Michigan Department of Community Health (MDCH)

Behavioral Health and Developmental Disabilities Administration

Prepaid Inpatient Health Plans

2012–2013 External Quality Review Compliance Monitoring Report

for

Macomb County CMH Services

July 2013

—Draft Copy for Review—

HSAG HEALTH SERVICES ADVISORY GROUP

3133 East Camelback Road, Suite 300 • Phoenix, AZ 85016

Phone 602.264.6382 • Fax 602.241.0757

CONTENTS

The Balanced Budget Act of 1997 (BBA), Public Law 105-33, requires that states conduct an annual evaluation of their managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs) to determine the MCOs' and PIHPs' compliance with regulations, contractual requirements, and the state's quality strategy. The Michigan Department of Community Health (MDCH) Behavioral Health and Developmental Disabilities Administration has elected to complete this requirement by contracting with an external quality review organization (EQRO). Health Services Advisory Group, Inc. (HSAG) is the EQRO for MDCH.

This is the eighth year that HSAG has performed compliance monitoring reviews of the Michigan PIHPs. The 2011–2012 reviews addressed the PIHPs' compliance with federal regulations and contract requirements in eight areas (standards): performance measurement and improvement, practice guidelines, customer services, enrollee rights and protections, subcontracts and delegation, provider network, credentialing, and coordination of care. The 2012–2013 review evaluated the PIHP's compliance in the six remaining areas:

- Standard I: Quality Assessment and Performance Improvement Program (QAPIP)
- Standard IV: Staff Qualifications and Training
- Standard V: Utilization Management
- Standard VII: Enrollee Grievance Process
- Standard XII: Access and Availability
- Standard XIV: Appeals

The review process remained essentially unchanged from prior years. The review tool underwent some minor modifications to reflect current contract requirements.

The 2012–2013 compliance reviews were conducted as a one-day site visit for those PIHPs that had a telephonic review in the prior year; for PIHPs that had a prior-year site visit, the 2012–2013 compliance review was conducted via a conference call between the PIHP staff and the HSAG review team.

This report documents the findings from HSAG's review of **Macomb County CMH Services**' performance in complying with requirements in the areas listed above.

2. Summary of the 2012–2013 Compliance Monitoring Review *for* Macomb County CMH Services

The 2012–2013 compliance monitoring review was a full review assessing **Macomb County CMH Services**' compliance with federal, State, and contractual requirements related to the following standards: *QAPIP Plan and Structure*, *Staff Qualifications and Training*, *Utilization Management*, *Enrollee Grievance Process*, *Access and Availability*, and *Appeals*.

The review processes and scoring methodology used by HSAG in evaluating **Macomb County CMH Services**' compliance were consistent with the Centers for Medicare & Medicaid Services (CMS) publication, *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.

The 2012–2013 compliance monitoring review for **Macomb County CMH Services** was conducted on-site.

The findings for the 2012–2013 compliance monitoring review were determined from a review of the documents submitted by **Macomb County CMH Services** to HSAG; a review of records of utilization review denials, grievances, and beneficiary appeals; and interviews with key **Macomb County CMH Services** staff members. Prior to the scheduled compliance review, HSAG conducted a desk review of documentation submitted by the PIHP, which included the *Desk Audit Form* describing the PIHP's structure and operations related to the standards addressed in the review, the *Documentation Request and Evaluation Tool*, as well as policies and procedures, member and provider information materials, minutes of key committee meetings, and other documents to provide evidence of the PIHP's compliance with the requirements as detailed in the compliance monitoring tool shown in Appendix A of this report.

Based on the results of findings from the review of documentation (including a random sample of case records for three of the standards), as well as information provided by the PIHP staff during the interviews, HSAG assigned each individual element reviewed for each standard a score of *Met*, *Substantially Met*, *Partially Met*, *Not Met*, or *Not Applicable (NA)*.

Table 2-1 presents the total number of elements for each of the six standards as well as the number of elements for each standard that received a score of *Met*, *Substantially Met*, *Partially Met*, *Not Met*, or *Not Applicable*. Table 2-1 also presents the overall compliance score for each of the standards, totals across the six standards, and the total overall compliance score across all standards for the 2012–2013 compliance monitoring review.

Appendix A of this report presents details of the scores for the review of the standards.

Table 2-1—Summary of 2012–2013 Scores for the Standards									
Standard	Standard Name	Total Elements	Total Applicable Elements	Number of Elements					Total Compliance Score
				M	*SM*	*PM*	*NM*	*NA*	
I	*QAPIP Plan and Structure*	19	19	19	0	0	0	0	**100%**
IV	*Staff Qualifications and Training*	6	6	6	0	0	0	0	**100%**
V	*Utilization Management*	19	19	19	0	0	0	0	**100%**
VII	*Enrollee Grievance Process*	13	13	13	0	0	0	0	**100%**
XII	*Access and Availability*	17	17	13	0	4	0	0	**88%**
XIV	*Appeals*	15	15	14	0	1	0	0	**97%**
	Overall	**89**	**89**	**84**	**0**	**5**	**0**	**0**	**97%**
***M**=Met, **SM**=Substantially Met, **PM**=Partially Met, **NM**=Not Met, **NA**=Not Applicable*									
Total Elements: The total number of elements in each standard.									
Total Applicable Elements: The total number of elements within each standard minus any elements that received a score of *NA*.									
Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* to the weighted (multiplied by 0.75) number of elements that received a score of *Substantially Met* and the weighted (multiplied by 0.50) number that received a score of *Partially Met*, then dividing this total by the total number of applicable elements.									

Macomb County CMH Services received an overall compliance score of 97 percent for the six standards reviewed by HSAG. The PIHP's strongest performances were in Standard I—QAPIP Plan and Structure, Standard IV—Staff Qualifications and Training, Standard V—Utilization Management, and Standard VII—Enrollee Grievance Process, which received compliance scores of 100 percent. HSAG identified opportunities for improvement for Standard XII—Access and Availability and Standard XIV—Appeals. **Macomb County CMH Services** demonstrated strong performance overall and an understanding of the federal regulations and State and contractual requirements for the standards under review.

Macomb County CMH Services is required to submit to MDCH a corrective action plan for all elements scored as *Substantially Met, Partially Met,* or *Not Met.* The corrective action plan must be submitted within 30 days of receipt of the final report. For each element that requires correction, the plan should identify the planned interventions to achieve compliance with the requirement(s), the individual(s) responsible, and the timeline.

Appendix A. Review of the Standards *for* Macomb County CMH Services

The review of the standards follows this cover page.

Standard I—Quality Assessment and Performance Improvement Program Plan and Structure

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
1. Quality Monitoring (QM) Goals and Objectives 42 CFR 438.240 Attachment P 6.7.1.1 PIHP Contract 6.1		
a. There is a written quality assessment performance improvement program (QAPIP) description.	• QAPIP description (Exhibit A to MCO Policy 8-001) • Meeting minutes from Board when approved (October 31, 2012)	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
b. The QAPIP description specifies an adequate organizational structure that allows for clear and appropriate administration and evaluation of the QAPIP.	• QAPIP description (Exhibit A to MCO Policy 8-001, Section II, Structure and Organization)	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Findings

Attachment A of the Macomb County Community Mental Health (MCCMH) Quality Improvement Program policy provided an overview of the quality program including its purpose and scope, the program's committee structure, and a description of quality studies and other quality activities in place at the Prepaid Inpatient Health Plan (PIHP). The program description, approved by the MCCMH Board of Directors on October 31, 2012, described the respective roles of the Board of Directors, Quality Council, and various sub-committees that comprised the PIHP's QAPIP. Under the direction of the Governing Body, the Quality Council oversaw the work of the various sub-committees of the QAPIP, reviewed and analyzed quality data, developed Key Performance Indicators (KPIs), and helped identify opportunities for improvement. The executive director sat on the Quality Council and provided periodic reports regarding the QAPIP to the Board of Directors.

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
2. Role of Beneficiaries The written QAPIP description includes a description of the role for beneficiaries. Attachment P 6.7.1.1	• QAPIP description (Exhibit A to MCO Policy 8-001), p. 4, IV. Structure, A.3. Stakeholders, and p.5, B. 2. • The MCCMH Citizens Advisory Councils (CAC) and the MCOSA Substance Abuse Advisory Council (SAAC) report directly to the Board of	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Standard I—Quality Assessment and Performance Improvement Program Plan and Structure

	Directors, and includes participation from consumers. Agendas and meeting minutes of the CAC and SAAC as well as membership rosters.	

Findings

The MCCMH QAPI program description stated that beneficiaries were represented on several advisory councils and committees involved in the quality improvement process including the Citizens Advisory Council (CAC), the Macomb County Office of Substance Abuse (MCOSA), Substance Abuse Advisory Council (SAAC), and the Clinical Innovation and Clinical Improvement Committee (CICIC). Minutes from a SAAC meeting held on March 7, 2012, for example, documented a discussion regarding PIHP performance indicator results. A membership list for the SAAC confirmed that beneficiaries were well represented on the council. At the interview, PIHP staff reported that beneficiaries also participated on the Improving Practices Leadership Team (IPLT), a subcommittee of the Quality Council.

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
3. Adopting and Communicating Process and Outcome Improvements Attachment P 6.7.1.1		
a. The written QAPIP description includes the mechanisms or procedures used or to be used for adopting process and outcome improvements.	• QAPIP description, Exhibit A to MCO Policy 8-001	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
b. The written QAPIP description includes the mechanisms or procedures used or to be used for communicating process and outcome improvements.	• QAPIP description, Exhibit A to MCO Policy 8-001	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Findings

The MCCMH QAPI program description stated that the PIHP adopted process and outcome improvements that were either mandated by the Michigan Department of Community Health (MDCH) or identified by MCCMH based on an analysis of system performance and input from stakeholders. Results related to KPIs, performance improvement projects (PIPs), and other quality studies were discussed at the PIHP Quality Council and/or its subcommittees and were reported through the executive director to the full Board. During the interview, PIHP staff clarified that information regarding quality initiatives was shared with network providers quarterly through the director of business management.

Standard I—Quality Assessment and Performance Improvement Program Plan and Structure

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
4. Accountability to the Governing Body Attachment P 6.7.1.1		
a. The QAPIP is accountable to the Governing Body.	• QAPIP description (Exhibit A to MCO Policy 8-001) • Meeting agendas/minutes /dates from Board reviewing QAPIP (October 31, 2012)	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Responsibilities of the Governing Body for monitoring, evaluating, and making improvements to care include the following:		
b. There is documentation that the Governing Body has approved the overall QAPIP Plan.	• Meeting minutes from Board reviewing QAPIP (October 31, 2012)	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
c. There is documentation that the Governing Body has approved an annual QI Plan.	• Meeting minutes from Board reviewing QAPIP (October 31, 2012)	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
d. The Governing Body routinely receives written reports from the QAPIP.	• Meeting minutes from Board reviewing QAPIP (October 31, 2012)	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
e. The written reports from the QAPIP describe performance improvement projects undertaken.	• QAPIP description (Exhibit A to MCO Policy 8-001) • Performance Improvement Project (PIP) Information (i.e., descriptions, reports)	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Standard I—Quality Assessment and Performance Improvement Program Plan and Structure

f. The written reports from the QAPIP describe <u>actions taken</u>.	• QAPIP description (Exhibit A to MCO Policy 8-001) • Performance Improvement Project (PIP) Information (i.e., descriptions, reports)	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
g. The written reports from the QAPIP describe the <u>results</u> of those actions.	• QAPIP description (Exhibit A to MCO Policy 8-001) • Performance Improvement Project (PIP) Information (i.e., descriptions, reports)	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
h. The Governing Body formally reviews on a periodic basis (but no less than annually) a written report on the operation of the QAPIP.	• QAPIP description (Exhibit A to MCO Policy 8-001) • MCCMH Board minutes from October 31, 2012	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Findings

The PIHP's QAPI program description stated that the MCCMH Board of Directors had overall responsibility for monitoring, evaluating, and making recommendations to improve care. Board of Director meeting minutes dated October 31, 2012, confirmed that the Governing Body approved the PIHP QAPI program description and QAPIP annual plan for FY 2012. The QAPIP plan provided detailed information to the Board regarding the quality studies, KPIs, and other performance improvement activities in place at the PIHP as well as FY 2012 data for MDCH-required performance indicators. MCCMH provided copies of several documents related to PIPs in place, throughout FY 2012, that provided an overview of the project purpose, a description of action taken, and the results of those interventions. For example, MCCMH instituted a PIP to reduce hospital recidivism among adults with a mental illness and used the provision of Assertive Community Treatment (ACT) teams and training on the recovery model as interventions to accomplish program goals. MCCMH staff reported that the Board of Directors was briefed throughout the year regarding performance on PIPs and Michigan Mission-Based Performance Indicator System (MMBPIS) measures.

Standard I—Quality Assessment and Performance Improvement Program Plan and Structure

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
5. Designated Senior Official There is a designated senior official responsible for the QAPIP implementation. Attachment P 6.7.1.1	• QAPIP description and organization structure (Exhibit A to MCO Policy 8-001)	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Findings

At the time of the interview, staff stated that the MCCMH Director of Clinical Strategies and Improvement was the senior official responsible for QAPIP implementation.

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
6. Active Participation Attachment P 6.7.1.1		
a. There is active participation of <u>providers</u> in the QAPIP.	• CAC and SAAC Meeting agendas and minutes (showing provider participation in respective committees) • Improving Practices Leadership Team (IPL) – composition of members, and meeting minutes	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
b. There is active participation of <u>consumers</u> in the QAPIP.	• CAC and SAAC meeting minutes • Improving Practices Leadership Team (IPL) – composition of members, and meeting minutes	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Findings

The PIHP included both provider and beneficiary representatives on committees and councils involved in the review and analysis of quality data. For example, providers and consumers actively participated in the PIHP's CAC and SAAC meetings as well as sat on the IPLT. Minutes from an IPLT meeting held on March 4, 2013, documented that an additional family member with a child receiving services in the system was being recruited for participation on the committee.

Standard I—Quality Assessment and Performance Improvement Program Plan and Structure

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
7. Verification of Services The written description of the PIHP's QAPIP addresses how it will verify whether services reimbursed by Medicaid were actually furnished to beneficiaries by affiliates (as applicable), providers, and subcontractors. Attachment P 6.7.1.1		
a. The PIHP must submit to the State for approval of its methodology for verification.	• QAPIP, Exhibit A to MCO Policy 8-001 (see p. 3, "Service Delivery Verification") • MCO Policy 3-001, Audit Content and Timetable • MCO Policy 3-002, Audit Follow-Up • MCCMH Medicaid Audit FY2012 -Experis • MCOSA, FY12 Audit Summaries	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
b. The PIHP must annually submit its findings from this process and provide any follow up actions that were taken as a result of the findings.	• QAPIP, Exhibit A to MCO Policy 8-001 (see p. 3, "Service Delivery Verification") • MCO Policy 3-001, Audit Content and Timetable • MCO Policy 3-002, Audit Follow-Up • MCCMH Medicaid Audit FY2012 -Experis • MCOSA, FY 12 Audit Summaries	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Findings

The MCCMH QAPI program description included an overview of the Medicaid Service Verification audit including a description of the audit's purpose, methodology, and information regarding the PIHP's process to address any identified performance issues uncovered by the audit. The PIHP provided a copy of the annual audit report that was prepared by an independent contractor and submitted as a deliverable to MDCH on October 22, 2012. The audit report described the sampling methodology, summarized audit findings, and detailed follow-up activities initiated by the PIHP as a result of the findings. The PIHP offered additional training and technical assistance to targeted providers and initiated financial recovery of undocumented claims as a result of the FY 2012 audit findings.

Standard I—Quality Assessment and Performance Improvement Program Plan and Structure

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
8. Data from the Behavior Treatment Committee The QAPIP quarterly reviews analyses of data from the behavior treatment review committee where intrusive or restrictive techniques have been approved for use with beneficiaries and where physical management has been used in an emergency situation. Data shall include numbers of interventions and length of time the interventions were used per person. Attachment P 6.7.1.1	• MCO Policy 8-008, Behavior Treatment Plan Review Committee • Behavior Treatment Plan Review Committee (BTPRC) meeting minutes • The Clinical Risk Management Committee (CRMC), as a formal standing committee of the QAPIP, reviews BTPRC meeting minutes and reports (CRMC meeting minutes available on site) • MCCMH ORR receives Incident Reports in situations where physical management has been used in an emergency; all Incident Reports are reviewed by BTPRC (see MCO Policy 9-321, Consumer Incident, Accident, Illness, Death or Arrest Report Monitoring, V.J., V.M., and VI.D.7, 8. CRMC meeting minutes)	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Findings

Policy 8-008, Behavior Treatment Plan Review Committee (BTPRC), included a comprehensive description of the composition and role of the BTPRC including the responsibility to conduct a quarterly analysis of the use of all emergency interventions and intrusive/restrictive techniques for each individual receiving the intervention. The PIHP convened a centralized BTPRC that evaluated the appropriateness of consumer-specific interventions and identified and made recommendations regarding trends in the use of intrusive or restrictive techniques. The PIHP provided meeting minutes from the BTPRC as well as summary information based on a quarterly analysis of the data. Summary data included agency name, program site, and number of interventions that were used per person as required. During the on-site review, the PIHP provided a copy of a Use of Physical Management form that was completed each time a physical intervention was used and submitted for review to the BTPRC. The form included information regarding the duration of each intervention. Data from the BTPCR were reviewed and evaluated by the Quality Council and reported to MDCH.

Results—Standard I						
Met	=	19	X	1.0	=	19.00
Substantially Met	=	0	X	.75	=	0.00
Partially Met	=	0	X	.50	=	0.00
Not Met	=	0	X	.00	=	0.00
Not Applicable	=	0				
Total Applicable	=	19	Total Score		=	19.00
Total Score ÷ Total Applicable					=	100%

Standard IV—Staff Qualifications and Training

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
1. Employed and Contracted Staff Qualifications Attachment P 6.7.1.1 PIHP Contract 6.4.3		
a. The QAPIP contains written procedures to determine whether physicians are qualified to perform their services.	• QAPIP description (Exhibit A to MCO Policy 8-001), II. Functions, B. Clinician Credentialing and Privileging • MCCMH Training Department Summary Report FY 2012 • MCCMH FY 2012 Training Office CE Clock Hrs • MCO Policy 3-015, Mandatory Network Training • MCO Policy 10-070, Credentialing • MCO Policy 10-075, Privileging	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
b. The QAPIP contains written procedures to determine whether other licensed health care professionals are qualified to perform their services.	• QAPIP description (Exhibit A to MCO Policy 8-001), II. Functions, B. Clinician Credentialing and Privileging • MCCMH Training Department Summary Report FY 2012 • MCCMH FY 2012 Training Office CE Clock Hrs • MCO Policy 3-015, Mandatory Network Training • MCO Policy 10-070, Credentialing • MCO Policy 10-075, Privileging	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
c. The QAPIP contains written procedures to ensure non-licensed providers of care or support are qualified to perform their jobs.	• MCCMH Training Department Summary Report FY 2012 • MCO Policy 3-015, Mandatory Network Training • MCO Policy 10-070, Credentialing • MCO Policy 10-075, Privileging	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Standard IV—Staff Qualifications and Training

Findings

MCCMH used both a formal credentialing process and initial and ongoing training to ensure that physicians, other licensed health care professionals, and non-licensed providers were qualified to perform their jobs. The PIHP's QAPI program description required that all staff providing direct services have appropriate credentials and/or experience for their position. Policy 10-070, Credentialing, described the PIHP's credentialing process for physicians and other licensed health care professionals including the application review process, the use of primary source verification to substantiate licensure/certification and education, and the screening process used to verify that providers were not barred from participation in federally funded health care programs. The policy also included a listing of credentialing requirements by position for both licensed and non-licensed providers.

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
2. Staff Training The PIHP's QAPI program for staff training includes: Attachment P 6.7.1.1		
a. Training for new personnel with regard to their responsibilities, program policy, and operating procedures.	• MCCMH Training Department Summary Report FY 2012 • MCO Policy 3-015, Mandatory Network Training • MCO Policy 10-070, Credentialing • MCO Policy 10-075, Privileging	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
b. Methods for identifying staff training needs.	• MCCMH Training Department Summary Report FY 2012 • MCO Policy 3-015, Mandatory Network Training • MCO Policy 10-070, Credentialing • MCO Policy 10-075, Privileging	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
c. In-service training, continuing education, and staff development activities.	• MCCMH Training Department Summary Report FY 2012 • MCCMH FY 2012 Training Office CE Clock Hr • MCO Policy 3-015, Mandatory Network Training • MCO Policy 10-070, Credentialing • MCO Policy 10-075, Privileging	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Standard IV—Staff Qualifications and Training

Findings

Policy 3-015, Mandatory Network Training, and a Training Department Summary Report for FY 2012 provided an overview of MCCMH training requirements and described the scope of both in-person and online trainings available to internal staff and personnel employed by contracted provider agencies. The policy also included a grid of all required trainings and timelines for completion. The PIHP provided a new hire orientation for all staff that covered training regarding the mission and vision of the organization, provided information regarding administrative structure and program operating procedures, and included training in core areas such as person-centered planning and cultural competency. Staff training needs were identified through audit report findings, opportunities for improvement identified through the PIHP's QAPIP, and through feedback from employees and other stakeholders. The PIHP delegated staff training to its contracted providers and monitored provider performance in the area of training. MCCMH made in-service and external conferences available to staff. At the interview, PIHP staff described plans to expand the use of technology both to increase the availability of online trainings across the county and to help track trainings attended by staff.

Results—Standard IV						
Met	=	6	X	1.0	=	6.00
Substantially Met	=	0	X	.75	=	0.00
Partially Met	=	0	X	.50	=	0.00
Not Met	=	0	X	.00	=	0.00
Not Applicable	=	0				
Total Applicable	=	6	Total Score		=	6.00
Total Score ÷ Total Applicable					=	100%

Standard V—Utilization Management

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
1. Written Program Description 42 CFR 438.210(a)(4) Attachment P 6.7.1.1		
a. The PIHP has a written utilization program description that includes procedures to evaluate medical necessity.	• Access Center Manual, Chapter 2, Access Center Services Authorization, and Chapter 3, Eligibility for Services • Utilization Management Program • 2013 UM Plan-1 • MCOSA Utilization Management Plan 2012, p. 2, "Utilization Management Procedures" • MCO Policy 12-002, Utilization Management • MCO Policy 2-013, Eligibility, Admission, Discharge, III.A; IV.B, C., E., H., I., J.; V.A.-B.	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
b. The PIHP has a written utilization program description that includes the criteria used in making decisions.	• Access Center Manual Chapter 2, Access Center Services Authorization, and Chapter 3, Eligibility for Services • Utilization Management Program • 2013 UM Plan-1 • MCOSA Utilization Management Plan 2012, p. 2, "Utilization Management Procedures" • MCOSA UM meeting minutes, on site • MCO Policy 12-002, Utilization Management • MCO Policy 2-013, Eligibility, Admission, Discharge, III.A; IV.B, C., E., H., I., J.; V.A.-B. • MDCH Medicaid Provider Manual, Mental Health/Substance Abuse	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Standard V—Utilization Management

c. The PIHP has a written utilization program description that includes the process used to review and approve the provision of medical services.	• Access Center Manual Chapter 2, Access Center Services Authorization, and Chapter 3, Eligibility for Services • Utilization Management Program • 2013 UM Plan-1 • MCOSA Utilization Management Plan 2012 • MCOSA UM meeting minutes, on site • MCO Policy 12-002, Utilization Management • MCO Policy 2-013, Eligibility, Admission, Discharge	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Findings

The MCCMH Utilization Management (UM) program description, the Access Center Manual, and Policy 12-002, Utilization Management, detailed the PIHP's process for evaluating medical necessity using prospective, concurrent, and retrospective reviews. The documents defined medical necessity and included information regarding how requests for services were made, the procedures for review of requests by UM staff, and the handling of UM denials. The Macomb County Office of Substance Abuse (MCOSA) published a UM Plan for Substance Abuse Services for FY 2012 that stated that level of care decisions for beneficiaries with substance use disorders were made based on the American Society of Addiction Medicine (ASAM) patient placement criteria and level of care criteria outlined in the MCOSA Quality Assurance Guidelines. The Quality Assurance Guidelines were reviewed on-site and demonstrated that the PIHP had admission and continued-stay criteria for various levels of care in place for beneficiaries with substance use disorders. At the interview, staff clarified that level of care decisions for consumers with mental health disorders were made based on diagnosis, the type and duration of services received, response to current treatment, and available supports.

Standard V—Utilization Management

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
2. Scope 42 CFR 438.240(b)(3) Attachment P 6.7.1.1		
a. The program has mechanisms to identify and correct under-utilization.	• Access Center Manual • Utilization Management Program • 2013 UM Plan-1 • MCOSA Utilization Management Plan 2012 • MCOSA UM Goals 2013 • MCOSA UM meeting minutes, on site • MCO Policy 12-002, Utilization Management	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
b. The program has mechanisms to identify and correct over-utilization.	• Access Center Manual • Utilization Management Program • 2013 UM Plan-1 • MCOSA Utilization Management Plan 2012 • MCOSA UM Goals 2013 • MCOSA UM meeting minutes, on site • MCO Policy 12-002, Utilization Management	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Findings

The PIHP's UM program description and policy addressed the role of the UM committee in monitoring service utilization and in identifying and correcting under- and overutilization of services. During the interview, MCCMH staff reported that the UM committee reviewed and analyzed encounter data by service type and trends in inpatient hospital and residential data to help identify patterns of under- and overutilization of services. Both the current MCCMH and MCOSA UM plans identified issues related to making changes in service utilization based on State standards, best practice, and community need. For example, the MCCMH UM Plan for FY 2012 included goals to decrease local inpatient utilization and to increase the use of community-based services for children and adolescents. A review of UM committee meeting minutes throughout FY 2012 demonstrated that the PIHP frequently addressed issues of under- and overutilization of services and discussed strategies to correct utilization patterns as appropriate. UM committee meeting minutes dated May 7, 2012, for example, documented a discussion regarding approaches to increasing the availability of community living arrangements in lieu of using out-of-home residential placements for children and adolescents.

Standard V—Utilization Management

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
3. Procedures Prospective (preauthorization), concurrent, and retrospective procedures are established and include: 42 CFR 438.210(b) Attachment P 6.7.1.1		
a. Review decisions are supervised by qualified medical professionals.	• Utilization Management Program • 2013 UM Plan-1 • Access Center Manual • MCOSA Utilization Management Plan 2012 • MCOSA UM meeting minutes, on site • MCO Policy 12-002, Utilization Management • MCOSA Provider Manual available on site and online at http://mcosa.net/documents.php?category_nb=4.	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
b. Decisions to deny or reduce services are made by health care professionals who have the appropriate clinical expertise to treat the conditions.	• Access Center Manual • MCCMH Utilization Management Plan (under revision) • MCOSA Utilization Management Plan 2012 • MCOSA UM meeting minutes, on site • MCO Policy 12-002, Utilization Management • MCO Policy 2-013, Access, Eligibility, Admission, Discharge • MCO Policy 4-020, Advance and Adequate Action Notices and Appeal Rights (MEDICAID) • MCO Policy 10-075, Privileging, VII.A., p. 10 • MCOSA Provider Manual available on site and online at http://mcosa.net/documents.php?category_nb=4.	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Standard V—Utilization Management		
c. Efforts are made to obtain all necessary information including pertinent clinical information and consult with treating physician as appropriate.	• Access Center Manual • MCOSA Utilization Management Plan 2012 • MCOSA Provider Manual available on site and online at http://mcosa.net/documents.php?category_nb=4.	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
d. The reasons for decisions are clearly documented.	• Access Center Manual • MCOSA Utilization Management Plan • MCO Policy 4-020, Advance and Adequate Action Notices and Appeal Rights (MEDICAID) • Sample Appeal	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
e. The reasons for decisions are available to the beneficiary.	• Access Center Manual • MCOSA Utilization Management Plan 2012 • Member Handbook, "Help When You Need It," • MCOSA Provider Manual on site and online at http://mcosa.net/documents.php?category_nb=4. • MCO Policy 4-020, Advance and Adequate Action Notices and Appeal Rights (MEDICAID) • MCO Policy 2-009, Consumer/Provider Appeals • MCO Policy 2-006, Service Provider Appeals	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
f. There are well-publicized and readily available appeals mechanisms for providers.	• Access Center Manual • MCOSA Utilization Management Plan 2012 • Member Handbook, "Help When You Need It," • MCOSA Provider Manual on site and online at http://mcosa.net/documents.php?category_nb=4. • MCO Policy 4-020, Advance and Adequate Action Notices and Appeal Rights (MEDICAID) • MCO Policy 2-009, Consumer/Provider Appeals • MCO Policy 2-006, Service Provider Appeals	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Standard V—Utilization Management		
g. There are well-publicized and readily available appeals mechanisms for beneficiaries.	• Access Center Manual • MCOSA Utilization Management Plan 2012 • Member Handbook, "Help When You Need It", • MCOSA Provider Manual on site and online at http://mcosa.net/documents.php?category_nb=4. • MCO Policy 4-020, Advance and Adequate Action Notices and Appeal Rights (MEDICAID) • MCO Policy 2-009, Consumer/Provider Appeals • MCO Policy 9-170, Local Appeals • MCO Policy 9-180, Second Opinion Rights • MCO Policy 9-405, Recipient Rights Protection Standards (and other policies on recipient rights investigations, including but not limited to 9-510 and 9-520) • MCO Policy 9-605, Bill or Rights/Bill of Responsibilities	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
h. Notification of the denial is sent to the beneficiary.	• Access Center Manual • MCOSA Utilization Management Plan 2012 • Member Handbook, "Help When You Need It," • MCO Policy 4-020, Advance and Adequate Action Notices and Appeal Rights (MEDICAID) • See the notice letters in the MCCMH electronic medical record system, FOCUS; a demonstration will be available on site	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
i. Notification of the denial is sent to the provider.	• Access Center Manual • MCOSA Utilization Management Plan 2012 • Member Handbook, "Help When You Need It", MCO Policy 4-020, Advance and Adequate Action Notices and Appeal Rights (MEDICAID)	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Standard V—Utilization Management		
	• See the notice letters in the MCCMH electronic medical record system, FOCUS; a demonstration will be available on site • MCO Policy 2-006, Service Provider Appeals	
j. Notification of a denial includes a description of how to file an appeal.	• Access Center Manual • MCOSA Utilization Management Plan 2012 • Member Handbook, "Help When You Need It" • MCO Policy 4-020, Advance and Adequate Action Notices and Appeal Rights (MEDICAID) • Notice of Advance Action Appeal Rights (MEDICAID), Exhibit A to MCO Policy 4-020 and in FOCUS • Notice of Adequate Action and Appeal Rights (MEDICAID), Exhibit B to MCO Policy 4-020 and in FOCUS	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
k. UM Decisions are made in a timely manner as required by the exigencies of the situation.	• Access Center Manual • MCOSA Utilization Management Plan 2012 • Member Handbook, "Help When You Need It," • MCO Policy 4-020, Advance and Adequate Action Notices and Appeal Rights (MEDICAID)	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
l. Decisions on appeals are made in a timely manner as required by the exigencies of the situation.	• Access Center Manual • MCOSA Utilization Management Plan 2012 • Member Handbook, "Help When You Need It", Help When You Need It • MCO Policy 4-020, Advance and Adequate Action Notices and Appeal Rights (MEDICAID)	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Standard V—Utilization Management

m. There are mechanisms to evaluate the effects of the program using data on beneficiary satisfaction, provider satisfaction, or other appropriate measures.	• CAC and SAAC meeting minutes (on site) • Access Center Manual • MCOSA Provider Manual (on site) and online at http://mcosa.net/documents.php?category_nb=4.	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
n. If the organization delegates responsibility for utilization management, it has mechanisms to ensure that these standards are met by the delegate.	• N/A for MCCMH • Interview with MCOSA staff regarding monitoring CARE on UM decisions	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Findings

The PIHP's UM program description required that utilization review decisions were supervised by qualified medical professionals and that efforts were made to obtain all information, including pertinent clinical information, prior to making decisions regarding medical necessity. Appeals mechanisms for providers were addressed in several MCCMH policies posted on the PIHP Web site. Policy 2-006, Service Provider Appeals, for example, included a description of the process for providers to appeal MCCMH decisions to deny a request for a new service or to reduce, suspend, or terminate an existing covered service. Policy 4-020, Advance and Adequate Action Notices and Appeal Rights (Medicaid), detailed the process for providers to request appeals on behalf of beneficiaries with the consumer's written authorization and defined timelines for making decisions on appeals based on beneficiary need. Information regarding appeal rights and the process to request an appeal was available to beneficiaries in the PIHP's member handbook, "Help When You Need It.". MCCMH relied on the CAC and SAAC to help evaluate the effects of the program and to identify levels of beneficiary satisfaction with services. The responsibility for UM for mental health services was not a delegated function and was provided directly by the PIHP through the Access Center. MCOSA delegated UM functions to Community Assessment Referral and Education (CARE) and monitored performance through periodic reviews of CARE's UM program. A sample of UM denial cases was reviewed on June 27, 2013. Findings from the review were that all of the cases met 42 CFR and MDCH contract requirements.

Results—Standard V						
Met	=	19	X	1.0	=	19.00
Substantially Met	=	0	X	.75	=	0.00
Partially Met	=	0	X	.50	=	0.00
Not Met	=	0	X	.00	=	0.00
Not Applicable	=	0				
Total Applicable	=	19	Total Score		=	19.00
Total Score ÷ Total Applicable					=	100%

Standard VII—Enrollee Grievance Process

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
1. General Requirement The PIHP has a grievance process in place for enrollees. 42 CFR 438.402	• MCO Policy 2-009, Consumer/Provider Grievances • Grievance logs, available on site • Member Handbook, "Help When You Need It," pp. 47-50	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Findings

The PIHP provided beneficiaries with access to a grievance process to resolve complaints related to service planning and service delivery. Policy 2-009, Consumer/Provider Grievances, established the procedures and standards for the resolution of complaints by consumers of services provided by the MCCMH Board and its directly-operated and contract network providers. While Macomb County Office of Substance Abuse (MCOSA) providers were required to follow the PIHP's policies on grievances, MCOSA developed its own policy (MCOSA Procedures—Grievance System for Medicaid Beneficiaries) and separate forms for Medicaid grievances.

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
2. Information to Enrollees The PIHP provides enrollees with information about the grievances, procedures, and timeframes that include: ◆ The right to file grievances; ◆ The requirements and timeframes for filing a grievance; ◆ The availability of assistance in the filing process; and ◆ The toll-free numbers that the enrollee can use to file a grievance by phone. 42 CFR 438.10(g)(1) PIHP Contract 6.3.3	• Member Handbook, "Help When You Need It," pp. 47-50 • Medicaid due process letters include information on the right to file grievances (see Advance and Adequate Action Notice and Appeal Right letters, Exhibits A and B to MCO Policy 4-020) • MCO Policy 2-009, Consumer/Provider Grievances • MCOSA Grievance Policies	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Findings

The PIHP's member handbook included the required information about the grievance process. Per Policy 4-010, Provision and Distribution of Information to Consumers, beneficiaries received the member handbook at the initial face-to-face assessment and at least annually thereafter. The policy further specified that beneficiaries must receive a brief verbal summary of the information and have the opportunity to ask questions.

Standard VII—Enrollee Grievance Process

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
3. Information to Subcontractors and Providers The PIHP provides information about the grievance system to all providers and subcontractors at the time they enter into a contract. The information includes: ◆ The right to file grievances; ◆ The requirement and timeframes for filing a grievance; ◆ The availability of assistance in the filing process; and ◆ The toll-free numbers that the enrollee can use to file a grievance by phone. 42 CFR 438.414 42 CFR 438.10(g)(1)	• MCO Policy 2-009, Consumer/Provider Grievances • MCCMH boilerplate contract states that contractors must comply with the Board's Managed Care Organization Policy Manual (A.7., p. 4), which would include compliance with MCCMH MCO Policy 2-009 • MCOSA boilerplate contract mandates that contractors adhere to the MCCMH Managed Care Organization policies for the Medicaid portions of the contract (first paragraph, p. 1), which would include compliance with MCCMH MCO Policy 2-009 • MCO policies are available on the internet; all contractors receive email notices of policy revisions as soon as they are implemented (see example of MCO Policy revision notice) • All providers receive the member material information which includes grievances; contractors are expected to know the information contained in the member materials	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Findings

MCCMH and MCOSA providers received the required information through policies and member materials. Contract provisions required compliance with the grievance policies, which were available on the Internet. In the event of a policy change, providers received an automated e-mail notification. During the interview, PIHP staff members stated that providers were required to complete training on the grievance process at the time of hire, and periodically thereafter, and that there were regular provider meetings to share information and discuss any issues.

Standard VII—Enrollee Grievance Process

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
4. Method for Filing Grievance procedures allow the enrollee to file a grievance either orally or in writing. 42 CFR 438.402(b)(3)(1)	• MCO Policy 2-009, Consumer/Provider Grievances, V.A.1. • Member Handbook, "Help When You Need It," p. 47	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Findings

The PIHP's grievance policy and the member handbook stated that beneficiaries may file a grievance orally or in writing. Information provided during the interview reflected that most grievances were filed over the telephone.

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
5. Providing Assistance In handling grievances, the PIHP gives enrollees reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. 42 CFR 438.406(a)(7)	• MCO Policy 2-009, Consumer/Provider Grievances, V.A.2.; VI.A.1, 2, and 4. • MCOSA subcontract providers are contractually required to follow the MCCMH Policies with regard to the PIHP Grievance System, although specific procedures and forms have been adapted to the Coordinating Agency's requirements and procedural manual. See MCOSA Instructions for Completion of Medicaid Local Grievance Form (p. 3 of pdf file); MCOSA Procedures Grievance System for Medicaid Beneficiaries (p. 9, 14 of the pdf file), and MCOSA Grievance/Appeal Notice Letter (p. 21 of the pdf file) • Member Handbook, "Help When You Need It," pp. 47-50; pp. 9	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Findings

Policy 2-009, Consumer/Provider Grievances, addressed the requirement for providing assistance in the filing process and detailed the procedures for the ombudsman to assist beneficiaries with the completion of forms and other procedural steps. The member handbook addressed access to interpreter services and TTY/TTD telephone numbers and stated that assistance is available in the filing process by contacting the ombudsman. PIHP staff members stated that translators were available to assist beneficiaries with filing a grievance or requesting an appeal.

Standard VII—Enrollee Grievance Process

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
6. Process for Handling Grievances Customer Services or the Recipient Rights Office performs the following functions: 42 CFR 438.406(a)(3)(i) and (ii) 42 CFR 438.408(a) 42 CFR 438.408(d)(1) Attachment P.6.3.2.1		
a. Logs the receipt of the verbal or written grievance for reporting to the PIHP QI Program.	• MCO Policy 2-009, Consumer/Provider Grievances, IV.A.4; VI.A.9 • MCOSA subcontract providers are contractually required to follow the MCCMH Policies with regard to the PIHP Grievance System, although specific procedures and forms have been adapted to the Coordinating Agency's requirements and procedural manual. • Grievance logs available on site in FOCUS module • The MCCMH CRMC, as a formal standing committee of the QAPIP, receives and reviews The Ombudsman's Report on consumer complaints/grievances. See meeting minutes from February 21, 2012 and August 20, 2012.	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
b. Determines whether the grievance is more appropriately an enrollee rights complaint, and if so, refers the grievance, with the beneficiary's permission, to the Office of Recipient Rights.	• MCO Policy 2-009, Consumer/Provider Grievances, V.G.; VI.A.9, VI.A.6, VI.B. • MCOSA subcontract providers are contractually required to follow the MCCMH Policies with regard to the PIHP Grievance System, although specific procedures and forms have been adapted to the Coordinating Agency's requirements and procedural manual.	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Standard VII—Enrollee Grievance Process		
	• Grievance logs available on site in FOCUS module • Recipient Rights records, available on site in FOCUS module	
c. Acknowledges to the beneficiary the receipt of the grievance.	• MCO Policy 2-009, Consumer/Provider Grievances, V.G.; VI.A.9, VI.A.6, VI.B. • MCOSA subcontract providers are contractually required to follow the MCCMH Policies with regard to the PIHP Grievance System, although specific procedures and forms have been adapted to the Coordinating Agency's requirements and procedural manual. • Grievance logs available on site in FOCUS module • Recipient Rights records, available on site in FOCUS module	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
d. Submits the written grievance to appropriate staff, including a PIHP administrator with the authority to require corrective action and none of whom shall have been involved in the initial determination.	• MCO Policy 2-009, Consumer/Provider Grievances, V.B., VI.3 • MCOSA Grievance Policy and consumer letters • Sample letter(s) (receipt and disposition of grievance) • Grievance logs available on site in FOCUS module	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
e. For grievances regarding denial of expedited resolution of an appeal and for a grievance that involves clinical issues, the grievance is reviewed by health care professionals who have the appropriate clinical expertise in treating the enrollee's condition or disease.	• There have been no denials of requests for expedited resolution of an appeal, nor for a grievance involving clinical issues. • MCO Policy 2-009, Consumer/Provider Grievance, V.D.	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
f. Facilitates resolution of the grievance as expeditiously as the enrollee's health condition requires, but no later than 60 calendar days of receipt of the grievance.	• MCO Policy 2-009, Consumer/Provider Grievances, V.E.; VI.A.5 • MCOSA Grievance Policy and consumer letters (Medicaid Grievance Form, p. 1-2; Instructions for	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met**

Standard VII—Enrollee Grievance Process

	Medicaid Grievance Form, p. 4; Community Grant Grievance/Complaint Form, p. 6; Instructions for Completing Community Grant Grievance/Complaint Form, p. 8; MCOSA Medicaid Grievance System, p. 15; Letters to Consumer, p. 21 and 22) • Sample letter(s) (receipt and disposition of grievance) • Grievance logs available on site in FOCUS module • Grievance record review	☐ **Not Applicable**
g. Provides a written disposition within 60 calendar days of the PIHP's receipt of the grievance to the customer, guardian, or parent of a minor child. The content of the notice of disposition includes: ◆ The results of the grievance process; ◆ The date the grievance process was conducted; ◆ The beneficiary's right to request a fair hearing if the notice is more than 60 calendar days from the date of the request for a grievance; and ◆ How to access the fair hearing process.	• MCO Policy 2-009, Consumer/Provider Grievances, V.E.; V.F.; VI.A.5; V.A.7, 8 • Sample letter of disposition of grievance • MCOSA Grievance Policy and consumer letters (Medicaid Grievance Form, p. 1-2; Instructions for Medicaid Grievance Form, p. 4; Community Grant Grievance/Complaint Form, p. 6; Instructions for Completing Community Grant Grievance/Complaint Form, p. 8; MCOSA Medicaid Grievance System, p. 15; Letters to Consumer, p. 21 and 22) • Grievance logs available on site in FOCUS module	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Findings

The PIHP maintained a Web-based application to maintain a log of grievances. Minutes of the Clinical Risk Management Committee (CRMC) reflected review and discussion of grievances. During the interview, PIHP staff members provided an example of actions taken as a result of reviewing data on grievances. Policy 2-009, Consumer/Provider Grievances, and MCOSA Procedures—Grievance System for Medicaid Beneficiaries, detailed the requirements for handling grievances. PIHP staff members discussed revisions to the MCOSA grievance procedures to ensure that the document reflects the current practice and includes sufficient detail about the process. All grievance records reviewed on-site reflected compliance with the requirements for handling grievances.

Standard VII—Enrollee Grievance Process

Requirement	Evidence/Documentation as Submitted by the	Score
7. Recordkeeping The PIHP maintains records of grievances. 42 CFR 438.416 PIHP Contract 6.3.2	• Grievance logs/records available on site in FOCUS module	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Findings

Policy 2-009, Consumer/Provider Grievances, addressed the requirement for maintaining records of grievances. The policy stated that the documentation will be maintained online using a Web-based application accessible to the ombudsman. During the interview, PIHP staff members provided a demonstration of the grievance module in the electronic record system.

Results—Standard VII						
Met	=	13	X	1.0	=	13.00
Substantially Met	=	0	X	.75	=	0.00
Partially Met	=	0	X	.50	=	0.00
Not Met	=	0	X	.00	=	0.00
Not Applicable	=	0				
Total Applicable	=	13	**Total Score**		=	13.00
Total Score ÷ Total Applicable					=	**100%**

Standard XII—Access And Availability

Findings were derived from the Michigan Mission-Based Performance Indicator System—Access Domain, Indicators 1 through 4.b. The PIHPs are required to report quarterly performance data to MDCH. MDCH provided data for the first three quarters of FY 2011–2012. For requirements numbered 1–5 below, the PIHPs' performance was evaluated and scored based on aggregated data across the three quarters.

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
Access Standards—Preadmission Reports The PIHP reports its performance on the standards in accordance with PIHP reporting requirements for Medicaid specialty supports and services beneficiaries. MDCH 3.1 P6.5.1.1		☒ **Met** ☐ **Partially Met** ☐ **Not Met**
1. Access Standards—Preadmission Screening The PIHP ensures that 95 percent of children and adults receive a preadmission screening for psychiatric inpatient care within three hours.		
a. Children	• CMHSP Performance Indicators 2012 year end • CMHSP Performance Indicators 2013 Q1 • PIHP (Medicaid) Performance Indicators 2012 year end • PIHP (Medicaid) Performance Indicators 2013 Q1	☒ **Met** ☐ **Partially Met** ☐ **Not Met**
b. Adults	• CMHSP Performance Indicators 2012 year end • CMHSP Performance Indicators 2013 Q1 • PIHP (Medicaid) Performance Indicators 2012 year end • PIHP Performance Indicators 2013 Q1	☒ **Met** ☐ **Partially Met** ☐ **Not Met**

Findings

The PIHP reported performance indicator data to MDCH as required. During the interview, PIHP staff members discussed the processes for collection, reporting, and review of performance indicators, including follow-up on any cases that fall outside the required time frame.

a. Children received timely preadmission screenings for psychiatric inpatient care 100 percent of the time across the three reporting quarters, exceeding the MDCH benchmark.

b. Adults received timely preadmission screenings for psychiatric inpatient care 100 percent of the time across the three reporting quarters, exceeding the MDCH benchmark.

Standard XII—Access And Availability

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
2. Access Standards—Face-to-Face Assessment The PIHP ensures that 95 percent of new beneficiaries receive a face-to-face assessment with a professional within 14 days of a nonemergency request for service.		
a. Children	• CMHSP Performance Indicators 2012 year end • CMHSP Performance Indicators 2013 Q1 • PIHP (Medicaid) Performance Indicators 2012 year end • PIHP (Medicaid) Performance Indicators 2013 Q1	☒ **Met** ☐ **Partially Met** ☐ **Not Met**
b. Adults	• CMHSP Performance Indicators 2012 year end • CMHSP Performance Indicators 2013 Q1 • PIHP (Medicaid) Performance Indicators 2012 year end • PIHP (Medicaid) Performance Indicators 2013 Q1	☒ **Met** ☐ **Partially Met** ☐ **Not Met**
c. Developmentally Disabled—Children	• CMHSP Performance Indicators 2012 year end • CMHSP Performance Indicators 2013 Q1 • PIHP (Medicaid) Performance Indicators 2012 year end • PIHP (Medicaid) Performance Indicators 2013 Q1	☐ **Met** ☒ **Partially Met** ☐ **Not Met**
d. Developmentally Disabled—Adults	• CMHSP Performance Indicators 2012 year end • CMHSP Performance Indicators 2013 Q1 • PIHP (Medicaid) Performance Indicators 2012 year end • PIHP (Medicaid) Performance Indicators 2013 Q1	☐ **Met** ☒ **Partially Met** ☐ **Not Met**
e. Substance Abuse	• PIHP (Medicaid) Performance Indicators 2012 year end • PIHP (Medicaid) Performance Indicators 2013 Q1	☒ **Met** ☐ **Partially Met** ☐ **Not Met**

Standard XII—Access And Availability

Findings

a. Children with a mental illness received a timely face-to-face assessment 95 percent of the time across the three reporting quarters, meeting the MDCH benchmark.
b. Adults with a mental illness received a timely face-to-face assessment 96 percent of the time across the three reporting quarters, exceeding the MDCH benchmark.
c. Developmentally disabled children received a timely face-to-face assessment 94 percent of the time across the three reporting quarters, falling below the MDCH benchmark.
d. Developmentally disabled adults received a timely face-to-face assessment 93 percent of the time across the three reporting quarters, falling below the MDCH benchmark.
e. Beneficiaries with a substance abuse disorder received a timely face-to-face assessment 100 percent of the time across the three reporting quarters, exceeding the MDCH benchmark.

Recommendation: The PIHP should ensure that children and adults with a developmental disability receive a timely face-to-face assessment at least 95 percent of the time.

Standard XII—Access And Availability

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
3. Access Standards—Ongoing Services The PIHP ensures that 95 percent of new beneficiaries start needed, ongoing service within 14 days of a nonemergent assessment with a professional.		
a. Mentally Ill—Children	• CMHSP Performance Indicators 2012 year end • CMHSP Performance Indicators 2013 Q1 • PIHP (Medicaid) Performance Indicators 2012 year end • PIHP (Medicaid) Performance Indicators 2013 Q1	☒ **Met** ☐ **Partially Met** ☐ **Not Met**
b. Mentally Ill—Adults	• CMHSP Performance Indicators 2012 year end • CMHSP Performance Indicators 2013 Q1 • PIHP (Medicaid) Performance Indicators 2012 year end • PIHP (Medicaid) Performance Indicators 2013 Q1	☒ **Met** ☐ **Partially Met** ☐ **Not Met**
c. Developmentally Disabled—Children	• CMHSP Performance Indicators 2012 year end • CMHSP Performance Indicators 2013 Q1 • PIHP (Medicaid) Performance Indicators 2012 year end • PIHP (Medicaid) Performance Indicators 2013 Q1	☐ **Met** ☒ **Partially Met** ☐ **Not Met**
d. Developmentally Disabled—Adults	• CMHSP Performance Indicators 2012 year end • CMHSP Performance Indicators 2013 Q1 • PIHP (Medicaid) Performance Indicators 2012 year end • PIHP (Medicaid) Performance Indicators 2013 Q1	☐ **Met** ☒ **Partially Met** ☐ **Not Met**
e. Substance Abuse	• PIHP (Medicaid) Performance Indicators 2012 year end • PIHP (Medicaid) Performance Indicators 2013 Q1	☒ **Met** ☐ **Partially Met** ☐ **Not Met**

Standard XII—Access And Availability

Findings

a. Children with a mental illness started needed, ongoing service within 14 days of a nonemergent assessment 99 percent of the time across the three reporting quarters, exceeding the MDCH benchmark.
b. Adults with a mental illness started needed, ongoing service within 14 days of a nonemergent assessment 99 percent of the time across the three reporting quarters, exceeding the MDCH benchmark.
c. Developmentally disabled children started needed, ongoing service within 14 days of a nonemergent assessment 94 percent of the time across the three reporting quarters, falling below the MDCH benchmark.
d. Developmentally disabled adults started needed, ongoing service within 14 days of a nonemergent assessment 91 percent of the time across the three reporting quarters, falling below the MDCH benchmark.
e. Beneficiaries with a substance abuse disorder started needed, ongoing service within 14 days of a nonemergent assessment 100 percent of the time across the three reporting quarters, exceeding the MDCH benchmark.

Recommendation: The PIHP should ensure that children and adults with a developmental disability start needed, ongoing service within 14 days of a nonemergent assessment at least 95 percent of the time.

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
4. Access Standards—Follow-up Care After Discharge/Inpatient The PIHP ensures that 95 percent of beneficiaries discharged from a psychiatric inpatient unit are seen for follow-up care within seven days.		
a. Children	• CMHSP Performance Indicators 2012 year end • CMHSP Performance Indicators 2013 Q1 • PIHP (Medicaid) Performance Indicators 2012 year end • PIHP (Medicaid) Performance Indicators 2013 Q1	☒ **Met** ☐ **Partially Met** ☐ **Not Met**
b. Adults	• CMHSP Performance Indicators 2012 year end • CMHSP Performance Indicators 2013 Q1 • PIHP (Medicaid) Performance Indicators 2012 year end • PIHP (Medicaid) Performance Indicators 2013 Q1	☒ **Met** ☐ **Partially Met** ☐ **Not Met**

Standard XII—Access And Availability

Findings

a. Children were seen for follow-up care within seven days after discharge from a psychiatric inpatient unit 96 percent of the time across the three reporting quarters, exceeding the MDCH benchmark.

b. Adults were seen for follow-up care within seven days after discharge from a psychiatric inpatient unit 95 percent of the time across the three reporting quarters, exceeding the MDCH benchmark.

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
5. Access Standards—Follow-up After Discharge/Detox The PIHP ensures that 95 percent of beneficiaries discharged from a substance abuse detoxification unit are seen for follow-up care within seven days.	• PIHP (Medicaid) Performance Indicators 2012 year end • PIHP (Medicaid) Performance Indicators 2013 Q1	☒ **Met** ☐ **Partially Met** ☐ **Not Met**

Findings

Beneficiaries discharged from a substance abuse detoxification unit were seen for follow-up care within seven days 99 percent of the time across the three reporting quarters, exceeding the MDCH benchmark.

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
6. Providers Required to Meet Access Standards The PIHP requires its providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services. 438.206(c)	• Provider Corrective Action Plans developed through the audit process (available on site) • MCCMH 2011-2013 Special Services Contract (IV.B.1. Agency Responsibilities, p. 6) • MCCMH Contract Attachment Section C, Quality Management Measures FY 11-13 • MCOSA Sample FY 2012 Contract (6.A. Reporting Requirements; 6.Y. Timely Access) • MCOSA Sample FY 2013 Contract (6.A. Reporting Requirements; 6.Y. Timely Access)	☒ **Met** ☐ **Partially Met** ☐ **Not Met**

Findings

MCCMH and MCOSA contracts included provisions requiring timely access to services and detailed the standards for the applicable performance indicators. During the interview, PIHP staff members described the process for follow-up with providers who did not meet the minimum performance standard for one or more indicators, which included technical assistance and corrective action plans when needed, and discussed an example where a corrective action plan was required after the first quarter of non-compliance.

Results—Standard XII						
Met	=	13	X	1.0	=	13.00
Substantially Met	=	N/A	X	.75	=	N/A
Partially Met	=	4	X	.50	=	2.00
Not Met	=	0	X	.00	=	0.00
Not Applicable	=	0				
Total Applicable	=	17	Total Score		=	15.00
Total Score ÷ Total Applicable					=	88%

Standard XIV—Appeals

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
1. Appeals The PIHP has internal appeals procedures that address: 438.402 MDCH 6.4(B) Attachment P6.3.2.1		
a. The beneficiary's right to a State fair hearing.	• MCO Policy 2-009, Consumer/Provider Grievances, V.F.; VI.A., Ex. B • MCO Policy 3-015, Mandatory Network Training • MCO Policy 4-010, Provision and Distribution of Information to Consumers, V.B.2 • MCO Policy 4-020, Notices of Advance and Adequate Action and Appeal Rights (MEDICAID), pp. 4, 7, 8, 10; Exhibit A, p. 13; Exhibit B, p. 16 • MCO Policy 9-170, Local Appeals, pp. 3, 4, 5, 6, Exhibits A-2 and A-3 • MCO Policy 9-180, Second Opinion Rights, p. 3 • MCOSA Grievance and Appeal Policy and Procedure documents (see uploaded folder). Documents include MCOSA Grievance and Appeal Policy, and MCOSA Medicaid Appeal Form Instructions • Member Handbook, "Help When You Need It," pp. 23, 47, 49, 50, 53, 64 • MCOSA Provider Contract, 6.CC. , p. 15	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
b. The method for a beneficiary to obtain a hearing.	• MCO Policy 4-020, Notices of Advance and Adequate Action and Appeal Rights (MEDICAID) • MCOSA Grievance and Appeal Policy; MCOSA Medicaid Appeal Form Instructions • MCOSA Provider Contract	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Standard XIV—Appeals

c. The beneficiary's right to file appeals.	• MCO Policy 2-009, Consumer/Provider Grievances, V.F.; VI.A., Ex. B • MCO Policy 3-015, Mandatory Network Training • MCO Policy 4-010, Provision and Distribution of Information to Consumers, V.B.2 • MCO Policy 4-020, Notices of Advance and Adequate Action and Appeal Rights (MEDICAID), pp. 4, 7, 8, 10; Exhibit A, p. 13; Exhibit B, p. 16 • MCO Policy 9-170, Local Appeals, pp. 3, 4, 5, 6, Exhibits A-2 and A-3 • MCO Policy 9-180, Second Opinion Rights, p. 3 • MCOSA Grievance and Appeal Policy, and MCOSA Medicaid Appeal Form Instructions • Member Handbook, "Help When You Need It," pp. 23, 47, 49, 50, 53, 64 • MCOSA Provider Contracts, 6.CC. , p. 15	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
d. The requirements and time frames for filing appeals.	• MCO Policy 4-020, Notices of Advance and Adequate Action and Appeal Rights (MEDICAID) • Member Handbook, "Help When You Need It," pp. 47, 49, 50 • MCOSA Grievance and Appeal Policy • MCOSA Medicaid Appeal Form Instructions • MCOSA "Dear Consumer" letter	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Findings

The PIHP established the standards and procedures for the State fair hearing and appeal processes through policies, including Policy 4-020, Notices of Advance and Adequate Action and Appeal Rights, Policy 9-170, Local Appeals/ Local Dispute Resolution Process, and the MCOSA Procedures—Grievance System for Medicaid Beneficiaries. These policies and procedures addressed the beneficiary's right to a State fair hearing, the method to obtain a hearing, the beneficiary's right to file appeals, and requirements and time frames for filing appeals. Beneficiaries received information about the appeal and State fair hearing processes through the member handbook, the brochure "Your Second Opinion and Appeal Rights," and notices sent to beneficiaries at the time of an advance or adequate action.

Standard XIV—Appeals

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
2. Local Appeals Process In handling appeals, the PIHP meets the following requirements:		
a. Acknowledges receipt of each appeal, in writing, unless the beneficiary or provider requests expedited resolution. 438.406(a)(2), (c)(1) Attachment P6.3.2.1	• MCO Policy 9-170, Local Appeals, V. C (last sentence); V. F. 2 • MCOSA Grievance and Appeal Procedures, p. 6 o (Section 4: Local Appeal Process, GI -3) • MCOSA Instructions for Completion of Medicaid Appeal Form • MCOSA Provider Contracts (see Section 1, MCCMH MCO policies shall govern Medicaid portion of the contract)	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
b. Ensures that oral inquiries seeking to appeal an action are treated as appeals in order to establish the earliest possible filing date. 438.406(b)(1) Attachment P6.3.2.1	• MCO Policy 9-170, Local Appeals, V. C • MCOSA Provider Contracts • MCOSA Grievance and Appeal Procedures, p. 6 (Section 4: Local Appeal Process, GI- 6) • MCOSA Medical Local Appeal Form	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
c. Maintains a log of all requests for appeals and reports data to the PIHP quality assessment/performance improvement program. Attachment P6.3.2.1	• MCO Policy 9-170, Local Appeals, V. F. 3; VI D • MCOSA Provider Contracts • MCOSA Grievance and Appeal Procedures, p. 6 (Section 4: Local Appeal Process, GI-2)	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Findings

Policy 9-170, Local Appeals, and the MCOSA Grievance and Appeal Procedures addressed the requirements to acknowledge in writing receipt of each appeal, to treat an oral request as the filing date for an appeal, and to maintain a log of all requests for appeals for reporting data to the PIHP's QAPIP. All appeal records reviewed on-site included written acknowledgement of receipt of the appeal. The PIHP maintained a log of all appeals and provided minutes of a CRMC meeting with a summary report that included information on appeals. During the interview, PIHP staff members discussed enhancing the reporting of appeals data to the QAPIP.

Standard XIV—Appeals

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
3. Expedited Process The PIHP has an expedited review process for appeals when the PIHP determines (from a request from the beneficiary) or the provider indicates (in making the request on the beneficiary's behalf or supporting the beneficiary's request) that taking the time for a standard resolution could seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function. 438.410(a) Attachment P6.3.2.1	• MCO Policy 9-170, Local Appeals, V. G.1 • Member Handbook, "Help When You Need It," p. 50 • MCO Policy 4-020, Notices of Advance and Adequate Action and Appeal Rights (MEDICAID), Exhibit A, Exhibit B • Notice of Denial of Expedited Appeal, Exhibit A-1 to 9-170, Local Appeals • MCOSA Provider Contracts • MCOSA Grievance and Appeal Procedures, p. 6 (Section 4: Local Appeal Process, GI-7)	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Findings

The PIHP's policies and procedures detailed the requirements for an expedited review process. Member materials included information about the expedited review of an appeal.

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
4. Individuals Making Decisions—Not Previously Involved The PIHP ensures that individuals who make decisions on appeals are individuals who were not involved in any previous level of review or decision-making. 438.406(a)(3)(i) Attachment P6.3.2.1	• MCO Policy 9-170, Local Appeals, V. F.4 • Member Handbook, "Help When You Need It," p. 48 • MCOSA Provider Contracts • MCOSA Grievance and Appeal Procedures, p. 6 (Section 4: Local Appeal Process, GI-4)	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Findings

Policy 9-170, Local Appeals, and the MCOSA Grievance and Appeal Procedures specified the requirement that individuals who make decisions on appeals are individuals who were not involved in any previous level of review or decision-making. During the interview, PIHP members discussed processes in place to ensure that decisions on appeals were made by staff members who were not involved in the denial that was appealed. All appeal records reviewed on-site demonstrated compliance with the requirement.

Standard XIV—Appeals

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
5. Individuals Making Decisions—Clinical Expertise The PIHP ensures that individuals who make decisions on appeals have the appropriate clinical expertise in treating the beneficiary's condition or disease when deciding any of the following: ◆ An appeal of a denial that is based on lack of medical necessity ◆ An appeal that involves clinical issues 438.406(a)(3)(ii) Attachment P6.3.2.1	• MCO Policy 9-170, Local Appeals, V. F. 5 • MCOSA Provider Contracts • MCOSA Grievance and Appeal Procedures, p. 6 (Section 4: Local Appeal Process, GI-4)	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Findings

Policy 9-170, Local Appeals, and the MCOSA Grievance and Appeal Procedure specified the requirement that individuals who make decisions on appeals have the appropriate clinical expertise. During the interview, PIHP members discussed processes in place to ensure that decisions on appeals were made by qualified staff members. All appeal records reviewed on-site demonstrated compliance with the requirement.

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
6. Right to Examine Records The appeals process provides the beneficiary and his or her representative the opportunity, before and during the appeals process, to examine the beneficiary's case file, including medical records and any other documents and records considered during the appeals process. 438.406(b)(3)(ii)	• MCO Policy 9-170, Local Appeals, V. F. 6. b. • MCOSA Provider Contracts • Advance Action Letter (Exhibit A to MCO Policy 4-020) • Adequate Action Letter (Exhibit B to MCO Policy 4-020) • Member Handbook, "Help When You Need It," p. 49 • MCOSA Grievance and Appeal Procedures, p. 6 (Section 4: Local Appeal Process, GI-5)	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Findings

The PIHP's policies and procedures addressed the beneficiaries' right to examine the case file, including medical records and any other documents and records considered during the appeals process. The member handbook informed beneficiaries of this right.

Standard XIV—Appeals

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
7. Notice of Disposition The PIHP provides written notice of the results of a standard resolution as expeditiously as the beneficiary's health condition requires, but no later than 45 calendar days from the day the PIHP received the request for a standard appeal and no later than three working days after the PIHP received a request for an expedited resolution of the appeal. 438.408(b) Attachment P6.3.2.1	• MCO Policy 9-170, Local Appeals, VI. A. 5. (a); VI. A. 5 (b) • MCOSA Provider Contracts • MCOSA Grievance and Appeal Procedures, p. 6 (Section 4: Local Appeal Process, GI-6)	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Findings

Policy 9-170, Local Appeals, and the MCOSA Grievance and Appeal Procedures detailed the requirements for standard resolution of appeals to be completed within 45 calendar days and expedited resolutions within three working days. All appeal records reviewed on-site demonstrated compliance with the requirement for standard resolutions.

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
8. Notice of Disposition The notice of disposition includes an explanation of the results of the resolution and the date it was completed. 438.408(e) Attachment P6.3.2.1	• MCO Policy 9-170, Local Appeals, VI. A. 7.a. • MCOSA Provider Contracts • MCOSA Grievance and Appeal Procedures, p. 6 (Section 4: Local Appeal Process, GI-6)	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Findings

The PIHP's local appeal policies and procedures specified that the notice of disposition must include an explanation of the results of the resolution and the date it was completed. All appeal records reviewed on-site demonstrated compliance with the requirement.

Standard XIV—Appeals

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
9. Appeals Not Resolved in Favor of Beneficiary When the appeal is not resolved wholly in favor of the beneficiary, the notice of disposition includes: ◆ The right to request a State fair hearing. ◆ How to request a State fair hearing. ◆ The right to request to receive benefits while the State fair hearing is pending, if requested within 12 days of the PIHP mailing the notice of disposition, and how to make the request. ◆ The fact that the beneficiary may be held liable for the cost of those benefits if the hearing decision upholds the PIHP's action. 438.408(e)(2) Attachment P6.3.2.1	• MCO Policy 9-170, Local Appeals, V. G.2; VI. A. 7. b, c., d.; Notice of Local Dispute Resolution Appeal Rights, Exhibit A-3 • Member Handbook, "Help When You Need It,", p. 49 • MCO Policy 4-020, Notices of Advance and Adequate Action and Appeal Rights (MEDICAID), Exhibit A • MCOSA Grievance and Appeal Policy, pp. 9, 11, 12 • MCOSA Provider Contracts	☒ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Findings

Policy 9-170, Local Appeals, and the MCOSA Grievance and Appeal Procedures detailed the information to be included in the notice of disposition when the appeal was not resolved fully in favor of the beneficiary. All applicable appeal records reviewed on-site demonstrated compliance with the requirement.

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
10. Denial of a Request for Expedited Resolution of an Appeal If a request for expedited resolution of an appeal is denied, the PIHP: ◆ Transfers the appeal to the time frame for standard resolution (i.e., no longer than 45 days from the date the PIHP received the appeal). ◆ Makes reasonable efforts to give the beneficiary prompt oral notice of the denial. ◆ Gives the beneficiary follow-up written notice within two calendar days. 438.410(c) Attachment P6.3.2.1	• MCO Policy 9-170, Local Appeals, VI. A. 5. (d) • MCOSA Provider Contracts • Advance Action Letter, Ex. A to MCO Policy 4-020 • Adequate Action Letter, Ex. B to MCO Policy 4-020 • Member Handbook, "Help When You Need It," p. 50	☐ **Met** ☐ **Substantially Met** ☒ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Findings

Policy 9-170, Local Appeals, and the MCOSA Grievance and Appeal Procedures detailed the process for denial of a request for expedited resolution of an appeal and included a template letter for the notice of denial of an expedited appeal. One of the appeal records reviewed on-site included a request for an immediate

Standard XIV—Appeals

resolution; however, the PIHP did not process the appeal as an expedited appeal. There was no documentation of a denial of the request for expedited resolution or of verbal or written notification to the beneficiary that the appeal would be resolved within the time frame for a standard resolution.

Recommendation: The PIHP should ensure that it consistently follows the process for denial of a request for expedited resolution of an appeal as detailed in its policies and the MDCH contract.

Results—Standard XIV						
Met	=	14	X	1.0	=	14.00
Substantially Met	=	0	X	.75	=	0.00
Partially Met	=	1	X	.50	=	0.50
Not Met	=	0	X	.00	=	0.00
Not Applicable	=	0				
Total Applicable	=	15	Total Score		=	14.50
Total Score ÷ Total Applicable					=	97%