's recommendations will be reviewed during the SFY 2024 compliance review activity, and the PIHP may receive a score of *Not Met* if not adequately addressed. Further, HSAG will be recommending that MDHHS develop a reporting template to include instructions and a standardized format for the PIHPs to report the SUD priority population admission standards to include in each PIHP's annual network adequacy analysis report.

Technical Assistance Required: ☐ Yes ☒ No

Standard III—Availability of Services		
Complete	=	1
Not Complete	=	0

Standard IV—Assurances of Adequate Capacity and Services		
Requirement	**Supporting Documentation**	**Score**
Basic Rule		
1. The PIHP gives assurances to MDHHS and provides supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with MDHHS' standards for access to care under 42 §438.207, including the standards at §438.68 and §438.206(c)(1). a. Each PIHP must submit documentation to MDHHS, in a format specified by MDHHS, to demonstrate that it complies with the following requirements: i. Offers an appropriate range of behavioral health, development disability, substance use and specialty services, and LTSS that is adequate for the anticipated number of members for the service area. ii. Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area. *42 CFR §438.68* *42 CFR §438.206(1)* *42 CFR §438.207(a), (b)(1-2)* *Contract Schedule A–1(E)(2)(a)*	**HSAG Required Evidence:** • Policies and procedures • Network adequacy reports (according to MDHHS' PIHP Network Adequacy Standard Procedural Document) • Network Adequacy Certification Report (due to MDHHS by February 28th annually) **Evidence as Submitted by the PIHP:** • Access Policy – Pages 1-2, Standard 2 a & b • Network Monitoring and Management Policy - Page 5- Standards 43, 44 and 47 • Network Adequacy Data SUD Request • FY 21-22 MDHHS Specialty Behavioral Network Adequacy Health Standards (Network Adequacy Certification Report) Pages 4- 7	☒ Complete ☐ Not Complete
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations**: The network adequacy report included a description of the standards that were reviewed in accordance with MDHHS' network adequacy procedural document. However, the report included an internal compliance benchmark of 85 percent. As MDHHS' policy does not stipulate a benchmark, HSAG strongly recommends the PIHP measure adequacy by indicating the percentage of all members who have access to provider types within MDHHS' time/distance standards (i.e., the expectation is that 100 percent of members have access to the provider type). Additionally, HSAG recommends the PIHP proceed with its plan to update its network adequacy calculation methodologies to include all members and providers as indicated during the site review. Finally, HSAG recommends the PIHP adhere to any guidance issued by MDHHS regarding the specifications and format for reporting network adequacy standards.		

Standard IV—Assurances of Adequate Capacity and Services		
Requirement	**Supporting Documentation**	**Score**
Technical Assistance Required: ☐ Yes ☒ No		
Timing of Documentation		
2. Each PIHP must submit the documentation described in 42 CFR §438.207(b) as specified by MDHHS, but no less frequently than the following: a. At the time it enters into a contract with MDHHS. b. On an annual basis. c. At any time there has been a significant change (as defined by MDHHS) in the PIHP's operations that would affect the adequacy of capacity and services, including— i. Changes in PIHP services, benefits, geographic service area, composition of or payments to its provider network; or ii. Enrollment of a new population in the PIHP. *42 CFR §438.207(c)(3)(i-iii)*	**HSAG Required Evidence:** • Policies and procedures • Network adequacy reports (according to MDHHS' PIHP Network Adequacy Standard Procedural Document) • Network Adequacy Certification Report (due to MDHHS by February 28th annually) **Evidence as Submitted by the PIHP:** • Network Monitoring and Management Policy - Pages 4-5-Standards 38, 43 and 44 • FY 21-22 MDHHS Specialty Behavioral Network Adequacy Health Standards (Network Adequacy Certification Report) Standards - Pages 4-7	☒ Complete ☐ Not Complete
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Technical Assistance Required: ☐ Yes ☒ No		
Changes in Provider Network		
3. The PIHP must: a. *Notify MDHHS within seven days of any changes to the composition of the provider network organizations that negatively affect access to care. The PIHP must have procedures to address changes in its network that negatively affect access to care. Changes in provider network composition that MDHHS determines to negatively affect*	**HSAG Required Evidence:** • Policies and procedures • One example of notifying MDHHS of a change in the composition of its provider network after implementation of remediation, including date the PIHP became aware of the change and the date of notification to MDHHS **Evidence as Submitted by the PIHP:**	☒ Complete ☐ Not Complete

Standard IV—Assurances of Adequate Capacity and Services		
Requirement	**Supporting Documentation**	**Score**
recipient access to covered services may be grounds for sanctions. b. *Have written procedures to address network changes that negatively affect beneficiaries' access to care; MDHHS may apply sanctions to the PIHP if a network change that negatively affects beneficiaries' access to care is not reported timely, or the PIHP is not willing or able to correct the issue.* *Contract Schedule A–1(E)(3)(a-b)*	• Network Monitoring and Management Policy - Pages 4- 5- Standards 38, and b, 43,44 and 47 • 7 Day Notification of Closures Emails • Network Adequacy Notification to MDHHS • MCO Close Out Plan 1.2023 – Page 2 • Terminated - Merger Closure Contract Log	
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Technical Assistance Required: ☐ Yes ☒ No		
Regional Specific Plans		
4. *The PIHP submits a plan on how standards will be effectuated by region. Understanding their diversity, MDHHS expects to see nuances within the PIHPs to best accommodate the local populations served. PIHPs must consider at least the following parameters for their plans:* a. *Maximum time and distance* b. *Timely appointments* c. *Language, Cultural competence, and Physical accessibility—42 CFR 438.68(c)(1)(vii-viii).* *42CFR 438.68(c)(1)(vii-viii)* *PIHP Network Adequacy Standard Procedural Document*	**HSAG Required Evidence:** • Regional Network Adequacy Plan (according to MDHHS' PIHP Network Adequacy Standard Procedural Document) **Evidence as Submitted by the PIHP:** • FY 21-22 MDHHS Specialty Behavioral Network Adequacy Health Standards (Network Adequacy Certification Report) – Pages 4-7 • Evidence of ADA Entry in MHWIN • DWIHN Provider Manual-1 FY22.23 Final on website pgs. 49,51,65,70	☒ Complete ☐ Not Complete
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** HSAG recommends the PIHP adhere to any guidance issued by MDHHS regarding the format for reporting its network adequacy plan, including required time/distance; timely appointments; and language, cultural competence, and physical accessibility. The results of all assessments should also be thoroughly documented within the network adequacy report.		

Standard IV—Assurances of Adequate Capacity and Services		
Requirement	**Supporting Documentation**	**Score**
Technical Assistance Required: ☐ Yes ☒ No		

Standard IV—Assurances of Adequate Capacity and Services		
Complete	**=**	**4**
Not Complete	**=**	**0**

Standard V—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
Person-Centered Planning Process/Service Plan		
12. Members must lead the person-centered planning process where possible. The member's representative should have a participatory role, as needed and as defined by the member, unless State law confers decision-making authority to the legal representative. a. The person-centered service plan must reflect that the setting in which the member resides is chosen by the member. The setting chosen by the member is integrated in, and supports full access of member receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS. b. The setting is selected by the member from among setting options, including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the member's needs, preferences, and, for residential settings, resources available for room and board. *42 CFR §441.301(c)(1),(2)(i)* *42 CFR §441.530(a)(ii)* *42 CFR §441.710(a)(1)(ii)* *Person-Centered Planning Practice Guideline Section VI*	**HSAG Required Evidence:** • Three examples of completed person-centered service plans (PCSP) for members receiving home and community-based services (HCBS) after implementation of remediation, including the assessment of residential settings • Oversight and monitoring documentation **Evidence as Submitted by the PIHP:** • 3 Examples of Monitoring for the selected Plans: o [redacted] Clinical Case Record Review_pg12 o [redacted] Case Record Review_pg4-5 o [redacted] Provider Review Protocol_pg24, 35-36 • 3 Examples of PCP Plans (HCBS): o [redacted] IPOS_pg.5 o [redacted] IPOS_pg.3 o [redacted] IPOS_pg.4	☒ Complete ☐ Not Complete
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Technical Assistance Required: ☐ Yes ☒ No		

Standard V—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
Home- and Community-Based Settings		
13. Any modification of the conditions, under 42 CFR §441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan: a. Identify a specific and individualized assessed need. b. Document the positive interventions and supports used prior to any modifications to the person-centered service plan. c. Document less intrusive methods of meeting the need that have been tried but did not work. d. Include a clear description of the condition that is directly proportionate to the specific assessed need. e. Include regular collection and review of data to measure the ongoing effectiveness of the modification. f. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated. g. Include the informed consent of the member. h. Include an assurance that interventions and supports will cause no harm to the member. *42 CFR §441.301(c)(4)(vi)(F)(1-8)* *42 CFR §441.530(a)(1)(vi)(F)(1-8)* *42 CFR §441.710(a)(1)(vi)(F)(1-8)* *Person-Centered Planning Practice Guideline Section VII*	**HSAG Required Evidence:** • Three examples of completed PCSP with restrictions to the member's freedom under the HCBS Final Rule after implementation of remediation plan • Oversight and monitoring documentation **Evidence as Submitted by the PIHP:** • Three Examples of PCP Plans: o [redacted] IPOS_Pg.4-5 o [redacted] IPOS_pg.5-6 o [redacted] IPOS_pg.3 • Oversight and Monitoring: o [redacted] Case Record Review_pg5,8 o [redacted] Clinical Case Record Review_pg12-13, 41 o [redacted] Provider Review Protocol_pg24	☒ Complete ☐ Not Complete
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** While the PIHP included a dedication section in the Individualized Plan of Service (IPOS) to document the requirements of this element when there is a modification of the conditions, under 42 CFR §441.301(c)(4)(vi)(A) through (D), HSAG recommends that the PIHP conduct ongoing training		

Standard V—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
to ensure this section is appropriately filled out. As an example, for the question: "WHO IS RESPONSIBLE FOR MONITORING THE MODIFICATIONS / LIMITATIONS THAT ARE IN PLACE TO ASSURE INTERVENTIONS AND SUPPORTS WILL CAUSE NO HARM TO THE MEMBERS? WHAT DATA IS / WILL BE COLLECTED AND HOW OFTEN (FREQUENCY OF MONITORING AND REPORTING OF PROGRESS)?", only "BTPC [Behavior Treatment Plan Committee] and home manager/staff" were documented. It did not include the data to be collected or the frequency of monitoring and reporting.		
Technical Assistance Required: ☐ Yes ☒ No		
Conflict-Free Case Management		
14. The PIHP must establish conflict of interest standards for the assessments of functional need and the person-centered service plan development process that apply to all individuals and entities, public or private. At a minimum, these standards must ensure that the individuals or entities conducting the assessment of functional need and person-centered service plan development process are not: a. Related by blood or marriage to the member, or to any paid caregiver of the member. b. Financially responsible for the member. c. Empowered to make financial or health-related decisions on behalf of the member. d. Individuals who would benefit financially from the provision of assessed needs and services. e. Providers of HCBS for the member, or those who have an interest in or are employed by a provider of HCBS for the member must not provide case management or develop the person-centered service plan, except when MDHHS demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS. In these cases, MDHHS must devise conflict of interest	**HSAG Required Evidence:** • Policies and procedures • Staff training on conflict-free care management • Oversight and monitoring documentation **Evidence as Submitted by the PIHP:** • Conflict-Free Case Management Policy (Entire Document) • Quality Ops Notes 09.28.2022 Agenda, Minutes, Attendance, pg. 5 • Quality Ops Notes 1.25.2023 Agenda, Notes, Attendance, pgs. 1, 8 • IPLT 11-1-22 Agenda, Minutes, Attendance, pgs. 1-4 • Oversight and Monitoring: o [redacted] Provider Protocol Review Report_Pg.35 o [redacted] Provider Review Protocol_pg.37 o [redacted] Provider Protocol Review Report_Pg.35	☒ Complete ☐ Not Complete

Standard V—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
protections including separation of entity and provider functions within provider entities, which must be approved by CMS. Members must be provided with a clear and accessible alternative dispute resolution process. *42 CFR §441.301(c)(1)(vi)* *42 CFR §441.555(c)(1-5)* *42 CFR §441.730(b)(1-5)* *Person-Centered Planning Practice Guideline Section VIII*		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Technical Assistance Required: ☐ Yes ☒ No		

Standard V—Coordination and Continuity of Care		
Complete	**=**	**3**
Not Complete	**=**	**0**

Standard VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
Notice of Adverse Benefit Determination		
6. The PIHP must notify the requesting provider (*notice of the provider does NOT need to be in writing*), and give the member written notice of any decision by the PIHP to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The member's notice must meet the requirements of 42 CFR §438.404. The notice must explain the following: a. The adverse benefit determination the PIHP has made or intends to make. b. The reasons for the adverse benefit determination, including the right of the member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits. c. The member's right to request an appeal of the PIHP's adverse benefit determination, including information on exhausting the PIHP's one level of appeal described at 42 CFR §438.402(b) and the right to request a State fair hearing consistent with 42 CFR §438.402(c). d. The procedures for exercising the rights specified in 42 CFR §438.404(b). e. The circumstances under which an appeal process can be expedited and how to request it. f. The member's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances, consistent with MDHHS policy, under which the member may be required to pay the costs of these services.	**HSAG Required Evidence:** • ABD notice template • Three examples of completed ABD notices after implementation of remediation plan **Evidence as Submitted by the PIHP:** • Updated Adequate ABD Medicaid Template • Three examples of completed ABD notices (Please see the case samples folder)	☒ Complete ☐ Not Complete

Standard VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
g. *An explanation the member may represent himself/herself or use legal counsel, a relative, a friend, or other spokesman.* *42 CFR §438.210(c)* *42 CFR §438.404(b)(1-6)* *Appeal and Grievance Resolution Processes Technical Requirement IV(A)(1-10)* *Appeal and Grievance Resolution Processes Technical Requirement IV(C)(1-2)*		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Technical Assistance Required: ☐ Yes ☒ No		
7. The PIHP must mail the notice within the following timeframes: a. For termination, suspension, or reduction of previously authorized Medicaid-covered services, within the timeframes specified in 42 CFR §431.211, §431.213, and §431.214. b. For denial of payment, at the time of any action affecting the claim. c. For standard or expedited service authorization decisions, (including the extension of service authorization timeframes), that deny or limit services, within the timeframe specified in 42 CFR §438.210(d)(l-2). d. For service authorization decisions not reached within the timeframes specified in 42 CFR §438.210(d) (which constitutes a denial and is thus an adverse benefit determination), on the date that the timeframes expire. *42 CFR §431.211* *42 CFR §431.213* *42 CFR §431.214* *42 CFR §438.210(d)(1-2)* *42 CFR §438.404(c)(1-6)* *Appeal and Grievance Resolution Processes Technical Requirement IV(B)(1-2)*	**HSAG Required Evidence:** • Policies and procedures • Workflows • Staff training materials • ABD notice templates • Three examples of completed ABD notices (for the suspension, reduction, or termination of a previously authorized service) after implementation of remediation plan • Three examples of completed ABD notices (for a denial of payment on a claim) after implementation of remediation plan **Evidence as Submitted by the PIHP:** • Denial of Medicaid Service Procedure page 2 #12, page 3 #13 and page 4 #28-29 • Denial of Service Policy Page 6 #23 • Claims Processing Procedure page 4 #7 • Notice of Denial of Payment form • Adequate ABD Medicaid 010623	☒ Complete ☐ Not Complete

Standard VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
	• Advance Notice of Adverse Benefit Determination • Utilization Staff Meeting (Training) July 19, 2021 • There are no examples of ABD notices for a denial of payment on a claim as there were no claim denials after implementation of the remediation plan.	
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Technical Assistance Required: ☐ Yes ☒ No		
Standard Authorization Decisions		
8. For standard authorization decisions, the PIHP must provide notice as expeditiously as the member's condition requires and within MDHHS-established timeframes that may not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days, if— a. The member, or the provider, requests extension; or b. The PIHP justifies (to MDHHS upon request) a need for additional information and how the extension is in the member's interest. *42 CFR §438.210(d)(1)(i-ii)* *Appeal and Grievance Resolution Processes Technical Requirement IV(B)(1)(b-c)*	**HSAG Required Evidence:** • Tracking and monitoring mechanisms • Three examples of prior authorizations after implementation of remediation plan, with the date of receipt of the request and ABD notice **Evidence as Submitted by the PIHP:** • Timeliness of UM Reviews Monitoring Process • There are no sample cases of prior authorizations after implementation of remediation plan.	☒ Complete ☐ Not Complete
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** Of note, after the site review, the PIHP provided three examples of requests for services that were approved within the 14-calendar-day time frame and, therefore, this element received a *Complete* status. The PIHP indicated that no requests for services were denied; therefore, no adverse benefit determination (ABD) notices were sent to members. This element will be reviewed during the SFY 2024 compliance review activity and, as such, the PIHP may receive a score of *Not Met* if all denial notices reviewed as part of the case file review process are not sent to members timely. Therefore, HSAG strongly recommends the PIHP continue its efforts to monitor ABD notice timeliness.		
Technical Assistance Required: ☐ Yes ☒ No		

Standard VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
Extension Notification		
10. If the PIHP extends the review of the service authorization timeframe NOT at the request of the member, the PIHP must: a. *Make reasonable efforts to give the member prompt oral notice of the delay;* b. *Within two calendar days,* provide the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he/she disagrees with that decision; and c. Issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date. *42 CFR §438.404(c)(4)(i-ii)* *Appeal and Grievance Resolution Processes Technical Requirement IV(B)(1)(c)*	**HSAG Required Evidence:** • Policies and procedures • Tracking and reporting mechanisms • Service authorization extension letter template • Three case examples of service authorization extensions after implementation of remediation plan, including oral and written notice of the extension **Evidence as Submitted by the PIHP:** • Process of Oral Notification to the Enrollee • Denial of Medicaid Service Procedures- Page 3 #13 and 15 • Extension Notification-Member • Extension Notification –Provider • Request for additional information form • Extension letter Audit Spreadsheet • There are no case examples of service authorization extensions to present after implementation of remediation plan.	☒ Complete ☐ Not Complete
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. Of note, the PIHP indicated it did not have any service authorization time frame extensions; therefore, no case examples were available for review. **Recommendations:** The PIHP provided a revised Member Extension Letter template. The template informed the member that the PIHP is taking a 14-day extension and the utilization management department is awaiting additional information to make an informed decision. The letter template also included the right to file a grievance, as required. Although the letter template included the required components to address this element, HSAG strongly recommends that the PIHP review the letter contents to ensure it meets an appropriate reading grade level, and that the information within the letter template is clear to the member. The PIHP could consider revising the language to indicate, "We received your request for authorization of services on [date]. To make a decision on your request, we need additional information from your provider. We are allowed under Medicaid rules to have 14 additional days to make an		

Standard VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
authorization decision if it is in your best interest. We will make a decision as fast as we can but will notify you of our decision no later than [initial due date plus the 14 days]. If you do not agree with our decision, you can file a grievance with ….”		
Technical Assistance Required: ☐ Yes ☒ No		

Standard VI—Coverage and Authorization of Services		
Complete	**=**	**4**
Not Complete	**=**	**0**

Standard VII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
File Reviews		
13. The PIHP complies with individual practitioner credentialing requirements as specified in the Practitioner Credentialing and Recredentialing File Review Tool. *42 CFR §438.214(e)* *Credentialing and Re-credentialing Processes*	**HSAG Required Evidence:** • Three practitioner initial credentialing files after implementation of remediation plan **Evidence as Submitted by the PIHP:** • [redacted] Initial Cred file • [redacted] Initial Cred file • [redacted] Initial Cred file	☒ Complete ☐ Not Complete
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Technical Assistance Required: ☐ Yes ☒ No		
14. The PIHP complies with individual practitioner recredentialing requirements as specified in the Practitioner Credentialing and Recredentialing File Review Tool. *42 CFR §438.214* *Credentialing and Re-credentialing Processes*	**HSAG Required Evidence:** • Three practitioner recredentialing files after implementation of remediation plan **Evidence as Submitted by the PIHP:** • [redacted] re-cred file • [redacted] re-cred file • [redacted] re-cred file	☒ Complete ☐ Not Complete
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Technical Assistance Required: ☐ Yes ☒ No		
15. The PIHP complies with organizational credentialing requirements as specified in the Organizational Credentialing and Recredentialing File Review Tool. *42 CFR §438.214*	**HSAG Required Evidence:** • Three organizational initial credentialing files after implementation of remediation plan **Evidence as Submitted by the PIHP:**	☒ Complete ☐ Not Complete

Standard VII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
Credentialing and Re-credentialing Processes	• [redacted] cred file • [redacted] cred file • [redacted] cred file	
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Technical Assistance Required: ☐ Yes ☒ No		
16. The PIHP complies with organizational recredentialing requirements as specified in the Organizational Credentialing and Recredentialing File Review Tool. *42 CFR §438.214* *Credentialing and Re-credentialing Processes*	**HSAG Required Evidence:** • Three organizational recredentialing files after implementation of remediation plan **Evidence as Submitted by the PIHP:** • [redacted] re-cred file • The implementation date for remediation was 4/28/2023 and there was only one re-cred file that occurred after that date	☒ Complete ☐ Not Complete
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Technical Assistance Required: ☐ Yes ☒ No		

Standard VII—Provider Selection		
Complete	**=**	**4**
Not Complete	**=**	**0**

Standard VIII—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
Notice of Privacy Practices		
11. 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 must provide a notice that is written in plain language and that contains the elements required by 45 CFR §164.520(b)(1)(i-viii). b. The PIHP must make the notice available to its members on request as required by 45 CFR §164.520(c)(1-3). *45 CFR §164.520(a)(1)* *45 CFR §164.520(b)(1)(i-viii)* *45 CFR §164.520(c)(1-3)*	**HSAG Required Evidence:** • Policies and procedures • Member handbook • Notice of Privacy Practices • Link to Notice of Privacy Practices on website • Dissemination of notice to members **Evidence as Submitted by the PIHP:** • HIPAA Privacy Manual and Policies; Pages 13-15 • https://www.dwihn.org/policies • Protected Health Information -PHI- Privacy and Confidentiality Policy • Notice of Privacy Practices.pdf • FY22_Unduplicated Members excel spreadsheet • Privacy Practice Postage Receipt • CV Meeting March 17,2023 Agenda, Minutes, Attendance Pgs. 1,3,5-6 • Spring 2023-PPV- Newsletter page 16- Privacy Practice Updates • Member Handbook- Member Rights and Responsibilities (Privacy Practice Page 14) • Privacy Practice Quote • Notice Privacy Practice Guidelines (mailed)	☒ Complete ☐ Not Complete
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Technical Assistance Required: ☐ Yes ☒ No		

Standard VIII—Confidentiality		
Complete	=	1
Not Complete	=	0

Standard IX—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Handling of Grievances		
4. The PIHP must acknowledge receipt of each grievance. *42 CFR §438.406(b)(1)* *42 CFR §438.228* *Contract Schedule A—1(L)(2)(e)* *Appeal and Grievance Resolution Processes Technical Requirement—VII(C)(2)*	**HSAG Required Evidence:** • Acknowledgement letter template • Three grievance case files after implementation of remediation plan, including acknowledgement notice **Evidence as Submitted by the PIHP:** • Medicaid Notice of Receipt of Grievance Template • Three Grievance Case Files (3036,3063 and 3069)	☒ Complete ☐ Not Complete
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Technical Assistance Required: ☐ Yes ☒ No		
Handling of Appeals		
15. If the PIHP denies a request for expedited resolution of an appeal, it must: a. Transfer the appeal to the timeframe for standard resolution in accordance with 42 CFR §438.408(b)(2). b. Follow the requirements in 42 CFR §438.408(c)(2), including: i. Make reasonable efforts to give the member prompt oral notice of the delay. ii. Within two (2) 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 the member disagrees with that decision. *42 CFR §438.406(b)(1)* *42 CFR §438.410(c)* *42 CFR §438.228*	**HSAG Required Evidence:** • Three appeal case files of denied expedited appeal resolution time frames after implementation of remediation plan, including date of the denied request, and oral and written notice of the denied request **Evidence as Submitted by the PIHP:** • No cases of denied expediated appeals to submit after implementation of remediation plan. • Proof of denial of expedited appeal request template and Denial of Expedited Appeal Request Link (MH-WIN)	☒ Complete ☐ Not Complete

Standard IX—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Contract Schedule A—1(L)(8)(b)(v) *Appeal and Grievance Resolution Processes Technical Requirement—VI(C)(2)(c)(i-iii)*		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. Of note, while the PIHP provided a denial of expedited appeal request template letter, member appeals checklist, and a screenshot of the link to the template letter within the PIHP's grievance and appeal information system, the PIHP confirmed it had no cases in which the PIHP denied the request for an expedited appeal resolution; therefore, no case examples were available for review.		
Technical Assistance Required: ☐ Yes ☒ No		
16. The PIHP must acknowledge receipt of each appeal. *42 CFR §438.406(b)(1)* *42 CFR §438.228* *Contract Schedule A—1(L)(2)(e)* *Appeal and Grievance Resolution Processes Technical Requirement—VI(B)(2)*	**HSAG Required Evidence:** • Acknowledgement letter template • Three appeal case files after implementation of remediation plan, including acknowledgement notice **Evidence as Submitted by the PIHP:** • Notice of Receipt of Appeal Medicaid Template • Case 1, Case 2, Case 3 • Emails with MDHHS regarding State Templates (1, 2, and 3).	☒ Complete ☐ Not Complete
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Technical Assistance Required: ☐ Yes ☒ No		
Resolution and Notification of Appeals		
26. For all appeals, the PIHP must provide written notice of the resolution in a format and language that, at a minimum, meets the requirements in accordance with 42 CFR §438.10. The written notice of the appeal resolution includes: a. The results of the resolution process and the date it was completed.	**HSAG Required Evidence:** • Three appeal case files after implementation of remediation plan, including the appeal resolution notice (upheld) **Evidence as Submitted by the PIHP:**	☒ Complete ☐ Not Complete

Standard IX—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
b. For appeals not resolved wholly in favor of the member: i. The right to request a State fair hearing, 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 state 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 §438.408(d)(2)(i)* *42 CFR §438.408(e)(1-2)* *42 CFR §438.10* *42 CFR §438.228* *Contract Schedule A—1(L)(2)(k); 1(L)(8)(b)(iv)* *Appeal and Grievance Resolution Processes Technical Requirement—VI(C)(4)(c); VI(C)(5)*	• Case 1, Case 2 • No other appeal case files to submit after implementation of remediation plan.	
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Technical Assistance Required: ☐ Yes ☒ No		
27. For notice of an expedited appeal resolution, the PIHP must make reasonable efforts to provide oral notice. *42 CFR §438.408(d)(2)(ii)* *42 CFR §438.228* *42 CFR §438.228* *Contract Schedule A—1(L)(8)(b)(iv)* *Appeal and Grievance Resolution Processes Technical Requirement—VI(C)(4)(a)*	**HSAG Required Evidence:** • Three expedited appeal case files after implementation of remediation plan, including the date of receipt of the appeal request and the oral notice of resolution **Evidence as Submitted by the PIHP:** • Case 1 • No other expedited appeal case files to submit after implementation of remediation plan.	☒ Complete ☐ Not Complete
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Technical Assistance Required: ☐ Yes ☒ No		

Standard IX—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Continuation of Benefits		
32. If the PIHP or the State fair hearing 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. *42 CFR §438.424(a)* *42 CFR §438.228* *Contract Schedule A—1(L)(5)(j)* *Appeal and Grievance Resolution Processes Technical Requirement—V(F)*	**HSAG Required Evidence:** • Three appeal case files (overturned) after implementation of remediation plan, including the date of the reversal and the date the services were reinstated/authorized **Evidence as Submitted by the PIHP:** • Case 1, Case 2, Case 3 including authorization entries.	☒ Complete ☐ Not Complete
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Technical Assistance Required: ☐ Yes ☒ No		

Standard IX—Grievance and Appeal Systems		
Complete	**=**	**6**
Not Complete	**=**	**0**

Standard X—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
Contract or Written Arrangement		
4. The contract or written arrangement indicates, and the delegate agrees that: a. The State, Centers for Medicare and 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 PAHP's contract with the State. b. The delegate agrees that 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 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 the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the delegate at any time. *42 CFR §438.230(c)(3)(i-iv)*	**HSAG Required Evidence:** • Subcontractor delegation agreement template • List of all delegated entities • Three examples of executed delegation agreements **Evidence as Submitted by the PIHP:** • Professional Services Agreement with Delegation FY2023 Page 7, Section 9.01 and 9.02 • DWIHN List of Delegated Entities • Executed Delegation Agreement MPRO FY2023 Pages 6-7, Sections 9.01 and 9.02 • Delegation Addendum The Professional Services Agreement Between DWHIN and Provider Template – Page 2/Performance Monitoring Evaluation Section 5 d, e, f and g. • Note: DWIHN has only one delegation agreement; MPRO	☒ Complete ☐ Not Complete
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Technical Assistance Required: ☐ Yes ☒ No		

Standard X—Subcontractual Relationships and Delegation		
Complete	=	**1**
Not Complete	=	**0**

Standard XI—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
Adoption of Practice Guidelines		
3. The PIHP must adopt practice guidelines that are adopted in consultation with network providers. *42 CFR §438.236(b)(3)*	**HSAG Required Evidence:** • Policies and procedures • Methodology for how network providers are included in the adoption of practice guidelines • Evidence of consultation with network providers when adopting/reviewing practice guidelines	☒ Complete ☐ Not Complete
	Evidence as Submitted by the PIHP: • Clinical Practice Guidelines Policy • QAPIP Annual Evaluation and Workplan pg. 2, 15 • QAPIP Plan Description Reviewed 3.1.2023 FY 21-23 pg. 3, 49 • CPG IPLT email.pdf • IPLT 12-6-22 Agenda, Attendance and Notes Combined • IPLT 1-10-23 Agenda, Attendance and Notes Combined • IPLT 2-7-23 Agenda, Attendance and Notes Combined • Methodology of Network Provider Consultation and Practice Guidelines • Medical Director's Meeting Agenda-attendance-notes-January 12th 2023-combined pgs.1, 2, 4-5 • Medical Director memo for CPG feedback pgs. 1-2	
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Technical Assistance Required: ☐ Yes ☒ No		

Standard XI—Practice Guidelines		
Complete	=	1
Not Complete	=	0

Standard XII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
Application Programming Interface (API)		
7. The PIHP must implement 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 MCO. Information must be 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 (1) business day after a claim is processed. b. Encounter data no later than one (1) business day after receiving the data from providers compensated on the basis of capitation payments. c. All other encounter data, including adjudicated claims and encounter data from any subcontractors. d. Clinical data, including laboratory results, no later than one (1) business day after the data is received by the MCO. e. Information about covered outpatient drugs and updates to such information, including, where applicable, preferred drug list information, no later than one (1) business day after the effective date of any such information or updates to such information. *42 CFR §438.242(b)(5)* *42 CFR §431.60*	**HSAG Recommended Evidence:** • Policies, procedures, and workflows • API project plan(s) • API documentation • HSAG will use the results from the API demonstration **Evidence as Submitted by the PIHP:** • API implemented in January 2023 • API Certified by ONC Health IT Certification - https://urldefense.proofpoint.com/v2/url?u=https-3A__chpl.healthit.gov_-23_listing_11045&d=DwMFAg&c=LFKLL4zDS98hXhqGXAbcKw&r=lPHZ_kCusrLrfRzzefIyuaM8ZBm12_IOv3VByFH0fbc&m=TVXeh80ZWegeqTO1mJW2mveEVLc1DoCUHjjpaN1g5mhqqZyks1qgDhyFGSFrXjOa&s=0nobqqJDhzQcgYpwJhX0p6SOv7qOdMtBFf6OwKGe92g&e= • API documentation - Standard XII. Element 7 PIX_9_4_API_Documentation.pdf • DWIHN Website provider page- https://www.dwihn.org/provider-MHWIN-API	☐ Complete ☒ Not Complete
HSAG Findings: The PIHP's health information system (HIS) vendor developed a Fast Healthcare Interoperability Resources (FHIR)-based Patient Access Application Programming Interface (API), and the PCE Care Management manual was posted on the PIHP's website. However, the API has not been made accessible to the PIHP's current members. In response to these findings, the PIHP must provide an action plan with specific timelines to:		

Standard XII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**

- In accordance with 42 CFR §431.60(f), develop a member-facing website with educational resources in nontechnical, simple, and easy-to-understand language explaining how members can access their health information via the API and a third-party application, including:
  - General information on steps the member may consider taking to help protect the privacy and security of their health information, including factors to consider in selecting an application, including secondary uses of data, and the importance of understanding the security and privacy practices of any application to which they will entrust their health information.
  - An overview of which types of organizations or individuals are and are not likely to be Health Insurance Portability and Accountability Act of 1996 (HIPAA)-covered entities, the oversight responsibilities of the United States Department of Health and Human Services (HHS) Office for Civil Rights (OCR) and the Federal Trade Commission (FTC), and how to submit a complaint to the HHS OCR and the FTC.
- Implement an authentication process that will be used to verify the identity of members who seek to access their claims and encounter data and other protected health information (PHI) through the API.
  - The action plan must include a detailed description of the authentication process that members will need to use to gain access to their health information via the API.

  Of note, CMS has issued a guidance document that provides an overview of what is required to be included in a Medicaid managed care plan's patient resource document related to privacy and security and some content Medicaid managed care plans may choose to use to help meet this requirement. Refer to: https://www.cms.gov/files/document/patient-privacy-and-security-resources.pdf.

Recommendations: While the PCE Care Management manual was posted on the PIHP's website, HSAG strongly recommends that the PIHP confirm this manual complies with 42 CFR §431.60(d) related to the information required to be posted on the PIHP's website, or update its website to include all of the following:

- API syntax, function names, required and optional parameters supported and their data types, return variables and their types/structures, exceptions and exception handling methods and their returns.
- The software components and configurations an application must use in order to successfully interact with the API and process its response(s).
- All applicable technical requirements and attributes necessary for an application to be registered with any authorization server(s) deployed in conjunction with the API.

The PIHP's implementation of HSAG's recommendations will be reviewed during the SFY 2025 compliance review activity, and the PIHP may receive a score of *Not Met* if not adequately addressed.

Technical Assistance Required: ☐ Yes ☒ No

Standard XII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
A technical assistance call is not required at this time as the PIHPs are in discussions with MDHHS regarding the applicability of the API requirements; however, the PIHP must proceed with fully implementing the Patient Access API to comply with all requirements of 42 CFR §431.60 and the CMS Interoperability and Patient Access Final Rule (CMS-9115-F).		
8. The MCO must maintain a publicly accessible standards-based API described in 42 CFR §431.70 (access to published provider directory information), which must include all information specified in 42 CFR §438.10(h)(1) and (2). *42 CFR §438.242(b)(6)* *42 CFR §431.70* *42 CFR §438.10(h)(1-2)*	**HSAG Required Evidence:** • Policies, procedures, and workflows • API project plan(s) • API documentation • HSAG will use the results from the API demonstration **Evidence as Submitted by the PIHP:** • API implemented in January 2023 • API documentation - Element XII. Element 8 Payer Data Exchange - PCE User Manual (1).pdf • DWIHN Website provider page- https://www.dwihn.org/provider-MHWIN-API	☐ Complete ☒ Not Complete
HSAG Findings: The PIHP's HIS vendor developed an FHIR-based Provider Directory API and the Payer Data Exchange—PCE User Manual was posted on the PIHP's website. However, the PIHP had not made its Provider Directory API publicly accessible. Discussion during the site review suggested that the API was publicly accessible via a link within the user manual. When questioned how one link in the user manual, which is used across all applicable PIHPs, could produce PIHP-specific provider directory information, the PIHP indicated that it was up to the developer to select which PIHP. However, this does not appear to align with the functionality of the API. Further, the Provider Directory API must be accessible via a public-facing digital endpoint on the PIHP's website to ensure public discovery and access; therefore, a PIHP-specific endpoint must be posted on the PIHP's website that would provide external stakeholders with immediate access to the PIHP's provider directory information via a third-party application. **Recommendations:** As 42 CFR §431.70 requires the Provider Directory API to make available all information specified in 42 CFR §438.10(h)(1) and (2), HSAG strongly recommends that the PIHP work with its HIS vendor to ensure the API has the capability of making available all information required by 42 CFR §438.10(h)(1): • The provider's name as well as any group affiliation. • Street address(es). • Telephone number(s).		

Standard XII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
• Website URL, as appropriate. • Specialty, as appropriate. • Whether the provider will accept new enrollees. • 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. The PIHP's implementation of HSAG's recommendations will be reviewed during the SFY 2025 compliance review activity, and the PIHP may receive a score of *Not Met* if not adequately addressed.		
Technical Assistance Required: ☐ Yes ☒ No A technical assistance call is not required at this time as the PIHPs are in discussions with MDHHS regarding the applicability of the API requirements; however, the PIHP must proceed with fully implementing the Provider Directory API to comply with all requirements of 42 CFR §431.70 and the CMS Interoperability and Patient Access Final Rule (CMS-9115-F).		

Standard XII—Health Information Systems		
Complete	**=**	**0**
Not Complete	**=**	**2**

Standard XIII—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
Sentinel Events and Critical Incidents		
20. *The QAPIP must describe how the PIHP will analyze, at least quarterly, the critical incidents, sentinel events, and risk events to determine what action needs to be taken to remediate the problem or situation and to prevent the occurrence of additional events and incidents.* *Contract Schedule A—1(K)(2)(a)* *QAPIPs for Specialty PIHPs, Section VIII(E)*	**HSAG Recommended Evidence:** • Most recent two quarterly quantitative and qualitative analysis of critical incidents, sentinel events, and risk events **Evidence as Submitted by the PIHP:** • Sentinel Event Review Flow-Chart Process • 2nd Quarter CE/SE and Risk Events Analysis Report • 3rd Quarter CE/SE and Risk Events Analysis Report will not be available until September 30th, 2023, due to data collection 90-day time lag, Committees and Full Board approval.	☒ Complete ☐ Not Complete
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Technical Assistance Required: ☐ Yes ☒ No		
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.*	**HSAG Required Evidence:** • Policies and procedures • Most recent two analyses of critical incidents and subsequent actions taken **Evidence as Submitted by the PIHP:** • Reporting of Member Critical Event- Sentinel Event- and Death Policy (Entire Document) • Reporting of Member Critical Event- Sentinel Event- and Death Reporting Procedures, pg. 2 • Analysis PRC Case Review 1571613 Guidance Center • Analysis PRC Case Review 17071 CLS • SEC PRC Review Committee Minutes 042023	☒ Complete ☐ Not Complete

Standard XIII—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
Contract Schedule A—1(K)(2)(a) *QAPIPs for Specialty PIHPs, Section VIII(F)*		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Technical Assistance Required: ☐ Yes ☒ No		
Behavior Treatment Review		
23. *The QAPIP quarterly reviews analyses of data from the Behavior Treatment Review Committee where intrusive or restrictive techniques have been approved for use with members and where physical management or 911 calls to law enforcement have been used in an emergency behavioral crisis.* a. *Only the techniques permitted by the Technical Requirement for Behavior Treatment Plans and have been approved during person-centered planning by the member or his/her guardian, may be used with members.* b. *Data shall include numbers of interventions and length of time the interventions were used per individual.* *Contract Schedule A—1(K)(2)(a)* *QAPIPs for Specialty PIHPs, Section IX*	**HSAG Required Evidence:** • Most recent quarterly analysis of data from the Behavior Treatment Review Committee (BTRC) **Evidence as Submitted by the PIHP:** • Q2 Analysis of data from the Behavior Treatment Advisory Committee (BTAC); Entire document. • Meeting Agenda, Notes Attendance QISC July 18 2023Draft pg. 7-8.	☒ Complete ☐ Not Complete
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** Although the PIHP tracked the length of time physical management interventions were used within the sentinel events reported through that process, HSAG strongly recommends that the PIHP also include the length of time physical management interventions were used per individual in its aggregated analysis. The PIHP's implementation of HSAG's recommendations will be reviewed during the SFY 2025 compliance review, and the PIHP may receive a score of *Not Met* if not adequately addressed.		
Technical Assistance Required: ☐ Yes ☒ No		

Standard XIII—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
Assessments of Member Experience		
25. *As a result of the assessments, the PIHP:* a. *Takes specific action on individual cases as appropriate;* b. *Identifies and investigates sources of dissatisfaction;* c. *Outlines systemic action steps to follow up on the findings;* d. *Informs practitioners, providers, recipients of service, and the Governing Body of assessment results; and* e. *Ensures the incorporation of individuals receiving long-term supports or services (e.g., individuals receiving case management or supports coordination) into the review and analysis of the information obtained from quantitative and qualitative methods.* f. *Evaluates the effects of activities implemented to improve satisfaction.* *Contract Schedule A—1(K)(2)(a)* *QAPIPs for Specialty PIHPs, Section X(B-D)*	**HSAG Required Evidence:** • Most recent quantitative and qualitative analysis of member experience activities • Action plans initiated due to the results of the member experience activities • Evaluation of the activities implemented to improve satisfaction • Methodology for incorporating members receiving long-term services and supports (LTSS) in the member experience activities • Confirmation the results of the member experience activities were communicated to providers and members **Evidence as Submitted by the PIHP:** • LTSS 2022 Survey Report July2022, pg. 2. • Examining Member Experience Outcomes Summary FY22 February 2023 (Entire Document) • LTSS Participants Next Steps January 2023 (Entire Document) • LTSS Evaluation Study July 2023 (Entire Document) • Program Compliance Committee Meeting Agenda Packet - March 8, 2023, pgs., 41-53 • QISC Agenda, Minutes, Attendance November 3,2022 pgs.1, 5-6 • CV Meeting Agenda, Minutes, Attendance June 16, 2023, pgs. 1,3,6	☒ Complete ☐ Not Complete

Standard XIII—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
	• Meeting Agenda, Notes Attendance QISC July 18 2023Draft	
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendation:** Although the PIHP's Member Experience Outcomes Summary documents included quantitative analysis, HSAG strongly recommends that the PIHP include a qualitative analysis, which includes the barriers identified, in order to develop effective interventions. The PIHP's implementation of HSAG's recommendations will be reviewed during the SFY 2025 compliance review, and the PIHP may receive a score of *Not Met* if not adequately addressed.		
Technical Assistance Required: ☐ Yes ☒ No		
QAPIP Reviews, Analysis, and Evaluation		
28. *Information on the effectiveness of the PIHP's QAPIP must be provided annually to network providers and to members upon request.* *Contract Schedule A—1(K)(3)(a)*	**HSAG Required Evidence:** • Confirmation the effectiveness of the QAPIP was disseminated to providers and members **Evidence as Submitted by the PIHP:** • Constituents Voice (CV) Agenda, Minutes, Attendance March 17, 2023, pgs. 1, 3, 5-6. • QOTAW Agenda, Minutes, Attendance February 22, 2023, pgs. 1, 9, 12-13. • Quality Improvement Steering Committee (QISC) Agenda, Minutes, Attendance January 31, 2023, pgs. 1, 6-10. • Member Newsletter Spring 2023, pg. 14. • Provider Newsletter April-June 2023, pg. 1 • DWIHN Webpage QAPIP Evaluation FY2022, (Entire Document). • DWIHN-Members Flyer RR 9.12.22, pg. 2	☒ Complete ☐ Not Complete
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**
Technical Assistance Required: ☐ Yes ☒ No		

Standard XIII—Quality Assessment and Performance Improvement Program		
Complete	=	**5**
Not Complete	=	**0**