Michigan Department of Health and Human Services

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

Region 7—Detroit Wayne Integrated Health Network

December 2024

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Overview

Background

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

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

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

Description of the External Quality Review Compliance Review

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

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

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

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

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

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

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

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

Summary of Findings

Review of the Standards

Table 1-2 presents an overview of the results of the standards reviewed during the SFY 2024 compliance review for **DWIHN**. 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 **DWIHN** during the period covered by the review, HSAG used a *Not Applicable* (*NA*) designation. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all five standards. Refer to Appendix A for a detailed description of the findings.

Table 1-2—Summary of Standard Compliance Scores

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard I—Member Rights and Member Information	24	22	18	4	2	**82%**
Standard III—Availability of Services	20	18	17	1	2	**94%**
Standard IV—Assurances of Adequate Capacity and Services	11	9	9	0	2	**100%**
Standard V—Coordination and Continuity of Care	16	15	15	0	1	**100%**
Standard VI—Coverage and Authorization of Services	23	22	17	5	1	**77%**
Total	**94**	**86**	**76**	**10**	**8**	**88%**

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.

DWIHN achieved an overall compliance score of 88 percent, indicating adherence to many of the reviewed federal and State requirements. However, opportunities for improvement were identified in the areas of Member Rights and Member Information and Coverage and Authorization of Services as these program areas received performance scores below 90 percent. Detailed findings, including recommendations for program enhancements, are documented in Appendix A.

Corrective Action Process

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

The CAP must be submitted to MDHHS and HSAG within 30 days of receipt of the final report. For each element that requires correction, **DWIHN** 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 **DWIHN**'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 **DWIHN**'s corrective actions to determine the sufficiency of the CAP. If an action plan is determined to be insufficient, **DWIHN** will be required to revise its CAP until deemed acceptable by HSAG and MDHHS.

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

2. Methodology

Activity Objectives

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

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

Table 2-1—Compliance Review Standards

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

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

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

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

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

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

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

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

Review of Standards

Technical Methods of Data Collection and Analysis

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

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

Pre-Site Review Activities:

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

Site Review Activities:

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

Post-Site Review Activities:

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

Data Aggregation and Analysis:

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

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

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

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

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

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

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

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

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

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

Description of Data Obtained

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

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

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

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

Data Obtained	Time Period to Which the Data Applied
Documentation submitted for HSAG's desk review and additional documentation available to HSAG during or after the site review	Prior to April 30, 2024
Information obtained from a review of a sample of service and payment denial files	Denials that occurred between October 1, 2023, and March 31, 2024
Information obtained through interviews	September 6, 2024
Documentation submitted after the site review	Prior to April 30, 2024

Standard I—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
General Rule		
1. The PIHP has written policies regarding member rights. 42 CFR §438.100(a)(1) 42 CFR §457.1220	**HSAG Required Evidence:** • Policies and procedures **Evidence as Submitted by the PIHP:** • Member Orientation Policy (entire policy) • Treatment with Dignity and Respect Policy, pgs.1 & 2, Standards 1-5 • Services Suited to Condition in The Least Restrictive Setting Policy (entire policy) • Seclusion Policy (entire policy) • Restraint Policy (entire policy)	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: DWIHN maintains policies and procedures to ensure members' rights are respected, protected, and followed in all interactions. DWIHN's staff and providers are trained on these policies and procedures. The policies listed above serves as the Provider's guide in working with DWIHN's members and includes the requirements of enrollee rights by which all providers and their staff must abide. The Office of Recipient Rights policies: Treatment with Dignity and Respect, Services Suited to Condition in the Least Restrictive Setting, Seclusion and Restraint describes the member's right to be treated with dignity and respect and to be free from any form of seclusion or restraint used as a means of coercion, discipline or retaliation.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		

Standard I—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
2. The PIHP complies with any applicable federal and State laws that pertain to member rights and ensures that its employees and contracted providers observe and protect those rights. 42 CFR §438.100(a)(2) 42 CFR §457.1220 Contract Schedule A–1(L)(1)(b)	**HSAG Required Evidence:** • Policies and procedures • Provider materials, such as the provider manual, provider contract, and provider training materials • Employee training materials • Auditing/oversight mechanisms **Evidence as Submitted by the PIHP:** • Member Orientation Policy (entire policy) • Member Grievance Policy (entire policy) • Customer Service Enrollee-Member Appeals Policy, (entire policy) • Local Appeal Procedures for Enrollees/Members with Medicaid Procedure (entire policy) • Standards of Conduct (entire policy) • Provider Manual, (pgs. 58-60 • 2023-2024 Provider Directory, (pgs. 69-71) • Estimated Cost of Service Template • Member Orientation Receipt Form • ABD and Due Process Form Training Feb 2024 • Appeals Form Refresher Training - Attendance report 2-15-24 • New Grievance Training Attendance 4/2024 • Customer Service Access Center Staff Orientation PowerPoint • Access Center Staff Sign-In Sheets • Provider Network Newsletter (Oct.-Dec. 2023) • DWIHN Required Courses Training Grid 2023 • FY ’23 Provider Flyer.png • Persons Point of View Member New Letters (Winter 2023 &Spring 2024)	☒ Met ☐ Not Met ☐ NA

Standard I—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
	• Qualification and Training for ORR staff • ORR NHRRT Survey Form FY 23-24 • ORR NHRRT Class Roster 01-29-24 • ORR NHRRT Class Roster 03-12-24 • ORR NHRRT Class Roster 11-01-23 • ORR NHRRT Desk Reference Guide 10-2023 • ORR NHRRT Quiz FY2024 • ORR NHRRT Survey Form FY 23-24 • NHRRT Revised PPT_240605	
PIHP Description of Process: The internal and external training plans provide evidence of DWIHN's procedures to train internal and external stakeholders on members' rights, what they are and their importance. The Members' Rights and Responsibilities are inclusive in the Provider Manual. The Provider Flyer is distributed to new and existing providers at minimum on an annual basis. The Provider Network Newsletter also serves as an avenue in which providers are again informed of the Members' Rights and Protections. The Persons Point of View is a quarterly newsletter that is distributed to our members which also serves as a reminder as to where they may reference the Member Handbook to obtain a list of their rights and responsibilities. There are continuous trainings such as Grievance and Appeals conducted within the provider network in addition to the required trainings all CMH staff are responsible for taking. DWIHN conducts annual reviews to monitor providers for compliance with the enrollee rights and protections.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
Specific Rights		
3. The PIHP complies with the requirements listed in the Member Rights Checklist. 42 CFR §438.100(b-d) 42 CFR §457.1220	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • HSAG will also use the results of the Member Rights Checklist **Evidence as Submitted by the PIHP:** • Member Orientation Policy (entire policy) • DWIHN Member Handbook (pgs. 13-15) • DWIHN Wants You To Know Flyer 12/2023	☒ Met ☐ Not Met ☐ NA

Standard I—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
	• DWIHN Members' Rights and Responsibilities Statement Brochure • www.dwihn.org, Member Materials • Postal Statement: Annual Mailing (12/2023) • 2023 Postal Statement • Member Rights Checklist	
PIHP Description of Process: DWIHN is committed to maintaining a mutually respectful relationship between our members and providers. Therefore, members and providers are informed of the members' rights and responsibilities. DWIHN distributes the "DWIHN Wants You to Know Flyer" to each member upon enrollment and annually thereafter. DWIHN also require providers to distribute the Member Handbook and the Members' Rights and Responsibilities Statement Brochure to each member at the time of enrollment and at least annually thereafter. It is important that members and providers are knowledgeable of those rights and responsibilities in order to assist the members in understanding and exercising their rights while accessing behavioral health care services in Detroit-Wayne County. This statement helps to minimize potential misunderstandings and promote compliance with all applicable statutory and regulatory requirements. By increasing the members understanding of their rights and responsibilities, it helps them to make informed decisions about their healthcare.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
Information Requirements		
4. The PIHP provides all required information referenced in 42 CFR §438.10 to members and potential members in a manner and format that may be easily understood and is readily accessible by members and potential members. "Readily accessible" means electronic information and services that comply with modern accessibility standards such as Section 508 guidelines, Section 504 of the Rehabilitation Act, and the World Wide Web Consortium's (W3C's) Web Content Accessibility Guidelines (WCAG) 2.0 AA and successor versions.	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook, provider directory, member notices, etc. • Mechanism to assess reading level of member materials and supporting evidence (e.g., screenshots of reading level of member materials) • Proof of website accessibility **Evidence as Submitted by the PIHP:** • Member Flyer	☒ Met ☐ Not Met ☐ NA

Standard I—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.10(c)(1) 42 CFR §457.1207 Contract Schedule A–1(M)(2)(a)(iii) Contract Schedule A–1(M)(2)(a)(i) Contract Schedule A–1(M)(2)(b)(i) Contract Schedule A–1(B)(4)(e)	• DWIHN Member Handbook, pages 22, 28, 78-85 • Provider Directory • ABD Grammarly readability • Grammarly Report to Provide Directory • Grammarly Report to Member Handbook • Grammarly Report on DWIHN website • www.dwihn.org • Customer Service Policy – Page 2 # 6	
PIHP Description of Process: DWIHN provides all required educational materials in a manner and format that is easily understood and accessible. Member materials are accessible via DWIHN's website www.dwihn.org and printed versions i.e. (brochures, handbook, directory, etc.) are made available and distributed by DWIHN and its provider network. Providers are responsible for distributing member materials to DWIHN's members at the time of intake, upon request and at least annually thereafter. DWIHN conducts readability reports on its member materials utilizing "Grammarly" software.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
5. The PIHP uses the definitions for managed care terminology developed by MDHHS including: a. Appeal, co-payment, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services and devices, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, medically necessary, network, non-participating provider, physician services, plan, preauthorization, participating provider, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, rehabilitation services and devices, skilled nursing care, specialist, and urgent care.	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook **Evidence as Submitted by the PIHP:** • Member Handbook, (pg. 84-94) • Glossary of Key Words and Commonly Used Terms • Policy Review Guidelines • Definitions and Glossary of Terms for Policies and Procedures • Member Handbook Policy-Stub	☒ Met ☐ Not Met ☐ NA

Standard I—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.10(c)(4)(i) 42 CFR §457.1207 Contract Schedule A–1(M)(2)(a)(vii)		
PIHP Description of Process: DWIHN maintains glossary of terms and definitions in the Member Handbook as required and provided by MDHHS. The definitions are therefore consistent and available to individuals for additional clarification and understanding.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** Although the PIHP's member handbook included definitions for managed care terminology developed by MDHHS, HSAG recommends that the PIHP request from MDHHS the definitions for the managed care terminology currently not included in the MDHHS-developed model member handbook template.		
Required Actions: None.		
6. The PIHP uses MDHHS-developed model member handbooks and member notices. 42 CFR §438.10(c)(4)(ii) 42 CFR §457.1207 Contract Schedule A–1(B)(4)(k)(i)	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Member notice templates, such as adverse benefit determination (ABD) notices, and grievance and appeal letter templates **Evidence as Submitted by the PIHP:** • Member Handbook (entire) • Medicaid Notice of Receipt of Grievance Template • Medicaid Final Response to Grievance Template • Local Appeal Request Form • Adequate ABD Template • Advance ABD Template • Member Handbook- MDHHS Approval Letter	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: DWIHN uses MDHHS-developed and approved model Member Handbooks and Member notices such as ABD Notices and Member Grievance & Appeals letters.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		

Standard I—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
Required Actions: None.		
Language and Format		
7. The PIHP makes its written materials that are critical to obtaining services, including, at a minimum, provider directories, member handbooks, appeal and grievance notices, and denial and termination notices, available in the prevalent non-English languages in its service areas. a. Written materials that are critical to obtaining services are also made available in alternative formats upon request of the member or potential member at no cost. b. Written materials that are critical to obtaining services include taglines in the prevalent non-English languages in the State in a conspicuously visible font size explaining the availability of written translation or oral interpretation to understand the information provided. c. Written materials that are critical to obtaining services include information on how to request auxiliary aids and services. d. Written materials that are critical to obtaining services include the toll-free and TTY/TDD telephone number of the PIHP's member/customer services unit. e. Auxiliary aids and services must be made available upon request of the member or potential member at no cost. 42 CFR §438.10(d)(3) 42 CFR §457.1207 Contract Schedule A–1(M)(2)(b)	**HSAG Required Evidence:** • Policies and procedures • Provider directory in prevalent languages • Member handbook in prevalent languages • Definition of "conspicuously visible font" • Mechanisms to ensure taglines are included as part of all critical member materials • All template notices required to include taglines **Evidence as Submitted by the PIHP:** • Member Orientation Policy (pg. 4-d 1-5) • Customer Service Policy (pg. 2&3, #6) • Provider Directory (pg. 4) • Customer Service (CS) Enrollee/Member Appeals Policy Pg.5 #15 i-iv. • Limited English Proficiency Policy (pg. .2-4) (Standard 5a-i & Standard 6) • Limited English Procedure, (entire) • DWIHN Member Handbook 2023 Spanish • DWIHN Member Handbook 2023 Arabic • Provider Directory Arabic • Provider Directory Spanish • FRG Redacted • Member Handbook Policy Stub • Member Handbook English • Member Handbook pg. 12, 20 & 21. • NOROG redacted	☐ Met ☒ Not Met ☐ NA

Standard I—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
	• Notice of Appeal Approval Redacted • Notice of Appeal Approval Form – Medicaid SMI-IDD- SUD-Stub • Notice of Appeal Denial Form-Medicaid SMI-IDD- SUD-Stub • Notice of Receipt of Appeal 2024 redacted • Final Response to Grievance - Spanish • Provider Directory Booklet • Non-English Brochures (Arabic & Spanish) • https://www.dwihn.org/brochures-and-handouts • DWIHN Member Handbook (pg. 10&21) • Definition of "conspicuously visible font"- Provider Directory pg. 4 • Mechanisms to ensure taglines are included as part of all critical member materials. - Handbook pg. 20, Provider Directory pg. 4 • Adequate ABD Redacted • Notices with taglines: Notice of Receipt of Appeal, Advance Notice of Adverse Benefit Determination, Adequate Notice of Adverse Benefit Determination, Final Response to Grievance, Notice of Receipt of Grievance, Notice of Appeal Approval, Notice of Appeal Denial	
PIHP Description of Process: DWIHN makes all Member written materials for obtaining services i.e. Provider Directory, Member Handbook and Appeal, Grievance and termination notices available in non-English languages as well as in Arabic and Spanish at no cost to the member. Taglines are provided on critical Member Materials for prevalent non-English languages. Conspicuously visible font size of availability of written translation, and/or oral interpretation is also prevalent for critical written materials i.e. Provider Directory, Handbook, and Member notices. Toll-free and TTY numbers of DWIHN's Customer Service Unit is included in all member written materials. Auxiliary aids and services are made available upon request as indicated in the DWIHN Handbook.		
HSAG Findings: Not all of the PIHP's written materials that are critical to obtaining services, such as the PIHP's paper provider directory, included taglines with information about how to request auxiliary aids and services and the toll-free and Teletypewriter/Telecommunications Device for the Deaf (TTY/TDY) telephone number of the PIHP's member/customer services unit.		

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Requirement	**Supporting Documentation**	**Score**
Recommendations: HSAG found inconsistencies such as sizes and formatting in the taglines included in various PIHP member materials, and the PIHP's *DWIHN Provider Directory-revised Dec2023 compressed* provider directory was missing the English tagline that was included in other member materials. As such, HSAG strongly recommends that the PIHP ensure that any written materials that are critical to obtaining services contain taglines that are consistent and contain all required information.		
Required Actions: The PIHP must ensure that its written materials that are critical to obtaining services include information about how to request auxiliary aids and services as well as include the toll-free and TTY/TDD telephone number of the PIHP's member/customer service unit.		
8. The PIHP makes interpretation services available to each member free of charge. a. This includes oral interpretation and the use of auxiliary aids such as TTY/TDD and American Sign Language (ASL). b. Oral interpretation requirements apply to all non-English languages, not just those that MDHHS identifies as prevalent. c. *In mental health settings, video remote interpreting (VRI) is to be used only in emergency situations, extenuating circumstances, or during a state or national emergency as a temporary solution until they can secure a qualified interpreter and in accordance with R 393.5055 VRI standards, usage, limitations, educational, legal, medical, and mental health standards.* 42 CFR §438.10(d)(4) 42 CFR §457.1207 Contract Schedule A–1(M)(2)(b)(i) Michigan Administrative Code R 393.5055	**HSAG Required Evidence:** • Policies and procedures • Executed interpretation services (oral and written) contract(s) • Workflow for obtaining oral interpretation services **Evidence as Submitted by the PIHP:** • Limited English Proficiency Policy (entire policy) • Limited English Procedure, (entire procedure) • Accommodation For Individuals with Visual & Mobility Impairment Policy, (entire policy) • Bromberg and Assoc Contract Extension • Dept. Memo on Bromberg Translation Services • Member Orientation_ MR and R Policy - Pg 8, 3a-b • 2023-24 Mbr Handbook -Non-Discrimination & Accessibility, pg.12 and Language Assistance & Accommodations, pg.21 • 2023-24 Mbr Handbook-Taglines pgs. 20-21	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: DWIHN's Member Orientation and the Customer Service policies detail the requirements for enrollee information to be in alternative formats, non-English languages, mechanisms to ensure that beneficiaries are able to understand the information. The Member Handbook provides informational and instructional materials for members should they require accommodation for interpreters or staff assistance to help them understand the information as needed. The Member Handbook also provides the phone numbers for members to contact Customer Service if they require interpreter services or alternative formats free of charge. DWIHN's Provider Directory provides a list of non-English speaking providers. Enrollees are		

Standard I—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
informed of the availability and methods of how to access information in alternative formats and language. DWIHN also has a contract with Bromberg & Associates to provide prevalent non-English translation and sign language to members as the request and/or need indicates.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
9. The PIHP notifies members: a. That oral interpretation is available for any language and written translation is available in prevalent languages; b. That auxiliary aids and services are available upon request and at no cost for members with disabilities; and c. How to access these services. 42 CFR §438.10(d)(5) 42 CFR §457.1207 Contract Schedule A–1(M)(2)(b)(i)	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook **Evidence as Submitted by the PIHP:** • Limited English Proficiency Policy (entire policy) • Limited English Proficiency Procedure (entire policy) • Member Handbook, pgs. 10, 12, and 21 • DWIHN's Interpretation Usage FY'24, pg. 2 • Bromberg & Associates Contract Extension • B&A Translation Invoice December 2023 • B&A Translation Invoice March 2024 • DWIHN Language Instructional Card	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: DWIHN has a language translation contract with Bromberg and Associates. They provide non-English and ASL translation to and for DWIHN members. Translation services are billed to DWIHN and therefore, members are not financially liable for the translation services received. The 711 number is noted on all DWIHN's member materials including but not limited to our Member Handbook.		
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**
10. The PIHP provides all written materials for potential members and members consistent with the following: a. Use easily understood language and format. b. *Written at or below the 6.9 grade reading level when possible (i.e., in some situations it is necessary to include medications, diagnosis, and conditions that do not meet the 6.9 grade reading level criteria).* c. Use a font size no smaller than 12 point. d. Be available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of members or potential members with disabilities or limited English proficiency. e. The PIHP shall also identify additional languages that are prevalent among the PIHP's membership. *For purposes of this requirement, "prevalent non-English language" is defined as any language spoken as the primary language by more than five percent (5%) of the population in the PIHP's region.* f. *Material must not contain false, confusing, and/or misleading information.* "Limited English proficient (LEP)" means potential members and members who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may be LEP and may be eligible to receive language assistance for a particular type of service, benefit, or encounter. 42 CFR §438.10(d)(6) 42 CFR §457.1207	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook and member newsletter • Mechanism to assess reading level of member materials and supporting evidence (e.g., screenshots of reading level of member materials) • Examples of member notices (in Microsoft Word), such as an ABD notice, grievance resolution letter, appeal resolution letter, etc. • Tracking or reporting mechanism on use of interpretation services and auxiliary aids and services • Mechanism to assess prevalent languages in the PIHP's region **Evidence as Submitted by the PIHP:** • Customer Service Policy, (pgs. 2-3) Standard 6a-d • Limited English Proficiency Policy (entire policy) • Limited English Proficiency Procedure (entire policy) • Member Handbook -Non-Discrimination & Accessibility, pg.12 and Language Assistance & Accommodations, pg.21 • DWIHN's Interpretation Usage FY'24, pg. 2 (orange highlight) • Persons' Point of View Winter Newsletter • Bromberg & Associates Contract Extension • B&A Translation Invoice December 2023 • B&A Translation Invoice March 2024 1. Samples of Member Notices a) Adverse Benefit Determination b) Final Response to Grievance c) Notice of Receipt of Grievance d) Notice of Appeal Approval 2024	☐ Met ☒ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
Contract Schedule A–1(B)(4)(e) Contract Schedule A–1(M)(2)(a)(i)-(ii) Contract Schedule A–1(M)(2)(a)(iv) Contract Schedule A–1(M)(2)(b)(i)	e) Notice of Receipt of Appeal 2024 • Person Point of View-Spring Edition Newsletter • Grammarly Report- Readability- Member- Provider Closure • Grammarly Readability Report-Spring Edition PPV 2024.docx page 23- Did you Know? And Mediation Helpline • Grammarly Readability Report. Spring Edition PPV 2024.docx Let's Talk about Human Trafficking-pages 7,8 • Grammarly Report of Member Handbook Readability • Grammarly Report of Provider Directory Readability • Grammarly Report on DWIHN Website Readability	
PIHP Description of Process: DWIHN distributes information to members in easily, understandable language. DWIHN also trains its' provider network to utilize easily, understandable language wherever possible when communicating with members. Members also contributed to the development and review of the Member Handbook as well as the Grievance/Appeal Member Bookmarks to ensure proper flow and ability to understand the information presented. A newsletter written by our members entitled The Persons' Point of View is the voice of our membership.		
HSAG Findings: Not all of the PIHP's written materials for potential members and members contained text with the minimum 12-point font size in all areas of the document, such as portions of the PIHP's member handbook and paper provider directory. Additionally, although the PIHP submitted *Grammarly* reports as evidence that the PIHP's member materials are written at or below the 6.9 reading grade level, most of these reports did not contain information related to reading grade level, and the reports that did contain reading grade-level information were above the 6.9 reading grade level.		
Required Actions: The PIHP must ensure that all written materials for potential members and members use a font size no smaller than 12 point and are written at or below the 6.9 reading grade level when possible.		

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Requirement	**Supporting Documentation**	**Score**
Information for Members		
11. The PIHP makes a good faith effort to give written notice of termination of a contracted provider to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider. Notice to the member must be provided by the later of: a. Thirty calendar days prior to the effective date of the termination; or b. Fifteen calendar days after receipt or issuance of the termination notice. 42 CFR §438.10(f)(1) 42 CFR §457.1207 Contract Schedule A–1(M)(2)(b)(ii)(3)	**HSAG Required Evidence:** • Policies and procedures • Workflow of provider termination process • Three examples of written notices to members of provider termination (include a copy of the notice of termination, with the date of notice) • Tracking or reporting mechanism that demonstrates timeliness **Evidence as Submitted by the PIHP:** • Network Monitoring and Management Policy (pg.4, Standards # 40) • DWIHN Member Handbook (pg. 15) • MCO Clos Out Plan • Three Sample Cases – Member Choice Letters, Proof of Mailing and Provider Closure Tracking Log Excerpt for: • Team Wellness- Westland • Community Program Services-Wick II • Community Administrative Services	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: Upon receipt of a closure/termination notification from the DWIHN Provider Network Manager, Customer Service staff makes a good faith effort in writing a letter to the impacted members/guardians informing them of the closure/termination and of their provider choice opportunities.		
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 makes available upon request any physician incentive plans in place as set forth in 42 CFR §438.3(i). 42 CFR §438.3(i) 42 CFR §438.10(f)(3) 42 CFR §457.1207 Contract Schedule A–1(M)(2)(b)(ii)(4)(b)	**HSAG Required Evidence:** • Policies and procedures • List of physician incentive plans • Example of physician incentive plan provided to a member upon request • If the PIHP does not have physician incentive plans, please state so under the PIHP Description of Process **Evidence as Submitted by the PIHP:** • HSW Supports Coordinator Incentive Procedure, pg. 1 • HSW Pay Incentive Program Memo 10/1/23	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: An outcome-based payment incentive program has been implemented for the Habilitation Support Waiver (HSW). The Clinically Responsible Service Provider (CRSP) receives $1,000 for each MDHHS approved and certified HSW application. The CRSP must share a minimum of $500 of the incentive payment with the staff and those who contribute significantly to the completion of the application.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
13. *The PIHP provides information to members about the managed care and care coordination responsibilities of the PIHP, including:* a. *Information on the structure and operation of the managed care organization (MCO) or the PIHP.* Contract Schedule A–1(M)(2)(b)(ii)(4)(a)	**HSAG Required Evidence:** • Policies and procedures • One example of the PIHP providing information to members about managed care and care coordination responsibilities **Evidence as Submitted by the PIHP:** • Care Coordination Policy Page 5 # 1-3 • Case Management Network Procedure pg. 3, 4 #1-8 • 2023-2024 -Member Handbook -DWIHN Organizational Structure Chart, pg.4 • 2023-2024- Member Handbook pg. 49 Case Management & Coordination of Care	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
PIHP Description of Process: The topics and content presented in the member handbook are mandated by MDHHS.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
Member Handbook		
14. The member handbook is provided to the member *upon first request of services and annually thereafter, or sooner if substantial revisions have been made*. The member handbook is considered provided if the PIHP: a. Mails a printed copy of the information to the member's mailing address; b. Provides the information by email after obtaining the member's agreement to receive the information by email; c. Posts the information on the PIHP's website and advises the member in paper or electronic form that the information is available on the internet and includes the applicable internet address, provided that members with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost; or d. Provides the information by any other method that can reasonably be expected to result in the member receiving that information. 42 CFR §438.10(g)(1) 42 CFR §438.10(g)(3) 42 CFR §457.1207 Contract Schedule A–1(B)(3)(f) Contract Schedule A–1(B)(3)(h) Contract Schedule A–1(B)(4)(b)	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as member welcome packet • Mechanism for disseminating the member handbook (e.g., mailing of printed copy, mailing of welcome packet with link to member handbook on website) • Tracking mechanism for mailings of the member handbook or welcome notice (include the date the PIHP received notice of the member's first request of services, and the mailing date of the member handbook/member enrollment materials) **Evidence as Submitted by the PIHP:** • Member Orientation-Member Rights & Responsibilities Policy pg.4 (Section C: 1-6) • DWIHN Member Handbook (pg. 10) Disclaimer • DWIHN Contact Us Screenshot • DWIHN Member materials (brochures & welcome packet) • DWIHN Member welcome packet mailing tracking mechanism • DWIHN Member Orientation Checklist (blank) • DWIHN Completed Member Orientation Checklist Form • DWIHN Member Rights & Resources Website Links visit https://www.dwihn.org/member-customer-service	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
PIHP Description of Process: Upon receiving a request for a Member Handbook, DWIHN ensures timely delivery by mailing or emailing (if granted permission to email) a copy to the member within five business days. Furthermore, members receive a Member Handbook during intake and annually upon renewal of their IPOS, ensuring ongoing access to essential information. At intake, members sign off on the orientation Checklist, with this data being tracked by the provider monthly and submitted to DWIHN's Customer Service Performance Monitors. Additionally, the Welcome Packet is promptly mailed to the member upon enrollment by DWIHN's Access Call Center, ensuring a smooth and seamless onboarding process.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
15. The member handbook includes all requirements listed in the Member Handbook Checklist. 42 CFR §438.10(g)(2) 42 CFR §457.1207 Contract Schedule A–1(B)(4)	**HSAG Required Evidence:** • Searchable (Word/PDF) version of member handbook (version that would be provided to member if paper copy requested) • Link to member handbook on the PIHP's website • HSAG will also use the results of the Member Handbook Checklist **Evidence as Submitted by the PIHP:** • DWIHN link to Member Handbook for hard copies • https://dwihn.org/documents/Member_Handbook.pdf • Member Handbook Checklist • Member Handbook English paper copy	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: DWIHN's Member Handbook complies with all stated requirements.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. Of note, the PIHP's member handbook did not contain a version number; however, HSAG confirmed with MDHHS that the revision dates were sufficient to demonstrate historical versions of the PIHP's member handbook.		
Required Actions: None.		

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Requirement	**Supporting Documentation**	**Score**
16. The PIHP gives each member notice of any change to the member handbook that MDHHS defines as significant in the information specified in the member handbook at least 30 days before the intended effective date of the change. a. "*Significant" is defined as any change that affects a member's Medicaid benefits, including but not limited to: PIHP contract information, authorization for services, covered benefits, and copays.* 42 CFR §438.10(g)(4) 42 CFR §457.1207 Contract Schedule A–1(B)(4)(c)	**HSAG Required Evidence:** • Policies and procedures • Workflow for member handbook changes • One example of a change to the member handbook and notice sent to members • Tracking mechanism for timely member notifications of significant changes **Evidence as Submitted by the PIHP:** • Member Rights & Responsibilities • Customer Service Policy pgs. 5,6, 21 a & b • The Member Handbook, (pg. 13)	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The Member Rights and Responsibilities is an attachment to the Member Orientation Policy, which details the members' being provided with timely written notice of any significant State and provider network-related changes. DWIHN is responsible for providing members with this information. There has yet to be any significant change or updates made to the 2023-2024 Member Handbook after MDHHS approval of 05/31/2023. Should a significant change be made, DWIHN will insert it to accompany the Member Handbook advising the members of the change. DWIHN would also update its website to inform members of the change.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** As the PIHP did not have a significant change during the review period, and the PIHP's policies included the requirements of this element, the PIHP received a *Met* score for this element. During the site review, PIHP staff members also explained various mechanisms they could use to notify members of a significant change, such as an insert into its member handbook, a member newsletter, a posting on the PIHP's website, and sharing through its provider network. However, HSAG strongly recommends that the PIHP enhance its policies to specifically outline the procedures and the methods that the PIHP would use to ensure that all members receive notice of any change to its member handbook that MDHHS defines as significant at least 30 days before the intended effective date of the change. HSAG also strongly recommends that the PIHP develop a tracking mechanism to confirm timely member notification when there are changes to the member handbook that MDHHS defines as significant. Implementation of HSAG's recommendation will be reviewed during the next compliance review cycle, and the PIHP will automatically receive a *Not Met* score if HSAG's recommendation is not adequately addressed.		
Required Actions: None.		

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Requirement	**Supporting Documentation**	**Score**
17. *The PIHP must obtain MDHHS approval, in writing, prior to publishing original and revised editions of the member handbook.* Contract Schedule A–1(B)(4)(g)	**HSAG Required Evidence:** • Policies and procedures • Most recent approval received from MDHHS, in writing, of revisions to the member handbook **Evidence as Submitted by the PIHP:** • DWIHN Member Handbook 23/24 • DWIHN Member Handbook 6/24 Revision Date- Pg 95 • Member Handbook Policy-Stub • Customer Service Policies 4/24 Pages 5& 6. #21 a. • Customer Service Policy 2/23 Page 4. #19a • State Approval Letter-DWIHN Guide to Services Handbook (5/31/2023)	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: DWIHN obtains MDHHS written approval before publishing original or revised additions to the Member Handbook, which is sent to MDHHS every two years for approval. The most recent approval (05/31/2023). In the event significant changes occur, DWIHN, within the two-year timeframe, will provide supplemental materials to the handbook as needed to ensure compliance with contractual requirements.		
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**
Provider Directory		
18. The PIHP makes the provider directory available in paper form upon request and electronic form. The provider directory must include the information from the Provider Directory Checklist. 42 CFR §438.10(h)(1-2) 42 CFR §457.1207 Contract Schedule A–1(M)(1) Contract Schedule A–1(M)(2)(a)(iii)	**HSAG Required Evidence:** • Policies and procedures • Process for generating a paper copy of the provider directory • Copy of provider directory in Word format or PDF (excerpts are acceptable) • Link to the online provider directory • HSAG will also use the results of the Provider Directory Checklist **Evidence as Submitted by the PIHP:** • Member Orientation: Member Rights and Responsibilities Page 4. Standard 2 c # 4 • Provider Directory Rev. 12/23 • Link to on-line Directory https://dwihn.org/members/Provider_Directory_Booklet.pdf • (2023-2024 version, revised June 2023) • https://dwihn.org/members/Provider_Directory_Booklet.pdf Link to Provider E directory https://dwihn.org/find-a-provider • Provider Directory Check List • Network Monitoring Management Page 5. #47 • Sample Screenshot – ADA Accessible	☐ Met ☒ Not Met ☐ NA
PIHP Description of Process: DWIHN's Provider Directory is online and in hard copy, which includes all the requirements of the Provider Checklist.		
HSAG Findings: Although the PIHP's electronic provider directory, machine-readable provider directory, and the PDF directory on its website contained information on whether the provider's office/facility has accommodations for people with physical disabilities including offices, exam room(s), and equipment, the PIHP's *DWIHN Provider Directory-revised Dec2023* compressed provider directory did not contain this information. Additionally, although the PIHP's *DWIHN Provider Directory-revised Dec2023* compressed provider directory contained information on independent facilitators, these providers were not listed in the other versions of the PIHP's provider directories. All versions of the PIHP's provider directories must contain all required information. Following the site review, MDHHS confirmed that independent facilitators must be included in the provider directory. Lastly, although the PIHP only		

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Requirement	**Supporting Documentation**	**Score**
serves members in Wayne County, its provider directory could not be sorted by county to accommodate any providers in the PIHP's provider network that may be located outside of the county or have additional locations outside of the county. **Recommendations:** HSAG recommends that the PIHP develop definitions for provider types that must be in the PIHP's provider directory (e.g., medical suppliers, ancillary health providers) for clarity about the services that fall under each provider type (e.g., occupational therapy and physical therapy are considered ancillary health providers).		
Required Actions: The PIHP must ensure that all versions of its provider directory include all of the required information in the Provider Directory Checklist.		
19. Information included in a paper provider directory must be updated *at least monthly*. 42 CFR §438.10(h)(3)(i) 42 CFR §457.1207 Contract Schedule A–1(M)(1)(b)	**HSAG Required Evidence:** • Policies and procedures • Workflow for updating paper provider directories • Three consecutive provider directory update examples **Evidence as Submitted by the PIHP:** • Procedure for Updates of Providers Information on DWIHN Website pgs. 1& 2 • Service Provider Change Procedure • Sample DWIHNs Monthly Electronic Provider Updates • Sample of on-line machine -readable Provider Directory (printed version) • American Disabilities Act-ADA- Accommodations Provider Compliance and Audit Procedure	☐ Met ☒ Not Met ☐ NA
PIHP Description of Process: DWIHN's online machine-readable directory is regularly updated twice a month and can be conveniently printed.		
HSAG Findings: The PIHP staff members explained during the site review that their electronic and machine-readable provider directories were updated at least twice a month. However, PIHP staff members also explained during the site review that the printed version of its provider directory that would be given to members was the PIHP's *DWIHN Provider Directory-revised Dec2023 compressed* provider directory, which is only updated on a quarterly basis instead of at least monthly.		
Required Actions: The PIHP must ensure that information included in its paper provider directory is updated at least monthly.		

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Requirement	**Supporting Documentation**	**Score**
20. Information included in the PIHP's electronic provider directory is updated no later than 30 calendar days after the PIHP receives updated provider information. 42 CFR §438.10(h)(3)(ii) 42 CFR §457.1207 Contract Schedule A–1(M)(1)(b)	**HSAG Required Evidence:** • Policies and procedures • Workflow for updating the electronic provider directory • Three consecutive provider directory update examples **Evidence as Submitted by the PIHP:** • Procedure for Updates of Providers Information on DWIHN Website pgs. 1&2 • Sample DWIHN's Bi-Monthly Electronic updates	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The DWIHN online directory is updated twice a month, as per procedure.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
21. The PIHP's provider directory is made available on the PIHP's website in a machine-readable file and format as specified by the Secretary. 42 CFR §438.10(h)(4) 42 CFR §457.1207 Contract Schedule A–1(M)(1)(c)	**HSAG Required Evidence:** • Policies and procedures • Confirmation of machine-readable provider directory (e.g., .JSON format) • If the provider directory is a delegated function, confirmation of delegated entities' machine-readable provider directories • Link to the machine-readable provider directory on website **Evidence as Submitted by the PIHP:** • Procedure for Updates of Providers Information on DWIHN Website- Procedure -Pages 1,2 • Basic On-Line Directory Instructions • Links to the Provider Directory and Provider E Directory • Sample of the Machine-Readable Directory in Printable Form – Pages 1-7 • Provider Directory Checklist	☒ Met ☐ Not Met ☐ NA

Standard I—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
	• Screenshot of DWIHN website showing Provider Directory in CSV	
PIHP Description of Process: The DWIHN website contains a machine-readable file and format that can be used to convert the document into the required format.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
Formulary		
22. The PIHP makes available in electronic or paper form the following information about its formulary: a. Which medications are covered (both generic and name brand). b. What tier each medication is on. 42 CFR §438.10(i)(1-2) 42 CFR §457.1207	**HSAG Required Evidence:** • Not applicable **Evidence as Submitted by the PIHP:** • Not applicable	☐ Met ☐ Not Met ☒ NA
PIHP Description of Process:		
HSAG Findings: This element is *Not Applicable* to the PIHP.		
Required Actions: None.		
23. The PIHP's formulary drug list is made available on the PIHP's website in a machine-readable file and format as specified by the Secretary. 42 CFR §438.10(i)(3) 42 CFR §457.1207	**HSAG Required Evidence:** • Not applicable **Evidence as Submitted by the PIHP:** • Not applicable	☐ Met ☐ Not Met ☒ NA
PIHP Description of Process:		

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Requirement	**Supporting Documentation**	**Score**
HSAG Findings: This element is *Not Applicable* to the PIHP.		
Required Actions: None.		
Electronic Materials and Communications		
24. Member information required in 42 CFR §438.10 may not be provided electronically unless the PIHP meets all of the following: a. The format is readily accessible. b. The information is placed in a location on the PIHP's website that is prominent and readily accessible. c. The information is provided in an electronic form which can be electronically retained and printed. d. The information is consistent with the content and language requirements of 42 CFR §438.10. e. The member is informed that the information is available in paper form without charge upon request and the PIHP provides it upon request within five business days. 42 CFR §438.10(c)(6) 42 CFR §457.1207 Contract Schedule A–1(M)(2)(a)(iii) Contract Schedule A–1(M)(2)(a)(v)	**HSAG Required Evidence:** • Policies and procedures • Workflow for disseminating member materials • List of all materials that are only provided electronically • Link to website **Evidence as Submitted by the PIHP:** • Customer Service Policy- Pg. 6 Standard #26 a-e • Member Orientation: Member Rights and Responsibilities Policy- Pages 8, 9 a-e • Sample of the on-line Machine-Readable Directory Printable Version (Arabic) Pages 1-7 • Sample of on-line Machine-Readable Directory Printable Version (English) pages 1-7 • Link to DWIHN Website-www.dwihn.org • Screenshot to Members Materials on DWIHN Website	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: DWIHN has complied with the requirements identified in 42 CFR.438.10 by adhering to the specified policies and procedures. In addition, we have provided comprehensive evidence in the form of samples, screenshots, and website links. Furthermore, all Member Materials are available electronically and can be obtained and printed.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** Although the PIHP's member handbook informed members that a copy of the member handbook is available in paper format, HSAG strongly recommends that the PIHP clarify this language to confirm that the handbook is also available in paper format without charge, as the PIHP staff		

Standard I—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
members confirmed this during the site review. Implementation of HSAG's recommendation will be reviewed during the next compliance review cycle, and the PIHP will automatically receive a *Not Met* score if HSAG's recommendation is not adequately addressed.		
Required Actions: None.		

Standard I—Member Rights and Member Information						
Met	=	18	X	1	=	18
Not Met	=	4	X	0	=	0
Not Applicable	=	2				
Total Applicable	=	22	**Total Score**		=	18
Total Score ÷ Total Applicable					=	82%

Standard I—Member Rights Checklist		
Reference	**Required Components**	
A member enrolled with the PIHP has the following rights:		
42 CFR §438.10 42 CFR §438.100(b)(2)(i) 42 CFR §457.1220	1. Receive information in accordance with 42 CFR §438.10. **Evidence as submitted by the PIHP:** • Member Handbook page 13 • Provider Directory Page 69-71 • Member Flyer • PPV Newsletter • Member Orientation Policy Page 6-7 #13	Y ☒ N ☐
42 CFR §438.100(b)(2)(ii) 42 CFR §457.1220	2. Be treated with respect and with due consideration for his or her dignity and privacy. **Evidence as submitted by the PIHP:** • Member Handbook page 13 • Provider Directory Page 69-71 • Member Flyer • PPV Newsletter • Member Orientation Policy Page 6-7 #13	Y ☒ N ☐
42 CFR §438.100(b)(2)(iii) 42 CFR §457.1220	3. Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. **Evidence as submitted by the PIHP:** • Member Handbook page 14 • Provider Directory Page 69-71 • Member Flyer • PPV Newsletter • Member Orientation Policy Page 6-7 #13	Y ☒ N ☐

Standard I—Member Rights Checklist		
Reference	**Required Components**	
42 CFR §438.100(b)(2)(iv) 42 CFR §457.1220	4. Participate in decisions regarding his or her healthcare, including the right to refuse treatment. **Evidence as submitted by the PIHP:** • Member Handbook page 13 • Provider Directory Page 69-71 • Member Flyer • PPV Newsletter • Member Orientation Policy Page 6-7 #13	Y ☒ N ☐
42 CFR §438.100(b)(2)(v) 42 CFR §457.1220	5. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in federal regulations on the use of restraints and seclusion. **Evidence as submitted by the PIHP:** • Member Handbook page 14 • Provider Directory Page 69-71 • Member Flyer • PPV Newsletter • Member Orientation Policy Page 6-7 #13	Y ☒ N ☐
42 CFR §438.100(b)(2)(vi) 42 CFR §457.1220 45 CFR Part 160 25 CFR Part 164, Subparts A and E 45 CFR §164.524 45 CFR §164.526	6. If the privacy rule (as set forth in 45 CFR parts 160 and 164 subparts A and E) applies, request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR §164.524 and §164.526. **Evidence as submitted by the PIHP:** • Member Handbook page 14 • Provider Directory Page 69-71 • Member Flyer • PPV Newsletter	Y ☒ N ☐

Standard I—Member Rights Checklist		
Reference	**Required Components**	
	• Member Orientation Policy Page 6-7 #13	
42 CFR §438.100(b)(3) 42 CFR §438.206 through §438.210 42 CFR §457.1220	7. Be furnished healthcare services in accordance with 42 CFR §438.206 through §438.210. **Evidence as submitted by the PIHP:** • Member Handbook page 13 • Provider Directory Page 69-71 • Member Flyer • PPV Newsletter • Member Orientation Policy Page 6-7 #13	Y ☒ N ☐
42 CFR §438.100(c) 42 CFR §457.1220	8. Exercise his or her rights, and that the exercise of those rights does not adversely affect the way the PIHP and its network providers or MDHHS treat the member. **Evidence as submitted by the PIHP:** • Member Handbook page 14 • Provider Directory Page 69-71 • Member Flyer • PPV Newsletter • Member Orientation Policy Page 6-7 #13	Y ☒ N ☐
42 CFR §438.100(d) 42 CFR §438.3(d)(3)(4) 42 CFR §457.1220 45 CFR Part 80 45 CFR Part 91 Rehabilitation Act of 1973 Education Amendments of 1972, Title IX ADA, Titles II and III ACA, Section 1557	9. The PIHP shall comply with any other applicable federal and State laws (including Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR Part 80, the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR Part 91, the Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972 [regarding education programs and activities], Titles II and III of the Americans with Disabilities Act [ADA], and Section 1557 of the Patient Protection and Affordable Care Act [ACA]). **Evidence as submitted by the PIHP:** • Member Handbook page 13, 15 • Provider Directory Page 69-71	Y ☒ N ☐

Standard I—Member Rights Checklist		
Reference	**Required Components**	
	• Member Flyer • PPV Newsletter • Member Orientation Policy Page 6-7 #13	

Standard I—Member Handbook Checklist		
Reference	**Required Components**	
The content of the member handbook includes information that enables the member to understand how to effectively use the managed care program. This information includes at a minimum:		
42 CFR §438.10(g)(2)(i) 42 CFR §457.1207 Contract Schedule A–1(B)(4)(k)(ii)(1)	1. Benefits provided by the PIHP. **Evidence as submitted by the PIHP:** • Member Handbook-Pages 32-41- Covered Services	Y ☒ N ☐
42 CFR §438.10(g)(2)(ii) 42 CFR §457.1207 Contract Schedule A–1(B)(4)(k)(ii)(2)	2. How and where to access any benefits provided by MDHHS. **Evidence as submitted by the PIHP:** • Member Handbook- Page 22, 23- How and where to Access Behavioral Health Services	Y ☒ N ☐
42 CFR §438.10(g)(2)(ii) 42 CFR §457.1207 Contract Schedule A–1(B)(4)(k)(ii)(2)	3. How transportation is provided. **Evidence as submitted by the PIHP:** • Member Handbook- Page 80- Transportation Resources	Y ☒ N ☐
42 CFR §438.10(g)(2)(ii)(A) 42 CFR §457.1207	4. In the case of a counseling or referral service that the PIHP does not cover because of moral or religious objections, the PIHP informs members that the service is not covered by the PIHP. **Evidence as submitted by the PIHP:** • Member Handbook- Page 13 – Member Rights and Responsibilities- You Have Rights Bullet 21	Y ☐ N ☐ NA ☒
42 CFR §438.10(g)(2)(ii)(A-B) 42 CFR §457.1207	5. The PIHP informs members how they can obtain information from MDHHS about how to access the services not provided by the PIHP because of moral or religious objections. **Evidence as submitted by the PIHP:** • Member Handbook- Page 23- Non-Emergency Services 2nd Paragraph	Y ☐ N ☐ NA ☒
42 CFR §438.10(g)(2)(iii) 42 CFR §457.1207 Contract Schedule A–1(M)(2)(b)(ii)(1)(c)	6. The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that members understand the benefits to which they are entitled. **Evidence as submitted by the PIHP:** • Member Handbook- Pages 30,31- Service Authorization, Pages 32 - Service Array, Covered Services, Pages 31-41- Detroit Wayne Integrated Health Network Benefit Chart- 33-41, Page 48- Michigan Medicaid Autism Benefit	Y ☒ N ☐

Standard I—Member Handbook Checklist		
Reference	**Required Components**	
42 CFR §438.10(g)(2)(iv) 42 CFR §457.1207 Contract Schedule A–1(M)(2)(b)(ii)(1)(d)	7. Procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care and for other benefits not furnished by the member's primary care provider. **Evidence as submitted by the PIHP:** • Member Handbook- Page 73- Services No Covered Under DWIHN	Y ☒ N ☐
42 CFR §438.10(g)(2)(v) 42 CFR §457.1207 Contract Schedule A–1(M)(2)(b)(ii)(1)(e)	8. The extent to which, and how, after-hours care is provided. **Evidence as submitted by the PIHP:** • Member Handbook- Page 24 – Crisis/Emergency After-Hours Access to Service	Y ☒ N ☐
42 CFR §438.10(g)(2)(v)(A) 42 CFR §457.1207	9. What constitutes an emergency medical condition and emergency services. **Evidence as submitted by the PIHP:** • Member Handbook- Page 24- Crisis/Emergency After-Hours Access to Services	Y ☒ N ☐
42 CFR §438.10(g)(2)(v)(B) 42 CFR §457.1207	10. The fact that prior authorization is not required for emergency services. **Evidence as submitted by the PIHP:** • Member Handbook- Page 24- Crisis/Emergency After-Hours Access to Services	Y ☒ N ☐
42 CFR §438.10(g)(2)(v)(C) 42 CFR §457.1207	11. The fact that the member has a right to use any hospital or other setting for emergency care. **Evidence as submitted by the PIHP:** • Page Member Handbook- 24- Crisis/Emergency After-Hours Access to Services	Y ☒ N ☐
42 CFR §438.10(g)(2)(vi) 42 CFR §457.1207 Contract Schedule A–1(M)(2)(b)(ii)(1)(a)	12. Any restrictions on the member's freedom of choice among network providers. **Evidence as submitted by the PIHP:** • Member Handbook- Page 13- Member Rights and Responsibilities- You Have the Right To: Bullet 5	Y ☒ N ☐

Standard I—Member Handbook Checklist		
Reference	**Required Components**	
42 CFR §438.10(g)(2)(vii) 42 CFR §457.1207 Contract Schedule A–1(M)(2)(b)(ii)(1)(e)	13. The extent to which, and how, members may obtain benefits, including family planning services and supplies from out-of-network providers. This includes an explanation that the PIHP cannot require members to obtain a referral before choosing a family planning provider. **Evidence as submitted by the PIHP:** • Member Handbook- Page 30- Out-Of-Network Services, Page 31- Payment for Service, Page 32- Service Array	Y ☐ N ☐ NA ☒
42 CFR §438.10(g)(2)(viii) 42 CFR §457.1207	14. Cost sharing. **Evidence as submitted by the PIHP:** • Member Handbook- Pages 13- Member Rights and Responsibilities-, Page 31-Payment of Service	Y ☒ N ☐
42 CFR §438.10(g)(2)(ix) 42 CFR §438.100 42 CFR §457.1207 Contract Schedule A–1(M)(2)(b)(ii)(1)(b)	15. Member rights and responsibilities, including the elements specified in 42 CFR §438.100. a. *Member rights and protections as specified in the contract as they relate to grievances and appeals.* **Evidence as submitted by the PIHP:** • Member Handbook- Page 13, Member Rights and Responsibilities- You Have the Right: Bullet 10	Y ☒ N ☐
42 CFR §438.10(g)(2)(x) 42 CFR §457.1207	16. The process of selecting and changing the member's primary care provider. **Evidence as submitted by the PIHP:** • Member Handbook- Page 50 -Person -Centered Planning (Bold Print)	Y ☒ N ☐
42 CFR §438.10(g)(2)(xi)(A) 42 CFR §457.1207 Contract Schedule A–1(L)(3-4)	17. The right to file grievances and appeals. **Evidence as submitted by the PIHP:** • You have the right to: Member Handbook- Page 13- Member Rights and Responsibilities – You Have the Right To: Bullet 24	Y ☒ N ☐
42 CFR §438.10(g)(2)(xi)(B) 42 CFR §457.1207 Contract Schedule A–1(L)(2)(b-c)	18. The requirements and time frames for filing a grievance or appeal. **Evidence as submitted by the PIHP:** • Member Handbook- Pages 58- 62 – Grievances and Appeals	Y ☒ N ☐

Standard I—Member Handbook Checklist		
Reference	**Required Components**	
42 CFR §438.10(g)(2)(xi)(C) 42 CFR §457.1207 Contract Schedule A–1(L)(2)(d)	19. The availability of assistance in the filing process for grievances and appeals.	Y ☒ N ☐
	Evidence as submitted by the PIHP: • Member Handbook- Page 58- Grievance- Last Paragraph on the page, Page 59- Appeals 5th Paragraph	
42 CFR §438.10(g)(2)(xi)(D) 42 CFR §457.1207 Contract Schedule A–1(L)(2)(a)(iii)	20. The right to request a State fair hearing (SFH) (or a State external review for the Children's Health Insurance Program [CHIP]) after the PIHP has made a determination on a member's appeal that is adverse to the member.	Y ☒ N ☐
	Evidence as submitted by the PIHP: • Member Handbook- Page 34, 35- Covered Services (EPSDT)	
42 CFR §438.10(g)(2)(xi)(E) Contract Schedule A–1(L)(5)(h)	21. The fact that, when requested by the member, benefits that the PIHP seeks to reduce or terminate will continue if the member files an appeal or a request for the SFH within the time frames specified for filing, and that the member may, consistent with MDHHS policy, be required to pay the cost of services furnished while the appeal or the SFH is pending if the final decision is adverse to the member.	Y ☒ N ☐
	Evidence as submitted by the PIHP: • Member Handbook- Page 63- Benefit Continuation	
42 CFR §438.10(g)(2)(xii) 42 CFR §438.3(j)(3) Contract Schedule A–1(Q)(5)	22. How to exercise an advance directive, as set forth in 42 CFR §438.3(j).	Y ☒ N ☐
	Evidence as submitted by the PIHP: • Member Handbook- Page 51- Topic Covered during PCP	
42 CFR §438.10(g)(2)(xiii) 42 CFR §457.1207 Contract Schedule A–1(M)(2)(b)(i)	23. How to access auxiliary aids and services, including additional information in alternative formats or languages.	Y ☒ N ☐
	Evidence as submitted by the PIHP: • Member Handbook- Page 21,22- Language Assistance and Accommodations	

Standard I—Member Handbook Checklist		
Reference	**Required Components**	
42 CFR §438.10(g)(2)(xiv) 42 CFR §457.1207 Contract Schedule A–1(B)(4)(k)(ii)(4)	24. The toll-free telephone number for member services, medical management, and any other unit providing services directly to members. **Evidence as submitted by the PIHP:** • Member Handbook- Customer Service Page 19, Recipient Rights Page 5, 16, 17, 24-hour Crisis and Referral Help Line Page 24, Mobile Crisis Unit DWIHN Crisis Call Center and the Back of the book.	Y ☒ N ☐
42 CFR §438.10(g)(2)(xv) 42 CFR §457.1207	25. Information on how to report suspected fraud or abuse. **Evidence as submitted by the PIHP:** • Member Handbook- Page 42, 45- Reporting Fraud, Waste and Abuse	Y ☒ N ☐
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 Contract Schedule A–1(B)(4)(a)	26. *The date of publication/revision and version number.* **Evidence as submitted by the PIHP:** • Member Handbook- Page 95- Thank You- Publication and Revision- Date (Bottom of Page)	Y ☒ N ☐
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 Contract Schedule A–1(B)(4)(h)	27. *Produce supplemental materials to the member handbook, as needed, to ensure compliance with the contractual requirements (e.g., inserts/stickers).* **Evidence as submitted by the PIHP:** • Member Handbook- Page 78,79 Family Support Subsidy (FSS) Program, Page 75-77-Federally Qualified, Centers Page 55,56-Trauma Informed Care Checklist, Page 56- Tip for interacting with people who have a disability, Page 57- Language Preferred by Individuals with a Disability, Page7- Mission Vision and Values Page 83- The DWIHN Anti-Stigma Campaign	Y ☒ N ☐
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 Contract Schedule A–1(B)(4)(i)	28. *Use MDHHS' description for each Medicaid covered service.* **Evidence as submitted by the PIHP:** • Member Handbook- Covered Services 32-41	Y ☒ N ☐
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 Contract Schedule A–1(B)(4)(j)	29. Include *the following contact information for Medicaid health plans (MHPs) or Medicaid fee-for-service (FFS) programs:* a. *Plan/program name* b. *Locations*	Y ☒ N ☐

Standard I—Member Handbook Checklist		
Reference	**Required Components**	
	c. *Telephone numbers* **Evidence as submitted by the PIHP:** • Member Handbook- Page 74- Medicaid Health Plans in Wayne County	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 Contract Schedule A–1(B)(4)(k)(i)	30. *Include the following topics in the Customer Services Handbook (topics requiring use of MDHHS template language, which can be found at: https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/customer-services)*: a. *Template #1: Confidentiality and Family Access to Information* b. *Template #2: Coordination of Care* c. *Template #3: Emergency and After-Hours Access to Services* d. *Template #4: Glossary or Definition of Terms* e. *Template #5: Grievance and Appeals Processes* f. *Template #6: Language Assistance and Accommodations* g. *Template #7: Payment for Services* h. *Template #8: Person-Centered Planning* i. *Template #9: Recipient Rights* j. *Template #10: Recovery and Resiliency* k. *Template #11: Service Array* l. *Template #12: Service Authorization* m. *Template #13: Tag Lines* n. *Template #14: Fraud, Waste and Abuse*	Y ☒ N ☐
	Evidence as submitted by the PIHP: Member Handbook- • Template #1: Confidentiality and Family Access to Information Page 17 • Template #2: Coordination of Care- Page 49 • Template #3: Emergency and After-Hours Access to Services Page 24 • Template #4: Glossary or Definition of Terms Page 84-94 • Template #5: Grievance and Appeals Processes Pages 58,59	

Standard I—Member Handbook Checklist		
Reference	**Required Components**	
	• Template #6: Language Assistance and Accommodations Page 21 • Template #7: Payment for Services Page 31 • Template #8: Person-Centered Planning Page 50 • Template #9: Recipient Rights Page 15,16 • Template #10: Recovery and Resiliency Page 53 • Template #11: Service Array Pages 22-40 • Template #12: Service Authorization Page 30 • Template #13: Tag Lines Page 20,21 • Template #14: Fraud, Waste and Abuse Page 42	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 Contract Schedule A–1(B)(4)(k)(ii)(4)	31. *Affiliate the names, addresses, and phone numbers of the following personnel:* a. *Executive director* b. *Medical director* c. *Recipient rights officer* d. *Customer services* e. *Emergency (911) and after-hours contact numbers*	Y ☒ N ☐
	Evidence as submitted by the PIHP: Member Handbook- • Executive director Page 1 • Medical director Page 2 • Recipient rights officer Page 16 • Customer services Page 19 • Emergency (911) and after-hours contact numbers Page 24	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 Contract Schedule A–1(B)(4)(k)(ii)(5)	32. *Community resource list (and advocacy organizations).*	Y ☒ N ☐
	Evidence as submitted by the PIHP: • Member Handbook- Advocacy Group Page 78,79	

Standard I—Member Handbook Checklist		
Reference	**Required Components**	
	• Member Handbook- Community Resource- Page 81-82	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 Contract Schedule A–1(B)(4)(k)(ii)(6)	33. *Index.* **Evidence as submitted by the PIHP:** • Member Handbook- Page 8, 9- Table of Contents	Y ☒ N ☐
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 Contract Schedule A–1(B)(4)(k)(ii)(7)	34. *Right to information about PIHP operations (e.g., organizational chart, annual report).* **Evidence as submitted by the PIHP:** • Member Handbook- Page 4- Organizational Chart, Page 13, DWIHN Responsibilities- Bullet 7, Page 14 bullet 6	Y ☒ N ☐
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 Contract Schedule A–1(B)(4)(k)(ii)(8)	35. *Services not covered under contract.* **Evidence as submitted by the PIHP:** • Member Handbook-Page 13- Member Rights and Responsibilities – You Have the Right TO: Bullet 24	Y ☒ N ☐
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 Contract Schedule A–1(B)(4)(k)(ii)(9)	36. *Welcome to the PIHP.* **Evidence as submitted by the PIHP:** • Member Handbook-Pages 1 &2-Dear Enrollees,	Y ☒ N ☐
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 Contract Schedule A–1(B)(4)(k)(ii)(10)	37. *What are customer services and what they can do for the individual; hours of operation and process for obtaining customer assistance after hours?* **Evidence as submitted by the PIHP:** • Member Handbook-Page 19- Customer Service -Hours of Operations, After-Hours (Back Cover)	Y ☒ N ☐
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 Contract Schedule A–1(M)(2)(b)(ii)(1)(b)	38. *Member rights and protections as specified in the contract as they relate to grievances and appeals.* **Evidence as submitted by the PIHP:** • Member Handbook-Page 58- Grievances, Pages 59, -62- Appeals /Local Disputes Resolution and State Fair Hearings (Medicaid or MI Health Link Enrollees Only)	Y ☒ N ☐

Standard I—Provider Directory Checklist		
Reference	**Required Components**	
The PIHP makes available in paper form, upon request, and electronic form the following information about its network providers:		
42 CFR §438.10(h)(1)(i) 42 CFR §457.1207 Contract Schedule A–1(M)(1)(f)(i) Contract Schedule A–1(M)(2)(b)(ii)(1)(a)	1. The provider's name as well as any group affiliation. **Evidence as submitted by the PIHP:** • Provider Directory - DWIHN Provider Network pages 17-61 • On- line Directory on the website- www.dwihn.org • https://dwihn.org/members/Provider_Directory_Booklet.pdf	Y ☒ N ☐
42 CFR §438.10(h)(1)(ii) 42 CFR §457.1207 Contract Schedule A–1(M)(1)(f)(ii) Contract Schedule A–1(M)(2)(b)(ii)(1)(a)	2. Street address(es). **Evidence as submitted by the PIHP:** • Provider Directory - DWIHN Provider Network pages 17-61 • On- line Directory on the website- www.dwihn.org	Y ☒ N ☐
42 CFR §438.10(h)(1)(iii) 42 CFR §457.1207 Contract Schedule A–1(M)(1)(f)(iii) Contract Schedule A–1(M)(2)(b)(ii)(1)(a)	3. Telephone number(s). **Evidence as submitted by the PIHP:** • Provider Directory - DWIHN Provider Network pages 17-61 • On- line Directory on the website- www.dwihn.org • https://dwihn.org/members/Provider_Directory_Booklet.pdf	Y ☒ N ☐
42 CFR §438.10(h)(1)(iv) 42 CFR §457.1207 Contract Schedule A–1(M)(1)(f)(iv) Contract Schedule A–1(M)(2)(b)(ii)(1)(a)	4. Website Uniform Resource Locator (URL), as appropriate. **Evidence as submitted by the PIHP:** • On- line Directory on the website- www.dwihn.org • https://dwihn.org/members/Provider_Directory_Booklet.pdf	Y ☒ N ☐
42 CFR §438.10(h)(1)(v) 42 CFR §457.1207 Contract Schedule A–1(M)(1)(f)(v) Contract Schedule A–1(M)(2)(b)(ii)(1)(a)	5. Specialty *and services provided*, as appropriate. **Evidence as submitted by the PIHP:** • Provider Directory - DWIHN Provider Network pages 17-61 • On- line Directory on the website- www.dwihn.org • https://dwihn.org/members/Provider_Directory_Booklet.pdf	Y ☒ N ☐

Standard I—Provider Directory Checklist		
Reference	**Required Components**	
42 CFR §438.10(h)(1)(vi) 42 CFR §457.1207 Contract Schedule A–1(M)(1)(f)(vi)	6. Whether the provider will accept new members.	Y ☒ N ☐
	• Evidence as submitted by the PIHP: • Provider Directory - DWIHN Provider Network pages 17-37 • On- line Directory on the website- www.dwihn.org • https://dwihn.org/members/Provider_Directory_Booklet.pdf	
42 CFR §438.10(h)(1)(vii) 42 CFR §457.1207 Contract Schedule A–1(M)(1)(f)(vii-viii) Contract Schedule A–1(M)(2)(b)(ii)(1)(a)	7. The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office.	Y ☒ N ☐
	Evidence as submitted by the PIHP: • Provider Directory - DWIHN Provider Network pages 17-37 • Provider Directory- Non-English Speaking Providers Pages 40-43 • On- line Directory on the website - https://www.dwihn.org/find-a-provider • https://dwihn.org/members/Provider_Directory_Booklet.pdf	
42 CFR §438.10(h)(1)(viii) 42 CFR §457.1207 Contract Schedule A–1(M)(1)(f)(ix) Contract Schedule A–1(M)(2)(b)(ii)(1)(a)	8. Whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s), and equipment, including but not limited to, wide entries, wheelchair access, accessible exam tables and rooms, lifts, scales, bathrooms, grab bars, or other equipment.	Y ☐ N ☒
	Evidence as submitted by the PIHP: • On-line Directory on the website - https://www.dwihn.org/find-a-provider	
42 CFR §438.10(h)(2) 42 CFR §457.1207 Contract Schedule A–1(M)(1)(a)	9. The provider directory components are included for the following provider types: a. Physicians, including specialists b. Hospitals c. Pharmacies (*not applicable for the PIHPs*) d. Behavioral health providers e. Long-term services and supports (LTSS) providers f. *Medical suppliers* g. *Ancillary health providers* h. *Independent facilitators* i. *Fiscal intermediaries*, as appropriate	Y ☒ N ☐

Standard I—Provider Directory Checklist		
Reference	**Required Components**	
	Evidence as submitted by the PIHP: • On- line Directory on the website - https://www.dwihn.org/find-a-provider • Provider Directory – DWIHN Provider Network pages 17-61 • Provider Directory – Non-English Speaking Providers Pages 40-43 • Provider Directory – Independent Facilitators Page13 • Provider Directory – Fiscal Intermediary Page 14 • Medical Suppliers – N/A • Ancillary Health Providers N/A • Hospitals N/A	
Contract Schedule A–1(M)(1)(e)	10. *Provider directory is organized by county.*	Y ☐ N ☒
	Evidence as submitted by the PIHP: •	

Standard III—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
Delivery Network		
1. The PIHP maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract for all members, including those with limited English proficiency or physical or mental disabilities. 42 CFR §438.206(b)(1) 42 CFR §457.1230(a) Contract Schedule A–1(E)(1) Contract Schedule A–1(E)(9)(a)	**HSAG Required Evidence:** • Policies and procedures • Analysis of provider network linguistic capabilities • Analysis of provider network capabilities to serve members with special health care needs • Provider materials, such as the provider manual • One example of each type of provider contract (ancillary, hospital, and individual/group) **Evidence as Submitted by the PIHP:** • Cultural Competency Policy (pg.2) • Access Policy (pgs. 2-3) • Provider Manual FY 23/24 (pg 17, #3c) • Member Handbook (pgs. 12, 20-22) • DWIHN FY 23-24 Fully Executed Clinical Outpatient Agreement – AWBS • DWIHN FY23-24 Clinical Residential Agreement Template, pg 18 • FY 23 Network Adequacy Assessment Report 2.26.24 pg 18-22	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: Contracted DWIHN providers are required to have provisions for DWIHN members with limited proficiency, physical or mental disabilities, in accordance to the contract. DWIHN policies, Provider Handbook and Member Handbook are updated annually. DWIHN also measures the cultural and linguistic capacity of its provider network annually.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		

Standard III—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
2. The MCO provides female members with direct access to a women's health specialist within the provider network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health specialist. 42 CFR §438.206(b)(2) 42 CFR §457.1230(a) Contract F.4.01	**HSAG Required Evidence:** • Not applicable **Evidence as Submitted by the MCO:** • Not applicable	☐ Met ☐ Not Met ☒ NA
MCO Description of Process:		
HSAG Findings: This element is *Not Applicable* to the PIHP.		
Required Actions: None.		
3. The MCO demonstrates that its network includes sufficient family planning providers to ensure timely access to covered services. 42 CFR §438.206(b)(7) 42 CFR §457.1230(a) Contract E.1.23	**HSAG Required Evidence:** • Not applicable **Evidence as Submitted by the MCO:** • Not applicable	☐ Met ☐ Not Met ☒ NA
MCO Description of Process:		
HSAG Findings: This element is *Not Applicable* to the PIHP.		
Required Actions: None.		
4. The PIHP provides for a second opinion from a network provider, or arranges for the member to obtain one outside the network, at no cost to the member.	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Second opinion tracking/analysis • Coverage/authorization guidelines	☒ Met ☐ Not Met ☐ NA

Standard III—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
*Note: Second opinion rights under Michigan Mental Health Code 330.1705, 330.1409, 330.1498e, or 330.1498h are a separate requirement than the federal requirement noted under this element. 42 CFR §438.206(b)(3) 42 CFR §457.1230(a) Contract Schedule A–1(E)(12)	**Evidence as Submitted by the PIHP:** • Second Opinion Procedure (pgs. 1, #1) • Member Handbook 2023-2024 (pgs. 14 and 15) • DWIHN member flyer – Member Rights and Responsibilities (pg. 1) • Behavioral Health Utilization Management Review Policy, Pg 3, #2a	
PIHP Description of Process: Per DWIHN's Second Opinion Procedure, Member Handbook, Member Flyer and Behavioral Health UM Review Policy, provisions are made for members to obtain a second opinion outside the network and no cost to the member.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
5. If the provider network is unable to provide necessary services, covered under the contract, to a particular member, the PIHP adequately and timely covers these services out of network for the member, for as long as the PIHP provider network is unable to provide them. 42 CFR §438.206(b)(4) 42 CFR §457.1230(a) Contract Schedule A–1(E)(4)(a)	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Network adequacy monitoring mechanisms • Three examples of executed single case agreements (SCAs) (if the execution of SCAs is also a delegated function, one case example must pertain to an SCA executed by the PIHP, and two case examples must pertain to an SCA executed by two different delegates) **Evidence as Submitted by the PIHP:** • Out or Network Policy (pg. 1, 2) • FY 23 Network Adequacy Assessment Report 2.26.24 pg 23 • Access Policy (pg. 1-2) • Member Handbook 2023-2024 (pg 30) • Member Handbook 2023-2024 (pg. 71) • 3 examples of single Case Agreements	☒ Met ☐ Not Met ☐ NA

Standard III—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
	○ Signed Hinton, M. ○ Signed Rivera, J. ○ Signed Zrebreic, J.	
PIHP Description of Process: Via DWIHN's Out of Network Policy services are arranged and authorized, for as long as the PIHP's provider network is unable to provide them. If necessary, a Single Case Agreement is established to facilitate provision of service(s).		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
6. The PIHP requires out-of-network providers to coordinate with the PIHP for payment and ensures the cost to the member is no greater than it would be if the services were furnished within the network, *including a prohibition on balance billing in compliance with 42 CFR 438.106, 42 CFR 438.116, and the Medicaid Provider Manual*. a. *The PIHP must comply with all related Medicaid policies regarding authorization and reimbursement for out-of-network providers*. b. *The PIHP must pay out-of-network Medicaid providers' claims at established Medicaid fees in effect on the date of service*. c. *If Michigan Medicaid has not established a specific rate for the covered service, the PIHP must follow Medicaid policy to determine the correct payment amount*. 42 CFR §438.206(b)(5) 42 CFR §457.1230(a) Contract Schedule A–1(E)(4)(c-d)	**HSAG Required Evidence:** • Policies and procedures • Claims processing guidelines for out-of-network providers • Member materials, such as the member handbook • Provider materials, such as materials on the PIHP's website • Three examples of executed SCAs (if the execution of SCAs is also a delegated function, one case example must pertain to an SCA executed by the PIHP, and two case examples must pertain to an SCA executed by two different delegates) **Evidence as Submitted by the PIHP:** • DWIHN Single Case Agreement (SCA) ○ - 164463 Between Detroit Wayne integrated Health Network and Bronson Behavioral Health Hospital ○ Signed Hinton, M. ○ Signed Rivera, J. • Non-Contracted Providers Claims Handling Policy (pgs 1,2) • Out of Network Policy (pg 2 #6)	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: Via DWIHN's Out of Network Policy, services are arranged and authorized for as long as the PIHP's provider network is unable to provide them. If necessary, a Single Case agreement is established to facilitate provision of service(s).		

Standard III—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
42 CFR §438.206(b)(6) requires the PIHP to demonstrate that its network providers are credentialed as required by §438.214. This requirement is reviewed under Standard VII: Provider Selection.		
Timely Access[2]		
7. *The Access System must operate or arrange an access line that is available 24 hours per day, seven days per week, including in-person and by-telephone access for hearing impaired individuals.* a. *Telephone lines are toll-free; accommodate limited English proficiency; are accessible for individuals with hearing impairments, using interpreters, text messaging, or videophone access; and have electronic caller identification, if locally available.* b. *Callers encounter no telephone "trees" and are not put on hold or sent to voicemail until they have spoken with a live representative from the Access System, and it is determined, following an empathetic opportunity for the caller to express their situation and circumstances, that their situation is not urgent or emergent.* c. *All crisis/emergent calls are immediately transferred to a qualified practitioner without requiring an individual to call back.* d. *For non-emergent calls, a person's time on hold awaiting a screening must not exceed three minutes without being offered*	**HSAG Required Evidence:** • Policies and procedures • Telephone system triage workflow • Timeliness monitoring reports **Evidence as Submitted by the PIHP:** • DWIHN Access Call Center Program Description and Scope of Services • Eligibility and Screening, pg. 2 #1-h • Genesys Cloud Flows ACCR • February2024 Access Call Center Monthly Report (pg 2)	☒ Met ☐ Not Met ☐ NA

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

Standard III—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
an option for callback or talking with a non-professional in the interim. e. *All non-emergent callbacks must occur within one business day of initial contact.* f. *For organizations with decentralized Access Systems, there must be a mechanism in place to forward the call to the appropriate access portal without the individual having to redial.* 42 CFR §438.206(c)(1)(i) 42 CFR §457.1230(a) Contract Schedule A–1(E)(7) MDHHS Behavioral Health and Developmental Disabilities Administration Access Standards I(B)		
PIHP Description of Process: Via Access Policy, Call Center Program Descriptions and Scope of Services, Call Center Clinical Screening and Call Center Welcoming Policy - The Access System must operate or arrange an access line that is available 24 hours per day, seven days per week, including in-person and by-telephone access for hearing impaired individuals.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element		
Required Actions: None.		
8. *The Access System shall provide a timely, effective response to all individuals who walk in.* a. *For individuals who walk in with urgent or emergent needs, an intervention shall be immediately initiated.* b. *Individuals with routine needs must be screened or other arrangements made within 30 minutes.* 42 CFR §438.206(c)(1)(i) 42 CFR §457.1230(a) Contract Schedule A–1(E)(7) MDHHS Behavioral Health and Developmental Disabilities Administration	**HSAG Required Evidence:** • Policies and procedures • Provider materials, such as the provider manual and provider contract • Monitoring reports **Evidence as Submitted by the PIHP:** • Time Frames and Procedural Steps for Priority Population Management (pg 1) • Customer Service Policy (pg 4) • Access Policy (pg 1)	☐ Met ☒ Not Met ☐ NA

Standard III—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
Access Standards I(C)(1-2)	• FY 23-24 SUD appointment availability report	
PIHP Description of Process: Via the Access Policy, Customer Service Policy and Time Frames & Procedural Steps for Priority Populations Management, individuals with urgent or emergent needs are to receive immediate interventions and individuals with routine needs are to receive a screening or other arrangements within 30 minutes. FY 23-24 appointment availability report monitors timeliness of services availability and scheduling.		
HSAG Findings: The PIHP staff members were able to describe the Access System's response to individuals who were walk-ins and the *Access Policy*, *Customer Service Policy*, and *Time Frames and Procedural Steps for Priority Population Management* documents included the required access time frame standards for walk-ins as well as the process for assisting individuals who walk-in; however, the PIHP was not able to demonstrate that it monitored the specific time frames for walk-ins to ensure that timeliness requirements were met. Additionally, although the PIHP's *FY 23-24 SUD appointment availability report* included timeliness of services availability and scheduling data, it did not specifically identify the access time frames for walk-ins.		
Required Actions: The PIHP must ensure that the Access System provides a timely, effective response to all individuals who walk in. For individuals who walk in with urgent or emergent needs, an intervention must be immediately initiated. For individuals with routine needs, they must be screened or have other arrangements made within 30 minutes. The PIHP must have monitoring mechanisms to ensure compliance with these access standards.		
9. *Pregnant injecting drug user:* a. *Screened and referred within 24 hours for admission* b. *Detoxification, methadone, or residential—offer admission within 24 business hours.* c. *Other levels of care—offer admission within 48 business hours.* 42 CFR §438.206(c)(1)(i) 42 CFR §457.1230(a) Contract Schedule A–1(E)(7) MDHHS Behavioral Health and Developmental Disabilities Administration Access Standards III(A)	**HSAG Required Evidence:** • Policies and procedures • Provider materials, such as the provider manual and provider contract • Timeliness monitoring reports **Evidence as Submitted by the PIHP:** • Timeframes and Procedural Steps for Priority Population Management (pg 1-2) • Access Call Center Clinical Screening Policy (Pg 7, #10) • FY23-24 SUD appointment availability report	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: Via the Access Call Center Clinical Screening Policy &Timeframes and Procedural Steps for Priority Populations Management, individuals that are pregnant injecting users should be screened and referred within 24 hours, offered detoxification, Methadone or residential services within 24 business hours and offered other levels of care within 48 business hours. FY 23-24 appointment availability report monitors timeliness of services availability and scheduling.		

Standard III—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
10. *Pregnant substance user:* a. *Screened and referred within 24 hours for admission.* b. *Detoxification, methadone, or residential—offer admission within 24 business hours.* c. *Other levels of care—offer admission within 48 business hours.* 42 CFR §438.206(c)(1)(i) 42 CFR §457.1230(a) Contract Schedule A–1(E)(7) MDHHS Behavioral Health and Developmental Disabilities Administration Access Standards III(A)	**HSAG Required Evidence:** • Policies and procedures • Provider materials, such as the provider manual and provider contract • Timeliness monitoring reports **Evidence as Submitted by the PIHP:** • Time Frames and Procedural Steps for priority Population Management (pg 2) • Access Call Center Clinical Screening Policy (Pg 7, #10) • Access Policy (pg 2, #3) • FY23-24 SUD appointment availability report	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: Via the Access Call Center Clinical Screening Policy, Access Policy &Timeframes and Procedural Steps for Priority Populations Management, individuals that are pregnant substance users should be screened and referred within 24 hours, offered detoxification, Methadone or residential services within 24 business hours and offered other levels of care within 48 business hours. FY 23-24 appointment availability report monitors timeliness of services availability and scheduling		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
11. *Injecting drug user:* a. *Screened and referred within 24 hours for admission.* b. *Offer admission within 14 days.* 42 CFR §438.206(c)(1)(i) 42 CFR §457.1230(a) Contract Schedule A–1(E)(7)	**HSAG Required Evidence:** • Policies and procedures • Provider materials, such as the provider manual and provider contract • Timeliness monitoring reports **Evidence as Submitted by the PIHP:**	☒ Met ☐ Not Met ☐ NA

Standard III—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
MDHHS Behavioral Health and Developmental Disabilities Administration Access Standards III(A)	• Time Frames and Procedural Steps for Priority Population Management (pg 2-3) • Access Call Center Clinical Screening Policy (Pg 7, #10) • FY 23-24 SUD appointment availability report	
PIHP Description of Process: Via the Access Call Center Clinical Screening Policy &Timeframes and Procedural Steps for Priority Populations Management, individuals that are Injecting drug users should be screened and referred within 24 hours, offered admission within 14 days. FY 23-24 appointment availability report monitors timeliness of services availability and scheduling		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
12. *Parent at risk of losing children:* a. *Screened and referred within 24 hours for admission.* b. *Offer admission within 14 days.* 42 CFR §438.206(c)(1)(i) 42 CFR §457.1230(a) Contract Schedule A–1(E)(7) MDHHS Behavioral Health and Developmental Disabilities Administration Access Standards III(A)	**HSAG Required Evidence:** • Policies and procedures • Provider materials, such as the provider manual and provider contract • Timeliness monitoring reports **Evidence as Submitted by the PIHP:** • Time Frames and Procedural Steps for Priority Population Management (pg 3) • FY 23-24 SUD appointment availability report	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: Via the Access Policy &Timeframes and Procedural Steps for Priority Populations Management, individuals that are a parent at risk of losing children should be screened and referred within 24 hours, offered admission within 14 days. FY 23-24 appointment availability report monitors timeliness of services availability and scheduling		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** The PIHP's screening process included questions to identify whether the individual presenting at the access centers met the criteria for a priority population designation; however, this information was not tracked separately, but rather, was included in either an emergent, urgent, or routine category. As such, HSAG strongly recommends that the PIHP report on each separate priority population to readily assess adherence to the access standards.		

Standard III—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
Required Actions: None.		
13. *Individual under supervision of Michigan Department of Corrections (MDOC) and referred by MDOC or individual being released directly from MDOC without supervision and referred by MDOC:* a. *Screened and referred within 24 hours for admission.* b. *Offer admission within 14 days.* 42 CFR §438.206(c)(1)(i) 42 CFR §457.1230(a) Contract Schedule A–1(E)(7) MDHHS Behavioral Health and Developmental Disabilities Administration Access Standards III(A)	**HSAG Required Evidence:** • Policies and procedures • Provider materials, such as the provider manual and provider contract • Timeliness monitoring reports **Evidence as Submitted by the PIHP:** • Timeframes and Procedural Steps for Priority Population Management (pg. 2) • FY 23-24 SUD appointment availability report	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: Via the Access Policy &Timeframes and Procedural Steps for Priority Populations Management, individuals that are under supervision of MDOC, referred by MDOC and being released directly from MDOC without supervision (referred by MDOC) should be screened and referred within 24 hours and offered admission within 14 days.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** The PIHP's screening process included questions to identify whether the individual presenting at the access centers met the criteria for a priority population designation; however, this information was not tracked separately (specifically for "parent at risk of losing children" and "individual under supervision of MDOC and referred by MDOC" or "individual being released directly from MDOC without supervision and referred by MDOC"), but rather, was included in either an emergent, urgent, or routine category. As such, HSAG strongly recommends that the PIHP report on each separate priority population to readily assess adherence to the access standards.		
Required Actions: None.		

Standard III—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
14. *All other populations:* a. *Screened and referred within seven calendar days.* b. *Capacity to offer admission within 14 days*. 42 CFR §438.206(c)(1)(i) 42 CFR §457.1230(a) Contract Schedule A–1(E)(7) MDHHS Behavioral Health and Developmental Disabilities Administration Access Standards III(A)	**HSAG Required Evidence:** • Policies and procedures • Provider materials, such as the provider manual and provider contract • Timeliness monitoring reports **Evidence as Submitted by the PIHP:** • Time Frames and Procedural Steps for Priority Population Management (pg 3) • Access Policy (pg 2, #3) • FY 23-24 SUD appointment availability report • Access Committee March 2024 – Access Call Center, pg. 4	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: Via the Access Policy &Timeframes and Procedural Steps for Priority Populations Management, all other populations should be screened and referred within 7 business days and offered admission within 14 days. FY 23-24 appointment availability report monitors timeliness of services availability and scheduling		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
15. The PIHP ensures that the network providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid fee-for service (FFS) if the provider serves only Medicaid members. 42 CFR §438.206(c)(1)(ii) 42 CFR §457.1230(a)	**HSAG Required Evidence:** • Policies and procedures • Provider materials, such as the provider manual and provider contract • Audit or secret shopper results/reports **Evidence as Submitted by the PIHP:** • Clinical Services Agreement (Judson Center) - pg 5, #1.15	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: Via the Clinical Outpatient Service Provider Agreement Between DWIHN and Provide, the PIHP ensures that the network provider offers hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid FFS		

Standard III—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
16. The PIHP makes services included in the contract available 24 hours a day, seven days a week, when medically necessary. 42 CFR §438.206(c)(1)(iii) 42 CFR §457.1230(a) MDHHS Behavioral Health and Developmental Disabilities Administration Access Standards (I)(B)	**HSAG Required Evidence:** • Policies and procedures • Provider materials, such as the provider manual and provider contract • Results of provider monitoring mechanisms • Audit or secret shopper results/reports **Evidence as Submitted by the PIHP:** • Network Monitoring and Management, pg 3, #21 • FY23 Network Adequacy Assessment	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: Via the Network Monitoring and Management Policy, the POHP makes services included in the contract available 24 hours a day, seven days a week, when medically necessary.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
17. The PIHP establishes mechanisms to ensure compliance with timely access to care and services standards by network providers. a. The PIHP monitors network providers regularly to determine compliance. b. The PIHP takes corrective action if there is a failure to comply by a network provider. 42 CFR §438.206(c)(1)(iv-vi) 42 CFR §457.1230(a) Contract Schedule A–1(E)(7)(a) MDHHS Behavioral Health and Developmental Disabilities Administration Access Standards (IX)(C)	**HSAG Required Evidence:** • Policies and procedures • Results of provider monitoring mechanisms • Audit or secret shopper results/reports • Three examples of corrective action taken when a provider fails to meet timely access standards **Evidence as Submitted by the PIHP:** • Network Monitoring and Management, Pg 3, #22-24 • Delegated functions, Pg. 2, #9 • Quarterly Contract Status form • Provider Capacity Memo	☒ Met ☐ Not Met ☐ NA

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

	• Sample Provider Capacity form
	  ○ TGC Dec 2023
	  ○ TCC Jan 2024	

PIHP Description of Process: Via the Network Monitoring and Management policy, the PIHP monitors network providers regularly to determine compliance and takes corrective action if there is a failure to comply.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
18. *The PIHP (for the Access System):* a. *Routinely measures telephone answering rates, call abandonment rates, and timeliness of appointments and referrals*; *and* b. *Any resulting performance issues are addressed through the PIHP's Quality Improvement Plan*. Contract Schedule A–1(E)(7)(a) MDHHS Behavioral Health and Developmental Disabilities Administration Access Standards (IX)(C)(5)	**HSAG Required Evidence:** • Policies and procedures • Results of Access System monitoring • Timeliness reports • Two examples of quality improvement plans related to the Access System **Evidence as Submitted by the PIHP:** • Access Call Center Data Collection and Reporting, pg 2, #2 • Access Call Center FY 23-24 1st Quarter Report, Pg 1-2 • Access Committee (Access Call Center Appointment Availability report Mar 2024) • FY 23-24 appointment availability report • Access Committee Meeting Notes 3.21.24 • Meeting Notes QISC March 26, 2024	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: Via the Access Call Center Data Collecting and Reporting policy the PIHP routinely measures telephone answering rates, call abandonment rates, timeliness of appointments and referrals.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		

Standard III—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
Access and Cultural Considerations		
19. The PIHP participates in MDHHS's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of sex. 42 CFR §438.206(c)(2) 42 CFR §457.1230(a) Contract Schedule A–1(E)(9)(a) Contract Schedule A–1(E)(9)(c)	**HSAG Required Evidence:** • Policies and procedures • Provider materials, such as the provider manual and provider contract • Cultural competency plan • Example(s) of provider profiles (e.g., cultural and linguistic capabilities) on provider directory • Analysis of provider network linguistic capabilities • Analysis of provider network cultural competence **Evidence as Submitted by the PIHP:** • Provider Contract – DWIHN FY 23-24 Fully Executed Clinical Outpatient Services – AWBS • Provider Manual 2023-2024 (pgs. 54-56) • Access Policy (pgs 1-3) • Cultural Competence Policy (pgs. 1-5) • Annual Assessment of Network Availability of providers and Practitioners • Member Handbook 2023-2024 (pg 12, 20-21)	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: According to DWIHN contract, contracted providers participate in MDHHS' efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English Proficiency and diverse cultural and ethnic backgrounds, disabilities and regardless of sex.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		

Standard III—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
Accessibility Considerations		
20. The PIHP ensures that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid members with physical or mental disabilities. 42 CFR §438.206(c)(3) 42 CFR §457.1230(a) Contract Schedule A–1(E)(20)(c)	**HSAG Required Evidence:** • Policies and procedures • Provider materials such as the provider manual and provider contract • Mechanism to assess network providers' accessibility • Example(s) of provider profiles (i.e., accessibility accommodations [e.g., wide entries, wheelchair access, accessible exam tables and rooms, lifts, scales, bathrooms, grab bars, or other equipment]) on provider directory • Analysis of provider network capability to provide services to members with physical or mental disabilities • Surveys or site review results **Evidence as Submitted by the PIHP:** • Provider Manual 2023-2024 (pgs. 49-51, 57-59) • Access Policy (pg 2) • Member Handbook 2023-2024, (pgs. 12, 20-22) • Accommodations for Individual with Visual, Mobility Impairment Policy (entire document)	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: As stated in the DWIHN's Provider Manual and Access Policy, network providers are required to provide physical access, reasonable accommodations and accessible equipment for Medicaid members with physical or mental disabilities. Annually, DWIHN conducts two surveys which query providers and practitioners about their capability to provide services to members with disabilities. Responses provide DWIHN of the capabilities within our provider network to provide services to members based upon their disabilities (e.g. SMI, SED, Autism, MI/SID). Note, that the 2 surveys are the Practitioner Satisfaction Survey and the Provider Satisfaction Survey. The Results of the surveys are provided in the Annual Assessment of the Network Availability of Providers & Practitioners.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		

Standard III—Availability of Services						
Met	=	17	X	1	=	17
Not Met	=	1	X	0	=	0
Not Applicable	=	2				
Total Applicable	=	18	Total Score		=	17
Total Score ÷ Total Applicable					=	94%

Standard IV—Assurances of Adequate Capacity and Services		
Requirement	**Supporting Documentation**	**Score**
Basic Rule		
1. The PIHP gives assurances to MDHHS and provides supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance MDHHS' standards for access to care under 42 CFR §438.207, including the standards at §438.68 and §438.206(c)(1). a. The PIHP submits documentation to MDHHS, in a format specified by the State, to demonstrate that it complies with the following requirements: i. Offers an appropriate range of preventive, primary care, specialty services, and long-term services and supports (LTSS) that is adequate for the anticipated number of members for the service area. ii. Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area. 42 CFR §438.207(a) 42 CFR §438.207(b)(1-2) 42 CFR §457.1230(b) Contract Schedule A–1(E)(2)(a) MDHHS Network Adequacy Standards—Medicaid Specialty Behavioral Health Services Procedure	**HSAG Required Evidence:** • Policies and procedures • Network adequacy reports and analyses • HSAG will also use the results of the Access Standards: Time/Distance Checklist • HSAG will also use the results of the Access Standards: Member-to-Provider Ratio Checklist **Evidence as Submitted by the PIHP:** • Access Policy Page 1- Purpose, Application #2 Page 2/Standards a & b • Network Monitoring & Management Policy Page 5- Standards 43, 44 & 47 • FY 23 MDHHS Specialty Behavioral Health Network Adequacy Standards PIHP Network Adequacy Reporting Template – Service & Availability Tab • FY 23 Network Adequacy Report	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The Network Management and Monitoring Policy and Access Policy governs and provides specifications for the structure of DWIHN's provider network to ensure that it is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area. Annually, DWIHN conducts an Annual Assessment to measure and demonstrate 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 CFR §438.207.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		

Standard IV—Assurances of Adequate Capacity and Services		
Requirement	**Supporting Documentation**	**Score**
Required Actions: None.		
Timing		
2. The PIHP submits the documentation in 42 CFR §438.207(b) as specified by MDHHS, but no less frequently than the following: a. At the time it enters into a contract with MDHHS. b. On an annual basis. c. At any time there has been a significant change (as defined by MDHHS) in the PIHP's operations that would affect the adequacy of capacity in services, including: i. Changes in PIHP services, benefits, geographic service area, composition of or payments to its provider network; or ii. Enrollment of a new population in the PIHP. 42 CFR §438.207(c) 42 CFR §457.1230(b)	**HSAG Required Evidence:** • Policies and procedures • Assurances of adequate capacity and services submissions to MDHHS (most recent annual submission) • Assurances of adequate capacity and services submission(s) to MDHHS due to a significant change **Evidence as Submitted by the PIHP:** • Network Monitoring & Management Policy- Pages 4-5, Standards 38,43 & 44 • FY 23 MDHHS Specialty Behavioral Health Network Adequacy Standards PIHP Network Adequacy Reporting Template – Service & Availability Tab • MCO Close Out Plan/Procedure	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The Network Management and Monitoring Policy and Access Policy governs and provides specifications for the structure of DWIHN's provider network to ensure that is in sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area. Annually, DWIHN conducts an Annual Assessment to measure and ensure network adequacy in accordance in accordance with MDHHS' defined network adequacy standards. Changes to DWIHN's provider network are reported to MDHHS within 7 days of notification from the provider and the DWIHN Close Out Plan is implemented to ensure maintenance of capacity as well as maintain services to members.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		

Standard IV—Assurances of Adequate Capacity and Services		
Requirement	**Supporting Documentation**	**Score**
3. *The PIHP must notify MDHHS within seven days of any changes to the composition of the provider network organizations that negatively affect access to care.* a. *The PIHP must have procedures to address changes in its network that negatively affect access to care.* Contract Schedule A–1(E)(3)(a)	**HSAG Required Evidence:** • Policies and procedures • Example of notification to MDHHS regarding provider network change that negatively affected access to care, including date of change to the provider network and date MDHHS was notified • Tracking mechanisms for timely notification to MDHHS of network change, including date of change to the provider network and date MDHHS was notified **Evidence as Submitted by the PIHP:** • Network Monitoring and Management Policy – Pages 4-5, Standards 38,43 & 44 • MCO Close Out Plan/Procedure • Terminated Merger Closure Log • 7 Day Notification of Closure Emails • October 2023 Access Committee Notes • January 2024 Access Committee Notes • April 2024 Access Committee Notes	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: To date, DWIHN has not experienced any changes to the composition of the provider network organizations that negatively impacted access to care. In accordance with DWIHN's Network Monitoring and Management Policy and DWIHN's Close Out Plan/Procedure, DWIHN notifies MDHHS of any closures upon 7 days of notification. Note also that DWIHN has an Access Committee that meets monthly that monitors the provider network and ensures member access and availability to services.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		

Standard IV—Assurances of Adequate Capacity and Services		
Requirement	**Supporting Documentation**	**Score**
4. *The PIHP must submit a plan on how the* [network adequacy] *standards will be effectuated by region. Understanding their diversity, MDHHS expects to see nuances within the PIHPs to best accommodate the local populations served. The PIHP must consider at least the following parameters for their plans*: a. *Maximum time and distance* b. *Timely appointments* c. *Language, cultural competence, and physical accessibility—§438.68(c)(vii-viii)* Contract Schedule A–1(E)(20)(c) MDHHS Network Adequacy Standards—Medicaid Specialty Behavioral Health Services Procedure	**HSAG Required Evidence:** • Policies and procedures • Regional network adequacy plan **Evidence as Submitted by the PIHP:** • Network Monitoring and Management Policy – Page 2-Standard 12 • Assessment of Members' Cultural, Linguistic and Ethnic Needs • Network Adequacy Needs Criteria • Access Policy – Pages 2-3/ Standards 1, 2 and 3 • Cultural Competence Policy – Pages 1-4, Purpose and Standards 1-4 • Limited English Proficiency Policy – Pages 1 –5/Purpose, Policy and Standards 1-8. • Limited English Proficiency Procedure – Page 1 – Procedure Purpose & Expected Outcome • FY 23 MDHHS Specialty Behavioral Health Network Adequacy Standards PIHP Network Adequacy Reporting Template – Service & Availability Tab. Timely Appointments Tab & Cultural Competence Tab • FY 23 Network Adequacy Report page 23-27	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: Annually, DWIHN conducts an Annual Assessment of the Network Availability of Providers & Practitioners to measure the accessibility availability of providers/services based upon MDHHS travel time and distance standards. The needs of members language, cultural needs are also assessed. DWIHN's provider contract and Provider Manual requires providers to adequate inclusion of culturally competent providers and provider services. DWIHN's Access Policy obligates providers to make reasonable accommodations for consumers and their supports as necessary.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. Of note, the documents submitted by the PIHPs for this element were not consistent; therefore, HSAG recommended to MDHHS that it provide clarification about its expectations for the PIHPs as it pertains to submission of a network adequacy plan, and specifically, whether a separate network adequacy plan is required in addition to the submission of the network		

Standard IV—Assurances of Adequate Capacity and Services		
Requirement	**Supporting Documentation**	**Score**
adequacy reporting template. As such, the PIHP should adhere to any guidance provided by MDHHS and incorporate the guidance into the PIHP's network adequacy planning and reporting processes.		
Required Actions: None.		
Network Adequacy Standards—Time/Distance		
5. *Inpatient psychiatric services for adults*: a. *Frontier: 150 minutes/125 miles* b. *Rural: 90 minutes/60 miles* c. *Urban: 30 minutes/30 miles* 42 CFR §438.207(a) 42 CFR §438.207(b)(1-2) 42 CFR §457.1218 Contract Schedule A–1(E)(20) MDHHS Network Adequacy Standards— Medicaid Specialty Behavioral Health Services Procedure	**HSAG Required Evidence:** • Policies and procedures • Network adequacy reports and analyses **Evidence as Submitted by the PIHP:** • Network Monitoring & Management Policy- Page 5 Standard 43 & 44 • FY 23 MDHHS Specialty Behavioral Health Network Adequacy Standards PIHP Network Adequacy Reporting Template – Service & Availability Tab/Inpatient Psychiatric Services for Adults • FY 23 Network Adequacy Report page 11	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: In accordance with MDHHS's Network Adequacy Standards DWIHN annually analyzes the availability and accessibility of inpatient psychiatric services for adults based upon the urban standard of 30 minutes/30 miles		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. Of note, the PIHP submitted documentation confirming that it maintained policies and contracts with providers, and that it monitored its network in accordance with the required time and distance standards, which resulted in the PIHP receiving a *Met* score for this element. **Recommendations:** HSAG recommends that the PIHP review the results, findings, and recommendations determined through the HSAG network adequacy validation (NAV) activity, and take action to ensure that the PIHP fully aligns with MDHHS' expectations regarding the methodology and calculation of time and distance standards.		
Required Actions: None.		

Standard IV—Assurances of Adequate Capacity and Services		
Requirement	**Supporting Documentation**	**Score**
6. *Inpatient psychiatric services for pediatrics*: a. *Frontier: 330 minutes/355 miles* b. *Rural: 120 minutes/125 miles* c. *Urban: 60 minutes/60 miles* 42 CFR §438.207(a) 42 CFR §438.207(b)(1-2) 42 CFR §457.1218 Contract Schedule A–1(E)(20) MDHHS Network Adequacy Standards— Medicaid Specialty Behavioral Health Services Procedure	**HSAG Required Evidence:** • Policies and procedures • Network adequacy reports and analyses **Evidence as Submitted by the PIHP:** • Network Monitoring & Management Policy- Page 5 Standard 43 & 44 • FY 23 MDHHS Specialty Behavioral Health Network Adequacy Standards PIHP Network Adequacy Reporting Template – Service & Availability Tab/Inpatient Psychiatric Services for Pediatrics • FY 23 Network Adequacy Report page 23	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: In accordance with MDHHS's Network Adequacy Standards DWIHN annually analyzes the availability and accessibility of Inpatient psychiatric services for pediatrics based upon the urban standard of 60 minutes/60 miles.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. Of note, the PIHP submitted documentation confirming that it maintained policies and contracts with providers, and that it monitored its network in accordance with the required time and distance standards, which resulted in the PIHP receiving a *Met* score for this element. **Recommendations:** HSAG recommends that the PIHP review the results, findings, and recommendations determined through the HSAG NAV activity, and take action to ensure that the PIHP fully aligns with MDHHS' expectations regarding the methodology and calculation of time and distance standards.		
Required Actions: None.		
7. *Assertive community treatment, crisis residential programs, opioid treatment programs, psychosocial rehabilitation (clubhouses) programs for adults*: a. *Frontier: 90 minutes/90 miles* b. *Rural: 60 minutes/60 miles* c. *Urban: 30 minutes/30 miles* 42 CFR §438.207(a)	**HSAG Required Evidence:** • Policies and procedures • Network adequacy reports and analyses **Evidence as Submitted by the PIHP:** • Network Monitoring & Management Policy- Page 5 Standard 43 & 44 • FY 23 MDHHS Specialty Behavioral Health Network Adequacy Standards PIHP Network Adequacy Reporting	☒ Met ☐ Not Met ☐ NA

Standard IV—Assurances of Adequate Capacity and Services		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.207(b)(1-2) 42 CFR §457.1218 Contract Schedule A–1(E)(20) MDHHS Network Adequacy Standards— Medicaid Specialty Behavioral Health Services Procedure	Template – Service & Availability Tab/ Assertive Community Treatment (ACT), Crisis Residential Programs, Opioid Treatment Programs, Psychosocial Rehabilitation (Clubhouse) Programs for Adults • FY 23 Network Adequacy Report	
PIHP Description of Process: In accordance with MDHHS's Network Adequacy Standards DWIHN annually analyzes the availability and accessibility of assertive community treatment, crisis residential programs, opioid treatment programs and psychosocial rehabilitation (clubhouses) programs for adults based upon the urban standard of 30 minutes/30 miles		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. Of note, the PIHP submitted documentation confirming that it maintained policies and contracts with providers, and that it monitored its network in accordance with the required time and distance standards, which resulted in the PIHP receiving a *Met* score for this element. **Recommendations:** HSAG recommends that the PIHP review the results, findings, and recommendations determined through the HSAG NAV activity, and take action to ensure that the PIHP fully aligns with MDHHS' expectations regarding the methodology and calculation of time and distance standards.		
Required Actions: None.		
8. *Crisis residential programs, home-based services, and wraparound services for children*: a. *Frontier: 90 minutes/90 miles* b. *Rural: 60 minutes/60 miles* c. *Urban: 30 minutes/30 miles* 42 CFR §438.207(a) 42 CFR §438.207(b)(1-2) 42 CFR §457.1218 Contract Schedule A–1(E)(20) MDHHS Network Adequacy Standards— Medicaid Specialty Behavioral Health Services Procedure	**HSAG Required Evidence:** • Policies and procedures • Network adequacy reports and analyses **Evidence as Submitted by the PIHP:** • Network Monitoring & Management Policy- Page 5 Standard 43 & 44 • FY 23 MDHHS Specialty Behavioral Health Network Adequacy Standards PIHP Network Adequacy Reporting Template – Service & Availability Tab/Crisis Residential Programs, Home-Based Services and Wraparound for Children. • FY 23 Network Adequacy Report	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: In accordance with MDHHS's Network Adequacy Standards DWIHN annually analyzes the availability and accessibility of, crisis residential programs, home-based services and wraparound services for children based upon the urban standard of 30 minutes/30 miles.		

Standard IV—Assurances of Adequate Capacity and Services		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. Of note, the PIHP submitted documentation confirming that it maintained policies and contracts with providers, and that it monitored its network in accordance with the required time and distance standards, which resulted in the PIHP receiving a *Met* score for this element. **Recommendations:** HSAG recommends that the PIHP review the results, findings, and recommendations determined through the HSAG NAV activity, and take action to ensure that the PIHP fully aligns with MDHHS' expectations regarding the methodology and calculation of time and distance standards.		
Required Actions: None.		
Network Adequacy Standards—Member-to-Provider Ratios		
9. *For adults*: a. *Assertive community treatment—30,000:1* b. *Psychosocial rehabilitation (clubhouse)—45,000:1* c. *Opioid treatment programs—35,000:1* d. *Crisis residential—16 beds per 500,000 total population* 42 CFR §438.207(a) 42 CFR §438.207(b)(1-2) 42 CFR §457.1218 Contract Schedule A–1(E)(20) MDHHS Network Adequacy Standards— Medicaid Specialty Behavioral Health Services Procedure	**HSAG Required Evidence:** • Policies and procedures • Network adequacy reports and analyses **Evidence as Submitted by the PIHP:** • Network Monitoring & Management Policy- Page 5 Standard 43 & 44 • FY 23 MDHHS Specialty Behavioral Health Network Adequacy Standards PIHP Network Adequacy Reporting Template – Service & Availability Tab • Adult Member To Provider Ratio	☐ Met ☐ Not Met ☒ NA
PIHP Description of Process: In accordance with MDHHS's Network Adequacy Standards DWIHN annually analyzes member – to- provider ratios for assertive community treatment, psychosocial rehabilitation (clubhouse), opioid treatment programs and crisis residential programs for adults.		
HSAG Findings: HSAG has determined that this element is *Not Applicable* for the time period of this review, as MDHHS did not require the PIHPs to report member-to-provider ratios in the new network adequacy reporting template required to be completed and submitted to MDHHS by May 31, 2024 (i.e., outside of the time period under review for this compliance review). Additionally, MDHHS has not provided the PIHPs with specifications for consistently calculating member-to-provider ratios. **Recommendations:** HSAG recommends that the PIHP adhere to any specifications provided by MDHHS, in the future to calculate and report member-to-provider ratio standards.		

Standard IV—Assurances of Adequate Capacity and Services		
Requirement	**Supporting Documentation**	**Score**
Required Actions: None.		
10. *For pediatrics*: a. *Home-based—2,000:1* b. *Wraparound—5,000:1* c. *Crisis residential—8–12 beds per 500,000 total population* 42 CFR §438.207(a) 42 CFR §438.207(b)(1-2) 42 CFR §457.1218 Contract Schedule A–1(E)(20) MDHHS Network Adequacy Standards— Medicaid Specialty Behavioral Health Services Procedure	**HSAG Required Evidence:** • Policies and procedures • Network adequacy reports and analyses **Evidence as Submitted by the PIHP:** • Network Monitoring & Management Policy- Page 5 Standard 43 & 44 • FY 23 MDHHS Specialty Behavioral Health Network Adequacy Standards PIHP Network Adequacy Reporting Template – Service & Availability Tab • Pediatric Member to Provider Ratio • FY 23 Network Adequacy Report	☐ Met ☐ Not Met ☒ NA
PIHP Description of Process: In accordance with MDHHS's Network Adequacy Standards DWIHN annually analyzes member – to- provider ratios for home-based, wraparound and crisis residential for children.		
HSAG Findings: HSAG has determined that this element is *Not Applicable* for the time period of this review, as MDHHS did not require the PIHPs to report member-to-provider ratios in the new network adequacy reporting template required to be completed and submitted to MDHHS by May 31, 2024 (i.e., outside of the time period under review for this compliance review). Additionally, MDHHS has not provided the PIHPs with specifications for consistently calculating member-to-provider ratios. **Recommendations:** HSAG recommends that the PIHP adhere to any specifications provided by MDHHS, in the future to calculate and report member-to-provider ratio standards.		
Required Actions: None.		

Standard IV—Assurances of Adequate Capacity and Services		
Requirement	**Supporting Documentation**	**Score**
Indian Health Care Providers		
11. The PIHP must demonstrate that there are sufficient Indian Health Care Providers (IHCPs) participating in the provider network to ensure timely access to services available under the Contract from such providers for Indian members who are eligible to receive services. a. If timely access to covered services cannot be ensured due to few or no IHCPs, the PIHP must: i. Allow Indian members to access out-of-state IHCPs or show good cause for disenrollment from both the PIHP and MDHHS' managed care program in accordance with 42 CFR §438.56(c). ii. Permit Indian members to obtain services covered under the Contract from out-of-network IHCPs from whom the member is otherwise eligible to receive such services. iii. Permit an out-of-network IHCP to refer an Indian member to a network provider. 42 CFR §438.14(b)(1-6) 42 CFR §438.56(c) Contract A-1(E)(2)(e)	**HSAG Required Evidence:** • Policies and procedures • Network adequacy reports **Evidence as Submitted by the PIHP:** • Out of Network Policy– Pages 1 and 2/ Purpose and Standards 2 • Out of Network Procedures for Behavioral Health- Pages 1 and 3 / Purpose and Standard 3 • Network Monitoring and Management Policy- Page 2/ Standard 12 • Access Policy - Page 2 / Standard 2 and 2a • FY 23 Network Adequacy Report page 19	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: DWIHN has 215 members (approximately 0.33%) that identify themselves as Native American and 9 individuals who identify themselves as Alaskan Native (0.01%). In accordance with DWIHN's Access Policy, DWIHN provides assistance to members who request culturally based services. Through a MDHHS grant funded program, Culture Keepers through American Indian Health and Family Services of Southeast Michigan, services are available and provided to Native Americans. The overarching goal of the program is to connect Native American individuals to integrated physical and behavioral health care. Note that Culture Keepers is the only program of its type in the Wayne County area, with the closest location in Fulton and Mt. Pleasant, MI respectively. In accordance with DWIHN's Out of Network Policy, access to care is given when service needs are not able to be met through the existing provider network and/or to accommodate enrollee/member choice preferences or during transition of care.		

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

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

Standard V—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
Care Coordination and Services		

1. The PIHP ensures that each member has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the member.
a. The member is provided information on how to contact their designated person or entity.
 	
42 CFR §438.208(b)(1)
42 CFR §457.1230(c)
	HSAG Required Evidence:
	• Policies and procedures
	• Care management program description
	• Member materials, such as the member handbook or example of a member notice
	• Screenshot of fields designating the assigned case manager
	
	Evidence as Submitted by the PIHP:
	• Access Policy (pgs. 2-3)
	• Case Management Network Procedure (entire document)
	• IPOS Individual Plan of Service/Person Centered Plan Policy (pg. 3)
	• Member materials:
	  ○ DWIHN Member Flyer (Bullets # 5,6)
	  ○ DWIHN Member Handbook FY 2023-2024 (pg. 23)
	  ○ DWIHN Provider Manual FY22.23 (pg. 103)
	  ○ DWIHN Welcoming Brochure 05-2024
	  ○ Example of Member Notice for Support Coordination
	  ○ Example of Member Notice for IPOS
	  ○ Example of Member Notice for Enrollment (Redacted)
	• Screenshot field designating the assigned Case Manager (Redacted)
		☒ Met
		☐ Not Met
		☐ NA

Standard V—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
PIHP Description of Process: The DWIHN Access Center operates 24/7 and is responsible for welcoming and orienting individuals to available services and benefits, as well as the provider network. DWIHN provides information on how to access mental health, primary health, and other community services, as well as details on how to access various Recipient Rights processes. We also assist individuals with benefit-related problems and inquiries, oversee local complaint and grievance processes, track, and report patterns of problem areas within the organization, monitor Customer Service functions provided by Service Providers, health plans, and their affiliates, and help individuals make informed choices regarding their treatment and any necessary changes. To enhance accessibility, it is vital to have a toll-free Customer Service telephone line and access to a Teletypewriter (TTY) phone number, clearly displayed in all DWIHN brochures and public information materials. Compliance with all contractual, regulatory, and accreditation requirements, including reading level (at or below 4th-grade level), font, type size, format, and language, in DWIHN materials is essential. DWIHN commits to providing reasonable accommodations as required by the Americans with Disabilities Act (ADA), Limited English Proficiency (LEP), and Cultural Competency guidelines, at no cost to the member. Essential written information should be available in prevalent non-English languages within the service area, in adherence to the LEP guidelines, the Center for Medicare and Medicaid Services (CMS), and/or DWIHN's contract with the Michigan Department of Health and Human Services (MDHHS), meeting the most stringent guideline. Upon request, DWIHN will provide materials in alternate formats to meet the needs of vision and/or hearing-impaired members, including large font (at least 18-point font), Braille, oral interpretation service, ASL, and audio and visual formats. Translation services will be readily available to the members upon request. It is crucial to provide interpreter services and toll-free numbers with adequate TTY and interpreter capability.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
2. The PIHP coordinates the services the PIHP furnishes to the member: a. Between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays. b. With the services the member receives from any other MCO, PIHP, or PAHP. c. With the services the member receives in fee-for-service (FFS) Medicaid.	**HSAG Required Evidence:** • Policies and procedures • Care management program description • Three examples of coordination of services related to this element (examples should include different entity types) • Transition of care program • Workflow for coordinating with other MCOs/PIHPs/PAHPs • Workflow for coordinating with FFS • Workflow for coordinating with community and social support resources	☒ Met ☐ Not Met ☐ NA

Standard V—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**

d. With the services the member receives from community and social support providers.
 	
42 CFR §438.208(b)(2)
42 CFR §457.1230(c)
	Evidence as Submitted by the PIHP:
	• Care Management Network Procedure (pg. 4; Item # 11)
	• Data Sharing Care Coordination Policy (pg. 1; Items # 1 and 3)
	• Care Coordination Policy (pgs. 1,3,4,5)
	• Psychiatric Hospitalization (pgs.1,2,3,5,6)
	• Three examples of coordination of services:
	  ○ Data Sharing- Case Sample 1 (a, b, c)
	  ○ Data Sharing- Case Sample 2 (a, b, c)
	  ○ Data Sharing- Case Sample 3 (d)
	• Care Coordination: Transitions in Care from Acute Settings Procedure (entire document)
	• Referral, Coordination and Integration of Care Procedure (entire document)
	• Medicaid Health Plan and Pre-Paid Inpatient Health Plan Care Coordination Plan
	• Workflow for coordinating with community and social support
	  ○ IPOS Individual Plan of Service Person Centered Plan (pg.4,7)
	• Workflow for coordinating with FFS
	  ○ Access Call Center Clinical Screening Policy (pg. 8)
	  ○ Benefits Policy (pgs.3,4,5)
	  ○ Ability to Pay Policy
	• Workflow for coordinating with other agencies
	  ○ County of Financial Responsibility (COFR) Policy (pgs. 1, 5)	

Standard V—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
PIHP Description of Process: DWIHN manages and promotes service coordination and integration at the organizational, provider, individual, and family level. This is achieved through an interdisciplinary approach that focuses integration and/or coordination of health care services, between DWIHN as an organization, primary care physicians, other physical care providers, behavioral health providers, SUD providers, integrated health care organizations, managed health care plans and other service providers on an individual's care team utilizing the person-centered care planning process as described in various documents including Care Coordination policy, Care Management Network Procedure and Referral, Coordination and Integration of Care Procedure. PIHP and its network coordinates care between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays as described in The Psychiatric Hospitalization Policy, and Care Coordination: Transitions in Care from Acute Settings Procedure. The PIHP also coordinates services the member receives from any other managed care entity such as health plan as additionally described in Data Sharing Care Coordination Policy and Medicaid Health Plan and Pre-Paid Inpatient Health Plan Care Coordination Plan. DWIHN ensures continued access to services during a transition from Fee for Service (FFS) to a managed care entity, or transition from one managed care entity to another when a beneficiary, in the absence of continued services, would suffer serious detriment to their health or be at risk of hospitalization or institutionalism. DWIHN coordinates transition of services for members on fee-for-service (FFS) Medicaid though State or General Fund as described in Coordination Policy, Benefits policy, Access Call Center Clinical Screening Policy and Ability to Pay Document. DWIHN and its network is expected to coordinate services the member receives from community and social support providers as outlined in IPOS Individual Plan of Service Person Centered Plan, Care Management Network Procedure and the overall Care Coordination and Policies. DWIHN is dedicated to developing and managing a service delivery system that coordinates and integrates care that is welcoming, recovery-focused, trauma-informed. DWIHN also collaborates with the Department of Health and Human Services (DHHS) for care coordination and services with the children population as appropriate.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
Information Sharing		
3. The PIHP shares with MDHHS or other MCOs, PIHPs, and PAHPs serving the member the results of any identification and assessment of that member's needs to prevent duplication of those activities. 42 CFR §438.208(b)(4) 42 CFR §457.1230(c)	**HSAG Required Evidence:** • Policies and procedures • Workflow for sharing assessment results with MDHHS • Workflow for sharing assessment results with other MCOs/PIHPs/PAHPs • Care management program description	☒ Met ☐ Not Met ☐ NA

Standard V—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
	• Three examples of sharing assessment results with MDHHS and/or appropriate MCOs, PIHPs, and/or PAHPs	

	Evidence as Submitted by the PIHP:
	• Data Sharing Care Coordination Procedure (pgs. 1-2)
	• Workflow for sharing information for MDHHS and other agencies
	  ○ Integrated Biopsychosocial Assessment Procedure (pgs. 2-3)
	• Case Management Network Procedure (pg. 4; Item # 9)
	• County of Financial Responsibility Policy (COFR) (entire document)
	• Level I and Level II Assessments and Integrated Care Teams Policy (pgs. 1-2)
	• OBRA/PASRR Policy (pgs. 1-3)
	• HSW Waiver Procedure (pgs. 4,8)
	• Habilitation Supports Waiver -Medicaid 1915 -c- Waiver Policy (entire document)
	• Children-s Home and Community Based Waiver Program -CWP- Annual Recertification Process (pgs.1-2.)
	• CHILDREN-S HOME AND COMMUNITY BASED WAIVER Policy (pg.3,5)
	• Workflow for sharing assessment results with MDHHS
	  ○ Behavioral Health 1915(i) SPA Home and Community-Based Waiver Procedure (pgs.1-2)
	  ○ Behavioral Health 1915 -I- Home and Community-Based Services Policy (pg. 1)
	  ○ MDHHS-5932 1915 (I) SPA Benefit Form (002)
	• Example of sharing assessment results with MDHHS
	  ○ Results shared w/MDHHS Example#1	

Standard V—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
	○ Results shared w/MDHHS Example #2 ○ Results shared w/MDHHS Example# 3	
PIHP Description of Process DWIHN promotes service coordination and integration at the Pre-paid Inpatient Plan (PIHP) and Medicaid Health Plan/Integrated Care Organizations (MHP/ICO), DWIHN's Community Care Clinic, DWIHN's Certified Community Behavioral Health Clinic (CCBHC) and Direct Collaborating Organizations (DCO), and Prepaid Ambulatory Health Plan (PAHP) level. DWIHN is committed to developing and implementing a care coordination/data sharing process with its partners and network service providers to enhance overall health outcomes for individuals receiving integrated care services. DWIHN will utilize available data sources (e.g., DWIHN data warehouse, Care Connect 360, etc.) to identify individuals shared with the Medicaid Health Plans (MHPs) or the Integrated Care Organizations (ICOs). DWIHN also shares Medicaid waiver eligibility results with MDHHS (e.g., Children's Waiver, Habilitation Supports Waiver, 1915 iSPA, and MI Health Link Demonstration). LOCUS assessments are shared with Integrated Care organizations overseeing MI Health Link Demonstration as discussed in Level I and Level II Assessments and Integrated Care Teams Policy. The submission process to MDHHS for Medicaid Waivers is described in Habilitation Supports Waiver Policy and Procedure, Children Home and Community Based Waiver Policy and Procedure and Behavioral Health 1915 I policy and procedure. DWIHN's Community Care Clinic, DWIHN's Certified Community Behavioral Health Clinic (CCBHC) and Direct Collaborating Organizations (DCO). DWIHN provides Pre-Admission Screening/Annual Resident Review (PASRR) services to all identified individuals in Wayne County seeking nursing home admission. It is expected that all assessments will meet the specified guidelines outlined by the Michigan Department of Health and Human Services (MDHHS) and the Omnibus Reconciliation Act of 1987 (OBRA). It is expected that all persons seeking admission to a nursing facility that are identified to have a serious mental illness and/or an intellectual/developmental disability will be evaluated to determine whether the nursing facility is the most appropriate placement for them and if specialized behavioral/mental health services are required and the assessments are shared with MDHHS.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
4. The PIHP ensures that each provider furnishing services to members maintains and shares, as appropriate, a member health record in accordance with professional standards. 42 CFR §438.208(b)(5) 42 CFR §457.1230(c)	**HSAG Required Evidence:** • Policies and procedures • Care management program description • Provider materials, such as the provider manual and provider contract • Results of medical record reviews (MRRs) or other oversight mechanisms for monitoring provider health record practices	☒ Met ☐ Not Met ☐ NA

Standard V—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**

	• **Evidence as Submitted by the PIHP:**
	• Acceptable Use Policy (entire document)
	• Record Retention and Disposal Policy (entire document)
	• Case Management Network Procedure (entire document)
	• Network Monitoring and Management Policy (pg. 3 Section # 22)
	• Case Records Maintenance and Review Policy (pgs. 3-4)
	• Disclosure of Confidential or Privileged Information Policy (entire document)
	• Provider Materials:
	  ○ DWIHN Provider Manual FY 2022/2023 pg. 72.73)
	  ○ Executed Contract – Services to Enhanced Potential (10/1/2023 -9/30/2024) pg. 9, 24
	• Results of Medical Record Reviews (MRRs) oversight and monitoring.
	  ○ Provider Review Audit ID 158941 (pg. 6)	

PIHP Description of Process: DWIHN requires Network Providers, including Substance Abuse provider agencies, to establish a process for maintaining case records for all beneficiaries under DWIHN's responsibility. These case records must adhere to standards for protection, completeness, accuracy, legibility, timeliness, and clinical relevance to ensure reliable documentation of services provided and beneficiary response.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		

Standard V—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
5. The PIHP ensures that in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E, to the extent that they are applicable. 42 CFR §438.208(b)(6) 42 CFR §457.1230(c) 45 CFR Part 160 45 CFR Part 164, Subparts A and E Contract Schedule A–1(Q)(4) Contract Schedule A–1(Q)(9) Contract Schedule B	**HSAG Required Evidence:** • Policies and procedures • Care management program description **Evidence as Submitted by the PIHP:** • Health Insurance Portability and Accountability Act HIPPA –Security • HIPPA Security Manual and Policies – DWIHN rev 09-2023.pdf	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: DWIHN ensures that every member's privacy is safeguarded while coordinating care, adhering to the highest privacy standards.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
Initial Health Risk Screening		
6. The PIHP makes a best effort to conduct an initial screening of each member's needs within 90 days of the effective date of enrollment for all new members, including subsequent attempts if the initial attempt to contact the member is unsuccessful. *Since the PIHP is not an enrollment model, screening once an individual presents for services would meet this requirement.* 42 CFR §438.208(b)(3) 42 CFR §457.1230(c) Contract Schedule A–1(H)(2)(a)(iii)	**HSAG Required Evidence:** • Policies and procedures • Care management program description • Initial screening template • Initial screening tracking and monitoring mechanisms and subsequent results/reports **Evidence as Submitted by the PIHP:** • Access Policy • CRSP Member Re-Engagement and Case Closure Policy • Integrated Biopsychosocial Assessment Procedure • IBPS Initial Screening Template (Adult)	☒ Met ☐ Not Met ☐ NA

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

	• IBPS Initial Screening Template (Children)
	• Initial screening tracking and monitoring results
	  ○ IBPS Monitoring Results Q1_2024
	  ○ IBPS Monitoring Results Q2_2024
	  ○ Michigan Mission Based Performance Indicator - MMBPI- Reporting Requirements	

PIHP Description of Process: DWIHN assures diligent screening upon the initial request date, regardless of any subsequent attempts required to establish contact. The 14-day countdown commences from the first request, ensuring timely response and support.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** As the PIHPs were not consistently applying the same screenings or assessments to this initial screening requirement, HSAG recommends that the PIHPs consult with MDHHS to confirm which screening or assessment (e.g., screening at access, assessment conducted within 14 days of a request for services) aligns to this element. After receiving MDHHS' guidance, the PIHP should ensure that its policies and procedures are updated to reference the appropriate screening or assessment and align associated time frames to the federal regulations for this element (i.e., 42 CFR §438.208[b][3] and 42 CFR §457.1230[c]) and maintain a monitoring process to demonstrate that all members receive initial screenings in a timely manner and in accordance with federal regulations and MDHHS' expectations.		
Required Actions: None.		
Comprehensive Assessment		
7. The PIHP implements mechanisms to comprehensively assess each Medicaid member identified by MDHHS and identified to the PIHP by MDHHS as needing long-term services and supports (LTSS) or having special health care needs to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring. a. The assessment mechanisms use appropriate providers or individuals meeting the LTSS service coordination requirements of MDHHS or the PIHP, as appropriate.	**HSAG Required Evidence:** • Policies and procedures • Care management program description • Documentation (e.g., program description, quality strategy) defining members with special health care needs and members needing LTSS • Comprehensive assessment template • Three case examples of completed comprehensive assessments	☒ Met ☐ Not Met ☐ NA

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

42 CFR §438.208(c)(2)
42 CFR §457.1230(c)
	• Job descriptions and/or training requirements for staff conducting comprehensive assessments
	
	Evidence as Submitted by the PIHP:
	• Nursing Assessment Protocol (pgs. 1-2)
	• Assessment Policy
	• PHQ-9 and PHQ-A Guidelines
	• CAFAS-PECFAS-DECA Procedure
	• LOCUS- Level of Care Utilization System Protocol
	• Complex Case Management Policy pg. 4-5
	• Documentation defining members with special health care needs and members needing LTSS
	  ○ Quality Assurance Performance Improvement Plan (QAPIP) Description Fiscal Year 2023-2025 (pgs. 29,73)
	• Comprehensive Assessment Template
	  ○ IBPS Assessment Template (Adult)
	  ○ IBPS Assessment Template (Child)
	  ○ PHQ-9 Assessment Template
	  ○ PHQ-A Assessment Template
	  ○ LOCUS Assessment Template
	• Example Cases of Comprehensive Assessments:
	  ○ IBPS Comprehensive Assessment
	  ○ OBRA Comprehensive Assessment
	  ○ LOCUS Comprehensive Assessment
	• Job Descriptions and Training Requirements of Staff:
	  ○ Residential Care Specialist Job Description
	  ○ OBRA/PASRR Evaluation Job Description	

PIHP Description of Process: DWIHN ensures that through assessments, each identified member in need of long-term services and supports (LTSS) or with special health care needs is comprehensively evaluated to identify any ongoing special conditions that require treatment or regular monitoring.		

Standard V—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
Personalized assessments are conducted for all individuals undergoing treatment to tailor the most effective treatment plan and to determine the optimal length of stay for their recovery.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** As PIHPs were not consistently defining LTSS, HSAG recommends that the PIHPs collaborate with MDHHS to develop a definition for LTSS that will be used by all PIHPs. As part of the definition, MDHHS and the PIHPs could develop a list of services and benefits under the PIHPs' scope of work (SOW) that are considered LTSS. Based on this collaboration and, with confirmation by MDHHS, the PIHP should update its policies and procedures and other utilization management (UM)-related program documents, as well as its quality assessment and performance improvement program (QAPIP) description to include the State's definition of LTSS. The PIHP should also ensure that its policies and procedures, UM-related program documents, and QAPIP description identify which members it has identified as having special health care needs (e.g., all members, a subset of members). If MDHHS declines to define LTSS and/or members having special health care needs, the PIHP should ensure that it has defined LTSS and members with special health care needs in its program documents. If the PIHP does not demonstrate adequate implementation of HSAG's recommendations during future compliance reviews, the PIHP will automatically receive a *Not Met* score.		
Required Actions: None.		
Person-Centered Planning/Service Plan		
8. The member leads the person-centered planning process where possible. a. The member's representative has a participatory role, as needed and as defined by the individual, unless State law confers decision-making authority to the legal representative. b. All references to members include the role of the member's representative. 42 CFR §441.301(c)(1) Person-Centered Planning Practice Guideline–Section VI	**HSAG Required Evidence:** • Policies and procedures • Three case examples of completed service plans (if the requirement is also a delegated function, one example must pertain to the PIHP, and two examples must pertain to different delegates) • Oversight and monitoring documentation • HSAG will also use the results of the system demonstration **Evidence as Submitted by the PIHP:** • IPOS Individual Plan of Service/Person Centered Plan Policy (pgs. 2, bottom of 8) • Home and Community Based Services Policy • Self-Determination and Self-Directed Arrangements Policy (pg. 2; Items 3,6, pg. 7 Item iv.)	☒ Met ☐ Not Met ☐ NA

Standard V—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**

	• Three Case Example of completed Service Plans:
	  ○ Example #1 Hegira Health (pg. 1)
	  ○ Example #2 The Children's Center (pg. 1)
	  ○ Example #3 MiSide (pg. 1)
	• Oversight and Monitoring Documentation:
	  ○ Results Provider Review Audit ID 158941 (pg. 11)
	  ○ Results Clinical Case Review Audit ID 158383 (pgs. 4,10)	

PIHP Description of Process: DWIHN is committed to ensuring that individuals receiving long-term services and supports through Home and Community Based Service (HCBS) programs have unrestricted access to the benefits of community living and the opportunity to receive services in the most suitable integrated setting. Our person-centered planning process places the individual at the core, fostering their ability to engage in activities that enrich community life while respecting their preferences, choices, and abilities. DWIHN diligently monitors compliance with HCBS requirements through activities such as conducting surveys and analyzing data collected, and if necessary, requesting plans of correction. Furthermore, our Quality Improvement (QI) unit maintains an updated directory of contracted service providers who are HCBS compliant within our network, accessible on our website under the Providers/Resources tab.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
9. The person-centered service plan reflects that the setting in which the member resides is chosen by the member. The PIHP ensures that the setting chosen by the member is integrated in, and supports full access of, the member receiving Medicaid home- and community-based services (HCBS) to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as members not receiving Medicaid HCBS. a. The setting is selected by the member from among setting options, including non-disability specific settings and an option	**HSAG Required Evidence:** • Policies and procedures • Three case examples of completed service plans (if the requirement is also a delegated function, one example must pertain to the PIHP, and two examples must pertain to different delegates) • Oversight and monitoring documentation • HSAG will also use the results of the system demonstration	☒ Met ☐ Not Met ☐ NA

Standard V—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**

for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the member's needs; preferences; and, for residential settings, resources available for room and board.
 	
42 CFR §441.301(c)(2)(i)
42 CFR §441.530(a)(1)(ii)
42 CFR §441.710(a)(1)(ii)
Person-Centered Planning Practice Guideline–Section VI
	Evidence as Submitted by the PIHP:
	• IPOS Individual Plan of Service/Person Centered Plan Policy (pgs. 4, 5)
	• Home and Community Based Services Policy (pgs. 3, 4)
	• Three Case Examples of completed service plans:
	  ○ CLS IPOS Redacted (pg. 2 Employment/Vocational Supports and pg. 5)
	  ○ Hegira Health Redacted (pg. 1 Employment/Vocational Supports, top of page 3)
	  ○ NSO IPOS Redacted (pg. 2 Employment/Vocational Supports, pg. 3 Community Inclusion and top of pg. 4)
	• Oversight and Monitoring Documentation:
	  ○ Redford Opportunity House pgs. 4, 5, and top of pg. 7
	  ○ ACCESS pgs. 23, 34
	• IPOS Template (pg.1)
	• Provider Audit Review Tool pgs. 17, 18)
	• Case Record Review Tool (pg. 6)
	• Residential Audit Review Tool (pgs. 11, 12)	

PIHP Description of Process: DWIHN ensures that individuals who receive long-term services and supports through Home and Community Based Service (HCBS) programs have full access to the benefits of community living and the opportunity to receive services in the most appropriate integrated setting. DWIHN's person-centered planning process reflects the individual receiving services, which builds upon the individual's capacity to engage in activities that promote community life and honors the individual's preferences, choices, and abilities. DWIHN monitors compliance with the HCBS requirements through activities such as completing surveys, analyzing collected survey data, and requesting plans of correction when appropriate. Additionally, DWIHN's Quality Improvement (QI) unit maintains a directory of contracted service providers that are HCBS compliant within the provider network. The HCBS directory is regularly updated and can be found on DWIHN's website under the Providers/Resources tab.		

Standard V—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		

10. The PIHP produces a treatment or service plan for members who require LTSS and, if MDHHS requires, members with special health care needs who are determined through assessment to need a course of treatment or regular care monitoring.
 	
42 CFR §438.208(c)(3)
42 CFR §457.1230(c)
Contract Schedule A–1(K)(2)(c)
	HSAG Required Evidence:
	• Policies and procedures
	• Care management program description
	• Person-centered service plan template
	• Three case examples of completed service plans (if the requirement is also a delegated function, one example must pertain to the PIHP, and two examples must pertain to different delegates)
	
	Evidence as Submitted by the PIHP:
	• IPOS Individual Plan of Service/ Person Centered Plan Policy (pgs. 2-3)
	• Case Management Network Procedure
	• IBPS Initial Screening Template
	• Three case examples of completed Service Plans:
	  ○ DWIHN (PIHP) Residential Assessment Service Plan Example # 1 (pgs.1-5)
	  ○ CLS Service Plan Example # 2 (pgs.1,2,3,4,6)
	  ○ Spectrum Service Plan Example # 3 (pgs. 1-3)
		☒ Met
		☐ Not Met
		☐ NA

PIHP Description of Process: DWIHN offers a variety of services and support to promote recovery and self-determination for Wayne County residents and their families. These services are available to individuals with intellectual or developmental disabilities, children with serious emotional disturbances, mental health issues, substance use disorders, and physical health conditions. The goal is to provide these services in a welcoming and recovery-oriented system of care that delivers integrated services to meet the clients' needs and preferences. Within thirty days of starting services at outpatient community mental health		

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Requirement	**Supporting Documentation**	**Score**
agencies, each individual and family will receive an Individualized Plan of Service (IPOS) developed through the Person-Centered Planning (PCP) process. The IPOS aims to establish a lasting partnership with physical health care providers, promote integrated health care, and ensure effective monitoring of current behavioral and physical health conditions.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
11. The treatment or service plan is: a. Developed by an individual meeting LTSS service coordination requirements with member participation and in consultation with any providers caring for the member. b. Developed by a person trained in person-centered planning using a person-centered planning process and plan as defined in 42 CFR §441.301(c)(1) and (2) for LTSS treatment or service plans. c. Approved by the PIHP in a timely manner, if this approval is required by the PIHP. d. In accordance with any applicable MDHHS quality assurance and utilization review standards. 42 CFR §438.208(c)(3)(i-iv) 42 CFR §441.301(c)(1-2) 42 CFR §457.1230(c) Contract Schedule A–1(K)(2)(c)	**HSAG Required Evidence:** • Policies and procedures • Case management program description • Staff qualifications for developing care plans and service plans (e.g., job description) • Service plan approval process • Mechanisms to actively involve the member and the member's formal and informal supports in the development of the service plan • Mechanisms to actively involve the member's primary care provider (PCP) (and any other providers involved in the member's care) in the development of the service plan • Three case examples of completed service plans (if the requirement is also a delegated function, one example must pertain to the PIHP, and two examples must pertain to different delegates) **Evidence as Submitted by the PIHP:** • IPOS Individual Plan of Service/ Person Centered Plan Policy (pg. 2; Standards 1,2,3c,5,12 and pg. 6; pre-planning process) • Case Management Network Procedure (entire document) • Procedure for Self-Directing Service Agreement (entire document)	☒ Met ☐ Not Met ☐ NA

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

	• Residential Care Specialist Job Description
	• ACT Manager Job Description (MiSide)
	• ACT Training Requirements
	• Supports Coordinator Job Description (CLS)
	• IBPS Assessment Template
	• Mechanisms to actively involve the member and the member's formal and informal supports in the development of the service plan
	  ○ IPOS Meeting Template (pg. 1)
	• Mechanisms to actively involve the member's primary care provider (PCP) (and any other providers involved in the member's care) in the development of the service plan
	  ○ Case Record Review Audit Tool (pgs.6-7)
	  ○ Provider Audit Review Tool (pgs. 6-7)
	• Three case examples of completed Service Plans:
	  ○ DWIHN (PIHP) Residential Service Plan Example # 1 (pg.1)
	  ○ CLS Service Plan Example # 2 (pgs. 1, 4, 5)
	  ○ Spectrum Service Plan Example # 3 (pgs. 1-3)	

PIHP Description of Process: DWIHN ensures that an individual's LTSS service coordination requirements are met with member participation and consultation with any providers caring for the member. This is developed by a person trained in person-centered planning using a process for LTSS treatment or service plans that is person-centered.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		

Standard V—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**

12. The treatment or service plan is reviewed and revised upon reassessment of functional need, at least every 12 months, or when the member's circumstances or needs change significantly, or at the request of the member per 42 CFR §441.301(c)(3).
 	
42 CFR §438.208(c)(3)(v)
42 CFR §441.301(c)(3)
42 CFR §457.1230(c)
	HSAG Required Evidence:
	• Policies and procedures
	• Care management program description
	• Care plan and service plan review and revision tracking mechanism
	• Three case examples of completed service plans and subsequent updates (if the requirement is also a delegated function, one example must pertain to the PIHP, and two examples must pertain to different delegates)
	
	Evidence as Submitted by the PIHP:
	• IPOS Individual Plan of Service/Person Centered Plan Policy (pg. 9 Item 7)
	• Case Management Network Procedure (pg. 4 Item 4)
	• IPOS Review Template
	• Three case examples of completed Service Plans Review:
	  ○ Gesher Human Service (pg. 1 Section Progress toward Goal/Objectives, pgs. 2 and 3)
	  ○ NSO Plan Review (pg. 2 Section Progress toward Goal/Objectives, pgs. 3, 4, and 5)
	  ○ The Guidance Center Plan Review Addendum (pgs. 1, 7)
		☒ Met
		☐ Not Met
		☐ NA

PIHP Description of Process: DWIHN ensures that the treatment or service plan undergoes thorough review and adjustments when necessary. This reassessment occurs at least once every 12 months, or when there is a significant change in the member's circumstances or needs, and upon the member's request.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		

Standard V—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
Home and Community-Based Settings		

13. Any modification of the conditions, under 42 CFR §441.301(c)(4)(vi)(A) through (D), is supported by a specific assessed need and justified in the person-centered service plan. The following requirements are documented in the person-centered service plan:
a. Specific and individualized assessed need.
b. Positive interventions and supports used prior to any modifications to the person-centered service plan.
c. Less intrusive methods of meeting the need that have been tried but did not work.
d. Clear description of the condition that is directly proportionate to the specific assessed need.
e. Regular collection and review of data to measure the ongoing effectiveness of the modification.
f. Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
g. Informed consent of the member.
h. Assurance that interventions and supports will cause no harm to the member.
 	
42 CFR §441.301(c)(4)(vi)(F)(1-8)
42 CFR §441.530(a)(1)(vi)(F)(1-8)
42 CFR §441.710(a)(1)(vi)(F)(1-8)
Person-Centered Planning Practice Guideline–Section VII
	HSAG Required Evidence:
	• Policies and procedures
	• Three case examples of completed service plans with restrictions to the member's freedom (if the requirement is also a delegated function, one example must pertain to the PIHP, and two examples must pertain to different delegates)
	• Oversight and monitoring documentation
	• Reporting and tracking mechanisms
	• HSAG will also use the results of the system demonstration
	
	Evidence as Submitted by the PIHP:
	• Home and Community Based Policy (pg. 3)
	• IPOS Individual Plan of Service/Person Centered Plan Policy (pg. 5)
	• Three case examples of completed service plans:
	  ○ Hegira Health IPOS Service Plan (pg. 3)
	  ○ CLS IPOS Service Plan (pgs. 7, 8)
	  ○ Wayne Center IPOS Service Plan (pgs. 5)
	• Oversight and Monitoring Documentation:
	  ○ Quest Dover (pg.5, 7-8)
	  ○ Community Opportunity Center (pg.5)
	• Reporting and tracking mechanisms:
	  ○ BTAC Meeting Notes 12.14.2023 (pg. 2)
	  ○ BTAC Meeting Notes 3.7.2024 (pg. 1)
	  ○ Provider Audit Review Tool (pg.17)
	  ○ Case Record Review Tool (pgs.9-10)
		☐ Met
		☐ Not Met
		☒ NA

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Requirement	**Supporting Documentation**	**Score**
	○ Residential Audit Tool (pgs.11-12)	

PIHP Description of Process: DWIHN monitors and tracks the requirements using IPOS and IBPS when conditions are modified. The process also identifies who is responsible for monitoring the limitations in place to ensure that interventions and supports do not cause harm to the members. It also specifies the frequency of monitoring and reporting progress by the BTPC.

HSAG Findings: HSAG has determined that this element is *Not Applicable* for the time period of this review, as MDHHS sent clarifying guidance to the PIHPs on May 17, 2024 (i.e., outside of the time period under review for this compliance review), that included detailed instructions for complying with the requirements under this element and is currently not penalizing the PIHPs for noncompliance with the expectations under 42 CFR §441.301(c)(4)(vi)(F)(1–8).

Recommendations: As MDHHS' expectation is that all PIHPs will be in compliance with the requirements under 42 CFR §441.301(c)(4)(vi)(F)(1–8) by the end of calendar year 2024, and because MDHHS has added two performance measures for SFY 2025 with the waiver renewal that will assess whether completed person-centered plans with identified restrictions/modifications comply with Home and Community-Based Settings requirements and that the PIHP has effective administrative policies in place regarding Home and Community-Based Settings compliance and monitoring processes, HSAG strongly recommends that the PIHP prioritize the inclusion of all required documentation when there is a modification of the conditions that are required for Home and Community-Based Settings directly within the person-centered plan. HSAG also recommends that the PIHP consider enhancing its modifications section template within the person-centered plan to ensure that all requirements are addressed when there is a modification to the Home and Community-Based Settings required under 42 CFR §441.301(c)(4). The template should have sections that address sub-elements (a) through (h) of this element, with detailed instructions for the documentation that must be included for each section to ensure compliance with the expectations set by MDHHS and the requirements under the federal rule. Further, the PIHP must ensure that it maintains a robust and ongoing auditing process to confirm that its delegated entities are also complying with the modification requirements stipulated by the federal rule and in alignment with the expectations required by MDHHS and the PIHP. If the PIHP does not demonstrate adequate implementation of HSAG's recommendations during future compliance reviews, the PIHP will likely receive a *Not Met* score.

Required Actions: None.

Standard V—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
Direct Access to Specialists		
14. For members with special health care needs determined through an assessment to need a course of treatment or regular care monitoring, the PIHP must have a mechanism in place to allow members to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs. 42 CFR §438.208(c)(4) 42 CFR §457.1230(c) Contract Schedule A–1(F)(9)(a)	**HSAG Required Evidence:** • Policies and procedures • Care management program description • Member materials, such as the member handbook or benefits grid • Provider materials, such as the provider manual or provider contracts **Evidence as Submitted by the PIHP:** • Referral Coordination and Integration of Care Procedure (pgs. 1-4) • Care Coordination Policy (entire document) • Benefit Policy (pgs.2-3) • Benefit Grid by Funding Source • Case Management Network Procedure (entire document) • UM Provider Procedures for Prior Authorized Behavioral Health Services (entire document) • DWIHN Provider Manual (pgs. 12-15) • DWIHN Member Handbook 2024 (pgs. 23-31)	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: DWIHN ensures that members with specific healthcare needs receive the necessary specialist care and monitoring. After conducting a thorough assessment, we provide personalized referrals tailored to the member's benefit guide and the availability of services in their area. This approach ensures that members receive the individualized care they deserve.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		

Standard V—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
Integrated Physical and Mental Health Care		

15. *The PIHP initiates affirmative efforts to ensure the integration of primary and specialty behavioral health services for Medicaid members. These efforts must focus on persons who have a chronic condition such as a serious mental health illness, co-occurring substance use disorder, children with serious emotional disorders or a developmental disability and who have been determined by the PIHP to be eligible for Medicaid Specialty Mental Health Services and Supports.*
a. *The PIHP implements practices to encourage all members eligible for specialty mental health services to receive a physical health assessment including identification of the primary health care home/provider, medication history, identification of current and past physical health care, and referrals for appropriate services. (The physical health assessment will be coordinated through the consumer's Medicaid health plan [MHP]as defined in Contract Schedule A–1[H][1]).*
b. *As authorized by the member, the PIHP includes the results of any physical health care findings that relate to the delivery of specialty mental health services and supports in the PCP process.*
 	
Contract Schedule A–1(H)(1)
Contract Schedule A–1(H)(2)(a)(i-ii)
	HSAG Required Evidence:
	• Policies and procedures
	• Care management program description
	• Algorithm to identify members eligible for Medicaid Specialty Mental Health Services and Supports
	• Three case examples of completed physical health assessments, coordinated through the MHP, within a member's health record (if the requirement is also a delegated function, one example must pertain to the PIHP, and two examples must pertain to different delegates)
	
	Evidence as Submitted by the PIHP:
	• Referral Coordination and Integration of Care Procedure (pgs. 1-4)
	• Care Coordination Policy (entire document)
	• Case Management Network Procedure (entire document)
	• Habilitation Supports Waiver (Medicaid 1915 Waiver Procedure) (entire document)
	• Children's Home and Community Based Waiver (entire document)
	• Clinical Practice Guidelines (pgs. 2-11)
	• Algorithm of members eligible Medicaid Specialty:
	  ○ Eligibility and Screening Policy (pg. 2 1 a-e)
	  ○ Integrated Biopsychosocial Assessment Procedure (pgs. 2-4)
	  ○ Access Call Center Program Description and Scope of Services (pgs. 2-4)
	• Three case examples of completed Physical Health Assessments:
		☒ Met
		☐ Not Met
		☐ NA

Standard V—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
	○ Example#1 Physical Health Assessment - CLS (pgs. 4, 11, 13) ○ Example#2 Physical Health Assessment - All Well Being (pgs. 4, 5, 11, 12, 13) ○ Example#3 Physical Health Assessment - LBS (pgs. 7, 8, 9, 14, 15, 16)	
PIHP Description of Process: DWIHN and the network providers are responsible for managing and promoting service coordination and integration at the individual and family level. They achieve this through an interdisciplinary approach that focuses on integrating and coordinating healthcare services among physical care providers, behavioral health providers, SUD (substance use disorder) providers, integrated healthcare organizations, healthcare plans, and other service providers on an individual's care team. This utilizes the person-centered care planning process. DWIHN is committed to developing and managing a service delivery system that coordinates and integrates care in a welcoming, recovery-focused, trauma-informed, and co-occurring disorders-capable manner to meet the needs of individuals and families, and to inspire hope for recovery.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
Primary Care Coordination		
16. *In accordance with 42 CFR Part 2, the PIHP takes all appropriate steps to assure that substance use disorder treatment services are coordinated with primary health care.* a. *Care coordinating agreements or joint referral agreements, by themselves, are not sufficient to show that the PIHP has taken all appropriate steps related to coordination of care.* b. *Member treatment case file documentation is also necessary.* c. *Member treatment case files must include, at minimum:* i. *The PCP's name and address;* ii. *A signed release of information for purposes of coordination; or* iii. *A statement that the member has refused to sign a release.*	**HSAG Required Evidence:** • Policies and procedures • Care management program description • Algorithm to identify members eligible for Medicaid Specialty Mental Health Services and Supports • Three case examples of completed physical health assessments, coordinated through the MHP, within a member's health record (each example must pertain to a different Community Mental Health Services Program [CMHSP]/provider) **Evidence as Submitted by the PIHP:** • Referral Coordination and Integration of Care Procedure	☒ Met ☐ Not Met ☐ NA

Standard V—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**

d. *The PIHP must coordinate the services furnished to the member with the services the member receives with FFS Medicaid.*
 	
Contract Schedule A–1(H)(3)(a-b)
	• Care Coordination Policy
	• Case Management Network Procedure
	• Consent to Share Behavioral Health Information
	• UM Procedures for SUD Policy
	• IBPOS Assessment Tool
	• Algorithm of members eligible for Medicaid Specialty
	  ○ Eligibility and Screening (pg.2 1 a-e)
	  ○ Access Call Center Program Description and Scope of Services (pg. 2-4)
	  ○ Integrated Biopsychosocial Assessment Procedure (pgs. 2-4)
	• Sobriety House Care Coordination Policy
	• Sobriety House Care Coordination Consent Form
	• Three case examples of completed Physical Health Assessments:
	  ○ CNS Physical Health Assessment (pgs. 2, 11, 12, 23-26)
	  ○ Wayne Center Physical Health Assessment (pgs. 13-16)
	  ○ MiSide Physical Health Assessment (pgs. 7,12,13-14)	

PIHP Description of Process: DWIHN champions the coordination and integration of healthcare services at the individual and family levels. Our focus is on connecting physical care providers, behavioral health providers, SUD providers, health plans, and other service providers on an individual's care team using person-centered planning. We are committed to creating a service delivery system that provides welcoming, recovery-focused, trauma-informed care capable of addressing co-occurring disorders. Our goal is to meet the diverse needs of individuals and families while instilling hope for recovery.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		

Standard V—Coordination and Continuity of Care						
Met	=	15	X	1	=	15
Not Met	=	0	X	0	=	0
Not Applicable	=	1				
Total Applicable	=	15	Total Score		=	15
Total Score ÷ Total Applicable					=	100%

Standard VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
Coverage		
1. The PIHP: a. Identifies, defines, and specifies the amount, duration, and scope of each service that the PIHP is required to offer. b. Ensures the services are furnished in an amount, duration, and scope for the same services furnished to members under fee-for-service (FFS) Medicaid, as set forth in 42 CFR §440.230, and for members under the age of 21, as set forth in 42 CFR §441 Subpart B. c. Ensures each service is sufficient in the amount, duration, and scope to reasonably achieve its purpose. 42 CFR §438.210(a)(1-2) 42 CFR §438.210(a)(3)(i) 42 CFR §440.230 42 CFR §441 Subpart B 42 CFR §457.1230(d) Contract Schedule A–1(F) Contract Schedule A–1(Q)(15)(a-c)	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook and benefits grid • Utilization Management (UM) program description • Coverage guidelines/criteria **Evidence as Submitted by the PIHP:** • 2022 to 2024 UM Program Description Pg. 4, the Purpose Statement, bullets 4, 5, 7 and 8, Pg. 19, last paragraph on Parity, Page 28, and Page 39, Section XXI - Bullets. • Member Handbook Pg 32, 4th paragraph • DWIHN Master Service Utilization Guidelines (SUG) List columns D, E and F • Benefit Policy-Full policy • Behavioral Health Service Medical Necessity Criteria Policy-Full Policy • Behavioral Health Services Medical Necessity Criteria Policy Pg. 2, Purpose, Pg. 2-4 Standards 1, 2, 5, 7 • Behavioral Health Utilization Management Review Policy Pg. 3, 2.b, Pg. 4 2.d 1-5 • CAFAS-PCAFAS-DECA Procedure Pg. 1 Procedure • LOCUS Level of Care Utilization System Protocol Pg. 2 #7 • UM Review Procedure for Substance Use Disorders Pg. 1 #3, Pg. 2 #3 a-f, Pg 2. #4 a-n	☒ Met ☐ Not Met ☐ NA

Standard VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
	• Use of MCG Indicia for Case Management Software and Behavioral Health Guidelines Supporting Medical Necessity Pg. 1 Procedure Purpose	
PIHP Description of Process: DWIHN has developed service utilization guidelines that identify the amount, scope and duration of each service offered. These service decisions are based on medical necessity determinations using defined criteria. DWIHN has adopted nationally developed Behavioral Health Guidelines from MCG (Hearst Health Network), which describe best practice care for the majority of mental health and substance use dis9rders. DWIHN also utilizes level of care assessments including, LOCUS, CAFAS/PECAFAS/DECA, and ASAM, to appropriately determine medical necessity and appropriateness of clinical care.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
2. The PIHP *must conform to professionally accepted standards of care and* may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition of the member. 42 CFR §438.210(a)(3)(ii) 42 CFR §440.230(c) 42 CFR §457.1230(d) Contract Schedule A–1(F)(1)(a) Contract Schedule A–1(Q)(15)(d)	**HSAG Required Evidence:** • Policies and procedures • UM program description • Coverage guidelines/criteria **Evidence as Submitted by the PIHP:** • 2022 to 2024 UM Program Description pg. 16-19 • DWIHN Master Service Utilization Guidelines (SUG) List • Behavioral Health Service Medical Necessity Criteria Policy-Pg. 6-7 #20 and 24	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: DWIHN has adopted nationally developed and published criteria and standards that are consistent with Clinical Practice Guidelines. As cited in the **2022 to 2024 UM Provider Manual** and **Behavioral Health Service Medical Necessity Criteria Policy**, DWIHN ensures that the same standards of care, based on standardized assessment tools, are provided for all members regardless of condition.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		

Standard VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
Required Actions: None.		
3. The PIHP may place appropriate limits on a service on the basis of criteria applied under the State plan *(i.e., Medicaid policies and publications for coverages and limitations; medical necessity criteria/service guidelines specified by MDHHS and based on practice guidelines)*, such as medical necessity, or on utilization control procedures, provided that: a. The services furnished can reasonably achieve their purpose. b. The services supporting individuals with ongoing or chronic conditions or who require long-term services and supports (LTSS) are authorized in a manner that reflects the member's ongoing need for such services and supports. 42 CFR §438.210(a)(4) 42 CFR §441.20 42 CFR §440.230(d) 42 CFR §457.1230(d) Contract Schedule A–1(F)(1)(b) Contract Schedule A–1(Q)(15)(c) and (e) Person-Centered Planning Practice Guideline–VI	**HSAG Required Evidence:** • Policies and procedures • UM plan • Member materials, such as the member handbook • Coverage guidelines/criteria **Evidence as Submitted by the PIHP:** • Quality Assurance Performance Improvement Plan- Pg 8 Standard #6 • DWIHN Master Service Utilization Guidelines (SUG) List • Member Handbook Pg. 22-24 • 2022 to 2024 UM Program Description Pg 16 #1, Pg17 #4, Pg. 19 last 3 paragraphs, Pg 23 last 3 paragraphs,	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: DWIHN evaluates medical necessity and level of care for members using standard assessment tools, criteria, and practice guidelines. A medical necessity evaluation is completed to determine the appropriate clinical services array based on individual clinical needs. Service Utilization Guidelines are utilized based on Best Practice and nationally recognized assessment tool level of care recommendations, including those members with chronic, long-term needs.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		

Standard VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
4. The PIHP specifies what constitutes "medically necessary services" in a manner that: a. Is no more restrictive than that used by the MDHHS Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in Michigan statutes and regulations, the State Plan, and other MDHHS policies and procedures; and b. Addresses the extent to which the PIHP is responsible for covering services that address: i. The prevention, diagnosis, and treatment of a member's disease, condition, and/or disorder that results in health impairments and/or disability. ii. The ability for a member to achieve age-appropriate growth and development. iii. The ability for a member to attain, maintain, or regain functional capacity. iv. The opportunity for a member receiving LTSS to have access to the benefits of community living, achieve person-centered goals, and live and work in the setting of their choice. 42 CFR §438.210(a)(5)	**HSAG Required Evidence:** • Policies and procedures • UM program description • Member materials, such as the member handbook • Provider materials, such as the provider manual **Evidence as Submitted by the PIHP:** • 2022-2024 UM Program Description Pg. 15. H & Pg. 16 & Pg. 23-24 section XIII • Autism Benefit Policy- Full policy • Provider Manual 2022-2023-Pg 64-65-Grievances, Pg 86-87-Medical Necessity Documentation, Pg. 103- person centered planning & Pg. 109-appeal timeframes • Member Handbook • Behavioral Health Medical Necessity Criteria Policy Pg.6 #17, 18,19, &20	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: DWIHN determines medical necessity based on State policies and benefits, National standards and assessment tools. DWIHN established UM Authorization Guidelines based on functional assessment tools and clinical presentation. DWIHN offer a full array of clinical services to address specific behavioral health conditions that age-appropriate and promotes recovery. As stated in the **Behavioral Health Medical Necessity Criteria Policy,** all members care must be person-centered and take into account needs, personal values, and clinical and environmental factors. Every treatment decision must consider the unique situation of the individual.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		

Standard VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
Recommendations: HSAG recommends that the PIHP include the federal Medicaid managed care definition of "medically necessary services," as outlined in this element, in its UM program description, or at minimum, cross-reference 42 CFR §438.210(a)(5) under the PIHP's internal definition of "medically necessary services."		
Required Actions: None.		
Authorization of Services		
5. The PIHP and its subcontractors have in place, and follow, written policies and procedures for the processing of requests for initial and continuing authorization of services. 42 CFR §438.210(b)(1) 42 CFR §457.1230(d)	**HSAG Required Evidence:** • Policies and procedures • UM program description • Coverage guidelines/criteria • List of delegated entities performing UM • Delegation oversight of policies and procedures (e.g., audit results) **Evidence as Submitted by the PIHP:** • 2022-2024 UM Program Description (pg. 21-23) & (Pg. 84) • UM Provider Procedures for Prior Authorized Behavioral Health Services (entire policy) • UM Review Procedure for SUD (entire procedure) • Behavioral Health Service Medical Necessity Criteria Policy (pgs. 1-2) • Appropriate Professionals for UM Decision Making Policy (pg. 2,3) • Delegated Functions Policy • Hegira Health UM Delegate Program Description Review Findings • New Oakland- UM Delegate Program Description Review Findings	☒ Met ☐ Not Met ☐ NA

Standard VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
	• The Children's Center- UM Delegate Program Description Review Findings • Delegated Entities • Inter-Rater Reliability Policy for Utilization Management Staff (pg. 2)	
PIHP Description of Process: DWIHN and its delegated entities have, and follow, written policies and procedures for processing of initial & continuing UM authorization requests. Each delegated entity must develop and implement their own UM program plan/description that mirrors DWIHN's own UM plan. DWIHN then reviews and monitors these plans to ensure that each entity has a well-structured UM program with consistent, fair, and impartial decision-making. **UM Delegate Program Description Review Findings** for our delegated entities demonstrate DWIHN's commitment to consistent oversight of those also responsible for serving our members.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
6. The PIHP has in effect mechanisms to ensure consistent application of review criteria for authorization decisions. 42 CFR §438.210(b)(2)(i) 42 CFR §457.1230(d)	**HSAG Required Evidence:** • Policies and procedures • UM program description • Coverage guidelines/criteria • Results of interrater reliability (IRR) activities • HSAG will also use the results of the service authorization denial file review	☒ Met ☐ Not Met ☐ NA
	Evidence as Submitted by the PIHP: • 2022-2024 UM Program Description (XI, pp. 16-19) • Inter-Rater Reliability Policy for Utilization Management (pg. 2) • Use of MCG Indicia for Case Management Software and Behavioral Health Guidelines Supporting Medical Necessity-Full policy • Behavioral Health Service Medical Necessity Criteria Policy	

Standard VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
	• IRR Case Study Completion • IRR Summary Questions Analysis Report	
PIHP Description of Process: DWIHN has adopted nationally developed and published guidelines & criteria to determine medical necessity and level of care decisions for our members. As noted in our **UM Program Description, Inter-Rater Reliability Policy, and Behavioral Health Service Medical Necessity Criteria Policy,** DWIHN has clear mechanisms in place to ensure consistent application of medical necessity criteria for authorization decisions. Additional evidence offers detailed insight into our monitoring of this process.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** While the PIHP's interrater reliability (IRR) activities covered a broad array of services (e.g., substance use disorder [SUD], residential, autism, behavioral health), HSAG recommends that the PIHP confirm its IRR process includes all levels of the PIHP's SOW (i.e., eligibility determinations, inpatient and outpatient behavioral health services, inpatient and outpatient SUD services, and LTSS).		
Required Actions: None.		
7. The PIHP consults with the requesting provider for medical services when appropriate. 42 CFR §438.210(b)(2)(ii) 42 CFR §457.1230(d)	**HSAG Required Evidence:** • Policies and procedures • UM program description • Provider materials, such as the provider manual, provider communications • Three case examples of peer-to-peer consults **Evidence as Submitted by the PIHP:** • 2022-2024 UM program description (pg. 28,29, 32) • Denial of Service Policy (Pg. 1 paragraph 2, Pg. 2 #2 • Denial of Medicaid Service Procedures (pg. 2 #8) • Provider Manual pg. 108 • Sample peer to peer consult #1 • Sample peer to peer consult # 2 • Sample peer to peer consult #3	☒ Met ☐ Not Met ☐ NA

Standard VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
PIHP Description of Process: DWIHN has a process to consult with the requesting provider for medical services. The **UM Program Descriptions** and **Denial of Service Policy** cites that practitioners have the right to discuss any UM decision with a physician. The **Denial of Medicaid Service Procedures** indicates that a provider can elect to do a peer-to-peer review with the treating physician.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
8. The PIHP authorizes LTSS based on a member's current needs assessment and consistent with the person-centered service plan. 42 CFR §438.210(b)(2)(iii) Person-Centered Planning Practice Guideline–VI	**HSAG Required Evidence:** • Policies and procedures • Authorization workflow for LTSS • UM program description • Coverage guidelines/criteria • Three examples of authorized LTSS and copies of the corresponding person-centered service plans **Evidence as Submitted by the PIHP:** • IBPS Template • Integrated Biopsychosocial Assessment Procedure • Residential Assessment (blank template) • Assessment Policy (pg 1,2) • UM Program Description (pg 8) • Example 1 (auth pg. 11) • Example 2 (auths pg 11) • Example 3 (auths pg. 11-12) • DWIHN Master Service Utilization Guidelines (SUG) List	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The **Assessment Policy** details the various standardized assessment used to determine the level of care for various populations. The Biopsychosocial Assessment (see **IBPS template)** is a comprehensive assessment required for all members that assesses multiple domains of life and helps formulate the need for LTSS. The **Residential Assessment** is used to assess community living support (non-licensed) and personal care and community living supports (licensed) needed in a member's home. Authorizations are at the end of the Individual Plan of Service.		

Standard VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** The PIHP did not have a clear definition of what constitutes LTSS. As such, HSAG recommends that the PIHP define LTSS in its UM program and include a list of services categorized as LTSS.		
Required Actions: None.		
9. The PIHP ensures that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by an individual who has appropriate expertise in addressing the member's condition. 42 CFR §438.210(b)(3) 42 CFR §457.1230(d) Contract Schedule A–1(E)(13)	**HSAG Required Evidence:** • Policies and procedures • UM program description • Job descriptions for UM decision makers • HSAG will also use the results of the service authorization denial file review **Evidence as Submitted by the PIHP:** -Denial of Service Policy (pg. 2) -Behavioral Health Medical Necessity Criteria Policy -Appropriate Professionals for Utilization Management Decision Making (pg. 2) - 2022-2024 UM Program Description (pg. 11) -DWIHN Medical Director Job Description -DWIHN Psychiatrist Job Description	☒ 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 VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
Notice of Adverse Benefit Determination		
10. The PIHP notifies the requesting provider of any decision by the PIHP to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. *Notice to the provider does not need to be in writing.* 42 CFR §438.210(c) 42 CFR §457.1230(d) Contract Schedule A–1(L)(5)(a) Appeal and Grievance Resolution Processes Technical Requirement–IV(C)(2)	**HSAG Required Evidence:** • Policies and procedures • UM program description • Adverse Benefit Determination (ABD) notice • HSAG will also use the results of the service authorization denial file review **Evidence as Submitted by the PIHP:** • Adverse Benefit Determination (ABD) notice • Advance Notice of Adverse Benefit Determination Form • Denial of Service Policy (pg.1 & pg. 3 # 7 and 8.a) • UM Program Description (pg. 28 & 29)	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: DWIHN provides an appropriate communication in regard to authorization request denials and determinations that authorize less service in regard to amount, scope, or duration that requested. This communication is completed in writing to the member and both in writing and verbally to the provider, as outlined **Denial of Service Policy**. The **UM Program Description** cites the written notification requirement including the member's due process and appeal rights.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
11. The PIHP defines an adverse benefit determination (ABD) as: a. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. b. The reduction, suspension, or termination of a previously authorized service.	**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:** • Customer Service Enrollee/Member Appeals Policy (pg. 9, 10) • How to Create an Adverse Benefit Determination • Denial of Service Policy pg. 5 #20	☒ Met ☐ Not Met ☐ NA

Standard VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
c. The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a "clean claim" is not an ABD. d. Failure to make a standard service authorization decision and provide notice about the decision within 14 calendar days from the date of receipt of a standard request for service. e. Failure to make an expedited service authorization decision within 72 hours after receipt of a request for expedited service authorization. f. The failure to provide services in a timely manner, as defined by MDHHS *(i.e., failure to provide services within 14 calendar days of the start date agreed upon during the person-centered planning meeting and as authorized by the PIHP)*. g. Failure of the PIHP to resolve standard appeals and provide notice within 30 calendar days from the date of a request for a standard appeal. h. Failure of the PIHP to resolve expedited appeals and provide notice within 72 hours from the date of a request for an expedited appeal. i. For a resident of a rural area with only one PIHP, the denial of a member's request to exercise his or her right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the network. j. The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.	• Denial of Medicaid Service Procedure (pg. 4-5 # 28,29) • ABD Notice of denial of payment • Advance ABD Notice • Adequate ABD Notice • Member Handbook- pg. 59-63 • DWIHN Provider Manual Pg. 60-65 • Notice of Denial of Payment	

Standard VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.52(b)(2)(ii) 42 CFR §438.400(b)(1-7) 42 CFR §438.408(b)(1-2) 42 CFR §457.1260(a)(2) Appeal and Grievance Resolution Processes Technical Requirement–II		
PIHP Description of Process: The Denial of Service Policy provides procedural and operational guidance on the denial process to all staff performing UM functions including UM Reviewers, UM Clinical Specialists, UM Appeals Coordinator and physicians. As it relates to a claim denial, once our claims department finds that a clean claim denial exists, they will contact the appeals coordinator. The appeals coordinator will send the member a Notice of Denial of Payment. **The Denial of Medicaid Service Procedures** provides detailed steps required to issue an adverse benefit determination to both members/enrollees and providers. **How to Create an Adverse Benefit determination** provides the definition of an Adverse Benefit Determination, when to issue an ABD, and the step-by-step process of how to create the document.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** The definition of an adverse benefit determination (ABD) in the *Member Handbook* did not include sub-elements (i) and (j); however, MDHHS' *Template #4: Glossary or Definition of Terms* does not include these sub-elements. HSAG has notified MDHHS of this finding. HSAG recommends that the PIHP implement updated terminology should it be issued by MDHHS in the future. Additionally, as the *DWIHN Provider Manual* also did not include sub-elements (i) and (j), HSAG recommends that the PIHP update its manual accordingly.		
Required Actions: None.		
12. The PIHP gives members written notice of any decision by the PIHP to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The ABD notice includes the following: a. *Notification that 42 CFR §440.230(d) provides the basic legal authority for an agency to place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.* b. The ABD the PIHP has made or intends to make. c. The reasons for the ABD. d. *The policy/authority relied upon in making the determination.*	**HSAG Required Evidence:** • Policies and procedures • UM program description • ABD notice template with taglines • HSAG will also use the results of the service authorization denial file review **Evidence as Submitted by the PIHP:** • UM Program Description – FY 22-24- Pg. 28 &29 • Adequate Notice of Adverse Benefit Determination Form • Advance Notice of Adverse Benefit Determination Form • Denial of Service Policy Pg 3 #7 & 8 a-i	☐ Met ☒ Not Met ☐ NA

Standard VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
e. The right of the member to be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's ABD. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits. f. The member's right to request an appeal of the PIHP's ABD, including information on exhausting the PIHP's one level of appeal, described at 42 CFR §438.402(b), and right to request a State fair hearing consistent with 42 CFR §438.402(c). g. The procedures for exercising the rights specified in 42 CFR §438.402(b). h. The circumstances under which an appeal process can be expedited and how to request it. i. The member's right to have benefits continue pending resolution of the appeal; how to request that benefits be continued; and the circumstances, consistent with State policy, under which the member may be required to pay the costs of these services *(only required when providing advance notice of an ABD)*. j. *An explanation that the member may represent himself/herself or use legal counsel, a relative, a friend, or other spokesman.* k. The notice must be consistent with the requirements of 42 CFR §438.10. 42 CFR §438.10 42 CFR §438.210(c) 42 CFR §438.402(b-c)	• Customer Service (CS) Enrollee/Member Appeals Policy Pg. 6-8 • Utilization Management Provider Appeals Policy Pg. 4-5	

Standard VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.404(a-b) 42 CFR §457.1230(d) 42 CFR §457.1260(b)(1) 42 CFR §457.1260(c)(1-2) Contract Schedule A–1(L)(2)(a)(i-v) Appeal and Grievance Resolution Processes Technical Requirement–IV(A) Appeal and Grievance Resolution Processes Technical Requirement–IV(C)(1)		

PIHP Description of Process: DWIHN provides the member a written ABD notice when a requested service is being denied or a service is being authorized at a rate less than requested in terms of amount, scope, or duration. This notification is consistent with 42 CFR §438.10 and includes information on the reasons for the ABD, the policy related to the determination, the member's right to appeal and their State Fair Hearing rights, the member's right to reasonable access to and copies of all relevant documents related to this determination.

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

- The ABD notice did not include reference to 42 CFR §440.230(d), which provides the basic legal authority for an agency to place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.
- The ABD notice included the following narrative: "You do not meet Medicaid eligibility criteria for services as a person with a serious mental illness, a person with a developmental disability, a child with a serious emotional disorder or a person with a substance abuse disorder." However, this general statement would not apply to every member (e.g., criteria as a person with a serious mental illness [SMI] would be irrelevant to a child, criteria for a child with a serious emotional disorder [SED] would be irrelevant to an adult).
- The ABD notice included the following narrative: "Based on the clinical interview, records review, results of the evaluation, and the clinical observations, [member name] is not eligible for services." However, this exact same narrative was used for every ABD notice pertaining to autism-related services. While the statement may be accurate, ABD notices should include member-specific information as to why the member was not eligible for services.
- The ABD notice included no citation or the incorrect citation for the policy/authority relied upon in making the ABD (e.g., review criteria, assessment tools). For example, the ABD notice included a "blanket" citation of 42 CFR §438.400(b)(1) or 42 CFR §438.400(b)(2), which were not specifically used to render the ABD.
- The ABD notice included second opinion rights for eligibility and inpatient hospitalization denials. However, this would be confusing for ABD notices outside of eligibility and inpatient hospitalization denials as members would not have second opinion rights. This language is also not part of MDHHS' model notice.

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

- The ABD notice informed the member that supportive housing was being reduced as clinical documentation did not support medical necessity. However, the ABD notice did not explain the reasoning. The PIHP must provide the member with sufficient information as to why the service(s) was denied so that the member can make an informed decision about whether to appeal the ABD. It was determined that the ABD notice was not populated correctly, as the service was not reduced but terminated, and the ABD was not based on medical necessity but rather the member was not engaged in services and was hospitalized out of state.
- The ABD notice included typographical errors and other errors (e.g., missing punctuation and an effective date was populated with the wrong date).
- The ABD notice included acronyms or abbreviations not spelled out with first use (e.g., ABA, UM, MCG). While some acronyms or abbreviations are common, the PIHP cannot assume a member would know their meaning. In support of plain language requirements, all acronyms and abbreviations must be spelled out at first use.
- The reading grade level was not provided as part of the case files as is requested via the case file review tool. Additionally, while PIHP staff members explained they do review for language requirements during chart audits, no documentation was provided to demonstrate that the PIHP had standardized or consistent processes to check the reading grade level of non-MDHHS template language in ABD notices prior to mailing, and/or that they attempted to reduce the reading grade level, when applicable, prior to mailing.

Recommendations:

- In support of plain language requirements, HSAG recommends that the PIHP simplify the service description in the ABD notices. For example, "9083X – Individual Therapy – bundle (90832, 90834, 90837)" could be simply stated as "Individual Therapy."
- HSAG recommends that the PIHP implement a regionwide performance improvement plan to improve the accuracy and/or specificity of the policy/authority included in the ABD notices and relied upon in making the ABD. The PIHP should avoid general citations that may support the provisions related to ABDs but were not specifically used by the UM reviewer to support the reason for the ABD. The PIHP should reference the specific review criteria (e.g., service-specific sections of the Michigan Medicaid Provider Manual, internal UM review criteria, Milliman Care Guidelines [MCG], and/or standardized assessment tools). This is particularly important for clinically based ABDs (i.e., based on medical necessity). For ABDs not based on medical necessity, the PIHP may cite process-based criteria (e.g., 42 CFR §438.404[c][5] for service authorization decisions not reached within the time frames, which constitutes a denial; and MDHHS' *Appeal and Grievance Resolution Processes Technical Requirement*, which defines an ABD for untimely service provision as the failure to provide services within 14 calendar days of the start date agreed upon during the person-centered planning meeting and as authorized by the PIHP). Additionally, the PIHP should be specific when citing the policy/authority. For example, the PIHP did not cite the *Medicaid Provider Manual for Overnight Health and Safety Supports*. The PIHP should clarify the specific section when citing the Michigan Medicaid Provider Manual.
- As MDHHS requires ABD notices to be written at or below the 6.9 reading grade level, the reading grade level of each ABD notice should be documented. HSAG recommends that the PIHP develop a process to ensure that the reading grade level is evaluated for all non-MDHHS model language in the ABD notices prior to mailing the notices to members. When the reading grade level is above 6.9, the UM reviewers should make every

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Requirement	**Supporting Documentation**	**Score**
effort to reduce the reading grade level. As the MDHHS contract with the PIHP stipulates that in some situations it may be necessary to include medications, diagnoses, and conditions that would not meet the 6.9 grade-level criteria, the PIHP could develop criteria for what terminology may be excluded from the reading grade analysis in certain instances. The reading grade level, including exclusions, should be documented along with evidence that the UM reviewer made efforts to reduce the reading grade level to at or below 6.9 to the extent possible. • While continuation of benefits information is included in MDHHS' model notice, MDHHS' *Appeal and Grievance Resolution Processes Technical Requirement* only requires this information for advance notices. HSAG recommends that the PIHP consult with MDHHS to determine if this section should be removed for adequate notices to avoid any potential member confusion since members can only request continuation of services for previously authorized services being terminated, reduced, or suspended (i.e., advance notice). • The MDHHS *Appeal and Grievance Resolution Process Technical Requirement* was last revised March 31, 2024, and included a revised *Letter of Adverse Benefit Determination* model notice that must be implemented no later than October 1, 2024. HSAG recommends that the PIHP ensure that this updated model notice is implemented regionwide no later than the required effective date.		
Required Actions: The PIHP must ensure that each ABD notice meet federal and state-specific content requirements and is written at or below the 6.9 reading grade level.		
Time Frame for Decisions		
13. For standard authorization decisions, the PIHP provides notice as expeditiously as the member's condition requires and within 14 calendar days following receipt of the request for service. 42 CFR §438.210(d)(1) 42 CFR §438.404(c)(3) 42 CFR §457.1230(d) 42 CFR §457.1260(c)(3) Contract Schedule A–1(L)(2)(b) Appeal and Grievance Resolution Processes Technical Requirement–IV(B)(1)(b)	**HSAG Required Evidence:** • Policies and procedures • UM program description • Tracking and reporting mechanisms • Service authorization log(s) within the time period under review • HSAG will also use the results of the service authorization denial file review **Evidence as Submitted by the PIHP:** • UM Program Description – FY 22-24 pg. 28 Table • UM Provider Procedures for Prior Authorized Behavioral Health Services • UM Decision Turn Around Times for Initial Determinations • Denial of Service policy page 6 • Denial of Medicaid Procedure pg. 2-3	☐ Met ☒ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
	• Standard and Urgent Authorization log • Standard and Urgent Authorization tracking queues screenshots • Approved standard authorizations within 14 calendar days following receipt of the request for service report	
PIHP Description of Process: DWIHN providers an authorization decision to members within 14 days of request for all standard authorizations. DWIHN outlines this in multiple documents including the **UM Program Description, UM Provider Procedures for Prior Authorized Behavioral Health Services, UM Decision Turn Around Times for Initial Determinations, Denial of Service policy**, and **Denial of Medicaid Procedure**. These requests are tracked in DWIHN MHWIN (electronic record) UM queue and internal tracking reports.		
HSAG Findings: The MDHHS *Service Authorization Denials Reporting Template* (MDHHS denials reporting template) identified several standard service authorizations that were not completed within 14 calendar days. Additionally, based on the reported date of the request (i.e., initiation date/time) and the date of the notice (i.e., resolution date/time) in the universe file for three cases pertaining to autism-related services and included as part of the sample selection, these cases were not completed in a timely manner (i.e., notice was not sent until 16 days or 18 days after receipt of the request). During the site review, PIHP staff members explained that they allow up to 14 calendar days to complete the comprehensive assessment/evaluation from the request for services, and then allow another 14 calendar days from the date of the assessment/evaluation to complete the service authorization. However, this does not align with the data reported via the MDHHS denials reporting template (i.e., the date of request was reported as the date/time of receipt and not the date of the assessment/evaluation). Therefore, it is unclear whether the PIHP is truly calculating service authorization timeliness using the date of request or using the date of the assessment/evaluation. Using the logic reported by the PIHP during the site review (i.e., using the date of the assessment/evaluation to start the time frame for approving/denying services), two of the three cases meet timeliness standards, but one case still did not. Using the data reported to MDHHS, all three cases were untimely. Further, the PIHP had a significantly lower volume of cases reported to MDHHS compared to the other PIHPs and only included three types of services (applied behavioral analysis adaptive behavior treatment, local psychiatric hospital/acute community, and enhanced medical equipment/supplies,) which is another outlier compared to the other PIHPs. Discussion during the site review confirmed that the PIHP was not reporting eligibility-related denials, which may be the root cause of these outliers. The PIHP should consult with MDHHS to ensure that its reporting adheres to MDHHS' specifications. **Recommendations:** HSAG recommends that the PIHP review the service authorization time frame requirements in its *UM Program Description*, and update as appropriate, as they do not appear to be accurate or align with the time frame requirements included in the *UM Decision Turn Around Times for Initial Determinations* document. Additionally, the *UM Decision Turn Around Times for Initial Determinations* document indicated that the PIHP could deny a request for a service if a provider does not respond to a request for additional information within two business days; however, the PIHP has 14 calendar days to collect the necessary information, and should use that time and make all necessary efforts to obtain missing documentation to render a decision based on medical necessity. HSAG recommends that the PIHP review and update this document, as appropriate.		

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Requirement	**Supporting Documentation**	**Score**
Required Actions: For standard authorization decisions, the PIHP must provide notice as expeditiously as the member's condition requires and within 14 calendar days following receipt of the request for service.		
14. For cases in which a provider indicates, or the PIHP determines, that following the standard time frame could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the PIHP must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than 72 hours after receipt of the request for service. 42 CFR §438.210(d)(2)(i) 42 CFR §438.404(c)(6) 42 CFR §457.1230(d) 42 CFR §457.1260(c)(3) Contract Schedule A–1(L)(2)(b) Appeal and Grievance Resolution Processes Technical Requirement–IV(B)(1)(b)	**HSAG Required Evidence:** • Policies and procedures • UM program description • Tracking and reporting mechanisms • Service authorization log(s) within the time period under review • HSAG will also use the results of the service authorization denial file review **Evidence as Submitted by the PIHP:** • 2022 to 2024 UM Program Description Pg. 24, Pg. 28 Table • Denial of Medicaid Service Procedure Pg. 2 # 12a and d • MDHHS State Fair Hearing Procedures for Enrollees/Members with Medicaid services- Pg.5z • Local Appeal Procedures for Enrollees/Members with Medicaid Pg. 3b • Standard and Urgent Authorization Log • Standard and Urgent Authorization tracking queues screenshots • Tracking and reporting mechanisms	☐ Met ☒ Not Met ☐ NA
PIHP Description of Process: DWIHN has an expedited review process for cases where the standard review timeframe could jeopardize a member's health or life. This expedited review will occur as soon as the member's condition requires, but no later than 72 hours. This expedited process is outlined in DWIHN's **UM Program Description**, **Denial of Medicaid Service Procedure**, **MDHHS State Fair Hearing Procedure** and **Local Appeal Procedures for Enrollees/Members with Medicaid**.		
HSAG Findings: The MDHHS denials reporting template identified one expedited case that was not completed within 72 hours. Additionally, the PIHP was not reporting both the date and *time* for the receipt date/time and the notice date/time for expedited cases, which is required for expedited cases. While all but one case was reported as being timely, HSAG was unable to confirm timeliness for all cases without a *time* being reported. For example, several cases were reported with a turnaround time (TAT) of three days and reported as timely; however, without the time, compliance with the 72-hour time frame could not be confirmed (e.g., if date/time of receipt was January 1, 2024, at 10 a.m. and the date/time of notice was January 4, 2024, at 3 p.m., even though		

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Requirement	**Supporting Documentation**	**Score**
this would equate to three calendar days, the TAT time is actually 77 hours). The MDHHS denials reporting template also confirmed that while most inpatient hospitalizations were reported as expedited cases, one case was reported as a standard case. It is unclear why this case was considered standard or if it was reported as a standard case in error. Further, the case file review and discussion with PIHP staff members confirmed that the PIHP was reporting inpatient concurrent review denials on the MDHHS denials reporting template. However, the reporting instructions require only "Standard service authorization (processed within 14 calendar days) or expedited service authorization (processed with 72 hours). Include only pre-service denials (prior authorizations)," which are typically categorized separately from concurrent reviews. The PIHP should consult with MDHHS to ensure that its reporting adheres to MDHHS' specifications. Further, while there were inconsistencies among the PIHPs related to expedited service authorizations (i.e., tracking and reporting), after further review and discussion among HSAG reviewers after the site review, it was determined to score this element as *Not Met* to assure timeliness and accurate reporting of expedited cases.		
Required Actions: For cases in which a provider indicates, or the PIHP determines, that following the standard time frame could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the PIHP must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than 72 hours after receipt of the request for service. The PIHP must ensure accurate implementation, documentation, tracking, and reporting of extensions.		
15. For standard and expedited authorization decisions, the PIHP may extend the resolution time frame up to an additional 14 calendar days if: a. The member or the provider requests the extension; or b. The PIHP justifies a need for additional information and how the extension is in the member's interest. 42 CFR §438.210(d)(1)(i-ii) 42 CFR §438.210(d)(2)(ii) 42 CFR §457.1230(d) 42 CFR §457.1260(c)(3) Contract Schedule A–1(L)(5)(e) Appeal and Grievance Resolution Processes Technical Requirement–IV(B)(1)(c)	**HSAG Required Evidence:** • Policies and procedures • UM program description • Tracking and reporting mechanisms • Extension notice template • HSAG will also use the results of the service authorization denial file review **Evidence as Submitted by the PIHP:** • UM Program Description – FY 22-24- Pg. 31 H. • Process of Oral Notification of Extensions to the Enrollee/Member • Member Extension Letter template • Denial of Medicaid Service Procedures Pg. 3 #13 • Extension Letter Audit Spreadsheet 2023-2024 report • Extension Letter Audit Spreadsheet tracking process	☐ Met ☒ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
PIHP Description of Process: DWIHN has extension process for authorization decisions that is cited in both the **UM Program Description** and **Denial of Medicaid Service Procedures.** This additional 14-day extension is initiated when the member or provider requests it or if DWIHN requires additional information to make an appropriate decision that is in the member's best interest.		
HSAG Findings: The two cases included as part of the sample selection of cases with an extension pertained to concurrent inpatient reviews. Both cases confirmed that the PIHP applied a 14-calendar-day extension to the concurrent review. While HSAG did not intend to review concurrent reviews as part of the case file review, and the PIHP did not take the full 14 calendar days to render a decision (i.e., a decision was made in 4.8 days for one case and five days for the second case), HSAG is very concerned about the PIHP's process allowing up to a 14-calendar-day extension on a continuing stay review when a member is currently inpatient; which, as a result, warrants a *Not Met* score for this element. **Recommendations:** The *Denial of Medicaid Service Procedures* included the following language: "The extension period, within which a decision must be made by the organization, begins on the date when the enrollee/member or their representative's response is received (even if not all of the information is provided), or at the end of the time period given to the enrollee/member to supply the information, if no response is received from their enrollee/representative." This language implies that the PIHP is pausing the time frame for completing the service authorization until the member provides the requested information, which is not allowable. PIHP staff members and the case files submitted after the site review confirmed that this is not the intent, and the time frame is never paused. HSAG recommends that the PIHP review and update its policy language for clarity.		
Required Actions: For standard and expedited authorization decisions, the PIHP may extend the resolution time frame up to an additional 14 calendar days if the member or the provider requests the extension; or the PIHP justifies a need for additional information and how the extension is in the member's interest.		
16. If the PIHP meets the criteria set forth for extending the time frame for standard and expedited service authorization decisions consistent with 42 CFR §438.210(d)(1)(ii) and 42 CFR §438.210(d)(2)(ii), it: a. Gives the member written notice of the reason for the decision to extend the time frame and informs the member of the right to file a grievance if he or she disagrees with that decision; and b. Issues and carries out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.	**HSAG Required Evidence:** • Policies and procedures • UM program description • Tracking and reporting mechanisms • Extension notice template(s) • HSAG will also use the results of the service authorization denial file review **Evidence as Submitted by the PIHP:** • UM Program Description – FY 22-24 Pg. 31 • Process of Oral Notification of Extensions to the Enrollee/Member	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
42 CFR §438.210(d)(1)(ii) 42 CFR §438.210(d)(2)(ii) 42 CFR §438.404(c)(4)(i-ii) 42 CFR §457.1230(d) Contract Schedule A–1(L)(5)(e) Appeal and Grievance Resolution Processes Technical Requirement–IV(B)(1)(c)	• Member Extension Letter template • Denial of Medicaid Service Procedures Pg. 3 #14 • Customer Service Enrollee-Member Appeals Policy Pg. 10 #5 • Extension Letter Audit Spreadsheet 2023-2024 report • Extension Letter Audit Spreadsheet tracking process	
PIHP Description of Process: DWIHN has an extension process for authorization decisions that provides the timeframe and reason for the extension in writing to the member, including their grievance rights. An authorization decision is completed by the extension deadline, or sooner based on the member's health condition as outlines in the **Customer Service Enrollee-Member Appeals Policy** and **UM Program Description**. An example **Member Extension Letter** is also included.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
17. For all covered outpatient drug authorization decisions, provide notice as described in section 1927(d)(5)(A) of the Social Security Act (SSA). a. Provides response by telephone or other telecommunication device within 24 hours of a request for prior authorization. 42 CFR §438.210(d)(3) 42 CFR §457.1230(d) SSA §1927(d)(5)(A)	**HSAG Required Evidence:** • Not applicable **Evidence as Submitted by the PIHP:** • Not applicable	☐ Met ☐ Not Met ☒ NA
PIHP Description of Process: Not applicable		
HSAG Findings: This element is *Not Applicable* to the PIHP.		
Required Actions: None.		

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Requirement	**Supporting Documentation**	**Score**
18. For termination, suspension, or reduction of previously authorized Medicaid-covered services, the PIHP mails the ABD notice to the member within at least 10 days before the date of action, except as permitted under 42 CFR §431.213 and §431.214. 42 CFR §431.211 42 CFR §431.213 42 CFR §431.214 42 CFR §438.210(c) 42 CFR §438.404(c)(1) 42 CFR §457.1230(d) Contract Schedule A–1(L)(6)(a)(i) Appeal and Grievance Resolution Processes Technical Requirement–IV(B)(2)(a-b)	**HSAG Required Evidence:** • Policies and procedures • UM program description • Advance ABD notice template(s) • Tracking and reporting mechanisms • HSAG will also use the results of the service authorization denial file review **Evidence as Submitted by the PIHP:** • Advance ABD notice template • Customer Service-CS-Enrollee Member Appeal Policy- Pg. 9 #2 a2 • Tracking and reporting mechanisms • UM Program Description 2022-2024 Pg. 45	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The DWIHN **Customer Service-CS- Enrollee/Member Appeal Policy** provides that the member be provided proper notice using an ABD letter to inform of the reduction, suspension, or termination of Medicaid-covered services. In this case the advance notice is sent out at least 10 calendar days prior to the action taking place. The **UM Program Description,** along with related denial of service policies & procedures, will be updated to reflect the required ten (10) day timeframe.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** The case file review identified one record in which a four-month advance notice was provided. While PIHP staff members explained there were extenuating circumstances, HSAG recommends that the PIHP review the appropriateness of providing such lengthy advance notices. Additionally, for one record, an advance notice was not provided due to a provider unexpectedly not being able to provide services. Therefore, this finding was not considered a deficiency. However, as the PIHP's provider network is responsible for issuing ABD notices for the termination, suspension, or reduction of previously authorized services, HSAG recommends that the PIHP enhance its oversight and monitoring of its provider network to ensure that advance ABD notices are being issued correctly, time frame requirements are being met (i.e., 10-day advance notice), and the notices meet content and plain language requirements. 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.		
Required Actions: None.		

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Requirement	**Supporting Documentation**	**Score**
19. The PIHP sends a notice not later than the date of action if: a. The PIHP has factual information confirming the death of a member; b. The PIHP receives a clear written statement signed by a member that: i. The member no longer wishes services; or ii. Gives information that requires termination or reduction of services and indicates that he understands that this must be the result of supplying that information; c. The member has been admitted to an institution where the member is ineligible under the plan for further services; d. The member's whereabouts are unknown, and the post office returns agency mail directed to the member indicating no forwarding address; e. The PIHP establishes the fact that the member has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth; f. A change in the level of medical care is prescribed by the member's physician; g. The notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the Social Security Act; or h. The date of action will occur in less than 10 days, in accordance with §483.15(b)(4)(ii) and (b)(8), which provides exceptions to the 30 days' notice requirements of §483.15(b)(4)(i). 42 CFR §431.213 42 CFR §438.210(c) 42 CFR §438.404(c)(1)	**HSAG Required Evidence:** • Policies and procedures • UM program description • ABD notice template(s) • Tracking and reporting mechanism(s) • Three examples of an ABD notice sent to a member that meets one of the criteria of this element • HSAG will also use the results of the service authorization denial file review **Evidence as Submitted by the PIHP:** • Customer Service Enrollee/Member Appeals Policy- Pg. 8-9 #12 i-viii, Pg. 9 #2 a2 • Local Appeal Procedures for Enrollees/Members with Medicaid-Pg 1-2 1.a 1-8, Pg. 2 1.b • MDHHS State Fair Hearing Procedures for Enrollees/Members with Medicaid Services. Pg.4 #3 u • Advance Notice ABD Template • UM Program Description • Tracking and reporting mechanism • Advance Notice Sample Case number 1 • Advance Notice Sample Case number 2 • Advance Notice Sample Case number 3	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
42 CFR §483.15(b)(4)(i-ii) 42 CFR §483.15(b)(8) 42 CFR §457.1230(d) SSA §1919(e)(7) Contract Schedule A–1(L)(6)(a)(ii) Appeal and Grievance Resolution Processes Technical Requirement–IV(B)(2)(c)(i-viii)		
PIHP Description of Process: DWIHN members receive an advance notice when there is a proposed negative action to their services. In the instances outlined in the element above, DWIHN provides that notice no later than the date of action. The **Customer Service Enrollee/Member Appeals Policy, Local Appeal Procedures for Enrollees/Members with Medicaid,** and **MDHHS State Fair Hearing Procedures for Enrollees/Members with Medicaid Services** offer technical guidance for providing notice to members, specifically when encountering the exceptions noted in the above element. The **UM Program Description** update, which occurs outside of the lookback period, will be expanded to include this information.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** The PIHP submitted a case example in which an adequate notice was provided and the PIHP received a written statement from the member requesting that services be terminated. The PIHP also submitted a case example in which an advance notice was provided when the member requested to terminate services. As such, the PIHP received a *Met* score for this element. However, HSAG recommends that the PIHP conduct staff training regionwide to ensure their understanding of the requirements for when a member wishes to no longer receive services. If a member requests that services be terminated, the PIHP must obtain the member's written statement to terminate services when providing notice on the date of the action. If the member's written statement is not received, the PIHP must provide the member with a 10-day advance notice.		
Required Actions: None.		

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Requirement	**Supporting Documentation**	**Score**
20. The PIHP may shorten the period of advance notice to five days before the date of action if: a. The PIHP has facts indicating that action should be taken because of probable fraud by the member; and b. The facts have been verified, if possible, through secondary sources. 42 CFR §431.214 42 CFR §438.210(c) 42 CFR §438.404(c)(1) 42 CFR §457.1230(d) Contract Schedule A–1(L)(6)(a)(iii) Appeal and Grievance Resolution Processes Technical Requirement–IV(B)(2)(c)(ix)	**HSAG Required Evidence:** • Policies and procedures • UM program description • ABD notice template(s) • Tracking and reporting mechanism(s) • Three examples of an ABD notice sent to a member due to probable fraud • HSAG will also use the results of the service authorization denial file review **Evidence as Submitted by the PIHP:** • Customer Service Enrollee/Member Appeals Policy- Pg. 9 ix • Local Appeal Procedures for Enrollee/Members with Medicaid Pg 2 #1.a.9 • Advance Notice ABD Template • UM Program Description • Compliance Investigation Guidance • Fraud, Waste, and Abuse Policy – Pg. 1 • **DWIHN does not have any examples of an ABD notice sent to a member due to probable fraud**	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: As outlined in the **Customer Service Enrollee/Member Appeals Policy**, the period of advance notice shortens to five (5) days in the event of probable fraud by the member. **Compliance Investigation Guidance** indicates steps for investigating potential fraud, beginning with a preliminary investigation by designated compliance staff. The current **UM Program Description** is included and references the other evidence provided, though does not explicitly address the contents of this element. The UM Program Description update, which occurs outside of the lookback period, will be expanded to include this information.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. Of note, the PIHP reported it had no instances of probable member fraud that warranted the mailing of any ABD notice.		
Required Actions: None.		

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Requirement	**Supporting Documentation**	**Score**
21. The PIHP mails the ABD notice for denial of payment at the time of any action affecting the claim. 42 CFR §438.210(c) 42 CFR §438.404(c)(2) 42 CFR §457.1230(d) Contract Schedule A–1(L)(5)(c) Appeal and Grievance Resolution Processes Technical Requirement–IV(B)(1)(a)	**HSAG Required Evidence:** • Policies and procedures • Workflow/guidelines for payment denial on a claim to trigger ABD notice • UM program description • ABD notice template for denial of payment • Tracking and reporting mechanism(s) • HSAG will also use the results of the service authorization denial file review **Evidence as Submitted by the PIHP:** • Denial of Service Policy Pg. 6 #23 • Denial of Medicaid Service Procedures Pg. 5 #29 • Claims Processing Procedure Pg. 4, #7(c) • Notice of Denial of Payment • UM Program Description, pg. 31 (l)	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The Denial of Service Policy provides procedural and operational guide on the denial process to all staff performing UM functions including UM Reviewers, UM Clinical Specialists, UM Appeals Coordinator and physicians. As it relates to a claim denial, once our claim department finds that a clean claim denial exists, they will contact the Appeals Coordinator. The Appeals Coordinator will then send the member a Notice of Denial of Payment. **The Denial of Medicaid Service Procedures** provides detailed steps required to issue an adverse benefit determination to both members/enrollees and providers. The **Claims Processing Procedure** provides guidelines for processing and adjudicating claims. If a member receives an uncovered service, the claim will deny, and an Explanation of Benefits (EOB) is mailed by DWIHN Customer Service. If a claim were denied, an Adverse Benefit Determination (ABD) letter would be mailed on the day of denial.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations**: The PIHP had no cases of claim payment denials. Discussion with PIHP staff members confirmed that the PIHP allows providers every opportunity to submit documentation to support medical necessity when a claim is received (e.g., when an out-of-network provider submits a claim with no prior authorization or when a hospital submits a claim for dates of services above what was authorized through the continuing stay review). Retroactive reviews are completed; therefore, a claim payment denial is a rare occurrence. However, HSAG recommends that the PIHP periodically (e.g., quarterly) review reports that display the number of claims received and paid for in full, as well as the number of claims received in which payment in full		

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Requirement	**Supporting Documentation**	**Score**
or payment in part was denied. For any payment denials, the PIHP must confirm that an ABD notice was provided to the member. If the PIHP does not provide evidence to demonstrate adequate implementation of HSAG's recommendations during future compliance reviews, the PIHP will automatically receive a *Not Met* score.		
Required Actions: None.		
22. For standard and expedited service authorization decisions not reached within the required time frames specified in 42 CFR §438.210(d) (which constitutes a denial and is thus an ABD), the PIHP provides notice on the date that the time frames expire. 42 CFR §438.210(c-d) 42 CFR §438.404(c)(5) 42 CFR §457.1230(d) Contract Schedule A–1(L)(5)(f) Appeal and Grievance Resolution Processes Technical Requirement–IV(B)(1)(c)	**HSAG Required Evidence:** • Policies and procedures • UM program description • ABD notice template for untimely determination • Service authorization log(s) within the time period under review • Tracking and reporting mechanism(s) • HSAG will also use the results of the service authorization denial file review **Evidence as Submitted by the PIHP:** • Denial of Medicaid Service Procedures- Pg. 2-3 #12-13 • Adequate Notice ABD Template • Member Extension letter • Extension Letter Audit Spreadsheet 2023-2024 • Snapshot of Service Authorization log within the time period under review • 2022 to 2024 UM Program Description – pg. 31, 34	☐ Met ☒ Not Met ☐ NA
PIHP Description of Process: Denial of Medicaid Service Procedures outline decision-making and timeframes for standard and expedited service authorizations. Templates, tracking sheets, and snapshot support the procedure/workflow. **UM Program Description** will be updated to provide expanded language describing extension timeframes for all service authorization decisions.		
HSAG Findings: The MDHHS denials reporting template identified several cases that were not completed in a timely manner (i.e., not completed within 72 hours or 14 calendar days [plus the 14-calendar-day extension, if applicable]). Additionally, all evidence submitted by the PIHP for this element was specific to extension provisions and did not clearly address the specific requirements in cases when a decision is not reached within the required time frames. HSAG requested additional information to support compliance, specifically, a case example when an ABD notice was issued due to the PIHP not rendering a decision in a timely manner. After the site review, the PIHP submitted a case example with an extension applied and a service authorization		

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Requirement	**Supporting Documentation**	**Score**
decision being made prior to the expiration of the time frame, which was not the type of case example HSAG requested. When the PIHP is unable to render a standard service authorization decision within 14 calendar days (and no extension is applied), it constitutes a denial and the PIHP is required to send the ABD notice on the date the time frame expired. If the PIHP is unable to render a standard service authorization with an extension applied within 28 calendar days, it constitutes a denial and the PIHP is required to send the ABD notice on the date the time frame expired. Based on the combination of the findings for this element, HSAG was unable to confirm compliance with these expectations or that PIHP staff members fully understood the requirements of this element.		
Required Actions: For standard and expedited service authorization decisions not reached within the required time frames specified in 42 CFR §438.210(d) (which constitutes a denial and is thus an ABD), the PIHP must provide notice on the date that the time frames expire.		
Compensation for Utilization Management Activities		
23. The PIHP provides that compensation to individuals or entities that conduct UM activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member. 42 CFR §438.210(e) 42 CFR §438.3(i) 42 CFR §422.208 42 CFR §457.1230(d) Contract Schedule A–1(K)(1)	**HSAG Required Evidence:** • Policies and procedures • UM program description • New hire and ongoing training for staff • Three examples of staff attestations **Evidence as Submitted by the PIHP:** • Appropriate Professionals for Utilization Management Decision Making Pg. 3 #18a • Utilization Management Affirmative Statement Pg. 1, Pg. 2 • Behavioral Health Utilization Management Review Policy Pg. 4. 2e • 2022 to 2024 UM Program Description Pg. 28 • Utilization Management Affirmative Statement About Incentives • Three examples of staff attestations • DWIHN Training Plan 2024	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: n/a		

Standard VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		

Standard VI—Coverage and Authorization of Services						
Met	=	17	X	1	=	17
Not Met	=	5	X	0	=	0
Not Applicable	=	1				
Total Applicable	=	22	Total Score		=	17
Total Score ÷ Total Applicable					=	77%

Appendix B. Compliance Review Corrective Action Plan

Standard I—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
7. The PIHP makes its written materials that are critical to obtaining services, including, at a minimum, provider directories, member handbooks, appeal and grievance notices, and denial and termination notices, available in the prevalent non-English languages in its service areas. a. Written materials that are critical to obtaining services are also made available in alternative formats upon request of the member or potential member at no cost. b. Written materials that are critical to obtaining services include taglines in the prevalent non-English languages in the State in a conspicuously visible font size explaining the availability of written translation or oral interpretation to understand the information provided. c. Written materials that are critical to obtaining services include information on how to request auxiliary aids and services. d. Written materials that are critical to obtaining services include the toll-free and TTY/TDD telephone number of the PIHP's member/customer services unit. e. Auxiliary aids and services must be made available upon request of the member or potential member at no cost. 42 CFR §438.10(d)(3) 42 CFR §457.1207 Contract Schedule A–1(M)(2)(b)	**HSAG Required Evidence:** • Policies and procedures • Provider directory in prevalent languages • Member handbook in prevalent languages • Definition of "conspicuously visible font" • Mechanisms to ensure taglines are included as part of all critical member materials • All template notices required to include taglines **Evidence as Submitted by the PIHP:** • Member Orientation Policy (pg. 4-d 1-5) • Customer Service Policy (pg. 2&3, #6) • Provider Directory (pg. 4) • Customer Service (CS) Enrollee/Member Appeals Policy Pg.5 #15 i-iv. • Limited English Proficiency Policy (pg. .2-4) (Standard 5a-i & Standard 6) • Limited English Procedure, (entire) • DWIHN Member Handbook 2023 Spanish • DWIHN Member Handbook 2023 Arabic • Provider Directory Arabic • Provider Directory Spanish • FRG Redacted • Member Handbook Policy Stub • Member Handbook English • Member Handbook pg. 12, 20 & 21. • NOROG redacted	☐ Met ☒ Not Met ☐ NA

Standard I—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
	• Notice of Appeal Approval Redacted • Notice of Appeal Approval Form – Medicaid SMI-IDD-SUD- Stub • Notice of Appeal Denial Form-Medicaid SMI-IDD- SUD-Stub • Notice of Receipt of Appeal 2024 redacted • Final Response to Grievance - Spanish • Provider Directory Booklet • Non-English Brochures (Arabic & Spanish) • https://www.dwihn.org/brochures-and-handouts • DWIHN Member Handbook (pg. 10&21) • Definition of "conspicuously visible font"- Provider Directory pg. 4 • Mechanisms to ensure taglines are included as part of all critical member materials. - Handbook pg. 20, Provider Directory pg. 4 • Adequate ABD Redacted • Notices with taglines: Notice of Receipt of Appeal, Advance Notice of Adverse Benefit Determination, Adequate Notice of Adverse Benefit Determination, Final Response to Grievance, Notice of Receipt of Grievance, Notice of Appeal Approval, Notice of Appeal Denial	
PIHP Description of Process: DWIHN makes all Member written materials for obtaining services i.e. Provider Directory, Member Handbook and Appeal, Grievance and termination notices available in non-English languages as well as in Arabic and Spanish at no cost to the member. Taglines are provided on critical Member Materials for prevalent non-English languages. Conspicuously visible font size of availability of written translation, and/or oral interpretation is also prevalent for critical written materials i.e. Provider Directory, Handbook, and Member notices. Toll-free and TTY numbers of DWIHN's Customer Service Unit is included in all member written materials. Auxiliary aids and services are made available upon request as indicated in the DWIHN Handbook.		

Standard I—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: Not all of the PIHP's written materials that are critical to obtaining services, such as the PIHP's paper provider directory, included taglines with information about how to request auxiliary aids and services and the toll-free and Teletypewriter/Telecommunications Device for the Deaf (TTY/TDY) telephone number of the PIHP's member/customer services unit. **Recommendations:** HSAG found inconsistencies such as sizes and formatting in the taglines included in various PIHP member materials, and the PIHP's *DWIHN Provider Directory-revised Dec2023 compressed* provider directory was missing the English tagline that was included in other member materials. As such, HSAG strongly recommends that the PIHP ensure that any written materials that are critical to obtaining services contain taglines that are consistent and contain all required information.		
Required Actions: The PIHP must ensure that its written materials that are critical to obtaining services include information about how to request auxiliary aids and services as well as include the toll-free and TTY/TDD telephone number of the PIHP's member/customer service unit.		
PIHP Corrective Action Plan		
Root Cause Analysis:		
PIHP Remediation Plan:		
Responsible Individual(s):		
Timeline:		
MDHHS/HSAG Response:	☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted	
10. The PIHP provides all written materials for potential members and members consistent with the following: a. Use easily understood language and format. b. *Written at or below the 6.9 grade reading level when possible (i.e., in some situations it is necessary to include medications,*	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook and member newsletter • Mechanism to assess reading level of member materials and supporting evidence (e.g., screenshots of reading level of member materials)	☐ Met ☒ Not Met ☐ NA

Standard I—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
diagnosis, and conditions that do not meet the 6.9 grade reading level criteria). c. Use a font size no smaller than 12 point. d. Be available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of members or potential members with disabilities or limited English proficiency. e. The PIHP shall also identify additional languages that are prevalent among the PIHP's membership. *For purposes of this requirement, "prevalent non-English language" is defined as any language spoken as the primary language by more than five percent (5%) of the population in the PIHP's region*. f. *Material must not contain false, confusing, and/or misleading information*. "Limited English proficient (LEP)" means potential members and members who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may be LEP and may be eligible to receive language assistance for a particular type of service, benefit, or encounter. 42 CFR §438.10(d)(6) 42 CFR §457.1207 Contract Schedule A–1(B)(4)(e) Contract Schedule A–1(M)(2)(a)(i)-(ii) Contract Schedule A–1(M)(2)(a)(iv) Contract Schedule A–1(M)(2)(b)(i)	• Examples of member notices (in Microsoft Word), such as an ABD notice, grievance resolution letter, appeal resolution letter, etc. • Tracking or reporting mechanism on use of interpretation services and auxiliary aids and services • Mechanism to assess prevalent languages in the PIHP's region **Evidence as Submitted by the PIHP:** • Customer Service Policy, (pgs. 2-3) Standard 6a-d • Limited English Proficiency Policy (entire policy) • Limited English Proficiency Procedure (entire policy) • Member Handbook -Non-Discrimination & Accessibility, pg.12 and Language Assistance & Accommodations, pg.21 • DWIHN's Interpretation Usage FY'24, pg. 2 (orange highlight) • Persons' Point of View Winter Newsletter • Bromberg & Associates Contract Extension • B&A Translation Invoice December 2023 • B&A Translation Invoice March 2024 1. Samples of Member Notices a) Adverse Benefit Determination b) Final Response to Grievance c) Notice of Receipt of Grievance d) Notice of Appeal Approval 2024 e) Notice of Receipt of Appeal 2024 • Person Point of View-Spring Edition Newsletter • Grammarly Report- Readability- Member- Provider Closure • Grammarly Readability Report-Spring Edition PPV 2024.docx page 23- Did you Know? And Mediation Helpline	

Standard I—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
	• Grammarly Readability Report. Spring Edition PPV 2024.docx Let's Talk about Human Trafficking-pages 7,8 • Grammarly Report of Member Handbook Readability • Grammarly Report of Provider Directory Readability • Grammarly Report on DWIHN Website Readability	
PIHP Description of Process: DWIHN distributes information to members in easily, understandable language. DWIHN also trains its' provider network to utilize easily, understandable language wherever possible when communicating with members. Members also contributed to the development and review of the Member Handbook as well as the Grievance/Appeal Member Bookmarks to ensure proper flow and ability to understand the information presented. A newsletter written by our members entitled The Persons' Point of View is the voice of our membership.		
HSAG Findings: Not all of the PIHP's written materials for potential members and members contained text with the minimum 12-point font size in all areas of the document, such as portions of the PIHP's member handbook and paper provider directory. Additionally, although the PIHP submitted *Grammarly* reports as evidence that the PIHP's member materials are written at or below the 6.9 reading grade level, most of these reports did not contain information related to reading grade level, and the reports that did contain reading grade-level information were above the 6.9 reading grade level.		
Required Actions: The PIHP must ensure that all written materials for potential members and members use a font size no smaller than 12 point and are written at or below the 6.9 reading grade level when possible.		
PIHP Corrective Action Plan		
Root Cause Analysis:		
PIHP Remediation Plan:		
Responsible Individual(s):		
Timeline:		
MDHHS/HSAG Response:	☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted	

Standard I—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
18. The PIHP makes the provider directory available in paper form upon request and electronic form. The provider directory must include the information from the Provider Directory Checklist. 42 CFR §438.10(h)(1-2) 42 CFR §457.1207 Contract Schedule A–1(M)(1) Contract Schedule A–1(M)(2)(a)(iii)	**HSAG Required Evidence:** • Policies and procedures • Process for generating a paper copy of the provider directory • Copy of provider directory in Word format or PDF (excerpts are acceptable) • Link to the online provider directory • HSAG will also use the results of the Provider Directory Checklist **Evidence as Submitted by the PIHP:** • Member Orientation: Member Rights and Responsibilities Page 4. Standard 2 c # 4 • Provider Directory Rev. 12/23 • Link to on-line Directory https://dwihn.org/members/Provider_Directory_Booklet.pdf • (2023-2024 version, revised June 2023) • https://dwihn.org/members/Provider_Directory_Booklet.pdf Link to Provider E directory https://dwihn.org/find-a-provider • Provider Directory Check List • Network Monitoring Management Page 5. #47 • Sample Screenshot – ADA Accessible	☐ Met ☒ Not Met ☐ NA
PIHP Description of Process: DWIHN's Provider Directory is online and in hard copy, which includes all the requirements of the Provider Checklist.		
HSAG Findings: Although the PIHP's electronic provider directory, machine-readable provider directory, and the PDF directory on its website contained information on whether the provider's office/facility has accommodations for people with physical disabilities including offices, exam room(s), and equipment, the PIHP's *DWIHN Provider Directory-revised Dec2023* compressed provider directory did not contain this information. Additionally, although the PIHP's *DWIHN Provider Directory-revised Dec2023* compressed provider directory contained information on independent facilitators, these providers were not listed in the other versions of the PIHP's provider directories. All versions of the PIHP's provider directories must contain all required information. Following the site review, MDHHS confirmed that independent facilitators must be included in the provider directory. Lastly, although the		

Standard I—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
PIHP only serves members in Wayne County, its provider directory could not be sorted by county to accommodate any providers in the PIHP's provider network that may be located outside of the county or have additional locations outside of the county. **Recommendations:** HSAG recommends that the PIHP develop definitions for provider types that must be in the PIHP's provider directory (e.g., medical suppliers, ancillary health providers) for clarity about the services that fall under each provider type (e.g., occupational therapy and physical therapy are considered ancillary health providers).		
Required Actions: The PIHP must ensure that all versions of its provider directory include all of the required information in the Provider Directory Checklist.		
PIHP Corrective Action Plan		
Root Cause Analysis:		
PIHP Remediation Plan:		
Responsible Individual(s):		
Timeline:		
MDHHS/HSAG Response:	☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted	
19. Information included in a paper provider directory must be updated *at least monthly*. 42 CFR §438.10(h)(3)(i) 42 CFR §457.1207 Contract Schedule A–1(M)(1)(b)	**HSAG Required Evidence:** • Policies and procedures • Workflow for updating paper provider directories • Three consecutive provider directory update examples **Evidence as Submitted by the PIHP:** • Procedure for Updates of Providers Information on DWIHN Website pgs. 1& 2 • Service Provider Change Procedure • Sample DWIHNs Monthly Electronic Provider Updates • Sample of on-line machine -readable Provider Directory (printed version)	☐ Met ☒ Not Met ☐ NA

Standard I—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
	• American Disabilities Act-ADA- Accommodations Provider Compliance and Audit Procedure	
PIHP Description of Process: DWIHN's online machine-readable directory is regularly updated twice a month and can be conveniently printed.		
HSAG Findings: The PIHP staff members explained during the site review that their electronic and machine-readable provider directories were updated at least twice a month. However, PIHP staff members also explained during the site review that the printed version of its provider directory that would be given to members was the PIHP's *DWIHN Provider Directory-revised Dec2023 compressed* provider directory, which is only updated on a quarterly basis instead of at least monthly.		
Required Actions: The PIHP must ensure that information included in its paper provider directory is updated at least monthly.		
PIHP Corrective Action Plan		
Root Cause Analysis:		
PIHP Remediation Plan:		
Responsible Individual(s):		
Timeline:		
MDHHS/HSAG Response:	☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted	

Standard III—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
8. *The Access System shall provide a timely, effective response to all individuals who walk in.* a. *For individuals who walk in with urgent or emergent needs, an intervention shall be immediately initiated.* b. *Individuals with routine needs must be screened or other arrangements made within 30 minutes.* 42 CFR §438.206(c)(1)(i) 42 CFR §457.1230(a) Contract Schedule A–1(E)(7) MDHHS Behavioral Health and Developmental Disabilities Administration Access Standards I(C)(1-2)	**HSAG Required Evidence:** • Policies and procedures • Provider materials, such as the provider manual and provider contract • Monitoring reports **Evidence as Submitted by the PIHP:** • Time Frames and Procedural Steps for Priority Population Management (pg 1) • Customer Service Policy (pg 4) • Access Policy (pg 1) • FY 23-24 SUD appointment availability report	☐ Met ☒ Not Met ☐ NA
PIHP Description of Process: Via the Access Policy, Customer Service Policy and Time Frames & Procedural Steps for Priority Populations Management, individuals with urgent or emergent needs are to receive immediate interventions and individuals with routine needs are to receive a screening or other arrangements within 30 minutes. FY 23-24 appointment availability report monitors timeliness of services availability and scheduling.		
HSAG Findings: The PIHP staff members were able to describe the Access System's response to individuals who were walk-ins and the *Access Policy*, *Customer Service Policy*, and *Time Frames and Procedural Steps for Priority Population Management* documents included the required access time frame standards for walk-ins as well as the process for assisting individuals who walk-in; however, the PIHP was not able to demonstrate that it monitored the specific time frames for walk-ins to ensure that timeliness requirements were met. Additionally, although the PIHP's *FY 23-24 SUD appointment availability report* included timeliness of services availability and scheduling data, it did not specifically identify the access time frames for walk-ins.		
Required Actions: The PIHP must ensure that the Access System provides a timely, effective response to all individuals who walk in. For individuals who walk in with urgent or emergent needs, an intervention must be immediately initiated. For individuals with routine needs, they must be screened or have other arrangements made within 30 minutes. The PIHP must have monitoring mechanisms to ensure compliance with these access standards.		
PIHP Corrective Action Plan		
Root Cause Analysis:		
PIHP Remediation Plan:		
Responsible Individual(s):		

Standard III—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
Timeline:		
MDHHS/HSAG Response:		☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Standard VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
12. The PIHP gives members written notice of any decision by the PIHP to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The ABD notice includes the following: a. *Notification that 42 CFR §440.230(d) provides the basic legal authority for an agency to place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.* b. The ABD the PIHP has made or intends to make. c. The reasons for the ABD. d. *The policy/authority relied upon in making the determination.* e. The right of the member to be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's ABD. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits. f. The member's right to request an appeal of the PIHP's ABD, including information on exhausting the PIHP's one level of appeal, described at 42 CFR §438.402(b), and right to request a State fair hearing consistent with 42 CFR §438.402(c). g. The procedures for exercising the rights specified in 42 CFR §438.402(b). h. The circumstances under which an appeal process can be expedited and how to request it. i. The member's right to have benefits continue pending resolution of the appeal; how to request that benefits be continued; and the circumstances, consistent with State policy, under which the member may be required to pay the costs of	**HSAG Required Evidence:** • Policies and procedures • UM program description • ABD notice template with taglines • HSAG will also use the results of the service authorization denial file review **Evidence as Submitted by the PIHP:** • UM Program Description – FY 22-24- Pg. 28 &29 • Adequate Notice of Adverse Benefit Determination Form • Advance Notice of Adverse Benefit Determination Form • Denial of Service Policy Pg 3 #7 & 8 a-i • Customer Service (CS) Enrollee/Member Appeals Policy Pg. 6-8 • Utilization Management Provider Appeals Policy Pg. 4-5	☐ Met ☒ Not Met ☐ NA

Standard VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
these services *(only required when providing advance notice of an ABD)*. j. *An explanation that the member may represent himself/herself or use legal counsel, a relative, a friend, or other spokesman.* k. The notice must be consistent with the requirements of 42 CFR §438.10. 42 CFR §438.10 42 CFR §438.210(c) 42 CFR §438.402(b-c) 42 CFR §438.404(a-b) 42 CFR §457.1230(d) 42 CFR §457.1260(b)(1) 42 CFR §457.1260(c)(1-2) Contract Schedule A–1(L)(2)(a)(i-v) Appeal and Grievance Resolution Processes Technical Requirement–IV(A) Appeal and Grievance Resolution Processes Technical Requirement–IV(C)(1)		
PIHP Description of Process: DWIHN provides the member a written ABD notice when a requested service is being denied or a service is being authorized at a rate less than requested in terms of amount, scope, or duration. This notification is consistent with 42 CFR §438.10 and includes information on the reasons for the ABD, the policy related to the determination, the member's right to appeal and their State Fair Hearing rights, the member's right to reasonable access to and copies of all relevant documents related to this determination.		
HSAG Findings: The case file review identified the following opportunities for improvement, which apply to one or more ABD notices in the sample selection: • The ABD notice did not include reference to 42 CFR §440.230(d), which provides the basic legal authority for an agency to place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures. • The ABD notice included the following narrative: "You do not meet Medicaid eligibility criteria for services as a person with a serious mental illness, a person with a developmental disability, a child with a serious emotional disorder or a person with a substance abuse disorder." However, this general statement would not apply to every member (e.g., criteria as a person with a serious mental illness [SMI] would be irrelevant to a child, criteria for a child with a serious emotional disorder [SED] would be irrelevant to an adult).		

Standard VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
• The ABD notice included the following narrative: "Based on the clinical interview, records review, results of the evaluation, and the clinical observations, [member name] is not eligible for services." However, this exact same narrative was used for every ABD notice pertaining to autism-related services. While the statement may be accurate, ABD notices should include member-specific information as to why the member was not eligible for services. • The ABD notice included no citation or the incorrect citation for the policy/authority relied upon in making the ABD (e.g., review criteria, assessment tools). For example, the ABD notice included a "blanket" citation of 42 CFR §438.400(b)(1) or 42 CFR §438.400(b)(2), which were not specifically used to render the ABD. • The ABD notice included second opinion rights for eligibility and inpatient hospitalization denials. However, this would be confusing for ABD notices outside of eligibility and inpatient hospitalization denials as members would not have second opinion rights. This language is also not part of MDHHS' model notice. • The ABD notice informed the member that supportive housing was being reduced as clinical documentation did not support medical necessity. However, the ABD notice did not explain the reasoning. The PIHP must provide the member with sufficient information as to why the service(s) was denied so that the member can make an informed decision about whether to appeal the ABD. It was determined that the ABD notice was not populated correctly, as the service was not reduced but terminated, and the ABD was not based on medical necessity but rather the member was not engaged in services and was hospitalized out of state. • The ABD notice included typographical errors and other errors (e.g., missing punctuation and an effective date was populated with the wrong date). • The ABD notice included acronyms or abbreviations not spelled out with first use (e.g., ABA, UM, MCG). While some acronyms or abbreviations are common, the PIHP cannot assume a member would know their meaning. In support of plain language requirements, all acronyms and abbreviations must be spelled out at first use. • The reading grade level was not provided as part of the case files as is requested via the case file review tool. Additionally, while PIHP staff members explained they do review for language requirements during chart audits, no documentation was provided to demonstrate that the PIHP had standardized or consistent processes to check the reading grade level of non-MDHHS template language in ABD notices prior to mailing, and/or that they attempted to reduce the reading grade level, when applicable, prior to mailing. **Recommendations:** • In support of plain language requirements, HSAG recommends that the PIHP simplify the service description in the ABD notices. For example, "9083X – Individual Therapy – bundle (90832, 90834, 90837)" could be simply stated as "Individual Therapy." • HSAG recommends that the PIHP implement a regionwide performance improvement plan to improve the accuracy and/or specificity of the policy/authority included in the ABD notices and relied upon in making the ABD. The PIHP should avoid general citations that may support the provisions related to ABDs but were not specifically used by the UM reviewer to support the reason for the ABD. The PIHP should reference the specific review criteria (e.g., service-specific sections of the Michigan Medicaid Provider Manual, internal UM review criteria, Milliman Care		

Standard VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
Guidelines [MCG], and/or standardized assessment tools). This is particularly important for clinically based ABDs (i.e., based on medical necessity). For ABDs not based on medical necessity, the PIHP may cite process-based criteria (e.g., 42 CFR §438.404[c][5] for service authorization decisions not reached within the time frames, which constitutes a denial; and MDHHS' *Appeal and Grievance Resolution Processes Technical Requirement*, which defines an ABD for untimely service provision as the failure to provide services within 14 calendar days of the start date agreed upon during the person-centered planning meeting and as authorized by the PIHP). Additionally, the PIHP should be specific when citing the policy/authority. For example, the PIHP did not cite the *Medicaid Provider Manual for Overnight Health and Safety Supports*. The PIHP should clarify the specific section when citing the Michigan Medicaid Provider Manual. • As MDHHS requires ABD notices to be written at or below the 6.9 reading grade level, the reading grade level of each ABD notice should be documented. HSAG recommends that the PIHP develop a process to ensure that the reading grade level is evaluated for all non-MDHHS model language in the ABD notices prior to mailing the notices to members. When the reading grade level is above 6.9, the UM reviewers should make every effort to reduce the reading grade level. As the MDHHS contract with the PIHP stipulates that in some situations it may be necessary to include medications, diagnoses, and conditions that would not meet the 6.9 grade-level criteria, the PIHP could develop criteria for what terminology may be excluded from the reading grade analysis in certain instances. The reading grade level, including exclusions, should be documented along with evidence that the UM reviewer made efforts to reduce the reading grade level to at or below 6.9 to the extent possible. • While continuation of benefits information is included in MDHHS' model notice, MDHHS' *Appeal and Grievance Resolution Processes Technical Requirement* only requires this information for advance notices. HSAG recommends that the PIHP consult with MDHHS to determine if this section should be removed for adequate notices to avoid any potential member confusion since members can only request continuation of services for previously authorized services being terminated, reduced, or suspended (i.e., advance notice). • The MDHHS *Appeal and Grievance Resolution Process Technical Requirement* was last revised March 31, 2024, and included a revised *Letter of Adverse Benefit Determination* model notice that must be implemented no later than October 1, 2024. HSAG recommends that the PIHP ensure that this updated model notice is implemented regionwide no later than the required effective date.		
Required Actions: The PIHP must ensure that each ABD notice meet federal and state-specific content requirements and is written at or below the 6.9 reading grade level.		
PIHP Corrective Action Plan		
Root Cause Analysis:		
PIHP Remediation Plan:		
Responsible Individual(s):		

Standard VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
Timeline:		
MDHHS/HSAG Response:	☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted	
13. For standard authorization decisions, the PIHP provides notice as expeditiously as the member's condition requires and within 14 calendar days following receipt of the request for service. 42 CFR §438.210(d)(1) 42 CFR §438.404(c)(3) 42 CFR §457.1230(d) 42 CFR §457.1260(c)(3) Contract Schedule A–1(L)(2)(b) Appeal and Grievance Resolution Processes Technical Requirement–IV(B)(1)(b)	**HSAG Required Evidence:** • Policies and procedures • UM program description • Tracking and reporting mechanisms • Service authorization log(s) within the time period under review • HSAG will also use the results of the service authorization denial file review **Evidence as Submitted by the PIHP:** • UM Program Description – FY 22-24 pg. 28 Table • UM Provider Procedures for Prior Authorized Behavioral Health Services • UM Decision Turn Around Times for Initial Determinations • Denial of Service policy page 6 • Denial of Medicaid Procedure pg. 2-3 • Standard and Urgent Authorization log • Standard and Urgent Authorization tracking queues screenshots • Approved standard authorizations within 14 calendar days following receipt of the request for service report	☐ Met ☒ Not Met ☐ NA
PIHP Description of Process: DWIHN providers an authorization decision to members within 14 days of request for all standard authorizations. DWIHN outlines this in multiple documents including the **UM Program Description, UM Provider Procedures for Prior Authorized Behavioral Health Services, UM Decision Turn Around Times for Initial Determinations, Denial of Service policy**, and **Denial of Medicaid Procedure**. These requests are tracked in DWIHN MHWIN (electronic record) UM queue and internal tracking reports.		

Standard VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: The MDHHS *Service Authorization Denials Reporting Template* (MDHHS denials reporting template) identified several standard service authorizations that were not completed within 14 calendar days. Additionally, based on the reported date of the request (i.e., initiation date/time) and the date of the notice (i.e., resolution date/time) in the universe file for three cases pertaining to autism-related services and included as part of the sample selection, these cases were not completed in a timely manner (i.e., notice was not sent until 16 days or 18 days after receipt of the request). During the site review, PIHP staff members explained that they allow up to 14 calendar days to complete the comprehensive assessment/evaluation from the request for services, and then allow another 14 calendar days from the date of the assessment/evaluation to complete the service authorization. However, this does not align with the data reported via the MDHHS denials reporting template (i.e., the date of request was reported as the date/time of receipt and not the date of the assessment/evaluation). Therefore, it is unclear whether the PIHP is truly calculating service authorization timeliness using the date of request or using the date of the assessment/evaluation. Using the logic reported by the PIHP during the site review (i.e., using the date of the assessment/evaluation to start the time frame for approving/denying services), two of the three cases meet timeliness standards, but one case still did not. Using the data reported to MDHHS, all three cases were untimely. Further, the PIHP had a significantly lower volume of cases reported to MDHHS compared to the other PIHPs and only included three types of services (applied behavioral analysis adaptive behavior treatment, local psychiatric hospital/acute community, and enhanced medical equipment/supplies,) which is another outlier compared to the other PIHPs. Discussion during the site review confirmed that the PIHP was not reporting eligibility-related denials, which may be the root cause of these outliers. The PIHP should consult with MDHHS to ensure that its reporting adheres to MDHHS' specifications. **Recommendations:** HSAG recommends that the PIHP review the service authorization time frame requirements in its *UM Program Description*, and update as appropriate, as they do not appear to be accurate or align with the time frame requirements included in the *UM Decision Turn Around Times for Initial Determinations* document. Additionally, the *UM Decision Turn Around Times for Initial Determinations* document indicated that the PIHP could deny a request for a service if a provider does not respond to a request for additional information within two business days; however, the PIHP has 14 calendar days to collect the necessary information, and should use that time and make all necessary efforts to obtain missing documentation to render a decision based on medical necessity. HSAG recommends that the PIHP review and update this document, as appropriate.		
Required Actions: For standard authorization decisions, the PIHP must provide notice as expeditiously as the member's condition requires and within 14 calendar days following receipt of the request for service.		
PIHP Corrective Action Plan		
Root Cause Analysis:		
PIHP Remediation Plan:		
Responsible Individual(s):		

Standard VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
Timeline:		
MDHHS/HSAG Response:	☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted	
14. For cases in which a provider indicates, or the PIHP determines, that following the standard time frame could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the PIHP must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than 72 hours after receipt of the request for service. 42 CFR §438.210(d)(2)(i) 42 CFR §438.404(c)(6) 42 CFR §457.1230(d) 42 CFR §457.1260(c)(3) Contract Schedule A–1(L)(2)(b) Appeal and Grievance Resolution Processes Technical Requirement–IV(B)(1)(b)	**HSAG Required Evidence:** • Policies and procedures • UM program description • Tracking and reporting mechanisms • Service authorization log(s) within the time period under review • HSAG will also use the results of the service authorization denial file review **Evidence as Submitted by the PIHP:** • 2022 to 2024 UM Program Description Pg. 24, Pg. 28 Table • Denial of Medicaid Service Procedure Pg. 2 # 12a and d • MDHHS State Fair Hearing Procedures for Enrollees/Members with Medicaid services- Pg.5z • Local Appeal Procedures for Enrollees/Members with Medicaid Pg. 3b • Standard and Urgent Authorization Log • Standard and Urgent Authorization tracking queues screenshots • Tracking and reporting mechanisms	☐ Met ☒ Not Met ☐ NA
PIHP Description of Process: DWIHN has an expedited review process for cases where the standard review timeframe could jeopardize a member's health or life. This expedited review will occur as soon as the member's condition requires, but no later than 72 hours. This expedited process is outlined in DWIHN's **UM Program Description**, **Denial of Medicaid Service Procedure**, **MDHHS State Fair Hearing Procedure** and **Local Appeal Procedures for Enrollees/Members with Medicaid**.		

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Requirement	**Supporting Documentation**	**Score**
HSAG Findings: The MDHHS denials reporting template identified one expedited case that was not completed within 72 hours. Additionally, the PIHP was not reporting both the date and *time* for the receipt date/time and the notice date/time for expedited cases, which is required for expedited cases. While all but one case was reported as being timely, HSAG was unable to confirm timeliness for all cases without a *time* being reported. For example, several cases were reported with a turnaround time (TAT) of three days and reported as timely; however, without the time, compliance with the 72-hour time frame could not be confirmed (e.g., if date/time of receipt was January 1, 2024, at 10 a.m. and the date/time of notice was January 4, 2024, at 3 p.m., even though this would equate to three calendar days, the TAT time is actually 77 hours). The MDHHS denials reporting template also confirmed that while most inpatient hospitalizations were reported as expedited cases, one case was reported as a standard case. It is unclear why this case was considered standard or if it was reported as a standard case in error. Further, the case file review and discussion with PIHP staff members confirmed that the PIHP was reporting inpatient concurrent review denials on the MDHHS denials reporting template. However, the reporting instructions require only "Standard service authorization (processed within 14 calendar days) or expedited service authorization (processed with 72 hours). Include only pre-service denials (prior authorizations)," which are typically categorized separately from concurrent reviews. The PIHP should consult with MDHHS to ensure that its reporting adheres to MDHHS' specifications. Further, while there were inconsistencies among the PIHPs related to expedited service authorizations (i.e., tracking and reporting), after further review and discussion among HSAG reviewers after the site review, it was determined to score this element as *Not Met* to assure timeliness and accurate reporting of expedited cases.		
Required Actions: For cases in which a provider indicates, or the PIHP determines, that following the standard time frame could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the PIHP must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than 72 hours after receipt of the request for service. The PIHP must ensure accurate implementation, documentation, tracking, and reporting of extensions.		
PIHP Corrective Action Plan		
Root Cause Analysis:		
PIHP Remediation Plan:		
Responsible Individual(s):		
Timeline:		
MDHHS/HSAG Response:	☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted	

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Requirement	**Supporting Documentation**	**Score**
15. For standard and expedited authorization decisions, the PIHP may extend the resolution time frame up to an additional 14 calendar days if: a. The member or the provider requests the extension; or b. The PIHP justifies a need for additional information and how the extension is in the member's interest. 42 CFR §438.210(d)(1)(i-ii) 42 CFR §438.210(d)(2)(ii) 42 CFR §457.1230(d) 42 CFR §457.1260(c)(3) Contract Schedule A–1(L)(5)(e) Appeal and Grievance Resolution Processes Technical Requirement–IV(B)(1)(c)	**HSAG Required Evidence:** • Policies and procedures • UM program description • Tracking and reporting mechanisms • Extension notice template • HSAG will also use the results of the service authorization denial file review **Evidence as Submitted by the PIHP:** • UM Program Description – FY 22-24- Pg. 31 H. • Process of Oral Notification of Extensions to the Enrollee/Member • Member Extension Letter template • Denial of Medicaid Service Procedures Pg. 3 #13 • Extension Letter Audit Spreadsheet 2023-2024 report • Extension Letter Audit Spreadsheet tracking process	☐ Met ☒ Not Met ☐ NA
PIHP Description of Process: DWIHN has extension process for authorization decisions that is cited in both the **UM Program Description** and **Denial of Medicaid Service Procedures.** This additional 14-day extension is initiated when the member or provider requests it or if DWIHN requires additional information to make an appropriate decision that is in the member's best interest.		
HSAG Findings: The two cases included as part of the sample selection of cases with an extension pertained to concurrent inpatient reviews. Both cases confirmed that the PIHP applied a 14-calendar-day extension to the concurrent review. While HSAG did not intend to review concurrent reviews as part of the case file review, and the PIHP did not take the full 14 calendar days to render a decision (i.e., a decision was made in 4.8 days for one case and five days for the second case), HSAG is very concerned about the PIHP's process allowing up to a 14-calendar-day extension on a continuing stay review when a member is currently inpatient; which, as a result, warrants a *Not Met* score for this element. **Recommendations:** The *Denial of Medicaid Service Procedures* included the following language: "The extension period, within which a decision must be made by the organization, begins on the date when the enrollee/member or their representative's response is received (even if not all of the information is provided), or at the end of the time period given to the enrollee/member to supply the information, if no response is received from their enrollee/representative." This language implies that the PIHP is pausing the time frame for completing the service authorization until the member provides		

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Requirement	**Supporting Documentation**	**Score**
the requested information, which is not allowable. PIHP staff members and the case files submitted after the site review confirmed that this is not the intent, and the time frame is never paused. HSAG recommends that the PIHP review and update its policy language for clarity.		
Required Actions: For standard and expedited authorization decisions, the PIHP may extend the resolution time frame up to an additional 14 calendar days if the member or the provider requests the extension; or the PIHP justifies a need for additional information and how the extension is in the member's interest.		
PIHP Corrective Action Plan		
Root Cause Analysis:		
PIHP Remediation Plan:		
Responsible Individual(s):		
Timeline:		
MDHHS/HSAG Response:		☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted
22. For standard and expedited service authorization decisions not reached within the required time frames specified in 42 CFR §438.210(d) (which constitutes a denial and is thus an ABD), the PIHP provides notice on the date that the time frames expire. 42 CFR §438.210(c-d) 42 CFR §438.404(c)(5) 42 CFR §457.1230(d) Contract Schedule A–1(L)(5)(f) Appeal and Grievance Resolution Processes Technical Requirement–IV(B)(1)(c)	**HSAG Required Evidence:** • Policies and procedures • UM program description • ABD notice template for untimely determination • Service authorization log(s) within the time period under review • Tracking and reporting mechanism(s) • HSAG will also use the results of the service authorization denial file review **Evidence as Submitted by the PIHP:** • Denial of Medicaid Service Procedures- Pg. 2-3 #12-13 • Adequate Notice ABD Template • Member Extension letter • Extension Letter Audit Spreadsheet 2023-2024	☐ Met ☒ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
	• Snapshot of Service Authorization log within the time period under review • 2022 to 2024 UM Program Description – pg. 31, 34	
PIHP Description of Process: Denial of Medicaid Service Procedures outline decision-making and timeframes for standard and expedited service authorizations. Templates, tracking sheets, and snapshot support the procedure/workflow. **UM Program Description** will be updated to provide expanded language describing extension timeframes for all service authorization decisions.		
HSAG Findings: The MDHHS denials reporting template identified several cases that were not completed in a timely manner (i.e., not completed within 72 hours or 14 calendar days [plus the 14-calendar-day extension, if applicable]). Additionally, all evidence submitted by the PIHP for this element was specific to extension provisions and did not clearly address the specific requirements in cases when a decision is not reached within the required time frames. HSAG requested additional information to support compliance, specifically, a case example when an ABD notice was issued due to the PIHP not rendering a decision in a timely manner. After the site review, the PIHP submitted a case example with an extension applied and a service authorization decision being made prior to the expiration of the time frame, which was not the type of case example HSAG requested. When the PIHP is unable to render a standard service authorization decision within 14 calendar days (and no extension is applied), it constitutes a denial and the PIHP is required to send the ABD notice on the date the time frame expired. If the PIHP is unable to render a standard service authorization with an extension applied within 28 calendar days, it constitutes a denial and the PIHP is required to send the ABD notice on the date the time frame expired. Based on the combination of the findings for this element, HSAG was unable to confirm compliance with these expectations or that PIHP staff members fully understood the requirements of this element.		
Required Actions: For standard and expedited service authorization decisions not reached within the required time frames specified in 42 CFR §438.210(d) (which constitutes a denial and is thus an ABD), the PIHP must provide notice on the date that the time frames expire.		
PIHP Corrective Action Plan		
Root Cause Analysis:		
PIHP Remediation Plan:		
Responsible Individual(s):		
Timeline:		
MDHHS/HSAG Response:	☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted	