Mental Health and Substance Abuse Administration

2007–2008 External Quality Review Technical Report

for

Prepaid Inpatient Health Plans

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HSAG HEALTH SERVICES ADVISORY GROUP

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Purpose of Report

The Balanced Budget Act of 1997 (BBA), Public Law 105-33, requires states to prepare an annual technical report that describes the manner in which data from activities conducted in accordance with 42 Code of Federal Regulations (CFR) 438.358 were aggregated and analyzed. The report must describe how conclusions were drawn as to the quality and timeliness of and access to care furnished by the states' managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs). The report of results must also contain an assessment of the strengths and weaknesses of the plans regarding health care quality, timeliness, and access, and must make recommendations for improvement. Finally, the report must assess the degree to which the MCOs and PIHPs addressed any previous recommendations. To meet this requirement, the State of Michigan, Michigan Department of Community Health (MDCH), contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare a report regarding the external quality review (EQR) activities performed on the State's contracted prepaid inpatient health plans (PIHPs) and the findings derived from the activities. MDCH contracted with 18 PIHPs:

- Access Alliance of Michigan (Access Alliance)
- CMH Affiliation of Mid-Michigan (CMHAMM)
- CMH for Central Michigan (CMH Central)
- CMH Partnership of Southeastern Michigan (CMHPSM)
- Detroit-Wayne County CMH Agency (Detroit-Wayne)
- Genesee County CMH (Genesee)
- Lakeshore Behavioral Health Alliance (Lakeshore)
- LifeWays
- Macomb County CMH Services (Macomb)
- network180
- NorthCare
- Northern Affiliation
- Northwest CMH Affiliation (Northwest CMH)
- Oakland County CMH Authority (Oakland)
- Saginaw County CMH Authority (Saginaw)
- Southwest Affiliation
- Thumb Alliance PIHP (Thumb Alliance)
- Venture Behavioral Health (Venture)

Scope of EQR Activities Conducted

This EQR technical report focuses on the three federally mandated EQR activities conducted by HSAG. As set forth in 42 CFR 438.352, these mandatory activities were:

- **Compliance monitoring.** The 2006–2007 evaluation was designed to determine the PIHPs' compliance with their contract and with State and federal regulations through review of performance in the seven compliance areas (i.e., Standards IX through XV) of Subcontracts and Delegation, Provider Network, Credentialing, Access and Availability, Coordination of Care, Appeals, and Advance Directives. The current year's compliance monitoring activities assessed the PIHPs' implementation of corrective actions for these standards to address areas of noncompliance identified in the 2006–2007 reviews and determined the degree to which the PIHP had moved into compliance with the related requirements. HSAG previously evaluated the PIHPs' performance on Standards I through VIII (Quality Assessment and Performance Improvement [QAPI] Plan and Structure, Performance Measurement and Improvement, Practice Guidelines, Staff Qualifications and Training, Utilization Management, Customer Service, Recipient Grievance Process, and Enrollee Rights and Protections).
- **Validation of performance measures.** HSAG validated each of the performance measures identified by MDCH to evaluate the accuracy of the performance measures reported by or on behalf of a PIHP. The validation also determined the extent to which Medicaid-specific performance measures calculated by a PIHP followed specifications established by MDCH.
- **Validation of performance improvement projects (PIPs).** For each PIHP, HSAG reviewed one PIP to ensure that the PIHP designed, conducted, and reported on the project in a methodologically sound manner, allowing real improvements in care and giving confidence in the reported improvements.

HSAG reported its results from these three EQR activities to MDCH and the PIHPs in activity reports for each PIHP. Section 3 and the tables in Appendix A detail the performance scores and validation findings from the activities for all PIHPs. Appendix A contains comparisons to prior-year performance, when applicable.

Definitions

The BBA states that "each contract with a Medicaid managed care organization must provide for an annual external independent review conducted by a qualified independent entity of the quality outcomes and timeliness of, and access to, the items and services for which the organization is responsible." [1-1] The Centers for Medicare & Medicaid Services (CMS) has chosen the domains of quality, timeliness, and access as keys to evaluating the performance of MCOs and PIHPs. HSAG used the following definitions to evaluate and draw conclusions about the performance of the PIHPs in each of these domains.

[1-1] Department of Health and Human Services Centers for Medicare & Medicaid Services. *Legislative Summary: Balanced Budget Act of 1997 Medicare and Medicaid Provisions.*

Quality

CMS defines quality in the final rule for 42 CFR 438.320 as follows: "Quality, as it pertains to external quality review, means the degree to which an MCO or PIHP increases the likelihood of desired health outcomes of its recipients through its structural and operational characteristics and through provision of health services that are consistent with current professional knowledge."[1-2]

Timeliness

The National Committee for Quality Assurance (NCQA) defines timeliness relative to utilization decisions as follows: "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[1-3] NCQA further discusses the intent of this standard to minimize any disruption in the provision of health care. HSAG extends this definition of timeliness to include other managed care provisions that impact services to enrollees and that require timely response by the MCO or PIHP—e.g., processing expedited appeals and providing timely follow-up care.

Access

In the preamble to the BBA Rules and Regulations,[1-4] CMS describes the access and availability of services to Medicaid enrollees as the degree to which MCOs and PIHPs implement the standards set forth by the State to ensure that all covered services are available to enrollees. Access includes the availability of an adequate and qualified provider network that considers the needs and characteristics of the enrollees served by the MCO or PIHP.

[1-2] Department of Health and Human Services Centers for Medicare & Medicaid Services. *Federal Register. Code of Federal Regulations*. Title 42, Vol. 3, October 1, 2005.

[1-3] National Committee on Quality Assurance. 2006 Standards and Guidelines for MBHOs and MCOs.

[1-4] Department of Health and Human Services Centers for Medicare & Medicaid Services. *Federal Register*, Vol. 67, No. 115, June 14, 2002.

Findings

To draw conclusions and make recommendations about the **quality** and **timeliness** of and **access** to care provided by the PIHPs, HSAG assigned each of the components (compliance monitoring standards, performance measures, PIPs) reviewed for each activity to one or more of these three domains.

The following is a high-level statewide summary of the conclusions drawn from the findings of the EQR activities, including HSAG recommendations with respect to **quality**, **timeliness**, and **access**. Section 3 of this report—Findings, Strengths, and Recommendations, With Conclusions Related to Health Care Quality, Timeliness, and Access—details PIHP-specific results.

Quality

Table 1-1 displays the statewide scores and the lowest and highest scores among the PIHPs for measures assessing the **quality** of care and services. For a detailed description of the performance measure indicators please refer to Table 1-6.

Table 1-1—Measures Assessing Quality

Measure		Statewide Score	PIHP Low Score	PIHP High Score
Compliance Monitoring Standards				
Standard IX. Subcontracts and Delegation		99%	96%	100%
Standard X. Provider Network		100%	98%	100%
Standard XI. Credentialing		99%	88%	100%
Standard XIII. Coordination of Care		100%	100%	100%
Standard XIV. Appeals		95%	87%	100%
Standard XV. Advance Directives		97%	71%	100%
Performance Measure Indicators				
Indicator 4a: Follow-Up Care	Children	95%	88%	100%
	Adults	89%	75%	100%
Indicator 4b: Follow-Up Care After Detox		98%	70%	100%
Indicator 8: Penetration Rate		97%	94%	100%
Indicator 10: Competitive Employment	Adults with MI	9%	3%	15%
	Adults with DD	9%	3%	19%
Indicator 11: Earning Minimum Wage	Adults with MI	45%	10%	75%
	Adults with DD	23%	1%	67%
Indicator 12†: Readmission Rate	Children	7%	0%	21%
	Adults	13%	0%	33%
Indicator 13*: Recipient Rights Complaints				
Indicator 14*: Sentinel Events				
Performance Improvement Projects				
	All evaluation elements *Met*	90%	63%	100%
	Critical elements *Met*	97%	82%	100%

† Lower rates are better for this measure. *Rates were not available for reporting.
MI = mental illness, DD = developmental disabilities

Overall, PIHP performance on the compliance monitoring standards in the domain of **quality** indicated a statewide strength. Statewide scores for the six quality-related standards ranged from a low of 95 percent for Appeals to a high of 100 percent for Provider Network and Coordination of Care. Most PIHPs achieved a score of 100 percent for these compliance standards.

The EQR activities related to the validation of PIPs addressed the validity and reliability of the PIHP's processes for conducting valid PIPs. Therefore, for purpose of the EQR technical report, HSAG assigned all PIPs to the **quality** domain. The PIHPs demonstrated strong performance related to the quality of their PIPs and maintained previously demonstrated improvement over the results from prior validations. The PIHPs demonstrated progress in the implementation of their PIPs, with 17 PIHPs completing at least 9 of the 10 activities. Thirteen of the 18 PIHPs received a validation status of *Met*, and three PIHPs met 100 percent of all assessed and applicable evaluation and critical elements. These findings indicated that most PIHPs designed, conducted, and reported their project in a methodologically sound manner, allowing real improvements in care and giving confidence in the reported results.

The PIHPs' results for performance measures related to **quality** of care and services reflected strong and improved performance. Six of the eight indicators received validation ratings of *Fully Compliant* across all PIHPs, including Indicator 13: Recipient Rights Complaints, which HSAG had rated *Substantially Compliant* for three PIHPs in the last validation. Indicators 10 and 11 (Competitive Employment and Earning Minimum Wage) received validation ratings of *Fully Compliant* for all but one PIHP. Statewide rates for the performance measures related to **quality** of care and services met or exceeded the performance standard set by MDCH for the following indicators: Indicator 4a, addressing follow-up care for children discharged from a psychiatric inpatient unit; Indicator 4b, addressing follow-up care after discharge from a detoxification (detox) unit; and the 30-day readmission rates to an inpatient psychiatric unit for children and adults (Indicator 12). The statewide rate for Indicator 4a related to timely follow-up care for adults after discharge from an inpatient psychiatric unit did not meet the minimum performance standard, indicating an opportunity for improvement. The number of PIHPs that met all performance standards in the **quality** domain increased to eight PIHPs. Rates for two measures (Indicator 13: Recipient Rights Complaints and Indicator 14: Sentinel Events) were not available for reporting, and the three remaining indicators related to **quality** of care (Indicators 8, 10, and 11 addressing the penetration rate, competitive employment, and minimum wage earners) did not have a performance standard set by MDCH.

Timeliness

Table 1-2 displays the statewide scores and the lowest and highest scores among the PIHPs for measures assessing **timeliness** of care and services.

Table 1-2—Measures Assessing Timeliness					
Measure		Statewide Score	PIHP Low Score	PIHP High Score
Compliance Monitoring Standards				
Standard XII. Access and Availability		91%	59%	100%
Standard XIV. Appeals		95%	87%	100%
Performance Measure Indicators				
Indicator 1: Preadmission Screenings	Children	99%	95%	100%
	Adults	96%	89%	100%
Indicator 2: Face-to-Face Assessments		98%	92%	100%
Indicator 3: Initiation of Ongoing Service		97%	94%	99%
Indicator 4a: Follow-Up Care	Children	95%	88%	100%
	Adults	89%	75%	100%
Indicator 4b: Follow-Up Care After Detox		98%	70%	100%

The two compliance monitoring standards assessing **timeliness** of care and services provided by the PIHPs showed the lowest statewide scores. While several PIHPs achieved 100 percent compliance with requirements related to these standards, HSAG identified the majority of continued recommendations in these two areas, reflecting opportunities for improvement.

Timeliness, as addressed by the validation of performance measures, reflected a statewide strength, with six of the seven indicators related to **timeliness** of care and services achieving statewide averages that met the minimum performance level as specified by MDCH. The statewide rates for Indicators 1, 2, 3, and 4, addressing timely preadmission screenings for children and adults, timely face-to-face assessments with a professional, and follow-up care for children and for beneficiaries discharged from a detox unit, met or exceeded the minimum performance standard. Only the indicator for follow-up care for adults after discharge from a psychiatric inpatient unit (Indicator 4a) had a statewide rate that fell below the MDCH benchmark, indicating an opportunity for improvement. The PIHPs demonstrated compliance with technical requirements and specifications in their collection and reporting of performance indicators, with 16 of the 18 PIHPs receiving validation scores of *Fully Compliant* for all indicators related to **timeliness** of care and services (two PIHPs received designations of *Substantially Compliant* for Indicator 1: Preadmission Screenings).

Access

Table 1-3 displays the statewide scores and the lowest and highest scores among the PIHPs for measures assessing **access** to care and services.

Table 1-3—Measures Assessing Access				
Measure		Statewide Score	PIHP Low Score	PIHP High Score
Compliance Monitoring Standards				
Standard X. Provider Network		100%	98%	100%
Standard XII. Access and Availability		91%	59%	100%
Standard XIII. Coordination of Care		100%	100%	100%
Performance Measure Indicators				
Indicator 1: Preadmission Screenings	Children	99%	95%	100%
	Adults	96%	89%	100%
Indicator 2: Face-to-Face Assessments		98%	92%	100%
Indicator 3: Initiation of Ongoing Service		97%	94%	99%
Indicator 4a: Follow-Up Care	Children	95%	88%	100%
	Adults	89%	75%	100%
Indicator 4b: Follow-Up Care After Detox		98%	70%	100%
Indicator 5: Penetration Rate		6%	4%	8%

Overall, PIHP performance on the compliance monitoring standards in the domain of **access** indicated another statewide strength. Statewide scores for the three access-related standards ranged from a low of 91 percent for the Access and Availability standard to a high of 100 percent for the Provider Network and Coordination of Care standards.

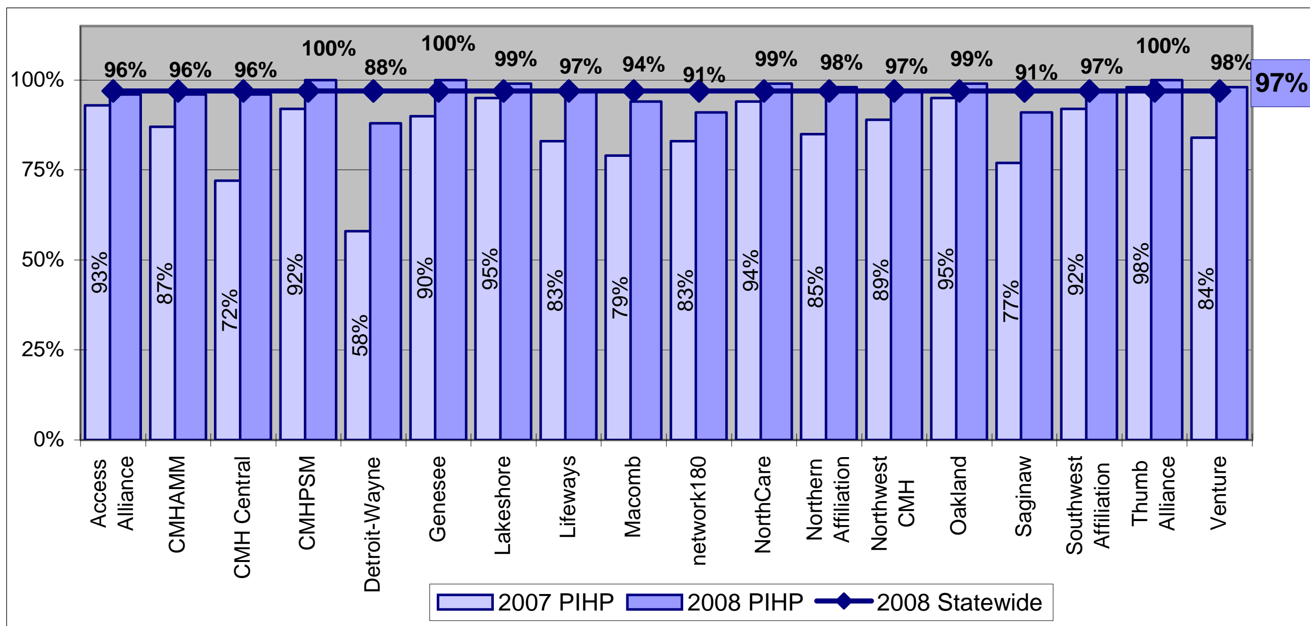
Access, as addressed by the validation of performance measures, indicated a statewide strength. PIHP performance, as reflected in the statewide rates, met or exceeded the minimum performance standard for all but one indicator (Indicator 4a), with rates for timely follow-up care for adults after discharge from a psychiatric inpatient unit below the minimum performance standard as specified by MDCH. For four of the six performance measures related to **access** to care and services, all PIHPs received a validation score of *Fully Compliant*, two PIHPs received a validation score of *Substantially Compliant* for Indicator 1: Preadmission Screenings, and one PIHP continued to receive a score of *Not Valid* for Indicator 5: Penetration Rate.

Findings for the 2007–2008 Compliance Monitoring Reviews

The regulatory provisions included for review in this fourth year included Subcontracts and Delegation (42 CFR 438.230); Provider Network (438.106, 438.12, 438.206, 438.207, and 438.214); Credentialing (438.12 and 438.214); Access and Availability (438.206); Coordination of Care (438.208); Appeals (438.402, 438.406, 438.408, and 438.410); and Advance Directives (422, 422.128, and 438.6). The individual PIHP follow-up compliance reviews included only those standards that had received a compliance score of less than 100 percent during the initial review in 2006–2007 and only those elements that had received an initial score of less than *Met*.

The overall compliance rating across all standards for the 18 PIHPs was 97 percent, with individual PIHP scores ranging from 88 to 100 percent. Scores ranging from 95 to 100 percent were rated *Excellent*, scores ranging from 85 to 94 percent were rated *Good*, scores ranging from 75 to 84 percent were rated *Average*, and scores of 74 percent and lower were rated *Poor*. Figure 1-1 displays PIHP scores for overall compliance across all compliance monitoring standards. Fourteen PIHPs performed at an overall *Excellent* level, with 3 PIHPS receiving compliance scores of 100 percent on all standards. Four PIHPs were rated *Good*. None of the PIHPs performed at the *Average* or *Poor* level.

Figure 1-1—Overall Compliance Scores – PIHP Scores and Statewide Score



PIHPs demonstrated high levels of compliance with contractual requirements in all areas assessed. The PIHPs' performance was strongest in Coordination of Care, with all 18 PIHPs receiving a compliance score of 100 percent after successfully addressing prior recommendations to improve coordination with beneficiaries' primary care physicians and other involved agencies.

Performance on the Subcontracts and Delegation and Provider Network standards was also very strong, with all PIHPs performing in the *Excellent* range. Continued recommendations in these areas

related to the requirements for monitoring of subcontractors' performance (four PIHPs), the assessment of network sufficiency (one PIHP) and notification of the reason to decline a provider's participation in the network (one PIHP). All other PIHPs met all requirements related to the management and oversight of their provider networks.

PIHPs demonstrated marked improvement in Credentialing, addressing most recommendations from the 2006–2007 review to bring their credentialing policies into compliance with the requirements of the MDCH credentialing policy. Seven of the 18 PIHPs received continued recommendations, mostly related to the role of participating providers in making credentialing decisions and the PIHPs' policies related to deeming. After the follow-up review, 17 PIHPs scored in the *Excellent* range and 1 PIHP performed at the *Good* level.

PIHP performance in Advance Directives was another statewide strength. Sixteen PIHPs received a compliance score of 100 percent and one PIHP each performed at the *Average* and *Poor* levels. The continued recommendations primarily addressed the requirement for staff education and training concerning policies and procedures on advance directives and providing information about advance directives to adult beneficiaries.

On the Appeals standard, 10 PIHPs performed at the *Excellent* level and 8 PIHPs performed at the *Good* level. While most PIHPs strengthened their compliance with contract requirements related to processing and responding to beneficiary appeals of the PIHP's decision to deny, reduce, suspend, or terminate services, PIHPs received continued recommendations primarily related to requirements for the content and timeliness of the notice of disposition.

For the Access and Availability standard, the PIHPs demonstrated much improved performance. The follow-up review excluded any standard that received a score of *Met* for the 2006–2007 review, and no conclusions could be drawn as to PIHP performance on these Access and Availability measures during the reporting period. The number of PIHPs that performed in the *Excellent* range increased to eight, with seven PIHPs receiving scores of 100 percent compliance and seven PIHPs performing in the *Good* range. Only one PIHP scored in the *Average* range and two PIHPs received scores in the *Poor* range. Most continued recommendations related to the access standard for ongoing services, primarily for mentally ill adults and children. The PIHPs continued to address this access standard in a statewide PIP.

Table 1-4 presents the compliance monitoring scores from the initial review in 2006–2007 (Year III) and the follow-up review in 2007–2008 (Year IV) for all PIHPs on the seven standards reviewed.

Table 1-4—Summary of PIHP Compliance Scores

PIHP	Year	Standard IX Subcontracts and Delegation	Standard X Provider Network	Standard XI Credentialing*	Standard XII Access and Availability	Standard XIII Coordination of Care	Standard XIV Appeals	Standard XV Advance Directives	Overall Compliance Monitoring*
Access Alliance	III	100%	100%	NA	76%	100%	98%	100%	93%
	IV			99%	88%		93%		96%
CMHAMM	III	96%	98%	NA	76%	100%	90%	71%	87%
	IV	96%	98%	100%	100%		92%	71%	96%
CMH Central	III	96%	92%	NA	68%	92%	67%	17%	72%
	IV	100%	100%	100%	94%	100%	87%	100%	96%
CMHPSM	III	100%	100%	NA	74%	100%	100%	92%	92%
	IV			100%	100%			100%	100%
Detroit-Wayne	III	86%	94%	NA	38%	92%	23%	79%	58%
	IV	96%	100%	97%	59%	100%	87%	100%	88%
Genesee	III	NA	100%	NA	71%	100%	100%	92%	90%
	IV	NA		100%	100%			100%	100%
Lakeshore	III	96%	100%	NA	88%	100%	95%	100%	95%
	IV	100%		100%	100%		97%		99%
LifeWays	III	96%	98%	NA	68%	100%	70%	100%	83%
	IV	100%	98%	99%	100%		87%		97%
Macomb	III	89%	95%	NA	79%	100%	57%	83%	79%
	IV	100%	100%	100%	79%		92%	100%	94%
network180	III	93%	100%	NA	77%	100%	82%	54%	83%
	IV	96%		88%	85%		93%	79%	91%
NorthCare	III	100%	100%	NA	82%	100%	100%	92%	94%
	IV			100%	97%			100%	99%
Northern Affiliation	III	93%	100%	NA	91%	92%	67%	71%	85%
	IV	100%		100%	94%	100%	97%	100%	98%
Northwest CMH	III	96%	94%	NA	76%	100%	98%	75%	89%
	IV	100%	100%	99%	88%		100%	100%	97%
Oakland	III	100%	100%	NA	88%	100%	97%	92%	95%
	IV			100%	100%		97%	100%	99%
Saginaw	III	86%	100%	NA	29%	100%	95%	100%	77%
	IV	100%		99%	62%		93%		91%
Southwest Affiliation	III	96%	98%	NA	85%	100%	97%	79%	92%
	IV	96%	100%	96%	94%		100%	100%	97%

Table 1-4—Summary of PIHP Compliance Scores

PIHP	Year	Standard IX Subcontracts and Delegation	Standard X Provider Network	Standard XI Credentialing*	Standard XII Access and Availability	Standard XIII Coordination of Care	Standard XIV Appeals	Standard XV Advance Directives	Overall Compliance Monitoring*
Thumb Alliance	III	100%	100%	NA	97%	100%	100%	83%	98%
	IV			100%	100%			100%	100%
Venture	III	96%	98%	NA	50%	100%	98%	96%	84%
	IV	100%	100%	100%	91%		100%	100%	98%
Statewide Score	**III**	**95%**	**98%**	**NA**	**73%**	**99%**	**85%**	**82%**	**86%**
	IV	**99%**	**100%**	**99%**	**91%**	**100%**	**95%**	**97%**	**97%**

*The 2006–2007 review did not assign a score for the Credentialing standard, nor was this standard included in the calculation of the overall compliance monitoring score. Therefore, the overall compliance monitoring scores are not fully comparable across the two years.

Section 3 (PIHP-specific findings) and Appendix A (statewide summaries) detail the PIHPs' performance on the compliance monitoring standards.

Findings for the 2007–2008 Validation of Performance Measures

CMS designed the validation of performance measures activity to ensure the accuracy of the performance indicator results reported by the PIHPs to MDCH. To determine that the results were valid and accurate, HSAG evaluated the PIHPs' data collection and calculation processes and the degree of compliance with the MDCH codebook specifications.

HSAG assessed 12 performance measures for each PIHP for compliance with technical requirements, specifications, and construction. HSAG scored the performance measures as *Fully Compliant* (the PIHP followed the specifications without any deviation), *Substantially Compliant* (some deviation was noted, but the reported rate was not significantly biased), or *Not Valid* (significant deviation from the specifications that resulted in a +/- bias of greater than 5 percent in the final reported rate). The 18 PIHPs calculated and reported a total of 216 performance measures. Table 1-5 presents the results.

Table 1-5—Overall Performance Indicator Compliance With MDCH Specifications Across all PIHPs

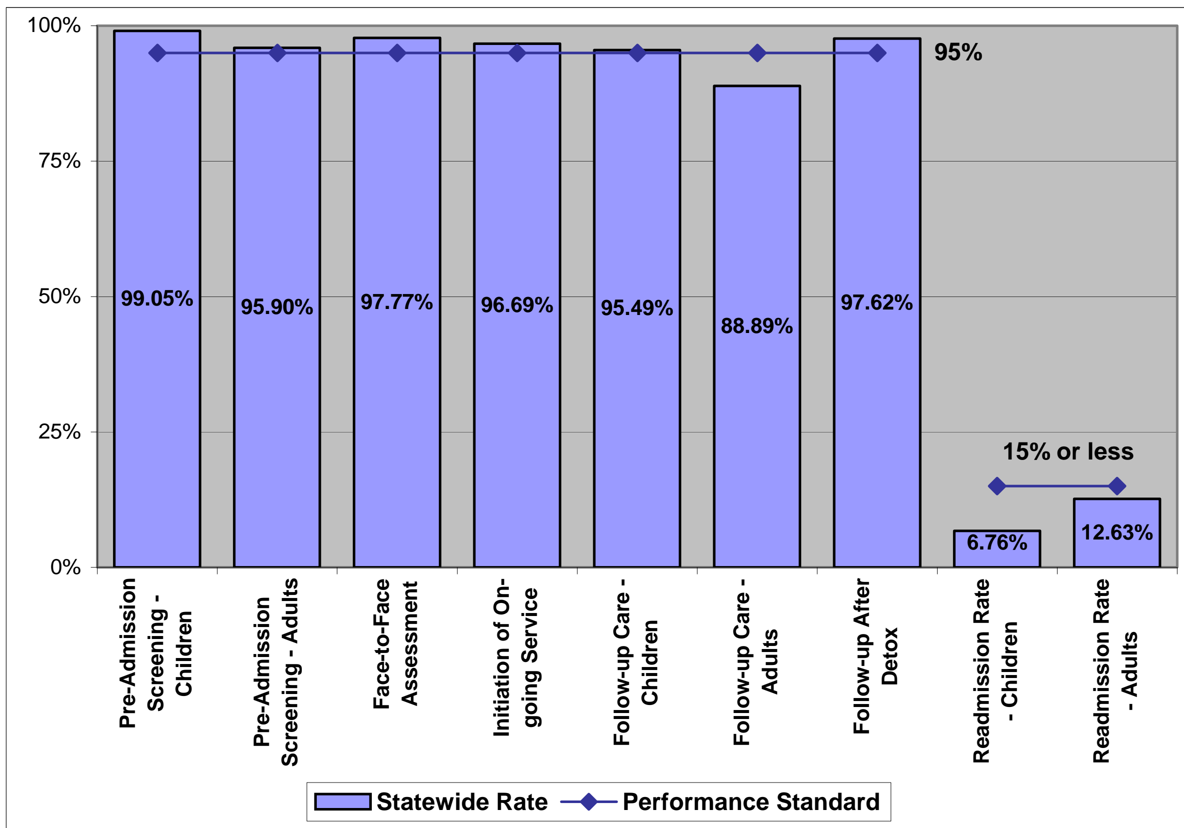
Validation Finding	Performance Indicators	
	Number	Percent
Fully Compliant	211	98%
Substantially Compliant	4	2%
Not Valid	1	<1%
Total	**216**	**100%**

Table 1-6 shows the overall PIHP compliance with the MDCH codebook specifications for each of the 12 performance indicators validated by HSAG. All but 4 of the 12 measures were *Fully Compliant* for all 18 PIHPs. One PIHP received a score of *Not Valid* on Indicator 5, two PIHPs received a score of *Substantially Compliant* on Indicator 1, and one PIHP received a score of *Substantially Compliant* on Indicators 10 and 11—new indicators for this validation cycle. These results show that almost all of the PIHPs were able to maintain the improvement achieved in the prior year. The three PIHPs that had received scores of *Substantially Compliant* for Indicator 13 were able to bring their processes for the calculation of this indicator into full compliance. The PIHPs demonstrated statewide strengths in the collaborative approach between PIHPs and their affiliates and the commitment to accurate performance measure reporting. Several PIHPs implemented new or updated existing data warehouses to increase data accuracy and reliability. The PIHPs demonstrated best practices in several areas, including implementation of an analytic tool, built-in edits for access screens, requirements for a corrective action plan for providers whose performance falls below the MDCH threshold, processes for oversight and verification of data completeness and assessment of data accuracy, and documentation of quality improvement processes, information systems, and performance measure calculation processes. Recommendations for improvement primarily addressed increased automation of performance measure calculations, increased audit processes to ensure the uniform collection of all indicators, and verification of the accuracy of claims and encounter data. The PIHPs should continue to increase the number of providers submitting claims electronically and implement system enhancements such as drop-down boxes to improve documentation of exclusions.

Table 1-6—Degree of Compliance Across all PIHPs				
	Performance Measure Indicator	Percent of PIHPs		
		Fully Compliant	*Substantially Compliant*	*Not Valid*
1.	Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	89%	11%	0%
2.	Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	100%	0%	0%
3.	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional.	100%	0%	0%
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	100%	0%	0%
4b.	Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	100%	0%	0%
5.	Percentage of Medicaid recipients having received PIHP-managed services (penetration rate).	94%	0%	6%
8.	Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination (HSW rate).	100%	0%	0%
10.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities, served by the PIHPs who are employed competitively.	94%	6%	0%
11.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who earned minimum wage or more from any employment activities.	94%	6%	0%
12.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	100%	0%	0%
13.	Annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by the PIHPs.	100%	0%	0%
14.	Number of sentinel events during the six-month period per 1,000 Medicaid beneficiaries served, by the following populations: adults with mental illness, children with mental illness, persons with developmental disabilities not on the HSW, persons on the HSW, and persons with substance abuse disorder.	100%	0%	0%

Overall, statewide performance met the MDCH-established performance standards for eight indicators, as shown in Figure 1-2. Statewide rates were calculated by summing the number of cases that met the requirements of the indicator across all PIHPs (e.g., the total number of adults for all 18 PIHPs who received a timely follow-up service) and dividing this number by the number of applicable cases across all PIHPs (e.g., the total number of adults for all 18 PIHPs who were discharged from a psychiatric inpatient facility). MDCH did not specify a standard for Indicators 5, 8, 10, and 11. While HSAG validated Indicators 13 and 14, rates for PIHP performance on these indicators were not available for reporting.

Figure 1-2—Statewide Rates for Performance Measures



Performance improved for most indicators and resulted in statewide rates for all but one indicator (follow-up care for adults) that met or exceeded the MDCH benchmark. In 2006–2007, three statewide rates (all indicators related to follow-up care after discharge) were below the standard of 95 percent. Indicator 1: Preadmission Screenings reflected the highest statewide rate (99.05 percent for children) and the highest number of PIHPs meeting the MDCH performance standard (17 of 18 PIHPs).

Table 1-7 displays the 2007–2008 PIHP results for the validated performance indicators.

Table 1-7—PIHP Performance Measure Results—Percentage Scores

PIHP	1. Preadmission Screening		2. Initial Assessment Within 14 Days	3. Initiate Ongoing Service Within 14 Days	4. Follow-Up Care			5. Penetration Rate	8. HSW Rate	10. Competitive Employment		11. Earning Minimum Wage		12. 30-Day Readmission Rate	
	Children	Adults			Psychiatric — Children	Psychiatric — Adults	Detox			Adults with Mental Illness	Adults with Developmental Disabilities	Adults with Mental Illness	Adults with Developmental Disabilities	Children	Adults
Access Alliance	100	98.90	99.43	97.70	96.15	92.93	100	6.94	97.38	12.51	8.77	42.38	34.32	3.57	18.92
CMHAMM	100	97.54	99.78	98.90	100	96.36	100	5.82	98.92	11.24	10.03	72.37	47.78	0.00	13.56
CMH Central	97.22	100	100	98.10	100	97.78	100	8.12	99.45	14.10	12.55	12.16	4.85	0.00	0.00
CMHPSM	100	100	98.03	98.97	100	98.51	100	5.83	96.97	13.27	13.55	43.61	40.43	6.06	5.95
Detroit-Wayne	99.07	89.30	92.00	93.94	89.42	74.88	100	5.08	93.93	3.12	2.80	10.32	1.49	6.82	13.41
Genesee	98.11	97.46	97.33	97.12	96.00	97.04	100	5.04	97.38	5.35	4.09	74.56	18.59	3.13	12.12
Lakeshore	96.30	99.12	95.08	94.48	100	100	100	NV	98.25	11.43	15.38	57.14	33.33	0.00	8.33
LifeWays	100	100	100	98.57	100	100	100	6.27	99.26	11.18	8.46	61.48	39.19	9.09	33.33
Macomb	100	99.61	98.85	94.51	100	98.08	100	6.67	98.76	9.09	6.84	37.40	16.35	15.38	12.65
network180	94.55	98.17	99.37	94.62	94.74	99.01	80.00	5.40	100	12.51	10.17	35.42	13.63	4.88	9.38
NorthCare	100	100	98.29	98.09	92.86	98.00	100	6.24	96.46	14.58	8.76	50.11	31.54	4.55	17.86
Northern Affiliation	100	100	99.28	97.70	100	97.73	100	6.99	97.94	12.15	9.78	59.18	46.82	8.33	12.50
Northwest CMH	100	100	94.88	97.81	87.50	91.18	100	7.47	96.11	14.33	15.94	66.39	66.19	21.05	13.70
Oakland	97.27	96.30	99.14	98.67	100	98.75	100	7.33	98.62	10.68	10.87	52.43	23.44	3.45	12.90
Saginaw	100	99.55	100	97.40	100	100	70.00	4.44	95.65	5.98	10.38	33.58	12.92	0.00	15.22
Southwest Alliance	98.90	98.83	99.69	98.04	100	95.74	94.44	6.21	98.05	9.83	18.58	66.22	66.76	12.50	5.26
Thumb Alliance	100	100	98.92	97.82	100	100	89.47	7.35	100	11.62	4.99	35.48	10.12	0.00	11.86
Venture	100	100	98.34	96.68	100	100	100	6.26	97.78	11.96	7.78	25.33	13.99	0.00	4.11
Statewide Rate	**99.05**	**95.90**	**97.77**	**96.69**	**95.49**	**88.89**	**97.62**	**5.95**	**97.49**	**9.11**	**8.71**	**44.77**	**22.76**	**6.76**	**12.63**
MDCH Standard	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	NA	NA	NA	NA	NA	NA	≤15%	≤15%

Note: Shaded cells indicate performance not meeting the MDCH minimum performance standard.
NA: Not Applicable NV: Not Valid

Section 3 (PIHP-specific findings) and Appendix A (comparison to prior-year performance) contain additional details about the PIHPs' performance on the validation of performance measures.

Findings for the 2007–2008 Validation of Performance Improvement Projects

For each PIHP, HSAG validated one PIP based on CMS' Protocol. PIHPs continued with their PIP topics validated in 2006–2007. MDCH mandated the study topic, *Ongoing Service Within 14 Days of Nonemergent Assessment,* in 2006–2007 for all but two PIHPs. MDCH had allowed two of the PIHPs that had met the performance standard to select a different PIP study topic. The PIHPs were in different stages of PIP implementation; therefore, the number of CMS PIP Protocol activities evaluated differed among the PIHPs.

Table 1-8 presents a summary of the PIHPs' validation status results. Most PIHPs received a *Met* validation status. For 2007–2008, the number of PIHPs that received a validation status of *Not Met* decreased from two PIHPs in 2006–2007 to only one.

Table 1-8—PIHPs' PIP Validation Status

Validation Status	Number of PIHPs
Met	13
Partially Met	4
Not Met	1

Table 1-9 presents a statewide summary of the PIHPs' PIP validation results for each of the CMS PIP Protocol activities. HSAG validated Activities I through VI for all 18 PIHPs. All or almost all of the PIHPs *Met* all critical and noncritical evaluation elements for Activities I, II, III, and IV. HSAG rated all elements for Activity V *NA* for all PIPs except one that used a revised methodology. Seventeen PIPs had progressed far enough to allow evaluation of Activity IX, and one had progressed to Activity X.

Table 1-9—Summary of Data from Validation of Performance Improvement Projects

Validation Activity		Number of PIPs Meeting All Evaluation Elements/ Number Reviewed	Number of PIPs Meeting All Critical Elements/ Number Reviewed
I.	Appropriate Study Topic	18/18	18/18
II.	Clearly Defined, Answerable Study Question	18/18	18/18
III.	Clearly Defined Study Indicator(s)	17/18	17/18
IV.	Correctly Identified Study Population	18/18	18/18
V.	Valid Sampling Techniques*	18/18	18/18
VI.	Accurate/Complete Data Collection	13/18	17/18
VII.	Appropriate Improvement Strategies	11/17	14/17
VIII.	Sufficient Data Analysis and Interpretation	6/17	16/17
IX.	Real Improvement Achieved	6/17	NA
X.	Sustained Improvement Achieved	1/1	NA

*HSAG scored all evaluation elements *Not Applicable* for 17 of the 18 PIPs, as the studies did not use sampling.

Overall, the PIHPs demonstrated compliance with CMS PIP Protocol requirements in the areas of the study topic, study question(s), study indicator(s), study population, and accurate and complete data collection. For PIHPs that had progressed far enough, the results of the validation reflected high levels of compliance with requirements related to appropriate improvement strategies. HSAG identified opportunities for improvement for the later activities, which addressed requirements related to data analysis and interpretation as well as the achievement of real improvement.

The PIHPs demonstrated statewide strengths in the following areas, particularly in the early activities: PIP documentation included comprehensive background information for the study topic, explanations of the study population, and detailed descriptions of the data collection methodology and qualifications of staff members involved in data collection. The PIHPs also selected improvement strategies related to causes/barriers identified through data analysis and that represented system changes that were likely to produce permanent change. Most PIHPs conducted sufficient data analysis and interpretation according to the PIP's analysis plan, used the same methodology for baseline and remeasurement data, and showed documented improvement that appeared to be the result of the planned interventions. Recommendations for improvement, when noted, primarily addressed the presentation of the data analysis and the need for appropriate statistical testing to determine whether or not observed improvement was true improvement.

Table 1-10 presents the PIHP results of the 2007-2008 PIP validation. Most PIHPs demonstrated high levels of compliance with the CMS PIP Protocols.

Table 1-10—PIHPs' PIP Validation Results

PIHP	% of All Elements *Met*	% of All Critical Elements *Met*	Validation Status
Access Alliance	94%	100%	*Met*
CMHAMM	95%	100%	*Met*
CMH Central	75%	90%	*Partially Met*
CMHPSM	100%	100%	*Met*
Detroit-Wayne	80%	91%	*Partially Met*
Genesee	100%	100%	*Met*
Lakeshore	91%	90%	*Partially Met*
LifeWays	94%	100%	*Met*
Macomb	91%	100%	*Met*
network180	91%	100%	*Met*
NorthCare	88%	100%	*Met*
Northern Affiliation	86%	100%	*Met*
Northwest CMH	63%	82%	*Not Met*
Oakland	93%	100%	*Met*
Saginaw[1-5]	100%	100%	*Met*
Southwest Affiliation	94%	100%	*Met*
Thumb Alliance	96%	100%	*Met*
Venture	94%	90%	*Partially Met*

[1-5] Saginaw achieved a *Met* validation status based on evaluation activities that focused on PIP design. They have failed to demonstrate any substantial progress toward fully implementing this PIP.

Section 3 (PIHP-specific findings) and Appendix A (comparison to prior-year performance) contain additional detail about the PIHPs' performance on the validation of PIPs.

Conclusions

Findings from the 2007–2008 EQR activities reflected continued improvement in the **quality** and **timeliness** of and **access** to care and services provided by the PIHPs. Across all three EQR activities, the PIHPs demonstrated improvements over prior-year performance and high levels of compliance with federal, State, and contractual requirements related to the provision of care to beneficiaries.

PIHP performance on the compliance monitoring standards reflected high levels of compliance across all standards. These findings indicated that overall, the PIHPs have been successful in implementing corrective actions identified in the 2006–2007 compliance reviews.

The PIHPs demonstrated high levels of compliance with the requirements of the CMS PIP Protocol, resulting in valid PIPs that gave confidence in the reported results and, when applicable, achieved real improvements in care.

The results from the validation of performance measures showed that the PIHPs continued to improve on their processes to collect and report valid performance indicator data. The performance measure rates continued to improve over previous years' results.

Introduction

This section of the report describes the manner in which the data from activities conducted in accordance with 42 CFR 438.358 were aggregated and analyzed and how conclusions were drawn as to the quality and timeliness of and access to care furnished by each PIHP.

Section 3 presents the conclusions drawn from the data and recommendations related to health care quality, timeliness, and access for each PIHP.

Compliance Monitoring Reviews

Objectives

Private accreditation organizations, state licensing and Medicaid agencies, and the federal Medicare program all recognize that having standards is only the first step in promoting safe and effective health care. Making sure that the standards are followed is the second step. According to 42 CFR 438.358, the state or its EQRO must conduct a review within a three-year period to determine the PIHPs' compliance with QAPI program standards. To complete this requirement, HSAG, through its EQRO contract with the State of Michigan, performed compliance evaluations of the 18 PIHPs with which the State contracts.

The 2004–2005 and 2005–2006 compliance monitoring reviews evaluated the PIHPs' compliance with federal and State regulations and with contractual requirements related to the following areas:

- Standard I. Plan and Structure
- Standard II. Performance Measurement and Improvement
- Standard III. Practice Guidelines
- Standard IV. Staff Qualifications and Training
- Standard V. Utilization Management
- Standard VI. Customer Service
- Standard VII. Recipient Grievance Process
- Standard VIII. Enrollee Rights and Protections

The primary objective of the 2006–2007 and 2007–2008 reviews was to determine the PIHPs' compliance with federal and State regulations and with contractual requirements for the following standards:

- Standard IX. Subcontracts and Delegation
- Standard X. Provider Network
- Standard XI. Credentialing
- Standard XII. Access and Availability
- Standard XIII. Coordination of Care
- Standard XIV. Appeals
- Standard XV. Advance Directives

MDCH and the individual PIHPs use the information and findings from the compliance reviews to:

- Evaluate the quality and timeliness of and access to behavioral health care furnished by the PIHPs.
- Identify, implement, and monitor system interventions to improve quality.
- Evaluate the current performance processes.
- Plan and initiate activities to sustain and enhance current performance processes.

This is the fourth year that HSAG has performed an evaluation of the PIHPs' compliance. The results from these reviews will provide an opportunity to inform MDCH and the PIHPs of areas of strength and any corrective actions needed.

Technical Methods of Data Collection

Prior to beginning compliance reviews of the PIHPs, HSAG developed standardized tools for use in the reviews. The content of the tools was based on applicable federal and State laws and regulations and the requirements set forth in the contract agreement between MDCH and the PIHPs. HSAG also followed the guidelines in the February 11, 2003, CMS protocol, *Monitoring Medicaid Managed Care Organizations and Prepaid Inpatient Health Plans*. For the 2007–2008 follow-up compliance reviews, the tools were customized for each PIHP, based on their performance in 2006–2007, to include only those standards for which the PIHP scored less than 100 percent and only those elements for which the PIHP scored *Substantially Met*, *Partially Met*, or *Not Met*.

For each of the PIHP reviews, HSAG followed the same basic steps:

- **Pre-review Activities:** In addition to scheduling the follow-up review and developing the review agenda, HSAG conducted the key pre-review activity of requesting and reviewing various documents to demonstrate the implementation of the corrective action plan developed in response to the 2006–2007 review (policies, member materials, subcontracts, etc.) and the customized comprehensive EQR compliance review tool that was adapted from CMS protocols. The focus of the desk review was to identify compliance with the BBA and MDCH contractual rules and regulations.
- HSAG developed an appeal record review tool and requested audit samples based on data files supplied by each PIHP. These files included logs of beneficiary appeals for the period of April 1, 2007, through September 30, 2007. From each of these files, HSAG selected random samples of appeal files for review. The follow-up reviews addressed only those criteria where the PIHP scored less than *Met* on the related element during the 2006–2007 compliance review.
- **Follow-Up Review:** The follow-up reviews were conducted either on-site (for PIHPs that scored 75 percent or less on two or more standards in the 2006–2007 compliance review) or via a telephone conference call between key PIHP staff members and the HSAG review team. The on-site reviews, lasting one to two days, included an entrance conference, document and record reviews using the HSAG compliance monitoring and record review tools, and interviews with key PIHP staff. An exit conference was conducted at the conclusion of the on-site reviews, when preliminary findings and recommendations were summarized. Telephonic reviews lasted one to two hours, and included an opening statement to detail the review process and objectives, discussions with key PIHP staff to evaluate the implementation of the corrective action plans

and degree of compliance for each of the standards and elements included in the follow-up review, a discussion of findings from the review of appeal records when applicable, and a closing statement.

- **Compliance Monitoring Report:** After completing the review, analysis, and scoring of the information obtained from the desk audit and the follow-up reviews, HSAG prepared a detailed report of the compliance monitoring review findings and recommendations for each PIHP.
- Based on the findings, each PIHP that did not receive a score of *Met* for all elements was required to submit a performance improvement plan to MDCH for any standard element receiving a finding of *Substantially Met, Partially Met,* or *Not Met*. HSAG provided each PIHP with a template for the corrective action plan.

Description of Data Obtained

To assess the PIHPs' compliance with federal and State requirements, HSAG obtained information from a wide range of written documents produced by the PIHPs, including:

- Committee meeting agendas, minutes, and handouts.
- Policies and procedures.
- The QAPI program plan, work plan, and annual evaluation.
- Management/monitoring reports (e.g., grievances, utilization).
- Provider service and delegation agreements and contracts.
- The provider manual and directory.
- The consumer handbook and informational materials.
- Staff training materials and documentation of attendance.
- Consumer satisfaction results.
- Correspondence.
- Records or files related to beneficiary appeals.

Interviews with PIHP staff (e.g., PIHP leadership, grievances and appeals staff, network management staff, etc.) provided additional information.

Table 2-1 lists the PIHP data sources used in the compliance determinations and the time period to which the data applied.

Table 2-1—Description of PIHP Data Sources	
Data Obtained	**Time Period to Which the Data Applied**
Desk Review Documentation	Date of Corrective Action Plan to Date of Review
Appeal Records	April 1, 2007, to September 30, 2007
Information From Interviews Conducted	Date of Corrective Action Plan to Date of Review

Data Aggregation, Analysis, and How Conclusions Were Drawn

Reviewers used the compliance monitoring and appeal record review tools to document findings regarding PIHP compliance with the standards. Results of the record review were incorporated into the scoring of the related elements. Based on the evaluation of findings, reviewers noted compliance with each element. The compliance monitoring tool listed the score for each element evaluated.

Findings for the Access and Availability standard were derived from the Michigan Mission-Based Performance Indicator System—Access Domain, Indicators 1 through 4.b. The PIHPs routinely report quarterly performance data to MDCH. MDCH provided data directly to HSAG for the second and third quarters of FY 2006–2007.

HSAG evaluated and scored each element addressed in the follow-up review as *Met, Substantially Met, Partially Met, Not Met*, or *Not Applicable,* except that *Substantially Met* was not applicable to the Access and Availability standard. The overall score for each of the seven standards was determined by totaling the number of *Met* from both the 2006–2007 and 2007–2008 reviews (value: 1 point) and the number of *Substantially Met* (0.75 points), *Partially Met* (0.50 points), *Not Met* (0.00 points), and *Not Applicable* (0.00 points) elements for the standard from the follow-up review, then dividing the summed score by the total number of applicable elements for that standard. The same methodology was used to determine the overall performance rating for each PIHP and the statewide scores, summing the values of the ratings and dividing that sum by the total number of applicable elements.

To draw conclusions and make overall assessments about the quality and timeliness of and access to care provided by the PIHPs from the findings of the compliance monitoring reviews (as described in Section 3), HSAG assigned each of the standards to one or more of the three domains as depicted in Table 2-2.

Table 2-2—Assignment of Standards to Performance Domains

Standard	Quality	Timeliness	Access
IX. Subcontracts and Delegation	✓		
X. Provider Network	✓		✓
XI. Credentialing	✓		
XII. Access and Availability		✓	✓
XIII. Coordination of Care	✓		✓
XIV. Appeals	✓	✓	
XV. Advance Directives	✓		

Validation of Performance Measures

Objectives

As set forth in 42 CFR 438.358, validation of performance measures was one of the mandatory EQR activities. The primary objectives of the performance measure validation process were to:

- Evaluate the accuracy of the performance measure data collected by the PIHP.
- Determine the extent to which the specific performance measures calculated by the PIHP (or on behalf of the PIHP) followed the specifications established for each performance measure.
- Identify overall strengths and areas for improvement in the performance measure calculation process.

HSAG validated a set of 12 performance indicators developed by MDCH and selected for validation. Each PIHP collected and reported seven of these indicators on a quarterly basis, with the remaining five calculated by MDCH.

Technical Methods of Data Collection and Analysis

HSAG conducted the performance measure validation process in accordance with CMS guidelines in *Validating Performance Measures: A Protocol for Use in Conducting Medicaid External Quality Review Activities, Final Protocol, Version 1.0, May 1, 2002*.

HSAG followed the same process when validating each performance measure for each PIHP, which included the following steps:

- **Pre-review Activities**: Based on the measure definitions and reporting guidelines, HSAG reviewed:
  - Measure-specific worksheets developed by HSAG based on the CMS protocol and used to improve the efficiency of validation work performed on-site.
  - An Information Systems Capabilities Assessment Tool (ISCAT) customized to Michigan's service delivery system and used to collect the necessary background information on the PIHPs' policies, processes, and data needed for the on-site performance validation activities.
  - Other requested documents. Prior to the on-site reviews, HSAG asked each PIHP to complete the ISCAT. In addition to the ISCAT, other requested documents included source code for performance measure calculation, prior performance measure reports, and supporting documentation that provided reviewers with additional information to complete the validation process. Other pre-review activities included scheduling the on-site reviews and preparing the agendas for the on-site visits. When requested, HSAG conducted pre-on-site conference calls with the PIHPs to discuss any outstanding ISCAT questions and the on-site visit activities.
- **On-site Review**: HSAG conducted site visits to each PIHP to validate the processes used to collect performance data and report the performance indicators, and a site visit to MDCH to validate the performance measure calculation process.

  The on-site reviews, which lasted one day, included:

- An opening meeting to review the purpose, required documentation, basic meeting logistics, and queries to be performed.
- Assessment of information systems compliance, focusing on the processing of claims and encounters, recipient Medicaid eligibility data, and provider data. Additionally, the review evaluated the processes used by MDCH to collect and calculate the performance measures, including accurate numerator and denominator identifications and algorithmic compliance to determine if rate calculations were correct.
- Review of the ISCAT and supporting documentation, including a review of processes used for collecting, storing, validating, and reporting the performance measure data. This interactive session with key PIHP and MDCH staff members allowed HSAG to obtain a complete picture of the degree of compliance with written documentation. HSAG conducted interviews to confirm findings from the documentation review, expand or clarify outstanding issues, and ascertain that the PIHPs used and followed written policies and procedures in daily practice.
- An overview of data integration and control procedures, including discussion and observation of source code logic and a review of how all data sources were combined. The data file was produced for the reporting of the selected performance measures. Primary source verification further validated the output files. HSAG reviewed backup documentation on data integration and addressed data control and security procedures during this session.
- A closing conference to summarize preliminary findings based on the review of the ISCAT and the on-site review, and to revisit the documentation requirements for any post-review activities.

Description of Data Obtained

As identified in the CMS protocol, HSAG obtained and reviewed the following key types of data as part of the validation of performance measures:

- **Information Systems Capabilities Assessment Tool (ISCAT).** HSAG received this tool from each PIHP. The completed ISCATs provided HSAG with background information on MDCH's and the PIHPs' policies, processes, and data in preparation for the on-site validation activities.
- **Source Code (Programming Language) for Performance Measures.** HSAG obtained this source code from each PIHP (if applicable) and MDCH. HSAG used the code to determine compliance with the performance measure definitions.
- **Previous Performance Measure Reports.** HSAG obtained these reports from each PIHP and reviewed the reports to assess trending patterns and rate reasonability.
- **Supporting Documentation.** This documentation provided additional information needed by HSAG reviewers to complete the validation process, including performance measure definitions, file layouts, system flow diagrams, system log files, policies and procedures, data collection process descriptions, and file consolidations or extracts.
- **Current Performance Measure Results.** HSAG obtained the calculated results from MDCH and each of the PIHPs.

- **On-site Interviews and Demonstrations.** HSAG also obtained information through interaction, discussion, and formal interviews with key PIHP and MDCH staff members, as well as through system demonstrations.

Table 2-3 displays the data sources used in the validation of performance measures and the time period to which the data applied.

Table 2-3—Description of Data Sources

Data Obtained	Time Period to Which the Data Applied
ISCAT (From PIHPs)	State Fiscal Year (SFY) 2007
Source Code (Programming Language) for Performance Measures (From MDCH)	SFY 2007
Previous Performance Measure Reports (From PIHPs)	SFY 2007
Performance Measure Reports (From PIHPs and MDCH)	First Quarter of SFY 2008
Supporting Documentation (From PIHPs and MDCH)	First Quarter of SFY 2008
On-site Interviews and Demonstrations (From PIHPs and MDCH)	First Quarter of SFY 2008

Table 2-4 displays the performance indicators included in the validation of performance measures, the agency responsible for calculating the indicator, and the validation review period to which the data applied.

Table 2-4—List of Performance Indicators for PIHPs

Indicator		Calculation by:	Validation Review Period
1.	Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	PIHP	First Quarter SFY 2008
2.	Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	PIHP	First Quarter SFY 2008
3.	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional.	PIHP	First Quarter SFY 2008
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	PIHP	First Quarter SFY 2008
4b.	Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	PIHP	First Quarter SFY 2008
5.	Percentage of Medicaid recipients having received PIHP-managed services (penetration rate).	MDCH	First Quarter SFY 2008
8.	Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination (HSW rate).	MDCH	First Quarter SFY 2008

Table 2-4—List of Performance Indicators for PIHPs			
Indicator		Calculation by:	Validation Review Period
10.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who are employed competitively.	MDCH	SFY 2007
11.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who earned minimum wage or more from any employment activities.	MDCH	SFY 2007
12.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	PIHP	First Quarter SFY 2008
13.	Annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by the PIHPs.	MDCH	SFY 2007
14.	Number of sentinel events during the six-month period per 1,000 Medicaid beneficiaries served, by the following populations: adults with mental illness, children with mental illness, persons with developmental disabilities not on the HSW, persons on the HSW, and persons with substance abuse disorder.	PIHP	Last Half of SFY 2007

Data Aggregation, Analysis, and How Conclusions Were Drawn

Based on all validation activities, HSAG determined results for each performance measure. As set forth in the CMS protocol, HSAG gave a validation finding of *Fully Compliant*, *Substantially Compliant*, *Not Valid,* or *Not Applicable* for each performance measure. HSAG based each validation finding on the magnitude of errors detected for the measure's evaluation elements, not by the number of elements determined to be *Not Met*. Consequently, it was possible that an error for a single element resulted in a designation of *Not Valid* because the impact of the error biased the reported performance measure by more than 5 percentage points. Conversely, it was also possible that several element errors had little impact on the reported rate and HSAG gave the indicator a designation of *Substantially Compliant*.

After completing the validation process, HSAG prepared a report of the performance measure review findings and recommendations for each PIHP reviewed. HSAG forwarded these reports, which complied with 42 CFR 438.364, to MDCH and the appropriate PIHPs.

To draw conclusions and make overall assessments about the quality and timeliness of and access to care provided by the PIHPs using the results of the performance measures (as described in Section 3), HSAG assigned each of the standards to one or more of the three domains, as depicted in Table 2-5.

Table 2-5—Assignment of Performance Measures to Performance Domains

	Indicator	Quality	Timeliness	Access
1.	Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.		✓	✓
2.	Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.		✓	✓
3.	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional.		✓	✓
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	✓	✓	✓
4b.	Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	✓	✓	✓
5.	Percentage of Medicaid recipients having received PIHP-managed services (penetration rate).			✓
8.	Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination (HSW rate).	✓		
10.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who are employed competitively.	✓		
11.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who earned minimum wage or more from any employment activities.	✓		
12.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	✓		
13.	Annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by the PIHPs.	✓		
14.	Number of sentinel events during the six-month period per 1,000 Medicaid beneficiaries served, by the following populations: adults with mental illness, children with mental illness, persons with developmental disabilities not on the HSW, persons on the HSW, and persons with substance abuse disorder.	✓		

Validation of Performance Improvement Projects

Objectives

As part of its QAPI program, each PIHP was required by MDCH to conduct PIPs in accordance with 42 CFR 438.240. The purpose of the PIPs was to achieve, through ongoing measurements and intervention, significant improvement sustained over time in both clinical care and nonclinical areas. This structured method of assessing and improving PIHP processes was expected to have a favorable affect on health outcomes and beneficiary satisfaction. Additionally, as one of the mandatory EQR activities under the BBA, the State was required to validate the PIPs conducted by its contracted MCOs and PIHPs. To meet this validation requirement for the PIHPs, MDCH contracted with HSAG.

The primary objective of PIP validation was to determine each PIHP's compliance with requirements set forth in 42 CFR 438.240(b)(1), including:

- Measurement of performance using objective quality indicators.
- Implementation of systematic interventions to achieve improvement in quality.
- Evaluation of the effectiveness of the interventions.
- Planning and initiation of activities for increasing or sustaining improvement.

For each PIHP, HSAG performed validation activities on one PIP.

Technical Methods of Data Collection and Analysis

HSAG based the methodology it used to validate PIPs on CMS guidelines as outlined in the CMS publication, *Validating Performance Improvement Projects: A Protocol for Use in Conducting Medicaid External Quality Review Activities, Final Protocol, Version 1.0, May 1, 2002* (CMS PIP Protocol). Using this protocol, HSAG, in collaboration with MDCH, developed the PIP Summary Form, which each PIHP completed and submitted to HSAG for review and evaluation. The PIP Summary Form standardized the process for submitting information regarding PIPs and ensured that all CMS protocol requirements were addressed.

HSAG, with MDCH's input and approval, developed a PIP Validation Tool to ensure uniform validation of PIPs. Using this tool, HSAG reviewed each of the PIPs for the following 10 CMS protocol activities:

- Activity I. Appropriate Study Topic
- Activity II. Clearly Defined, Answerable Study Question(s)
- Activity III. Clearly Defined Study Indicator(s)
- Activity IV. Correctly Identified Study Population
- Activity V. Valid Sampling Techniques (If Sampling Was Used)
- Activity VI. Accurate/Complete Data Collection
- Activity VII. Appropriate Improvement Strategies
- Activity VIII. Sufficient Data Analysis and Interpretation
- Activity IX. Real Improvement Achieved
- Activity X. Sustained Improvement Achieved

Description of Data Obtained

HSAG obtained the data needed to conduct the PIP validation from each PIHP's PIP Summary Form. This form provided detailed information about each PIHP's PIP as it related to the 10 activities being reviewed and evaluated. Table 2-6 presents the source from which HSAG obtained the data and the time period for which the data applied.

Table 2-6—Description of PIHP Data Sources	
Data Obtained	**Time Period to Which the Data Applied**
PIP Summary Form (completed by the PIHP)	FY 2007–2008

Data Aggregation, Analysis, and How Conclusions Were Drawn

Each required protocol activity consisted of evaluation elements necessary to complete a valid PIP. The HSAG PIP Review Team scored the evaluation elements within each activity as *Met*, *Partially Met*, *Not Met*, or *Not Applicable*. The scoring methodology included the *Not Applicable* designation for evaluation elements (including critical elements) that did not apply to the PIP (e.g., all elements in Activity V would be *Not Applicable* in a PIP that did not use any sampling techniques). HSAG used the *Not Assessed* designation when the PIP had not progressed to the remaining steps in the CMS protocol. HSAG removed elements designated as *Not Applicable* or *Not Assessed* from all scoring.

HSAG further identified any applicable *Point of Clarification* when the documentation for an evaluation element included the basic components to meet requirements for the evaluation element (as described in the narrative of the PIP), but enhanced documentation would demonstrate a stronger understanding of the CMS PIP Protocol.

To ensure a valid and reliable review, HSAG designated some of the elements as critical elements. All of the critical elements had to be *Met* for the PIP to produce valid and reliable results.

All PIPs were scored as follows:

- *Met*: All critical elements were *Met* and 80 to 100 percent of all evaluation elements were *Met* across all activities.
- *Partially Met*: All critical elements were *Met* and 60 to 79 percent of all evaluation elements were *Met* across all activities, or one or more critical element(s) were *Partially Met* and the percentage score for all elements across all activities was 60 percent or more.
- *Not Met*: All critical elements were *Met* and less than 60 percent of all evaluation elements were *Met* across all activities or one or more critical element(s) were *Not Met*.

In addition to the validation status (e.g., *Met*), HSAG gave each PIP an overall percentage score for all evaluation elements (including critical elements), which was calculated by dividing the total *Met* by the sum of the total *Met*, *Partially Met,* and *Not Met*. A critical element percentage score was then calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met.*

HSAG assessed the implications of the study's findings on the likely validity and reliability of the results as follows:

- *Met*: Confidence/high confidence in the reported PIP results.
- *Partially Met*: Low confidence in the reported PIP results.
- *Not Met*: Reported PIP results that were not credible.

After completing the validation review, HSAG prepared a report of findings and recommendations for each validated PIP. HSAG forwarded these reports, which complied with 42 CFR 438.364, to MDCH and the appropriate PIHP.

The EQR activities related to PIPs were designed to evaluate the validity and reliability of the PIHP's processes in conducting the PIPs; therefore, HSAG assigned all PIPs to the quality domain as depicted in Table 2-7.

Table 2-7—Assignment of PIPs to Performance Domains

Topic	Quality	Timeliness	Access
One PIP topic for each of the 18 PIHPs	✓		

3. Findings, Strengths, and Recommendations With Conclusions Related to Health Care Quality, Timeliness, and Access

Introduction

This section of the report contains findings from the three EQR activities—compliance monitoring, validation of performance measures, and validation of PIPs—for the 18 PIHPs. It includes a summary of each PIHP's strengths and recommendations for improvement and a summary assessment related to the **quality** and **timeliness** of and **access** to care and services provided by the PIHP. The individual PIHP reports for each EQR activity contain a more detailed description of the results.

Compliance Monitoring

This section of the report presents the results of the 2007–2008 compliance monitoring follow-up reviews. These reviews evaluated the PIHPs' progress in achieving compliance with federal and State regulations and contractual requirements related to those elements in the areas of subcontracts and delegation, provider network, credentialing, access and availability, coordination of care, appeals, and advance directives that scored less than *Met* in the previous review.

HSAG assigned the compliance standards to the domains of **quality**, **timeliness**, and **access** to care as follows: standards addressing the **quality** of care included Standard IX. Subcontracts and Delegation, Standard X. Provider Network, Standard XI. Credentialing, Standard XIII. Coordination of Care, Standard XIV. Appeals, and Standard XV. Advance Directives. HSAG assigned Standard XII. Access and Availability and Standard IV. Appeals to the **timeliness** domain. Standards addressing the **access** domain included Standard X. Provider Network, Standard XII. Access and Availability, and Standard XIII. Coordination of Care.

Access Alliance of Michigan

Overall Compliance Monitoring Results

Table 3-1 presents the results from the initial review in 2006–2007 and the follow-up review in 2007–2008, showing the number of elements for each of the standards that received a score of *Met*, *Substantially Met*, *Partially Met, Not Met*, or *NA* for both review periods. The table also shows total compliance scores after the follow-up review for each of the standards and across all standards. The 2007–2008 External Quality Review Compliance Monitoring Report for **Access Alliance of Michigan** contains details of the follow-up review of standards.

Table 3-1—Summary of Scores for the Standards
Year III (2006–2007) and Year IV (2007–2008)
***for* Access Alliance of Michigan**

Standard		Year	Total Elements	Total Applicable Elements	# *M*	# *SM*	# *PM*	# *NM*	# *NA*	Year IV Total Compliance Score
IX	Subcontracts and Delegation	III	7	7	7	0	0	0	0	100%
		IV		No follow-up review required for this standard.						
X	Provider Network	III	12	12	12	0	0	0	0	100%
		IV		No follow-up review required for this standard.						
XI	Credentialing	III	25	24	9	8	4	3	1	99%
		IV		24	14	1	0	0	0	
XII	Access and Availability	III	17	17	11		4	2	0	88%
		IV		17	3		2	1	0	
XIII	Coordination of Care	III	3	3	3	0	0	0	0	100%
		IV		No follow-up review required for this standard.						
XIV	Appeals	III	15	15	14	1	0	0	0	93%
		IV		15	0	0	0	1	0	
XV	Advance Directives	III	6	6	6	0	0	0	0	100%
		IV		No follow-up review required for this standard.						
	Totals	III	85	84	62	9	8	5	1	96%
		IV		84	17	1	2	2	0	

***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*.

Year IV Total Compliance Score: The overall percentages were calculated by adding the number of elements that received a score of *Met* (initial and follow-up review combined) 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* from the follow-up review, then dividing this total by the total number of applicable elements.

Strengths

Access Alliance of Michigan received an overall compliance score of 96 percent across all standards. In the initial review, the PIHP had achieved 100 percent compliance on the Subcontracts and Delegation, Provider Network, Coordination of Care, and Advance Directives standards, and no follow-up review was required for these standards. **Access Alliance of Michigan** successfully addressed most recommendations for improvement from the initial review, addressing the areas of Credentialing, Access and Availability, and Appeals.

Recommendations

Continued recommendations for improving **Access Alliance of Michigan**'s performance addressed Credentialing, Access and Availability, and Appeals. The PIHP should revise its credentialing policy related to the requirement for primary source verification, continue its efforts to ensure that the PIHP meets or exceeds the contractually required performance level for provision of ongoing services and follow-up care after discharge from a detox unit, and ensure that the local appeal process is fully compliant with the requirements related to the timeliness of the notice of disposition.

Summary Assessment Related to Quality, Timeliness, and Access

Access Alliance of Michigan demonstrated excellent performance across the three domains of **quality**, **timeliness**, and **access**. After the follow-up review, the PIHP achieved full compliance on four of the six standards in the **quality** domain and two of the three standards in the **access** domain. The PIHP received its highest follow-up scores on standards related to **quality**—Credentialing and Appeals—with scores of 99 percent and 93 percent, respectively. The follow-up review included both standards related to **timeliness**—Access and Availability and Appeals—resulting in scores of 88 percent and 93 percent, respectively. Most of the continued recommendations related to this domain. The follow-up review addressed only one of the three standards related to **access** (Access and Availability).

CMH Affiliation of Mid-Michigan

Overall Compliance Monitoring Results

Table 3-2 presents the results from the initial review in 2006–2007 and the follow-up review in 2007–2008, showing the number of elements for each of the standards that received a score of *Met*, *Substantially Met*, *Partially Met, Not Met*, or *NA* for both review periods. The table also shows total compliance scores after the follow-up review for each of the standards and across all standards. The 2007–2008 External Quality Review Compliance Monitoring Report for **CMH Affiliation of Mid-Michigan** contains details of the follow-up review of the standards.

Table 3-2—Summary of Scores for the Standards
Year III (2006–2007) and Year IV (2007–2008)
***for* CMH Affiliation of Mid-Michigan**

Standard		Year	Total Elements	Total Applicable Elements	# *M*	# *SM*	# *PM*	# *NM*	# *NA*	Year IV Total Compliance Score
IX	Subcontracts and Delegation	III	7	7	6	1	0	0	0	96%
		IV		7	0	1	0	0	0	
X	Provider Network	III	12	12	11	1	0	0	0	98%
		IV		12	0	1	0	0	0	
XI	Credentialing	III	25	22	17	1	4	0	3	100%
		IV		22	5	0	0	0	0	
XII	Access and Availability	III	17	17	12		2	3	0	100%
		IV		17	5		0	0	0	
XIII	Coordination of Care	III	3	3	3	0	0	0	0	100%
		IV		No follow-up review required for this standard.						
XIV	Appeals	III	15	15	11	2	2	0	0	92%
		IV		15	1	1	2	0	0	
XV	Advance Directives	III	6	6	3	1	1	1	0	71%
		IV		6	0	1	1	1	0	
	Totals	III	85	82	63	6	9	4	3	96%
		IV		82	11	4	3	1	0	

***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*.

Year IV Total Compliance Score: The overall percentages were calculated by adding the number of elements that received a score of *Met* (initial and follow-up review combined) 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* from the follow-up review, then dividing this total by the total number of applicable elements.

Strengths

CMH Affiliation of Mid-Michigan received an overall compliance score of 96 percent across all standards. In the initial review, the PIHP had achieved 100 percent compliance on the Coordination of Care standard, and no follow-up review was required for this standard. On the Credentialing and Access and Availability standards, **CMH Affiliation of Mid-Michigan** successfully addressed all recommendations for improvement from the 2006–2007 review, achieving 100 percent compliance.

Recommendations

Continued recommendations for improving **CMH Affiliation of Mid-Michigan**'s performance addressed Subcontracts and Delegation, Provider Network, Appeals, and Advance Directives. The PIHP should continue its efforts to ensure that the PIHP's policies, procedures, and processes in these areas are fully compliant with all contractual requirements.

Summary Assessment Related to Quality, Timeliness, and Access

CMH Affiliation of Mid-Michigan demonstrated strong performance across the three domains of **quality**, **timeliness**, and **access**. After the follow-up review, the PIHP achieved full compliance in two of the six standards in the **quality** domain and two of the three standards in the **access** domain. The PIHP showed the largest increase in score from the initial review in the **access** domain for the Access and Availability standard. The **timeliness** domain also reflected improvement, with increased scores for the Access and Availability and Appeals standards. Most of the continued recommendations for improvement related to the **quality** domain, where scores for three of the five standards addressed in the follow-up review remained unchanged (Subcontracts and Delegation, Provider Network, and Advance Directives), with improvement noted on the other two standards (Credentialing and Appeals).

CMH for Central Michigan

Overall Compliance Monitoring Results

Table 3-3 presents the results from the initial review in 2006–2007 and the follow-up review in 2007–2008, showing the number of elements for each of the standards that received a score of *Met*, *Substantially Met*, *Partially Met, Not Met*, or *NA* for both review periods. The table also shows total compliance scores after the follow-up review for each of the standards and across all standards. The 2007–2008 External Quality Review Compliance Monitoring Report for **CMH for Central Michigan** contains details of the follow-up review of the standards.

Table 3-3—Summary of Scores for the Standards
Year III (2006–2007) and Year IV (2007–2008)
***for* CMH for Central Michigan**

Standard		Year	Total Elements	Total Applicable Elements	# *M*	# *SM*	# *PM*	# *NM*	# *NA*	Year IV Total Compliance Score
IX	Subcontracts and Delegation	III	7	7	6	1	0	0	0	100%
		IV		7	1	0	0	0	0	
X	Provider Network	III	12	12	9	2	1	0	0	100%
		IV		12	3	0	0	0	0	
XI	Credentialing	III	25	24	18	5	1	0	1	100%
		IV		24	6	0	0	0	0	
XII	Access and Availability	III	17	17	11		1	5	0	94%
		IV		17	5		0	1	0	
XIII	Coordination of Care	III	3	3	2	1	0	0	0	100%
		IV		3	1	0	0	0	0	
XIV	Appeals	III	15	15	5	0	10	0	0	87%
		IV		15	6	0	4	0	0	
XV	Advance Directives	III	6	6	0	0	2	4	0	100%
		IV		6	6	0	0	0	0	
	Totals	III	85	84	51	9	15	9	1	96%
		IV		84	28	0	4	1	0	

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*.

Year IV Total Compliance Score: The overall percentages were calculated by adding the number of elements that received a score of *Met* (initial and follow-up review combined) 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* from the follow-up review, then dividing this total by the total number of applicable elements.

Strengths

CMH for Central Michigan received an overall compliance score of 96 percent across all standards. On the Subcontracts and Delegation, Provider Network, Credentialing, Coordination of Care, and Advance Directives standards the PIHP successfully addressed all recommendations for improvement from the initial review and achieved 100 percent compliance. The PIHP also improved its performance in the areas of Access and Availability and Appeals, addressing most of the prior recommendations.

Recommendations

Continued recommendations for improving **CMH for Central Michigan**'s performance addressed the areas of Access and Availability and Appeals. The PIHP should continue its efforts to ensure timely ongoing services for developmentally disabled children, that individuals making decisions on beneficiary appeals have the appropriate clinical expertise and were not involved in any previous level of review, and that the PIHP's appeal process complies with all requirements related to the notice of disposition.

Summary Assessment Related to Quality, Timeliness, and Access

CMH for Central Michigan demonstrated excellent performance across the three domains of **quality**, **timeliness**, and **access.** After the follow-up review, the PIHP achieved full compliance on five of the six standards in the **quality** domain and two of the three standards in the **access** domain. The PIHP's strongest performance was in the area of compliance monitoring standards related to **quality**, with five of the six standards receiving scores of 100 percent. In this domain, only the Appeals standard required continued corrective actions. The PIHP's performance in the **access** domain was strong, with two of the three standards (Provider Network and Coordination of Care) receiving scores of 100 percent. While both standards in the **timeliness** domain (Access and Availability and Appeals) showed marked improvement, opportunities for improvement remained in these areas.

CMH Partnership of Southeastern Michigan

Overall Compliance Monitoring Results

Table 3-4 presents the results from the initial review in 2006–2007 and the follow-up review in 2007–2008, showing the number of elements for each of the standards that received a score of *Met*, *Substantially Met*, *Partially Met, Not Met*, or *NA* for both review periods. The table also shows total compliance scores after the follow-up review for each of the standards and across all standards. The 2007–2008 External Quality Review Compliance Monitoring Report for **CMH Partnership of Southeastern Michigan** contains details of the follow-up review of the standards.

Table 3-4—Summary of Scores for the Standards
Year III (2006–2007) and Year IV (2007–2008)
***for* CMH Partnership of Southeastern Michigan**

Standard		Year	Total Elements	Total Applicable Elements	# *M*	# *SM*	# *PM*	# *NM*	# *NA*	Year IV Total Compliance Score
IX	Subcontracts and Delegation	III	7	7	7	0	0	0	0	100%
		IV		No follow-up review required for this standard.						
X	Provider Network	III	12	12	12	0	0	0	0	100%
		IV		No follow-up review required for this standard.						
XI	Credentialing	III	25	23	21	1	1	0	2	100%
		IV		23	2	0	0	0	0	
XII	Access and Availability	III	17	17	10		5	2	0	100%
		IV		17	7		0	0	0	
XIII	Coordination of Care	III	3	3	3	0	0	0	0	100%
		IV		No follow-up review required for this standard.						
XIV	Appeals	III	15	15	15	0	0	0	0	100%
		IV		No follow-up review required for this standard.						
XV	Advance Directives	III	6	6	5	0	1	0	0	100%
		IV		6	1	0	0	0	0	
	Totals	III	85	83	73	1	7	2	2	100%
		IV		83	10	0	0	0	0	

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*.

Year IV Total Compliance Score: The overall percentages were calculated by adding the number of elements that received a score of *Met* (initial and follow-up review combined) 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* from the follow-up review, then dividing this total by the total number of applicable elements.

Strengths

CMH Partnership of Southeastern Michigan received an overall compliance score of 100 percent across all standards. In the initial review, the PIHP had achieved 100 percent compliance on the Subcontracts and Delegation, Provider Network, Coordination of Care, and Appeals standards, and no follow-up review was required for these standards. **CMH Partnership of Southeastern Michigan** achieved 100 percent compliance on the Credentialing, Access and Availability, and Advance Directives standards after the follow-up review.

Recommendations

HSAG had no continued recommendations for improvement as the PIHP achieved 100 percent compliance on all standards.

Summary Assessment Related to Quality, Timeliness, and Access

CMH Partnership of Southeast Michigan demonstrated exceptional performance across the three domains of **quality**, **timeliness**, and **access,** with 100 percent compliance on all standards after the follow-up review. The PIHP addressed all recommendations on the one standard related to **timeliness** and **access** that had previously not been fully compliant—Access and Availability—improving the score from 74 percent to 100 percent. In the **quality** domain, the PIHP implemented corrective actions in the areas of Credentialing and Advance Directives, achieving 100 percent compliance after follow-up on these standards.

Detroit-Wayne County CMH Agency

Overall Compliance Monitoring Results

Table 3-5 presents the results from the initial review in 2006–2007 and the follow-up review in 2007–2008, showing the number of elements for each of the standards that received a score of *Met*, *Substantially Met*, *Partially Met, Not Met*, or *NA* for both review periods. The table also shows total compliance scores after the follow-up review for each of the standards and across all standards. The 2007–2008 External Quality Review Compliance Monitoring Report for **Detroit-Wayne County CMH Agency** contains details of the follow-up review of the standards.

Table 3-5—Summary of Scores for the Standards
Year III (2006–2007) and Year IV (2007–2008)
***for* Detroit-Wayne County CMH Agency**

	Standard	Year	Total Elements	Total Applicable Elements	# M	# SM	# PM	# NM	# NA	Year IV Total Compliance Score
IX	Subcontracts and Delegation	III	7	7	4	2	1	0	0	96%
		IV		7	2	1	0	0	0	
X	Provider Network	III	12	12	10	1	1	0	0	100%
		IV		12	2	0	0	0	0	
XI	Credentialing	III	25	24	2	1	4	17	1	97%
		IV		24	19	3	0	0	0	
XII	Access and Availability	III	17	17	4		5	8	0	59%
		IV		17	3		6	4	0	
XIII	Coordination of Care	III	3	3	2	1	0	0	0	100%
		IV		3	1	0	0	0	0	
XIV	Appeals	III	15	15	3	0	1	11	0	87%
		IV		15	7	4	0	1	0	
XV	Advance Directives	III	6	6	4	1	0	1	0	100%
		IV		6	2	0	0	0	0	
	Totals	III	85	84	29	6	12	37	1	88%
		IV		84	36	8	6	5	0	

***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*.

Year IV Total Compliance Score: The overall percentages were calculated by adding the number of elements that received a score of *Met* (initial and follow-up review combined) 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* from the follow-up review, then dividing this total by the total number of applicable elements.

Strengths

Detroit-Wayne County CMH Agency received an overall compliance score of 88 percent across all standards. On the Provider Network, Coordination of Care, and Advance Directives standards, the PIHP successfully addressed all recommendations from the 2006–2007 review and achieved 100 percent compliance. **Detroit-Wayne County CMH Agency** also addressed almost all of the prior recommendations on the Subcontracts and Delegation, Credentialing, and Appeals standards.

Recommendations

Continued recommendations for improving **Detroit-Wayne County CMH Agency**'s performance addressed Subcontracts and Delegation, Credentialing, Access and Availability, and Appeals. The PIHP should implement corrective actions to ensure that its policies, procedures, and processes in these areas are fully compliant with all contractual requirements.

Summary Assessment Related to Quality, Timeliness, and Access

Detroit-Wayne County CMH Agency demonstrated strong and markedly improved performance across the three domains of **quality**, **timeliness**, and **access**. After the follow-up review, the PIHP achieved full compliance on three of the six standards in the **quality** domain and two of the three standards in the **access** domain. In the **quality** domain, compliance on all six standards improved, with three of the standards receiving 100 percent compliance (Provider Network, Coordination of Care, and Advance Directives). In the **access** domain, **Detroit-Wayne County CMH Agency** achieved 100 percent compliance on two of the three standards (Provider Network and Coordination of Care). While the PIHP markedly increased its compliance in the areas of Access and Availability (from 38 percent to 59 percent) and Appeals (from 23 percent to 87 percent), the two standards in the **timeliness** domain remained the lowest-scoring standards and the areas with most continued opportunities for improvement.

Genesee County CMH

Overall Compliance Monitoring Results

Table 3-6 presents the results from the initial review in 2006–2007 and the follow-up review in 2007–2008, showing the number of elements for each of the standards that received a score of *Met*, *Substantially Met*, *Partially Met, Not Met*, or *NA* for both review periods. The table also shows total compliance scores after the follow-up review for each of the standards and across all standards. The 2007–2008 External Quality Review Compliance Monitoring Report for **Genesee County CMH** contains details of the follow-up review of the standards.

Table 3-6—Summary of Scores for the Standards
Year III (2006–2007) and Year IV (2007–2008)
***for* Genesee County CMH**

Standard		Year	Total Elements	Total Applicable Elements	# *M*	# *SM*	# *PM*	# *NM*	# *NA*	Year IV Total Compliance Score
IX	Subcontracts and Delegation	III	7	0	0	0	0	0	7	NA
		IV		No follow-up review required for this standard.						
X	Provider Network	III	12	12	12	0	0	0	0	100%
		IV		No follow-up review required for this standard.						
XI	Credentialing	III	25	23	21	0	1	1	2	100%
		IV		23	2	0	0	0	0	
XII	Access and Availability	III	17	17	10		4	3	0	100%
		IV		17	7		0	0	0	
XIII	Coordination of Care	III	3	3	3	0	0	0	0	100%
		IV		No follow-up review required for this standard.						
XIV	Appeals	III	15	15	15	0	0	0	0	100%
		IV		No follow-up review required for this standard.						
XV	Advance Directives	III	6	6	5	0	1	0	0	100%
		IV		6	1	0	0	0	0	
	Totals	III	85	76	66	0	6	4	9	100%
		IV		76	10	0	0	0	0	

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*.

Year IV Total Compliance Score: The overall percentages were calculated by adding the number of elements that received a score of *Met* (initial and follow-up review combined) 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* from the follow-up review, then dividing this total by the total number of applicable elements.

Strengths

Genesee County CMH received an overall compliance score of 100 percent across all standards. In the initial review, the PIHP had achieved 100 percent compliance on the Provider Network, Coordination of Care, and Appeals standards. The Subcontracts and Delegation standard was not applicable. No follow-up review was required for these standards. **Genesee County CMH** achieved 100 percent compliance on the Credentialing, Access and Availability, and Advance Directives standards after the follow-up review.

Recommendations

HSAG had no continued recommendations for improvement as the **Genesee County CMH** achieved 100 percent compliance on all standards.

Summary Assessment Related to Quality, Timeliness, and Access

Genesee County CMH demonstrated exceptional performance across the three domains of **quality**, **timeliness**, and **access**, with 100 percent compliance on all standards after the follow-up review. The PIHP addressed all recommendations on the one standard related to **timeliness** and **access** that had not been fully compliant—Access and Availability—improving the score from 71 to 100 percent. In the **quality** domain, the PIHP implemented corrective actions in the areas of Credentialing and Advance Directives, achieving 100 percent compliance in the follow-up review of these standards.

Lakeshore Behavioral Health Alliance

Overall Compliance Monitoring Results

Table 3-7 presents the results from the initial review in 2006–2007 and the follow-up review in 2007–2008, showing the number of elements for each of the standards that received a score of *Met*, *Substantially Met*, *Partially Met, Not Met*, or *NA* for both review periods. The table also shows total compliance scores after the follow-up review for each of the standards and across all standards. The 2007–2008 External Quality Review Compliance Monitoring Report for **Lakeshore Behavioral Health Alliance** contains details of the follow-up review of the standards.

Table 3-7—Summary of Scores for the Standards
Year III (2006–2007) and Year IV (2007–2008)
***for* Lakeshore Behavioral Health Alliance**

Standard		Year	Total Elements	Total Applicable Elements	# *M*	# *SM*	# *PM*	# *NM*	# *NA*	Year IV Total Compliance Score
IX	Subcontracts and Delegation	III	7	7	6	1	0	0	0	100%
		IV		7	1	0	0	0	0	
X	Provider Network	III	12	12	12	0	0	0	0	100%
		IV		No follow-up review required for this standard.						
XI	Credentialing	III	25	23	17	1	4	1	2	100%
		IV		23	6	0	0	0	0	
XII	Access and Availability	III	17	17	14		2	1	0	100%
		IV		17	3		0	0	0	
XIII	Coordination of Care	III	3	3	3	0	0	0	0	100%
		IV		No follow-up review required for this standard.						
XIV	Appeals	III	15	15	13	1	1	0	0	97%
		IV		15	1	0	1	0	0	
XV	Advance Directives	III	6	6	6	0	0	0	0	100%
		IV		No follow-up review required for this standard.						
	Totals	III	85	83	71	3	7	2	2	99%
		IV		83	11	0	1	0	0	

***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*.

Year IV Total Compliance Score: The overall percentages were calculated by adding the number of elements that received a score of *Met* (initial and follow-up review combined) 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* from the follow-up review, then dividing this total by the total number of applicable elements.

Strengths

Lakeshore Behavioral Health Alliance received an overall compliance score of 99 percent across all standards. In the initial review, the PIHP had achieved 100 percent compliance on the Provider Network, Coordination of Care, and Advance Directives standards, and no follow-up review was required for these standards. On the Subcontracts and Delegation, Credentialing, and Access and Availability standards, **Lakeshore Behavioral Health Alliance** successfully addressed all recommendations for improvement from the 2006–2007 review, achieving 100 percent compliance.

Recommendations

The follow-up review identified one continued recommendation for improving **Lakeshore Behavioral Health Alliance**'s performance in the area of appeals: the PIHP should ensure that it complies with all requirements related to the notice of disposition.

Summary Assessment Related to Quality, Timeliness, and Access

Lakeshore Behavioral Health Alliance demonstrated outstanding performance across the three domains of **quality**, **timeliness**, and **access**. After the follow-up review, the PIHP achieved full compliance on five of the six standards in the **quality** domain, one of the two standards in the **timeliness** domain, and all three standards in the **access** domain. In the **quality** domain, the PIHP received compliance scores of 100 percent for two (Subcontracts and Delegation and Credentialing) of the three standards in this domain that were addressed in the follow-up review, with one continued recommendation on the Appeal standard. In the **timeliness** domain, **Lakeshore Behavioral Health Alliance** received a compliance score of 100 percent for one of the two standards (Access and Availability) , and a score of 97 percent for the other (Appeals). The PIHP received 100 percent compliance on the one standard (Access and Availability) in the **access** domain that had not been fully compliant in the initial review.

LifeWays

Overall Compliance Monitoring Results

Table 3-8 presents the results from the initial review in 2006–2007 and the follow-up review in 2007–2008, showing the number of elements for each of the standards that received a score of *Met*, *Substantially Met*, *Partially Met, Not Met*, or *NA* for both review periods. The table also shows total compliance scores after the follow-up review for each of the standards and across all standards. The 2007–2008 External Quality Review Compliance Monitoring Report for **LifeWays** contains details of the follow-up review of the standards.

Table 3-8—Summary of Scores for the Standards
Year III (2006–2007) and Year IV (2007–2008)
***for* LifeWays**

Standard		Year	Total Elements	Total Applicable Elements	# *M*	# *SM*	# *PM*	# *NM*	# *NA*	Year IV Total Compliance Score
IX	Subcontracts and Delegation	III	7	7	6	1	0	0	0	100%
		IV		7	1	0	0	0	0	
X	Provider Network	III	12	12	11	1	0	0	0	98%
		IV		12	0	1	0	0	0	
XI	Credentialing	III	25	23	14	8	1	0	2	99%
		IV		23	8	1	0	0	0	
XII	Access and Availability	III	17	17	9		5	3	0	100%
		IV		17	8		0	0	0	
XIII	Coordination of Care	III	3	3	3	0	0	0	0	100%
		IV		No follow-up review required for this standard.						
XIV	Appeals	III	15	15	5	4	5	1	0	87%
		IV		15	6	2	1	1	0	
XV	Advance Directives	III	6	6	6	0	0	0	0	100%
		IV		No follow-up review required for this standard.						
	Totals	III	85	83	54	14	11	4	2	97%
		IV		83	23	4	1	1	0	

***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*.

Year IV Total Compliance Score: The overall percentages were calculated by adding the number of elements that received a score of *Met* (initial and follow-up review combined) 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* from the follow-up review, then dividing this total by the total number of applicable elements.

Strengths

LifeWays received an overall compliance score of 97 percent across all standards. In the initial review, the PIHP had achieved 100 percent compliance on the Coordination of Care and Advance Directives standards and no follow-up review was required for these standards. On the Subcontracts and Delegation and Access and Availability standards, **LifeWays** successfully addressed all recommendations for improvement from the 2006–2007 review, achieving 100 percent compliance.

Recommendations

Continued recommendations for improving **LifeWays**'s performance addressed Provider Network, Credentialing, and Appeals. The PIHP should implement corrective actions to ensure that its policies, procedures, and processes in these areas are fully compliant with all contractual requirements.

Summary Assessment Related to Quality, Timeliness, and Access

LifeWays demonstrated excellent performance across the three domains of **quality**, **timeliness**, and **access**. After the follow-up review, the PIHP achieved full compliance on three of the six standards in the **quality** domain, one of the two standards in the **timeliness** domain, and two of the three standards in the **access** domain. In the **quality** domain, the PIHP received compliance scores of 100 percent for one (Subcontracts and Delegation) of the four standards in this domain that were addressed in the follow-up review. Most of the continued opportunities for improvement related to standards in this domain. In the **timeliness** domain, **LifeWays** received a compliance score of 100 percent for one of the two of the standards (Access and Availability) and a score of 87 percent for the other (Appeals). The PIHP received 100 percent compliance on one (Access and Availability) of the two standards in the **access** domain that had not been fully compliant in the initial review, and had one continued recommendation for the other (Provider Network).

Macomb County CMH Services

Overall Compliance Monitoring Results

Table 3-9 presents the results from the initial review in 2006–2007 and the follow-up review in 2007–2008, showing the number of elements for each of the standards that received a score of *Met*, *Substantially Met*, *Partially Met, Not Met*, or *NA* for both review periods. The table also shows total compliance scores after the follow-up review for each of the standards and across all standards. The 2007–2008 External Quality Review Compliance Monitoring Report for **Macomb County CMH Services** contains details of the follow-up review of the standards.

Table 3-9—Summary of Scores for the Standards
Year III (2006–2007) and Year IV (2007–2008)
***for* Macomb County CMH Services**

Standard		Year	Total Elements	Total Applicable Elements	# *M*	# *SM*	# *PM*	# *NM*	# *NA*	Year IV Total Compliance Score
IX	Subcontracts and Delegation	III	7	7	5	1	1	0	0	100%
		IV		7	2	0	0	0	0	
X	Provider Network	III	12	11	10	0	1	0	1	100%
		IV		11	1	0	0	0	0	
XI	Credentialing	III	25	22	19	2	1	0	3	100%
		IV		22	3	0	0	0	0	
XII	Access and Availability	III	17	17	13		1	3	0	79%
		IV		17	0		1	3	0	
XIII	Coordination of Care	III	3	3	3	0	0	0	0	100%
		IV		No follow-up review required for this standard.						
XIV	Appeals	III	15	15	1	4	9	1	0	92%
		IV		15	9	5	0	0	0	
XV	Advance Directives	III	6	6	4	0	2	0	0	100%
		IV		6	2	0	0	0	0	
	Totals	III	85	81	55	7	15	4	4	94%
		IV		81	17	5	1	3	0	

***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*.

Year IV Total Compliance Score: The overall percentages were calculated by adding the number of elements that received a score of *Met* (initial and follow-up review combined) 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* from the follow-up review, then dividing this total by the total number of applicable elements.

Strengths

Macomb County CMH Services received an overall compliance score of 94 percent across all standards. In the initial review, the PIHP had achieved 100 percent compliance on the Coordination of Care standard, and no follow-up review was required for this standard. **Macomb County CMH Services** successfully addressed all recommendations from the initial review and achieved 100 percent compliance on the Subcontracts and Delegation, Provider Network, Credentialing, and Advance Directives standards after the follow-up review.

Recommendations

Continued recommendations for improving **Macomb County CMH Service'**s performance addressed the Access and Availability and Appeals standards. The PIHP should implement corrective actions to ensure that its rates for ongoing services and follow-up care after discharge meet or exceed the MDCH benchmark and that its beneficiary appeals policies, procedures, and processes are fully compliant with all contractual requirements.

Summary Assessment Related to Quality, Timeliness, and Access

Macomb County CMH Services demonstrated strong performance across the three domains of **quality**, **timeliness**, and **access**. After the follow-up review, the PIHP achieved full compliance on five of the six standards in the **quality** domain and two of the three standards in the **access** domain. In the **quality** domain, the PIHP received 100 percent compliance on four of the five standards in this domain that were addressed in the follow-up review, with continued recommendations on one standard (Appeals). In the **timeliness** domain, the score for one of the two standards remained the same (Access and Availability), while the score for the second standard (Appeals) improved. All of the continued opportunities for improvement addressed this domain. **Macomb County CMH Services** achieved 100 percent compliance on one (Provider Network) of the two standards that had not been fully compliant, with continued recommendations on the other (Access and Availability).

network180

Overall Compliance Monitoring Results

Table 3-10 presents the results from the initial review in 2006–2007 and the follow-up review in 2007–2008, showing the number of elements for each of the standards that received a score of *Met*, *Substantially Met*, *Partially Met, Not Met*, or *NA* for both review periods. The table also shows total compliance scores after the follow-up review for each of the standards and across all standards. The 2007–2008 External Quality Review Compliance Monitoring Report for **network180** contains details of the follow-up review of the standards.

Table 3-10—Summary of Scores for the Standards
Year III (2006–2007) and Year IV (2007–2008)
***for* network180**

Standard		Year	Total Elements	Total Applicable Elements	# M	# SM	# PM	# NM	# NA	Year IV Total Compliance Score
IX	Subcontracts and Delegation	III	7	7	6	0	1	0	0	96%
		IV		7	0	1	0	0	0	
X	Provider Network	III	12	12	12	0	0	0	0	100%
		IV		No follow-up review required for this standard.						
XI	Credentialing	III	25	23	3	2	18	0	2	88%
		IV		23	13	3	4	0	0	
XII	Access and Availability	III	17	17	12		2	3	0	85%
		IV		17	2		1	2	0	
XIII	Coordination of Care	III	3	3	3	0	0	0	0	100%
		IV		No follow-up review required for this standard.						
XIV	Appeals	III	15	15	11	1	1	2	0	93%
		IV		15	0	4	0	0	0	
XV	Advance Directives	III	6	6	2	1	1	2	0	79%
		IV		6	1	1	2	0	0	
	Totals	III	85	83	49	4	23	7	2	91%
		IV		83	16	9	7	2	0	

***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*.

Year IV Total Compliance Score: The overall percentages were calculated by adding the number of elements that received a score of *Met* (initial and follow-up review combined) 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* from the follow-up review, then dividing this total by the total number of applicable elements.

Strengths

network180 received an overall compliance score of 91 percent across all standards. In the initial review, the PIHP had achieved 100 percent compliance on the Provider Network and Coordination of Care standards, and no follow-up review was required for these standards. **network180** successfully addressed most recommendations from the initial review, addressing the areas of Subcontracts and Delegation, Credentialing, Access and Availability, Appeals, and Advance Directives.

Recommendations

Continued recommendations for improving **network180**'s performance addressed Subcontracts and Delegation, Credentialing, Access and Availability, Appeals, and Advance Directives. The PIHP should implement corrective actions to ensure that its policies, procedures, and processes in these areas are fully compliant with all contractual requirements.

Summary Assessment Related to Quality, Timeliness, and Access

network180 demonstrated strong performance across the three domains of **quality**, **timeliness**, and **access**. After the follow-up review, the PIHP achieved full compliance on two of the six standards in the **quality** domain and two of the three standards in the **access** domain. The PIHP's performance on compliance monitoring standards related to **quality** showed marked improvement in the areas of Credentialing, Appeals, and Advance Directives**.** The PIHP also improved its performance on standards related to **timeliness**, improving the scores on the standards Access and Availability and Appeals. In the **access** domain, **network180** showed improvement on the one standard that had not been in full compliance, Access and Availability. While **network180** implemented corrective actions to increase compliance, continued opportunities for improvement remained across all three domains.

NorthCare

Overall Compliance Monitoring Results

Table 3-11 presents the results from the initial review in 2006–2007 and the follow-up review in 2007–2008, showing the number of elements for each of the standards that received a score of *Met*, *Substantially Met*, *Partially Met, Not Met*, or *NA* for both review periods. The table also shows total compliance scores after the follow-up review for each of the standards and across all standards. The 2007–2008 External Quality Review Compliance Monitoring Report for **NorthCare** contains details of the follow-up review of the standards.

Table 3-11—Summary of Scores for the Standards
Year III (2006–2007) and Year IV (2007–2008)
for **NorthCare**

	Standard	Year	Total Elements	Total Applicable Elements	# *M*	# *SM*	# *PM*	# *NM*	# *NA*	Year IV Total Compliance Score
IX	Subcontracts and Delegation	III	7	7	7	0	0	0	0	100%
		IV		No follow-up review required for this standard.						
X	Provider Network	III	12	12	12	0	0	0	0	100%
		IV		No follow-up review required for this standard.						
XI	Credentialing	III	25	23	15	0	5	3	2	100%
		IV		23	8	0	0	0	0	
XII	Access and Availability	III	17	17	12		4	1	0	97%
		IV		17	4		1	0	0	
XIII	Coordination of Care	III	3	3	3	0	0	0	0	100%
		IV		No follow-up review required for this standard.						
XIV	Appeals	III	15	15	15	0	0	0	0	100%
		IV		No follow-up review required for this standard.						
XV	Advance Directives	III	6	6	5	0	1	0	0	100%
		IV		6	1	0	0	0	0	
	Totals	III	85	83	69	0	10	4	2	99%
		IV		83	13	0	1	0	0	

***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*.

Year IV Total Compliance Score: The overall percentages were calculated by adding the number of elements that received a score of *Met* (initial and follow-up review combined) 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* from the follow-up review, then dividing this total by the total number of applicable elements.

Strengths

NorthCare received an overall compliance score of 99 percent across all standards. In the initial review, the PIHP had achieved 100 percent compliance on the Subcontracts and Delegation, Provider Network, Coordination of Care, and Appeals standards, and no follow-up review was required for these standards. On the Credentialing and Advance Directives standards, **NorthCare** successfully addressed all recommendations for improvement from the 2006–2007 review, achieving 100 percent compliance.

Recommendations

The follow-up review identified one continued recommendation for improving **NorthCare**'s performance: the PIHP should continue its efforts to ensure timely access to ongoing services for children with developmental disabilities.

Summary Assessment Related to Quality, Timeliness, and Access

NorthCare demonstrated outstanding performance across the three domains of **quality**, **timeliness**, and **access**. After the follow-up review, the PIHP achieved full compliance on all six standards in the **quality** domain, one of the two standards in the **timeliness** domain, and two of the three standards in the **access** domain. In the **quality** domain, the PIHP implemented corrective actions in the areas of Credentialing and Advance Directives, achieving 100 percent compliance on follow-up. The PIHP addressed four out of five recommendations on the one standard related to **timeliness** and **access** that had not been fully compliant—Access and Availability—improving the score from 82 to 97 percent.

Northern Affiliation

Overall Compliance Monitoring Results

Table 3-12 presents the results from the initial review in 2006–2007 and the follow-up review in 2007–2008, showing the number of elements for each of the standards that received a score of *Met*, *Substantially Met*, *Partially Met, Not Met*, or *NA* for both review periods. The table also shows total compliance scores after the follow-up review for each of the standards and across all standards. The 2007–2008 External Quality Review Compliance Monitoring Report for **Northern Affiliation** contains details of the follow-up review of the standards.

Table 3-12—Summary of Scores for the Standards
Year III (2006–2007) and Year IV (2007–2008)
***for* Northern Affiliation**

Standard		Year	Total Elements	Total Applicable Elements	# *M*	# *SM*	# *PM*	# *NM*	# *NA*	Year IV Total Compliance Score
IX	Subcontracts and Delegation	III	7	7	6	0	1	0	0	100%
		IV		7	1	0	0	0	0	
X	Provider Network	III	12	12	12	0	0	0	0	100%
		IV		No follow-up review required for this standard.						
XI	Credentialing	III	25	24	18	3	0	3	1	100%
		IV		24	6	0	0	0	0	
XII	Access and Availability	III	17	17	14		3	0	0	94%
		IV		17	1		2	0	0	
XIII	Coordination of Care	III	3	3	2	1	0	0	0	100%
		IV		3	1	0	0	0	0	
XIV	Appeals	III	15	15	8	2	1	4	0	97%
		IV		15	6	0	1	0	0	
XV	Advance Directives	III	6	6	3	1	1	1	0	100%
		IV		6	3	0	0	0	0	
	Totals	III	85	84	63	7	6	8	1	98%
		IV		84	18	0	3	0	0	

***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*.

Year IV Total Compliance Score: The overall percentages were calculated by adding the number of elements that received a score of *Met* (initial and follow-up review combined) 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* from the follow-up review, then dividing this total by the total number of applicable elements.

Strengths

Northern Affiliation received an overall compliance score of 98 percent across all standards. In the initial review, the PIHP had achieved 100 percent compliance on the Provider Network standard, and no follow-up review was required for this standard. On the Subcontracts and Delegation, Credentialing, Coordination of Care, and Advance Directives standards, **Northern Affiliation** successfully addressed all recommendations for improvement from the 2006–2007 review, achieving 100 percent compliance.

Recommendations

Continued recommendations for improving **Northern Affiliation**'s performance addressed the areas of Access and Availability and Appeals. The PIHP should continue its efforts to ensure timely access to ongoing services for children and adults with a mental illness and implement corrective actions to ensure that its beneficiary appeals processes comply with all contractual requirements.

Summary Assessment Related to Quality, Timeliness, and Access

Northern Affiliation demonstrated outstanding performance across the three domains of **quality**, **timeliness**, and **access**. After the follow-up review, the PIHP achieved full compliance on five of the six standards in the **quality** domain and two of the three standards in the **access** domain. In the **quality** domain, the PIHP received compliance scores of 100 percent for four of the five standards in this domain that were addressed in the follow-up review, with one continued recommendation in the Appeals standard. In the **timeliness** domain, **Northern Affiliation** improved its performance on the two standards, Access and Availability and Appeals. The PIHP received 100 percent compliance on one of the two standards in the **access** domain that had not been fully compliant (Coordination of Care) and improved compliance on the other (Access and Availability).

Northwest CMH Affiliation

Overall Compliance Monitoring Results

Table 3-13 presents the results from the initial review in 2006–2007 and the follow-up review in 2007–2008, showing the number of elements for each of the standards that received a score of *Met*, *Substantially Met*, *Partially Met, Not Met*, or *NA* for both review periods. The table also shows total compliance scores after the follow-up review for each of the standards and across all standards. The 2007–2008 External Quality Review Compliance Monitoring Report for **Northwest CMH Affiliation** contains details of the follow-up review of the standards.

Table 3-13—Summary of Scores for the Standards
Year III (2006–2007) and Year IV (2007–2008)
***for* Northwest CMH Affiliation**

	Standard	Year	Total Elements	Total Applicable Elements	# *M*	# *SM*	# *PM*	# *NM*	# *NA*	Year IV Total Compliance Score
IX	Subcontracts and Delegation	III	7	7	6	1	0	0	0	100%
		IV		7	1	0	0	0	0	
X	Provider Network	III	12	12	9	3	0	0	0	100%
		IV		12	3	0	0	0	0	
XI	Credentialing	III	25	23	22	1	0	0	2	99%
		IV		23	0	1	0	0	0	
XII	Access and Availability	III	17	17	11		4	2	0	88%
		IV		17	3		2	1	0	
XIII	Coordination of Care	III	3	3	3	0	0	0	0	100%
		IV		No follow-up review required for this standard.						
XIV	Appeals	III	15	15	14	1	0	0	0	100%
		IV		15	1	0	0	0	0	
XV	Advance Directives	III	6	6	3	0	3	0	0	100%
		IV		6	3	0	0	0	0	
	Totals	III	85	83	68	6	7	2	2	97%
		IV		83	11	1	2	1	0	

***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*.

Year IV Total Compliance Score: The overall percentages were calculated by adding the number of elements that received a score of *Met* (initial and follow-up review combined) 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* from the follow-up review, then dividing this total by the total number of applicable elements.

Strengths

Northwest CMH Affiliation received an overall compliance score of 97 percent across all standards. In the initial review, the PIHP had achieved 100 percent compliance on the Coordination of Care standard, and no follow-up review was required for this standard. On the Subcontracts and Delegation, Provider Network, Appeals, and Advance Directives standards, **Northwest CMH Affiliation** successfully addressed all recommendations for improvement from the 2006–2007 review, achieving 100 percent compliance.

Recommendations

Continued recommendations for improving **Northwest CMH Affiliation**'s performance addressed Credentialing and Access and Availability. The PIHP should bring its credentialing policy into compliance by addressing the requirements related notifying providers of adverse credentialing decisions and continue its efforts to provide timely access to ongoing services for developmentally disabled children and timely follow-up care after discharge from an inpatient unit for both children and adults.

Summary Assessment Related to Quality, Timeliness, and Access

Northwest CMH Affiliation demonstrated excellent performance across the three domains of **quality**, **timeliness**, and **access**. After the follow-up review, the PIHP achieved full compliance on five of the six standards in the **quality** domain, one of the two standards in the **timeliness** domain, and two of the three standards in the **access** domain. In the **quality** domain, the PIHP received compliance scores of 100 percent for four of the five standards in this domain that were addressed in the follow-up review, with one continued recommendation for the Credentialing standard. In the **timeliness** domain, **Northwest CMH Affiliation** improved its performance on the two standards that were not fully compliant in the initial review, Access and Availability and Appeals, receiving scores of 88 percent and 100 percent, respectively. The PIHP received 100 percent compliance on one of the two standards in the **access** domain that had not been fully compliant (Provider Network) and improved compliance on the other (Access and Availability).

Oakland County CMH Authority

Overall Compliance Monitoring Results

Table 3-14 presents the results from the initial review in 2006–2007 and the follow-up review in 2007–2008, showing the number of elements for each of the standards that received a score of *Met*, *Substantially Met*, *Partially Met, Not Met*, or *NA* for both review periods. The table also shows total compliance scores after the follow-up review for each of the standards and across all standards. The 2007–2008 External Quality Review Compliance Monitoring Report for **Oakland County CMH Authority** contains details of the follow-up review of the standards.

Table 3-14—Summary of Scores for the Standards
Year III (2006–2007) and Year IV (2007–2008)
***for* Oakland County CMH Authority**

	Standard	Year	Total Elements	Total Applicable Elements	# M	# SM	# PM	# NM	# NA	Year IV Total Compliance Score
IX	Subcontracts and Delegation	III	7	7	7	0	0	0	0	100%
		IV		No follow-up review required for this standard.						
X	Provider Network	III	12	12	12	0	0	0	0	100%
		IV		No follow-up review required for this standard.						
XI	Credentialing	III	25	22	18	1	0	3	3	100%
		IV		22	4	0	0	0	0	
XII	Access and Availability	III	17	17	15		0	2	0	100%
		IV		17	2		0	0	0	
XIII	Coordination of Care	III	3	3	3	0	0	0	0	100%
		IV		No follow-up review required for this standard.						
XIV	Appeals	III	15	15	13	2	0	0	0	97%
		IV		15	0	2	0	0	0	
XV	Advance Directives	III	6	6	5	0	1	0	0	100%
		IV		6	1	0	0	0	0	
	Totals	III	85	82	73	3	1	5	3	99%
		IV		82	7	2	0	0	0	

***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*.

Year IV Total Compliance Score: The overall percentages were calculated by adding the number of elements that received a score of *Met* (initial and follow-up review combined) 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* from the follow-up review, then dividing this total by the total number of applicable elements.

Strengths

Oakland County CMH Authority received an overall compliance score of 99 percent across all standards. In the initial review, the PIHP had achieved 100 percent compliance on the Subcontracts and Delegation, Provider Network, and Coordination of Care standards, and no follow-up review was required for these standards. On the Credentialing, Access and Availability, and Advance Directives standards, **Oakland County CMH Authority** successfully addressed all recommendations for improvement from the 2006–2007 review, achieving 100 percent compliance.

Recommendations

The follow-up review identified two continued recommendations for improving **Oakland County CMH Authority**'s performance related to the Appeals standard. The PIHP should ensure that its beneficiary appeals process complies with all requirements related to the content and timeliness of the notice of disposition.

Summary Assessment Related to Quality, Timeliness, and Access

Oakland County CMH Authority demonstrated outstanding performance across the three domains of **quality**, **timeliness**, and **access**. After the follow-up review, the PIHP achieved full compliance on five of the six standards in the **quality** domain, one of the two standards in the **timeliness** domain, and all three standards in the **access** domain. On the **quality** domain, the PIHP achieved 100 percent compliance on two of the three standards addressed in the follow-up review (Credentialing and Advance Directives). There were two continued opportunities for improvement for the Appeals standard addressing the domains of **quality** and **timeliness**. The PIHP addressed all recommendations on the one standard related to **timeliness** and **access** that had not been fully compliant—Access and Availability.

Saginaw County CMH Authority

Overall Compliance Monitoring Results

Table 3-15 presents the results from the initial review in 2006–2007 and the follow-up review in 2007–2008, showing the number of elements for each of the standards that received a score of *Met*, *Substantially Met*, *Partially Met, Not Met*, or *NA* for both review periods. The table also shows total compliance scores after the follow-up review for each of the standards and across all standards. The 2007–2008 External Quality Review Compliance Monitoring Report for **Saginaw County CMH Authority** contains details of the follow-up review of the standards.

Table 3-15—Summary of Scores for the Standards Year III (2006–2007) and Year IV (2007–2008) *for* Saginaw County CMH Authority

Standard		Year	Total Elements	Total Applicable Elements	# *M*	# *SM*	# *PM*	# *NM*	# *NA*	Year IV Total Compliance Score
IX	Subcontracts and Delegation	III	7	7	6	0	0	1	0	100%
		IV		7	1	0	0	0	0	
X	Provider Network	III	12	12	12	0	0	0	0	100%
		IV		No follow-up review required for this standard.						
XI	Credentialing	III	25	24	13	8	3	0	1	99%
		IV		24	10	1	0	0	0	
XII	Access and Availability	III	17	17	5		0	12	0	62%
		IV		17	4		3	5	0	
XIII	Coordination of Care	III	3	3	3	0	0	0	0	100%
		IV		No follow-up review required for this standard.						
XIV	Appeals	III	15	15	13	1	1	0	0	93%
		IV		15	1	0	0	1	0	
XV	Advance Directives	III	6	6	6	0	0	0	0	100%
		IV		No follow-up review required for this standard.						
	Totals	III	85	84	58	9	4	13	1	91%
		IV		84	16	1	3	6	0	

***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*..

Year IV Total Compliance Score: The overall percentages were calculated by adding the number of elements that received a score of *Met* (initial and follow-up review combined) 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* from the follow-up review, then dividing this total by the total number of applicable elements.

Strengths

Saginaw County CMH Authority received an overall compliance score of 91 percent across all standards. In the initial review, the PIHP had achieved 100 percent compliance on the Provider Network, Coordination of Care, and Advance Directives standards, and no follow-up review was required for these standards. **Saginaw County CMH Authority** implemented corrective actions and achieved 100 percent compliance on the Subcontracts and Delegation standard.

Recommendations

Continued recommendations for improving **Saginaw County CMH Authority**'s performance addressed Credentialing, Access and Availability, and Appeals. The PIHP should implement corrective actions to ensure that its credentialing policy addresses the role of participating providers in making credentialing decisions, that the PIHP meets or exceeds the contractually required performance level for all access standards, and that local appeals are resolved within the applicable time frame.

Summary Assessment Related to Quality, Timeliness, and Access

Saginaw County CMH Authority demonstrated strong performance across the three domains of **quality**, **timeliness**, and **access**. After the follow-up review, the PIHP achieved full compliance on four of the six standards in the **quality** domain and two of the three standards in the **access** domain. On the **quality** domain, the PIHP achieved 100 percent compliance on one of the three standards addressed in the follow-up review (Subcontracts and Delegation) and addressed all but one recommendation in the area of Credentialing. **Saginaw County CMH Authority** markedly improved its performance on the Access and Availability standard, which addressed the domains of **timeliness** and **access**, increasing compliance from 29 to 62 percent.

Southwest Affiliation

Overall Compliance Monitoring Results

Table 3-16 presents the results from the initial review in 2006–2007 and the follow-up review in 2007–2008, showing the number of elements for each of the standards that received a score of *Met*, *Substantially Met*, *Partially Met, Not Met*, or *NA* for both review periods. The table also shows total compliance scores after the follow-up review for each of the standards and across all standards. The 2007–2008 External Quality Review Compliance Monitoring Report for **Southwest Affiliation** contains details of the follow-up review of the standards.

Table 3-16—Summary of Scores for the Standards
Year III (2006–2007) and Year IV (2007–2008)
***for* Southwest Affiliation**

Standard		Year	Total Elements	Total Applicable Elements	# *M*	# *SM*	# *PM*	# *NM*	# *NA*	Year IV Total Compliance Score
IX	Subcontracts and Delegation	III	7	7	6	1	0	0	0	96%
		IV		7	0	1	0	0	0	
X	Provider Network	III	12	12	11	1	0	0	0	100%
		IV		12	1	0	0	0	0	
XI	Credentialing	III	25	24	8	14	1	1	1	96%
		IV		24	12	4	0	0	0	
XII	Access and Availability	III	17	17	13		3	1	0	94%
		IV		17	2		2	0	0	
XIII	Coordination of Care	III	3	3	3	0	0	0	0	100%
		IV		No follow-up review required for this standard.						
XIV	Appeals	III	15	15	13	2	0	0	0	100%
		IV		15	2	0	0	0	0	
XV	Advance Directives	III	6	6	3	1	2	0	0	100%
		IV		6	3	0	0	0	0	
	Totals	III	85	84	57	19	6	2	1	97%
		IV		84	20	5	2	0	0	

***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*.

Year IV Total Compliance Score: The overall percentages were calculated by adding the number of elements that received a score of *Met* (initial and follow-up review combined) 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* from the follow-up review, then dividing this total by the total number of applicable elements.

Strengths

Southwest Affiliation received an overall compliance score of 97 percent across all standards. In the initial review, the PIHP had achieved 100 percent compliance on the Coordination of Care standard, and no follow-up review was required for this standard. On the Provider Network, Appeals, and Advance Directives standards, **Southwest Affiliation** successfully addressed all recommendations for improvement from the 2006–2007 review, achieving 100 percent compliance.

Recommendations

Continued recommendations for improving **Southwest Affiliation**'s performance addressed Subcontracts and Delegation, Credentialing, and Access and Availability. The PIHP should ensure adequate monitoring of its subcontractors' performance, that the credentialing policy is compliant with all requirements of the MDCH credentialing policy, and that the PIHP meets or exceeds the MDCH benchmark for access to ongoing services for mentally ill children and follow-up care for adults.

Summary Assessment Related to Quality, Timeliness, and Access

Southwest Affiliation demonstrated strong performance across the three domains of **quality**, **timeliness**, and **access**. After the follow-up review, the PIHP achieved full compliance on four of the six standards in the **quality** domain, one of the two standards in the **timeliness** domain, and two of the three standards in the **access** domain. In the **quality** domain, the PIHP achieved 100 percent compliance on three (Provider Network, Appeals, and Advance Directives) of the five standards addressed in the follow-up review and addressed most recommendations in the area of Credentialing. **Southwest Affiliation** improved its performance in the **timeliness** domain, increasing compliance on the Access and Availability standard to 94 percent and compliance on the Appeals standard to 100 percent. The PIHP also improved performance related to the **access** domain, achieving 100 percent compliance on one of the two standards addressed in the follow-up review (Provider Network) and improving compliance on the Access and Availability standard.

Thumb Alliance PIHP

Overall Compliance Monitoring Results

Table 3-17 presents the results from the initial review in 2006–2007 and the follow-up review in 2007–2008, showing the number of elements for each of the standards that received a score of *Met*, *Substantially Met*, *Partially Met, Not Met*, or *NA* for both review periods. The table also shows total compliance scores after the follow-up review for each of the standards and across all standards. The 2007–2008 External Quality Review Compliance Monitoring Report for **Thumb Alliance PIHP** contains details of the follow-up review of the standards.

Table 3-17—Summary of Scores for the Standards
Year III (2006–2007) and Year IV (2007–2008)
***for* Thumb Alliance PIHP**

Standard		Year	Total Elements	Total Applicable Elements	# *M*	# *SM*	# *PM*	# *NM*	# *NA*	Year IV Total Compliance Score
IX	Subcontracts and Delegation	III	7	7	7	0	0	0	0	100%
		IV		No follow-up review required for this standard.						
X	Provider Network	III	12	12	12	0	0	0	0	100%
		IV		No follow-up review required for this standard.						
XI	Credentialing	III	25	23	23	0	0	0	2	100%
		IV		No follow-up review required for this standard.						
XII	Access and Availability	III	17	17	16		1	0	0	100%
		IV		17	1		0	0	0	
XIII	Coordination of Care	III	3	3	3	0	0	0	0	100%
		IV		No follow-up review required for this standard.						
XIV	Appeals	III	15	15	15	0	0	0	0	100%
		IV		No follow-up review required for this standard.						
XV	Advance Directives	III	6	6	4	0	2	0	0	100%
		IV		6	2	0	0	0	0	
	Totals	III	85	83	80	0	3	0	2	100%
		IV		83	3	0	0	0	0	

***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*.

Year IV Total Compliance Score: The overall percentages were calculated by adding the number of elements that received a score of *Met* (initial and follow-up review combined) 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* from the follow-up review, then dividing this total by the total number of applicable elements.

Strengths

Thumb Alliance PIHP received an overall compliance score of 100 percent across all standards. In the initial review, the PIHP had achieved 100 percent compliance on the Subcontracts and Delegation, Provider Network, Credentialing, Coordination of Care, and Appeals standards, and no follow-up review was required for these standards. **Thumb Alliance PIHP** achieved 100 percent compliance on the Access and Availability and Advance Directives standards after the follow-up review.

Recommendations

HSAG had no continued recommendations for improvement as the PIHP achieved 100 percent compliance on all standards.

Summary Assessment Related to Quality, Timeliness, and Access

Thumb Alliance PIHP demonstrated exceptional performance across the three domains of **quality**, **timeliness**, and **access,** with 100 percent compliance on all standards after the follow-up review. The PIHP addressed the single recommendation on the one standard related to **timeliness** and **access** that had not been fully compliant—Access and Availability. In the **quality** domain, **Thumb Alliance PIHP** addressed two recommendations in the area of Advance Directives, achieving 100 percent compliance on follow-up for this standard.

Venture Behavioral Health

Overall Compliance Monitoring Results

Table 3-18 presents the results from the initial review in 2006–2007 and the follow-up review in 2007–2008, showing the number of elements for each of the standards that received a score of *Met*, *Substantially Met*, *Partially Met, Not Met*, or *NA* for both review periods. The table also shows total compliance scores after the follow-up review for each of the standards and across all standards. The 2007–2008 External Quality Review Compliance Monitoring Report for **Venture Behavioral Health** contains details of the follow-up review of the standards.

Table 3-18—Summary of Scores for the Standards
Year III (2006–2007) and Year IV (2007–2008)
***for* Venture Behavioral Health**

Standard		Year	Total Elements	Total Applicable Elements	# *M*	# *SM*	# *PM*	# *NM*	# *NA*	Year IV Total Compliance Score
IX	Subcontracts and Delegation	III	7	7	6	1	0	0	0	100%
		IV		7	1	0	0	0	0	
X	Provider Network	III	12	12	11	1	0	0	0	100%
		IV		12	1	0	0	0	0	
XI	Credentialing	III	25	24	23	0	0	1	1	100%
		IV		24	1	0	0	0	0	
XII	Access and Availability	III	17	17	8		1	8	0	91%
		IV		17	7		1	1	0	
XIII	Coordination of Care	III	3	3	3	0	0	0	0	100%
		IV		No follow-up review required for this standard.						
XIV	Appeals	III	15	15	13	2	0	0	0	100%
		IV		15	2	0	0	0	0	
XV	Advance Directives	III	6	6	5	1	0	0	0	100%
		IV		6	1	0	0	0	0	
	Totals	III	85	84	69	5	1	9	1	98%
		IV		84	13	0	1	1	0	

***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*.

Year IV Total Compliance Score: The overall percentages were calculated by adding the number of elements that received a score of *Met* (initial and follow-up review combined) 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* from the follow-up review, then dividing this total by the total number of applicable elements.

Strengths

Venture Behavioral Health received an overall compliance score of 98 percent across all standards. In the initial review, the PIHP had achieved 100 percent compliance on the Coordination of Care standard, and no follow-up review was required for this standard. On the Subcontracts and Delegation, Provider Network, Credentialing, Appeals, and Advance Directives standards, **Venture Behavioral Health** successfully addressed all recommendations for improvement from the 2006–2007 review, achieving 100 percent compliance.

Recommendations

The follow-up review identified two continued recommendations for improving **Venture Behavioral Health**'s performance related to the Access and Availability standard. The PIHP should ensure that it meets or exceeds the MDCH benchmark for face-to-face assessments and access to ongoing services for beneficiaries with a substance abuse disorder.

Summary Assessment Related to Quality, Timeliness, and Access

Venture Behavioral Health demonstrated outstanding performance across the three domains of **quality**, **timeliness**, and **access**. After the follow-up review, the PIHP achieved full compliance on all six standards in the **quality** domain, one of the two standards in the **timeliness** domain, and two of the three standards in the **access** domain. On the **quality** domain, the PIHP implemented corrective actions in the areas of Subcontracts and Delegation, Provider Network, Credentialing, Appeals, and Advance Directives, achieving 100 percent compliance on follow-up. The PIHP markedly improved performance on the one standard related to **timeliness** and **access** that had not been fully compliant (Access and Availability), increasing the score from 50 to 91 percent.

Validation of Performance Measures

This section of the report presents the results for the validation of performance measures and shows audit designations and reported rates. The 2007–2008 validation of performance measures included Indicators 13 and 14; however, MDCH and the PIHPs agreed to report the validation results only and not the actual rates for the measures due to the sensitive nature of the indicators. Indicators 10 and 11 were added for the 2007–2008 validation.

HSAG assigned performance measures to the domains of **quality**, **timeliness**, and **access**. Indicators addressing the **quality** of services provided by the PIHP included follow-up after discharge from a psychiatric inpatient or detox unit, 30-day readmission rates, HSW rate, the percentages of adults who were employed competitively or earned minimum wage or more, and the number of substantiated recipient rights complaints and sentinel events (validation status only for these two measures). The following indicators addressed the **timeliness** of and **access** to services: timely pre-admission screenings, initial assessments, ongoing services, and follow-up care after discharge. The penetration rate addressed the **access** domain.

Access Alliance of Michigan

Findings

Table 3-19 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2008 Validation of Performance Measures Report for **Access Alliance of Michigan** includes additional details of the validation results.

Table 3-19—2007–2008 Performance Measure Results *for* Access Alliance of Michigan			
Indicator		Reported Rate	Audit Designation
1.	Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children: 100%	*Fully Compliant*
		Adults: 98.90%	
2.	Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	99.43%	*Fully Compliant*
3.	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional.	97.70%	*Fully Compliant*
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children: 96.15%	*Fully Compliant*
		Adults: 92.93%	
4b.	Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	100%	*Fully Compliant*
5.	Percentage of Medicaid recipients having received PIHP-managed services (penetration rate).	6.94%	*Fully Compliant*

Table 3-19—2007–2008 Performance Measure Results
***for* Access Alliance of Michigan**

	Indicator	Reported Rate	Audit Designation
8.	Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination (HSW rate).	97.38%	*Fully Compliant*
10.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who are employed competitively.	MI Adults: 12.51% DD Adults: 8.77%	*Fully Compliant*
11.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who earned minimum wage or more from any employment activities.	MI Adults: 42.38% DD Adults: 34.32%	*Fully Compliant*
12.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children: 3.57% Adults: 18.92%	*Fully Compliant*
13.	Annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by the PIHPs.		*Fully Compliant*
14.	Number of sentinel events during the six-month period per 1,000 Medicaid beneficiaries served, by the following populations: adults with mental illness, children with mental illness, persons with developmental disabilities not on the HSW, persons on the HSW, and persons with substance abuse disorder.		*Fully Compliant*

Strengths

Identified strengths for **Access Alliance of Michigan** included the highly collaborative approach to accurate performance measure reporting. The PIHP and the affiliates demonstrated collaboration in the identification of outliers, distribution of results, and development of data completeness protocols. The PIHP implemented a new requirement for its affiliates whereby a written action plan is required when the completeness of quality improvement (QI) data elements falls below 95 percent.

Recommendations

Access Alliance of Michigan should continue its efforts to implement the "clipper" system to facilitate common practices in eligibility and demographic data collection and verification and formal documentation of the processes to verify the accuracy of claims data entry.

Summary Assessment Related to Quality, Timeliness, and Access

Access Alliance of Michigan's performance indicators related to **quality** were *Fully Compliant* with MDCH specifications, including Indicator 13, which received a designation of *Substantially Compliant* last year. The PIHP met or exceeded three of the five contractually required performance standards related to **quality** of services provided by the PIHP. For the remaining indicators in the **quality** domain, **Access Alliance of Michigan** demonstrated the following results: The PIHP's HSW rate of 97 percent equaled the statewide rate. The rates for MI and DD adults who were

employed competitively and the rate of DD adults who earned minimum wage were at or above the statewide rates, while the rate for MI adults who earned minimum wage fell slightly below the statewide rate. Performance indicators related to **timeliness** of and **access** to services were *Fully Compliant* with MDCH specifications. The PIHP met or exceeded the contractually required performance standards for six of the seven performance measures related to **timeliness** of and **access** to services provided by the PIHP. **Access Alliance of Michigan**'s penetration rate of 7 percent exceeded the statewide rate of 6 percent. **Access Alliance of Michigan** demonstrated strong performance across all three domains of **quality**, **timeliness**, and **access** and met the minimum performance standard for a total of seven of the nine indicators.

CMH Affiliation of Mid-Michigan

Findings

Table 3-20 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2008 Validation of Performance Measures Report for **CMH Affiliation of Mid-Michigan** includes additional details of the validation results.

Table 3-20—2007–2008 Performance Measure Results *for* CMH Affiliation of Mid-Michigan

	Indicator	Reported Rate	Audit Designation
1.	Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children: 100% Adults: 97.54%	*Fully Compliant*
2.	Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	99.78%	*Fully Compliant*
3.	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional.	98.90%	*Fully Compliant*
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children: 100% Adults: 96.36%	*Fully Compliant*
4b.	Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	100%	*Fully Compliant*
5.	Percentage of Medicaid recipients having received PIHP-managed services (penetration rate).	5.82%	*Fully Compliant*
8.	Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination (HSW rate).	98.92%	*Fully Compliant*
10.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who are employed competitively.	MI Adults: 11.24% DD Adults: 10.03%	*Fully Compliant*
11.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who earned minimum wage or more from any employment activities.	MI Adults: 72.37% DD Adults: 47.78%	*Fully Compliant*
12.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children: 0.00% Adults: 13.56%	*Fully Compliant*
13.	Annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by the PIHPs.		*Fully Compliant*
14.	Number of sentinel events during the six-month period per 1,000 Medicaid beneficiaries served, by the following populations: adults with mental illness, children with mental illness, persons with developmental disabilities not on the HSW, persons on the HSW, and persons with substance abuse disorder.		*Fully Compliant*

Strengths

CMH Affiliation of Mid-Michigan demonstrated an excellent process for reviewing encounter, QI, and performance improvement data from each affiliate, including feedback and requests for corrective action. The PIHP implemented a Medicaid eligibility warehouse and upgraded its data warehouse, increasing data accuracy and reliability.

Recommendations

CMH Affiliation of Mid-Michigan should increase the sample size for its performance indicator audit to ensure that the PIHP has enough data from which to draw valid conclusions and improve processes based on the findings. Other suggestions included adding reasons for exclusions to the appointment entry system and bringing all affiliates into the same data system to ensure uniformity in data capture throughout the PIHP.

Summary Assessment Related to Quality, Timeliness, and Access

CMH Affiliation of Mid-Michigan's performance indicators related to **quality** were *Fully Compliant* with MDCH specifications. The PIHP met or exceeded all contractually required performance standards related to **quality** of services provided by the PIHP. For the remaining indicators in the **quality** domain, **CMH Affiliation of Mid-Michigan** achieved the following results: The PIHP's HSW rate of 99 percent exceeded the statewide rate of 97 percent. The rates for MI and DD adults who were employed competitively and the rate of MI and DD adults who earned minimum wage were higher than the statewide rates. Performance indicators related to **timeliness** of and **access** to services were *Fully Compliant* with MDCH specifications. **CMH Affiliation of Mid-Michigan** met or exceeded the contractually required performance standards for all performance measures related to **timeliness** of and **access** to services provided by the PIHP. The PIHP's penetration rate of 6 percent equaled the statewide rate. **CMH Affiliation of Mid-Michigan** demonstrated exceptional performance across all three domains of **quality**, **timeliness**, and **access** and met the minimum performance standard for all nine indicators.

CMH for Central Michigan

Findings

Table 3-21 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2008 Validation of Performance Measures Report for **CMH for Central Michigan** includes additional details of the validation results.

Table 3-21—2007–2008 Performance Measure Results *for* CMH for Central Michigan

	Indicator	Reported Rate	Audit Designation
1.	Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children: 97.22% Adults: 100%	*Substantially Compliant*
2.	Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	100%	*Fully Compliant*
3.	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional.	98.10%	*Fully Compliant*
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children: 100% Adults: 97.78%	*Fully Compliant*
4b.	Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	100%	*Fully Compliant*
5.	Percentage of Medicaid recipients having received PIHP-managed services (penetration rate).	8.12%	*Fully Compliant*
8.	Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination (HSW rate).	99.45%	*Fully Compliant*
10.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who are employed competitively.	MI Adults: 14.10% DD Adults: 12.55%	*Fully Compliant*
11.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who earned minimum wage or more from any employment activities.	MI Adults: 12.16% DD Adults: 4.85%	*Fully Compliant*
12.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children: 0.00% Adults: 0.00%	*Fully Compliant*
13.	Annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by the PIHPs.		*Fully Compliant*
14.	Number of sentinel events during the six-month period per 1,000 Medicaid beneficiaries served, by the following populations: adults with mental illness, children with mental illness, persons with developmental disabilities not on the HSW, persons on the HSW, and persons with substance abuse disorder.		*Fully Compliant*

Strengths

CMH for Central Michigan implemented additional oversight activities for its coordinating agency (CA), including regular telephone consultations and using standard query language (SQL) to review data submitted in the 837 file. Other strengths identified for **CMH for Central Michigan** included automated processes for tracking provider performance and providing feedback and making indicator data available online. The PIHP's ability to obtain most of its claims and encounter data electronically and edits built into the system promoted the collection of accurate data.

Recommendations

CMH for Central Michigan should implement a validation process for entering preadmission screening data and automate the calculation of the duration between start and stop date for Indicator 1. The PIHP should improve its data collection processes for minimum wage and developmental disabilities by including these indicators in the e-mail alert system and other feedback mechanisms. The PIHP should explore adding additional explanations for exclusions to the data entry screen.

Summary Assessment Related to Quality, Timeliness, and Access

CMH for Central Michigan's performance indicators related to **quality** were *Fully Compliant* with MDCH specifications. The PIHP met or exceeded all contractually required performance standards related to **quality** of services provided by the PIHP. For the remaining indicators in the **quality** domain, **CMH for Central Michigan** demonstrated the following results: The PIHP's HSW rate of 99 percent exceeded the statewide rate. The rates for MI and DD adults who were employed competitively were higher than the statewide rates. The rates of MI and DD adults who earned minimum wage were markedly lower that the statewide rates; however, completeness of data for these two measures was low. Performance indicators related to **timeliness** of and **access** to services were *Fully Compliant* with MDCH specifications except for Indicator 1, which received a designation of *Substantially Compliant*. **CMH for Central Michigan** met or exceeded the contractually required performance standards for all performance measures related to **timeliness** of and **access** to services provided by the PIHP. The PIHP's penetration rate of 8 percent exceeded the statewide rate. **CMH for Central Michigan** demonstrated exceptional performance across all three domains of **quality**, **timeliness**, and **access** and met the minimum performance standard for all nine indicators.

CMH Partnership of Southeastern Michigan

Findings

Table 3-22 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2008 Validation of Performance Measures Report for **CMH Partnership of Southeastern Michigan** includes additional details of the validation results.

Table 3-22—2007–2008 Performance Measure Results
***for* CMH Partnership of Southeastern Michigan**

	Indicator	Reported Rate	Audit Designation
1.	Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children: 100% Adults: 100%	*Fully Compliant*
2.	Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	98.03%	*Fully Compliant*
3.	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional.	98.97%	*Fully Compliant*
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children: 100% Adults: 98.51%	*Fully Compliant*
4b.	Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	100%	*Fully Compliant*
5.	Percentage of Medicaid recipients having received PIHP-managed services (penetration rate).	5.83%	*Fully Compliant*
8.	Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination (HSW rate).	96.97%	*Fully Compliant*
10.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who are employed competitively.	MI Adults: 13.27% DD Adults: 13.55%	*Fully Compliant*
11.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who earned minimum wage or more from any employment activities.	MI Adults: 43.61% DD Adults: 40.43%	*Fully Compliant*
12.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children: 6.06% Adults: 5.95%	*Fully Compliant*
13.	Annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by the PIHPs.		*Fully Compliant*
14.	Number of sentinel events during the six-month period per 1,000 Medicaid beneficiaries served, by the following populations: adults with mental illness, children with mental illness, persons with developmental disabilities not on the HSW, persons on the HSW, and persons with substance abuse disorder.		*Fully Compliant*

Strengths

CMH Partnership of Southeastern Michigan enhanced data accuracy and completeness through the use of standardized processes and identical information systems across the affiliates and ensured the comparability of data through uniform data collection activities and ongoing monitoring. The PIHP continued efforts to automate the recipient rights function and improved the HSW reconciliation process.

Recommendations

CMH Partnership of Southeastern Michigan should consider extending the audit process across all performance indicators to ensure that all indicators are evaluated in a uniform manner. The PIHP was encouraged to monitor internally for the minimum wage flag until its clinical dashboard is developed and brought online and to implement drop-down boxes to capture reasons for exceptions.

Summary Assessment Related to Quality, Timeliness, and Access

CMH Partnership of Southeastern Michigan's performance indicators related to **quality** were *Fully Compliant* with MDCH specifications. The PIHP met or exceeded all contractually required performance standards related to **quality** of services provided by the PIHP. For the remaining indicators in the **quality** domain, **CMH Partnership of Southeastern Michigan** demonstrated the following results: The PIHP's HSW rate of 97 percent equaled the statewide rate. The rates for MI and DD adults who were employed competitively and the rate of DD adults who earned minimum wage were higher than the statewide rates. The rate of MI adults who earned minimum wage fell slightly below the statewide rate. Performance indicators related to **timeliness** of and **access** to services were *Fully Compliant* with MDCH specifications. **CMH Partnership of Southeastern Michigan** met or exceeded the contractually required performance standards for all performance measures related to **timeliness** of and **access** to services provided by the PIHP. The PIHP's penetration rate of 6 percent equaled the statewide rate. **CMH Partnership of Southeastern Michigan** demonstrated exceptional performance across all three domains of **quality**, **timeliness**, and **access** and met the minimum performance standard for all nine indicators.

Detroit-Wayne County CMH Agency

Findings

Table 3-23 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2008 Validation of Performance Measures Report for **Detroit-Wayne County CMH Agency** includes additional details of the validation results.

Table 3-23—2008 Performance Measure Results *for* Detroit-Wayne County CMH Agency

	Indicator	Reported Rate	Audit Designation
1.	Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children: 99.07% Adults: 89.30%	*Fully Compliant*
2.	Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	92.00%	*Fully Compliant*
3.	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional.	93.94%	*Fully Compliant*
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children: 89.42% Adults: 74.88%	*Fully Compliant*
4b.	Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	100%	*Fully Compliant*
5.	Percentage of Medicaid recipients having received PIHP-managed services (penetration rate).	5.08%	*Fully Compliant*
8.	Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination (HSW rate).	93.93%	*Fully Compliant*
10.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who are employed competitively.	MI Adults: 3.12% DD Adults: 2.80%	*Substantially Compliant*
11.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who earned minimum wage or more from any employment activities.	MI Adults: 10.32% DD Adults: 1.49%	*Substantially Compliant*
12.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children: 6.82% Adults: 13.41%	*Fully Compliant*
13.	Annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by the PIHPs.		*Fully Compliant*
14.	Number of sentinel events during the six-month period per 1,000 Medicaid beneficiaries served, by the following populations: adults with mental illness, children with mental illness, persons with developmental disabilities not on the HSW, persons on the HSW, and persons with substance abuse disorder.		*Fully Compliant*

Strengths

Detroit-Wayne County CMH Agency demonstrated a collaborative relationship with its subcontracted managers of comprehensive provider networks (MCPNs) that has shown marked progress and improved communication. The three-phase transition process to the Peter Chang Enterprises (PCE) system was designed to ensure a seamless transition to the new information system.

Recommendations

Detroit-Wayne County CMH Agency should continue its efforts to improve the completeness of quality improvement data, specifically minimum wage and employment. The PIHP should review and consider revising the processes currently in place for MCPNs to provide data to the PIHP. **Detroit-Wayne County CMH Agency** should continue to work on the transition to the PCE system, documenting all system change procedures to ensure a seamless transition with minimal loss of data.

Summary Assessment Related to Quality, Timeliness, and Access

Detroit-Wayne County CMH Agency's performance indicators related to **quality** were *Fully Compliant* with MDCH specifications except for Indicators 10 and 11, which received a designation of *Substantially Compliant*. The PIHP met or exceeded three of the five contractually required performance standards related to **quality** of services provided by the PIHP. For the remaining indicators in the **quality** domain, **Detroit-Wayne County CMH Agency** demonstrated the following results: The PIHP's HSW rate of 94 percent fell below the statewide rate. The rates for MI and DD adults who were employed competitively and the rates of MI and DD adults who earned minimum wage were lower than the statewide rates. Performance indicators related to **timeliness** of and **access** to services were *Fully Compliant* with MDCH specifications. **Detroit-Wayne County CMH Agency** met or exceeded the contractually required performance standards for two of the seven performance measures related to **timeliness** of and **access** to services provided by the PIHP. The PIHP's penetration rate of 5 percent was lower than the statewide rate. The PIHP met the minimum performance standard for four of the nine indicators. While **Detroit-Wayne County CMH Agency** demonstrated improved performance on several measures across the domains of **quality**, **timeliness**, and **access**, performance on other measures declined and opportunities for improvement remained in all three domains.

Genesee County CMH

Findings

Table 3-24 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2008 Validation of Performance Measures Report for **Genesee County CMH** includes additional details of the validation results.

Table 3-24—2007–2008 Performance Measure Results *for* Genesee County CMH

	Indicator	Reported Rate	Audit Designation
1.	Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children: 98.11% Adults: 97.46%	*Fully Compliant*
2.	Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	97.33%	*Fully Compliant*
3.	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional.	97.12%	*Fully Compliant*
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children: 96.00% Adults: 97.04%	*Fully Compliant*
4b.	Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	100%	*Fully Compliant*
5.	Percentage of Medicaid recipients having received PIHP-managed services (penetration rate).	5.04%	*Fully Compliant*
8.	Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination (HSW rate).	97.38%	*Fully Compliant*
10.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who are employed competitively.	MI Adults: 5.35% DD Adults: 4.09%	*Fully Compliant*
11.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who earned minimum wage or more from any employment activities.	MI Adults: 74.56% DD Adults: 18.59%	*Fully Compliant*
12.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children: 3.13% Adults: 12.12%	*Fully Compliant*
13.	Annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by the PIHPs.		*Fully Compliant*
14.	Number of sentinel events during the six-month period per 1,000 Medicaid beneficiaries served, by the following populations: adults with mental illness, children with mental illness, persons with developmental disabilities not on the HSW, persons on the HSW, and persons with substance abuse disorder.		*Fully Compliant*

Strengths

Genesee County CMH demonstrated a highly collaborative hands-on approach to accurate performance measure reporting. The quality improvement data contest represented an innovative way of improving data completeness. The PIHP implemented a continuous feedback loop, considered an industry best practice, through its multidisciplinary data certification committee that reviewed data on a monthly basis and provided feedback on its findings and on other quality initiatives that resulted from these meetings. The proactive approach to ensuring continuity of beneficiary eligibility was also an industry best practice.

Recommendations

Genesee County CMH should continue to work with the provider network to increase the number of providers submitting claims electronically through the online provider service center (OPSC).

Summary Assessment Related to Quality, Timeliness, and Access

Genesee County CMH's performance indicators related to **quality** were *Fully Compliant* with MDCH specifications, including Indicator 13, which received a designation of *Substantially Compliant* last year. The PIHP met or exceeded all contractually required performance standards related to **quality** of services provided by the PIHP. For the remaining indicators in the **quality** domain, **Genesee County CMH** demonstrated the following results: The PIHP's HSW rate of 97 percent equaled the statewide rate. The rates for MI and DD adults who were employed competitively and the rate of DD adults who earned minimum wage were lower than the statewide rates. The rate of MI adults who earned minimum wage was markedly higher than the statewide rate. Performance indicators related to **timeliness** of and **access** to services were *Fully Compliant* with MDCH specifications. **Genesee County CMH** met or exceeded the contractually required performance standards for all performance measures related to **timeliness** of and **access** to services provided by the PIHP. The PIHP's penetration rate of 5 percent fell below the statewide rate. **Genesee County CMH** demonstrated exceptional performance across all three domains of **quality**, **timeliness**, and **access** and met the minimum performance standard for all nine indicators.

Lakeshore Behavioral Health Alliance

Findings

Table 3-25 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2008 Validation of Performance Measures Report for **Lakeshore Behavioral Health Alliance** includes additional details of the validation results.

Table 3-25—2007–2008 Performance Measure Results *for* Lakeshore Behavioral Health Alliance

	Indicator	Reported Rate	Audit Designation
1.	Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children: 96.30% Adults: 99.12%	*Substantially Compliant*
2.	Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	95.08%	*Fully Compliant*
3.	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional.	94.48%	*Fully Compliant*
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children: 100% Adults: 100%	*Fully Compliant*
4b.	Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	100%	*Fully Compliant*
5.	Percentage of Medicaid recipients having received PIHP-managed services (penetration rate).	NA	*Not Valid*
8.	Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination (HSW rate).	98.25%	*Fully Compliant*
10.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who are employed competitively.	MI Adults: 11.43% DD Adults: 15.38%	*Fully Compliant*
11.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who earned minimum wage or more from any employment activities.	MI Adults: 57.14% DD Adults: 33.33%	*Fully Compliant*
12.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children: 0.00% Adults: 8.33%	*Fully Compliant*
13.	Annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by the PIHPs.		*Fully Compliant*
14.	Number of sentinel events during the six-month period per 1,000 Medicaid beneficiaries served, by the following populations: adults with mental illness, children with mental illness, persons with developmental disabilities not on the HSW, persons on the HSW, and persons with substance abuse disorder.		*Fully Compliant*

Strengths

Identified strengths for **Lakeshore Behavioral Health Alliance** included the use of multiple committees and work groups to maintain consistent interpretation of indicators and uniform data collection. The PIHP provided excellent oversight of the affiliates' and the CA's data prior to reporting to MDCH. The PIHP also provided technical assistance to its subcontractors when they experienced difficulties reporting performance indicator data.

Recommendations

Lakeshore Behavioral Health Alliance should continue to work with one of its subcontractors to ensure successful data extraction from the Avatar system to have a reportable rate. The PIHP's penetration rate was again found to be *Not Valid* due to one affiliate's difficulties with its encounter file generation. **Lakeshore Behavioral Health Alliance** should implement validation of data entry for all manual processes and continue to work with its vendor, Avatar, toward further automation of performance indicator reporting to reduce multiple manual checks.

Summary Assessment Related to Quality, Timeliness, and Access

Lakeshore Behavioral Health Alliance's performance indicators related to **quality** were *Fully Compliant* with MDCH specifications. The PIHP met or exceeded all contractually required performance standards related to **quality** of services provided by the PIHP. For the remaining indicators in the **quality** domain, **Lakeshore Behavioral Health Alliance** achieved the following results: The PIHP's HSW rate of 98 percent exceeded the statewide rate. The rates for MI and DD adults who were employed competitively and the rates of MI and DD adults who earned minimum wage were higher than the statewide rates. Performance indicators related to **timeliness** of and **access** to services were *Fully Compliant* with MDCH specifications except for Indicator 1, which received a designation of *Substantially Compliant,* and Indicator 5, which again was rated *Not Valid*. **Lakeshore Behavioral Health Alliance** met or exceeded the contractually required performance standards for six of the seven performance measures related to **timeliness** of and **access** to services provided by the PIHP. The PIHP did not report a valid penetration rate. **Lakeshore Behavioral Health Alliance** demonstrated strong performance across all three domains of **quality**, **timeliness**, and **access** and met the minimum performance standard for a total of eight of the nine indicators.

LifeWays

Findings

Table 3-26 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2008 Validation of Performance Measures Report for **LifeWays** includes additional details of the validation results.

Table 3-26—2007–2008 Performance Measure Results *for* LifeWays

	Indicator	Reported Rate	Audit Designation
1.	Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children: 100% Adults: 100%	*Fully Compliant*
2.	Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	100%	*Fully Compliant*
3.	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional.	98.57%	*Fully Compliant*
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children: 100% Adults: 100%	*Fully Compliant*
4b.	Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	100%	*Fully Compliant*
5.	Percentage of Medicaid recipients having received PIHP-managed services (penetration rate).	6.27%	*Fully Compliant*
8.	Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination (HSW rate).	99.26%	*Fully Compliant*
10.	Percentage of adults with mental illness and the percent of adults with developmental disabilities served by the PIHPs who are employed competitively.	MI Adults: 11.18% DD Adults: 8.46%	*Fully Compliant*
11.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who earned minimum wage or more from any employment activities.	MI Adults: 61.48% DD Adults: 39.19%	*Fully Compliant*
12.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children: 9.09% Adults: 33.33%	*Fully Compliant*
13.	Annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by the PIHPs.		*Fully Compliant*
14.	Number of sentinel events during the six-month period per 1,000 Medicaid beneficiaries served, by the following populations: adults with mental illness, children with mental illness, persons with developmental disabilities not on the HSW, persons on the HSW, and persons with substance abuse disorder.		*Fully Compliant*

Strengths

LifeWays demonstrated dedication to accurate and complete reporting of performance indicator data. The PIHP implemented automated collection for some of the data used for the calculation of performance indicators. The PIHP worked closely with providers to monitor performance of quality improvement data, including providing data integrity reports and annual reviews of medical record and encounter data to ensure that data reflected the actual services provided. **LifeWays** required corrective action plans and increased the frequency of reviews for providers who did not meet the performance standards.

Recommendations

LifeWays should continue to work with providers to ensure that data for submissions to MDCH is entered as required. For Indicator 1, the PIHP should ensure that the start time for members who present for services that do not require clinical clearance is the time that the member requested the service.

Summary Assessment Related to Quality, Timeliness, and Access

LifeWays' performance indicators related to **quality** were *Fully Compliant* with MDCH specifications. The PIHP met or exceeded four of the five contractually required performance standards related to **quality** of services provided by the PIHP. For the remaining indicators in the **quality** domain, **LifeWays** achieved the following results: The PIHP's HSW rate of 99 percent exceeded the statewide rate. The rate for MI adults who were employed competitively and the rates of MI and DD adults who earned minimum wage were higher than the statewide rates. The rate for DD adults who were employed competitively fell slightly below the statewide rate. Performance indicators related to **timeliness** of and **access** to services were *Fully Compliant* with MDCH specifications. **LifeWays** met or exceeded the contractually required performance standards for all performance measures related to **timeliness** of and **access** to services provided by the PIHP. The PIHP's penetration rate of 6 percent equaled the statewide rate. **LifeWays** demonstrated strong performance across all three domains of **quality**, **timeliness**, and **access** and met the minimum performance standard for a total of eight of the nine indicators.

Macomb County CMH Services

Findings

Table 3-27 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2008 Validation of Performance Measures Report for **Macomb County CMH Services** includes additional details of the validation results.

Table 3-27—2007–2008 Performance Measure Results *for* Macomb County CMH Services

	Indicator	Reported Rate	Audit Designation
1.	Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children: 100% Adults: 99.61%	*Fully Compliant*
2.	Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	98.85%	*Fully Compliant*
3.	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional.	94.51%	*Fully Compliant*
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children: 100% Adults: 98.08%	*Fully Compliant*
4b.	Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	100%	*Fully Compliant*
5.	Percentage of Medicaid recipients having received PIHP-managed services (penetration rate).	6.67%	*Fully Compliant*
8.	Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination (HSW rate).	98.76%	*Fully Compliant*
10.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who are employed competitively.	MI Adults: 9.09% DD Adults: 6.84%	*Fully Compliant*
11.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who earned minimum wage or more from any employment activities.	MI Adults: 37.40% DD Adults: 16.35%	*Fully Compliant*
12.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children: 15.38% Adults: 12.65%	*Fully Compliant*
13.	Annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by the PIHPs.		*Fully Compliant*
14.	Number of sentinel events during the six-month period per 1,000 Medicaid beneficiaries served, by the following populations: adults with mental illness, children with mental illness, persons with developmental disabilities not on the HSW, persons on the HSW, and persons with substance abuse disorder.		*Fully Compliant*

Strengths

Macomb County CMH Services worked with its providers to achieve more than 98 percent electronic submission of service data, including hospital data. The accuracy of performance measure data was improved through the monthly/quarterly outlier verification process using the data warehouse. The PIHP's policy of requiring a corrective action plan from providers who had cases outside the standard but no reasonable explanation was an industry best practice.

Recommendations

Macomb County CMH Services should continue its quality improvement strategy targeted at increasing performance measure rates. The PIHP should also continue its efforts to automate the recipient rights measure.

Summary Assessment Related to Quality, Timeliness, and Access

Macomb County CMH Services' performance indicators related to **quality** were *Fully Compliant* with MDCH specifications. The PIHP met or exceeded four of the five contractually required performance standards related to **quality** of services provided by the PIHP. For the remaining indicators in the **quality** domain, **Macomb County CMH Services** achieved the following results: The PIHP's HSW rate of 99 percent exceeded the statewide rate. The rates for MI and DD adults who were employed competitively and the rates of MI and DD adults who earned minimum wage were at or below the statewide rates. Performance indicators related to **timeliness** of and **access** to services were *Fully Compliant* with MDCH specifications. **Macomb County CMH Services** met or exceeded the contractually required performance standards for six of the seven performance measures related to **timeliness** of and **access** to services provided by the PIHP. The PIHP's penetration rate of 7 percent exceeded the statewide rate. **Macomb County CMH Services** demonstrated strong performance across all three domains of **quality**, **timeliness**, and **access** and met the minimum performance standard for a total of seven of the nine indicators.

network180

Findings

Table 3-28 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2008 Validation of Performance Measures Report for **network180** includes additional details of the validation results.

Table 3-28—2007–2008 Performance Measure Results *for* network180

	Indicator	Reported Rate	Audit Designation
1.	Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children: 94.55% Adults: 98.17%	*Fully Compliant*
2.	Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	99.37%	*Fully Compliant*
3.	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional.	94.62%	*Fully Compliant*
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children: 94.74% Adults: 99.01%	*Fully Compliant*
4b.	Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	80.00%	*Fully Compliant*
5.	Percentage of Medicaid recipients having received PIHP-managed services (penetration rate).	5.40%	*Fully Compliant*
8.	Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination (HSW rate).	100%	*Fully Compliant*
10.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who are employed competitively.	MI Adults: 12.51% DD Adults: 10.17%	*Fully Compliant*
11.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who earned minimum wage or more from any employment activities.	MI Adults: 35.42% DD Adults: 13.63%	*Fully Compliant*
12.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children: 4.88% Adults: 9.38%	*Fully Compliant*
13.	Annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by the PIHPs.		*Fully Compliant*
14.	Number of sentinel events during the six-month period per 1,000 Medicaid beneficiaries served, by the following populations: adults with mental illness, children with mental illness, persons with developmental disabilities not on the HSW, persons on the HSW, and persons with substance abuse disorder.		*Fully Compliant*

Strengths

Strengths identified for **network180** included the upgraded eligibility system that ensured real-time verification and the PIHP's automated tickler for keeping demographic data updated, as well as built-in edits for access screens, which were best practices. The PIHP demonstrated a coordinated approach to dealing with the challenges of information system upgrades that resulted in improved communications with key data stakeholders.

Recommendations

network180 should implement a process to validate data entry for the recipient rights database. The PIHP should continue to work with provider groups that have ongoing issues with timely encounter data submission and explore alternative methods to encourage these providers to submit encounter data in a timely fashion. **network180** should continue to work toward its goal of a fee-for-service structure to ensure complete encounter data submission.

Summary Assessment Related to Quality, Timeliness, and Access

network180's performance indicators related to **quality** were *Fully Compliant* with MDCH specifications. The PIHP met or exceeded three of the five contractually required performance standards related to **quality** of services provided by the PIHP. For the remaining indicators in the **quality** domain, **network180** demonstrated the following results: The PIHP's HSW rate of 100 percent exceeded the statewide rate. The rates for MI and DD adults who were employed competitively were higher than the statewide rates, while the rates of MI and DD adults who earned minimum wage fell below the statewide rates. Performance indicators related to **timeliness** of and **access** to services were *Fully Compliant* with MDCH specifications. **network180** met or exceeded the contractually required performance standards for three of the seven performance measures related to **timeliness** of and **access** to services provided by the PIHP, missing the MDCH benchmark by less than 1 percentage point for three indicators. The PIHP's penetration rate of 5 percent was lower than the statewide rate. **network180** demonstrated good performance on several measures, and opportunities for improvement were identified across all three domains of **quality**, **timeliness**, and **access**. The PIHP met the minimum performance standard for a total of five of the nine indicators.

NorthCare

Findings

Table 3-29 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2008 Validation of Performance Measures Report for **NorthCare** includes additional details of the validation results.

Table 3-29—2007–2008 Performance Measure Results *for* NorthCare

	Indicator	Reported Rate	Audit Designation
1.	Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children: 100% Adults: 100%	*Fully Compliant*
2.	Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	98.29%	*Fully Compliant*
3.	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional.	98.09%	*Fully Compliant*
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children: 92.86% Adults: 98.00%	*Fully Compliant*
4b.	Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	100%	*Fully Compliant*
5.	Percentage of Medicaid recipients having received PIHP-managed services (penetration rate).	6.24%	*Fully Compliant*
8.	Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination (HSW rate).	96.46%	*Fully Compliant*
10.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who are employed competitively.	MI Adults: 14.58% DD Adults: 8.76%	*Fully Compliant*
11.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who earned minimum wage or more from any employment activities.	MI Adults: 50.11% DD Adults: 31.54%	*Fully Compliant*
12.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children: 4.55% Adults: 17.86%	*Fully Compliant*
13.	Annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by the PIHPs.		*Fully Compliant*
14.	Number of sentinel events during the six-month period per 1,000 Medicaid beneficiaries served, by the following populations: adults with mental illness, children with mental illness, persons with developmental disabilities not on the HSW, persons on the HSW, and persons with substance abuse disorder.		*Fully Compliant*

Strengths

NorthCare's performance indicator methodology document, which included service code parameters, supported uniform collection and interpretation of performance indicator data across the PIHP. **NorthCare**'s Medicaid verification audit reports included corrective actions for the affiliate boards, ensuring a continuous quality improvement loop within the organization. The quality committee reviewed performance indicator data and required corrective action of any community mental health center (CMHC) that under-performed for two consecutive quarters.

Recommendations

NorthCare should implement audits at the CMHC level for all manual entry of encounter data to ensure accuracy. The PIHP should ensure that one claims processor discontinues its practice of adding a V-code to a claim when no diagnosis was submitted. **NorthCare** should revise its performance indicator methodology document to include language specific to excluding individuals covered under the Omnibus Budget Reconciliation Act (OBRA) for Indicators 2 and 3.

Summary Assessment Related to Quality, Timeliness, and Access

NorthCare's performance indicators related to **quality** were *Fully Compliant* with MDCH specifications. The PIHP met or exceeded three of the five contractually required performance standards related to **quality** of services provided by the PIHP. For the remaining indicators in the **quality** domain, **NorthCare** demonstrated the following results: The PIHP's HSW rate of 96 percent fell below the statewide rate of 97 percent. The rates for MI and DD adults who were employed competitively and the rates of MI and DD adults who earned minimum wage were at or above the statewide rates. Performance indicators related to **timeliness** of and **access** to services were *Fully Compliant* with MDCH specifications. **NorthCare** met or exceeded the contractually required performance standards for six of the seven performance measures related to **timeliness** of and **access** to services provided by the PIHP. The PIHP's penetration rate of 6 percent equaled the statewide rate. **NorthCare** demonstrated strong performance across all three domains of **quality**, **timeliness**, and **access** and met the minimum performance standard for a total of seven of the nine indicators.

Northern Affiliation

Findings

Table 3-30 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2008 Validation of Performance Measures Report for **Northern Affiliation** includes additional details of the validation results.

Table 3-30—2007–2008 Performance Measure Results *for* Northern Affiliation

	Indicator	Reported Rate	Audit Designation
1.	Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children: 100% Adults: 100%	*Fully Compliant*
2.	Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	99.28%	*Fully Compliant*
3.	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional.	97.70%	*Fully Compliant*
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children: 100% Adults: 97.73%	*Fully Compliant*
4b.	Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	100%	*Fully Compliant*
5.	Percentage of Medicaid recipients having received PIHP-managed services (penetration rate).	6.99%	*Fully Compliant*
8.	Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination (HSW rate).	97.94%	*Fully Compliant*
10.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who are employed competitively.	MI Adults: 12.15% DD Adults: 9.78%	*Fully Compliant*
11.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who earned minimum wage or more from any employment activities.	MI Adults: 59.18% DD Adults: 46.82%	*Fully Compliant*
12.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children: 8.33% Adults: 12.50%	*Fully Compliant*
13.	Annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by the PIHPs.		*Fully Compliant*
14.	Number of sentinel events during the six-month period per 1,000 Medicaid beneficiaries served, by the following populations: adults with mental illness, children with mental illness, persons with developmental disabilities not on the HSW, persons on the HSW, and persons with substance abuse disorder.		*Fully Compliant*

Strengths

Identified strengths for **Northern Affiliation** were the use of a single information system for all affiliates and the implementation of the electronic medical record. **Northern Affiliation**'s oversight and verification of the completeness of quality improvement data and the PIHP's documentation of its information system and performance measure calculation process were considered best practices. The PIHP's requirement of a corrective action plan for providers whose performance indicator fell below the State threshold was also among the industry's best practices.

Recommendations

Northern Affiliation should consider adding a table with the top reasons for audit errors identified in the PIHP's internal audit report. The PIHP should continue moving eligibility analysis to an automated, PIHP-level process in Avatar. **Northern Affiliation** should consider modifying the dashboard reports to contain trend and/or goal information.

Summary Assessment Related to Quality, Timeliness, and Access

Northern Affiliation's performance indicators related to **quality** were *Fully Compliant* with MDCH specifications. The PIHP met or exceeded all contractually required performance standards related to **quality** of services provided by the PIHP. For the remaining indicators in the **quality** domain, **Northern Affiliation** achieved the following results: The PIHP's HSW rate of 98 percent exceeded the statewide rate. The rates for MI and DD adults who were employed competitively and the rates of MI and DD adults who earned minimum wage were higher than the statewide rates. Performance indicators related to **timeliness** of and **access** to services were *Fully Compliant* with MDCH specifications. **Northern Affiliation** met or exceeded the contractually required performance standards for all performance measures related to **timeliness** of and **access** to services provided by the PIHP. The PIHP's penetration rate of 7 percent exceeded the statewide rate. **Northern Affiliation** demonstrated exceptional performance across all three domains of **quality**, **timeliness**, and **access** and met the minimum performance standard for all nine indicators.

Northwest CMH Affiliation

Findings

Table 3-31 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2008 Validation of Performance Measures Report for **Northwest CMH Affiliation** includes additional details of the validation results.

Table 3-31—2007–2008 Performance Measure Results *for* Northwest CMH Affiliation

	Indicator	Reported Rate	Audit Designation
1.	Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children: 100% Adults: 100%	*Fully Compliant*
2.	Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	94.88%	*Fully Compliant*
3.	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional.	97.81%	*Fully Compliant*
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children: 87.50% Adults: 91.18%	*Fully Compliant*
4b.	Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	100%	*Fully Compliant*
5.	Percentage of Medicaid recipients having received PIHP-managed services (penetration rate).	7.47%	*Fully Compliant*
8.	Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination (HSW rate).	96.11%	*Fully Compliant*
10.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who are employed competitively.	MI Adults: 14.33% DD Adults: 15.94%	*Fully Compliant*
11.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who earned minimum wage or more from any employment activities.	MI Adults: 66.39% DD Adults: 66.19%	*Fully Compliant*
12.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children: 21.05% Adults: 13.70%	*Fully Compliant*
13.	Annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by the PIHPs.		*Fully Compliant*
14.	Number of sentinel events during the six-month period per 1,000 Medicaid beneficiaries served, by the following populations: adults with mental illness, children with mental illness, persons with developmental disabilities not on the HSW, persons on the HSW, and persons with substance abuse disorder.		*Fully Compliant*

Strengths

Northwest CMH Affiliation demonstrated strong collaboration between the CMHCs and the PIHP. The Northern Lakes Community Mental Health data assumptions document detailed the assumptions for each of the MDCH performance indicators. The CMHCs demonstrated a proactive approach to ensuring data completeness at the provider level and improvement in the automation of day-to-day processes and performance measure reporting.

Recommendations

Northwest CMH Affiliation should continue the automation of performance measure calculations and formalize the existing outlier analysis and quality improvement data completeness processes to be consistent affiliation wide. The PIHP should continue its efforts to develop version control mechanisms and systematic edits for services.

Summary Assessment Related to Quality, Timeliness, and Access

Northwest CMH Affiliation's performance indicators related to **quality** were *Fully Compliant* with MDCH specifications. The PIHP met or exceeded two of the five contractually required performance standards related to **quality** of services provided by the PIHP. For the remaining indicators in the **quality** domain, **Northwest CMH Affiliation** demonstrated the following results: The PIHP's HSW rate of 96 percent fell below the statewide rate of 97 percent. The rates for MI and DD adults who were employed competitively and the rates of MI and DD adults who earned minimum wage were higher than the statewide rates. Performance indicators related to **timeliness** of and **access** to services were *Fully Compliant* with MDCH specifications. **Northwest CMH Affiliation** met or exceeded the contractually required performance standards for four of the seven performance measures related to **timeliness** of and **access** to services provided by the PIHP. The PIHP's penetration rate of 7 percent exceeded the statewide rate. **Northwest CMH Affiliation** demonstrated mixed performance, with opportunities for improvement across all three domains of **quality**, **timeliness**, and **access**. **Northwest CMH Affiliation** met the minimum performance standard for a total of five of the nine indicators.

Oakland County CMH Authority

Findings

Table 3-32 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2008 Validation of Performance Measures Report for **Oakland County CMH Authority** includes additional details of the validation results.

Table 3-32—2007–2008 Performance Measure Results *for* Oakland County CMH Authority

	Indicator	Reported Rate	Audit Designation
1.	Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children: 97.27% Adults: 96.30%	*Fully Compliant*
2.	Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	99.14%	*Fully Compliant*
3.	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional.	98.67%	*Fully Compliant*
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children: 100% Adults: 98.75%	*Fully Compliant*
4b.	Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	100%	*Fully Compliant*
5.	Percentage of Medicaid recipients having received PIHP-managed services (Penetration rate).	7.33%	*Fully Compliant*
8.	Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination (HSW rate).	98.62%	*Fully Compliant*
10.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who are employed competitively.	MI Adults: 10.68% DD Adults: 10.87%	*Fully Compliant*
11.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who earned minimum wage or more from any employment activities.	MI Adults: 52.43% DD Adults: 23.44%	*Fully Compliant*
12.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children: 3.45% Adults: 12.90%	*Fully Compliant*
13.	Annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by the PIHPs.		*Fully Compliant*
14.	Number of sentinel events during the six-month period per 1,000 Medicaid beneficiaries served, by the following populations: adults with mental illness, children with mental illness, persons with developmental disabilities not on the HSW, persons on the HSW, and persons with substance abuse disorder.		*Fully Compliant*

Strengths

Oakland County CMH Authority's unified system used by the majority of providers ensured accurate and complete data. The PIHP demonstrated best practices in several areas: the "InfoMart" analytical tool, the "Charges Trended by Core Category" process, and the procedure code work group that reviewed quality improvement data completeness and performance measures on a monthly basis.

Recommendations

Oakland County CMH Authority should continue to centralize its system to ensure accurate and complete service data and automate the process of calculating performance indicators. The PIHP should continue to integrate benchmarking information in its analytical reporting activities.

Summary Assessment Related to Quality, Timeliness, and Access

Oakland County CMH Authority's performance indicators related to **quality** were *Fully Compliant* with MDCH specifications. The PIHP met or exceeded all contractually required performance standards related to **quality** of services provided by the PIHP. For the remaining indicators in the **quality** domain, **Oakland County CMH Authority** achieved the following results: The PIHP's HSW rate of 99 percent exceeded the statewide rate. The rates for MI and DD adults who were employed competitively and the rates of MI and DD adults who earned minimum wage were higher than the statewide rates. Performance indicators related to **timeliness** of and **access** to services were *Fully Compliant* with MDCH specifications. **Oakland County CMH Authority** met or exceeded the contractually required performance standards for all performance measures related to **timeliness** of and **access** to services provided by the PIHP. The PIHP's penetration rate of 7 percent exceeded the statewide rate. **Oakland County CMH Authority** demonstrated exceptional performance across all three domains of **quality**, **timeliness**, and **access** and met the minimum performance standard for all nine indicators.

Saginaw County CMH Authority

Findings

Table 3-33 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2008 Validation of Performance Measures Report for **Saginaw County CMH Authority** includes additional details of the validation results.

Table 3-33—2007–2008 Performance Measure Results *for* Saginaw County CMH Authority

	Indicator	Reported Rate	Audit Designation
1.	Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children: 100% Adults: 99.55%	*Fully Compliant*
2.	Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	100%	*Fully Compliant*
3.	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional.	97.40%	*Fully Compliant*
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children: 100% Adults: 100%	*Fully Compliant*
4b.	Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	70.00%	*Fully Compliant*
5.	Percentage of Medicaid recipients having received PIHP-managed services (penetration rate).	4.44%	*Fully Compliant*
8.	Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination (HSW rate).	95.65%	*Fully Compliant*
10.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who are employed competitively.	MI Adults: 5.98% DD Adults: 10.38%	*Fully Compliant*
11.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who earned minimum wage or more from any employment activities.	MI Adults: 33.58% DD Adults: 12.92%	*Fully Compliant*
12.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children: 0.00% Adults: 15.22%	*Fully Compliant*
13.	Annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by the PIHPs.		*Fully Compliant*
14.	Number of sentinel events during the six-month period per 1,000 Medicaid beneficiaries served, by the following populations: adults with mental illness, children with mental illness, persons with developmental disabilities not on the HSW, persons on the HSW, and persons with substance abuse disorder.		*Fully Compliant*

Strengths

Saginaw County CMH Authority demonstrated a collaborative approach to accurate performance measure reporting. The PIHP audited 5 percent of all provider services to ensure that encounter data were accurate and complete. An increasing number of providers submitted claims and encounter data electronically. The data warehouse allowed real-time verification and tracking of data. The PIHP's "Revenue Calculator" for verification of eligibility data was an industry best practice. **Saginaw County CMH Authority** distributed performance measure results via the Performance Measure Trending Report.

Recommendations

Saginaw County CMH Authority should continue the rigorous verification of performance measure data and the automation of the processes to calculate the measures. PIHP staff should continue to work with the CA on the integration of substance abuse data into the Encompass system and data warehouse.

Summary Assessment Related to Quality, Timeliness, and Access

Saginaw County CMH Authority's performance indicators related to **quality** were *Fully Compliant* with MDCH specifications. The PIHP met or exceeded three of the five contractually required performance standards related to **quality** of services provided by the PIHP. For the remaining indicators in the **quality** domain, **Saginaw County CMH Authority** demonstrated the following results: The PIHP's HSW rate of 96 percent fell below the statewide rate. The rate for DD adults who were employed competitively was above the statewide rate, while the rate for MI adults who were employed competitively and the rates of MI and DD adults who earned minimum wage were lower than the statewide rates. Performance indicators related to **timeliness** of and **access** to services were *Fully Compliant* with MDCH specifications. **Saginaw County CMH Authority** met or exceeded the contractually required performance standards for six of the seven performance measures related to **timeliness** of and **access** to services provided by the PIHP. The PIHP's penetration rate of 4 percent was lower than the statewide rate. **Saginaw County CMH Authority** demonstrated improved performance across all three domains of **quality**, **timeliness**, and **access** and met the minimum performance standard for a total of seven of the nine indicators.

Southwest Affiliation

Findings

Table 3-34 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2008 Validation of Performance Measures Report for **Southwest Affiliation** includes additional details of the validation results.

Table 3-34—2007–2008 Performance Measure Results *for* Southwest Affiliation

	Indicator	Reported Rate	Audit Designation
1.	Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children: 98.90% Adults: 98.83%	*Fully Compliant*
2.	Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	99.69%	*Fully Compliant*
3.	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional.	98.04%	*Fully Compliant*
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children: 100% Adults: 95.74%	*Fully Compliant*
4b.	Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	94.44%	*Fully Compliant*
5.	Percentage of Medicaid recipients having received PIHP-managed services (penetration rate).	6.21%	*Fully Compliant*
8.	Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination (HSW rate).	98.05%	*Fully Compliant*
10.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who are employed competitively.	MI Adults: 9.83% DD Adults: 18.58%	*Fully Compliant*
11.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who earned minimum wage or more from any employment activities.	MI Adults: 66.22% DD Adults: 66.76%	*Fully Compliant*
12.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children: 12.50% Adults: 5.26%	*Fully Compliant*
13.	Annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by the PIHPs.		*Fully Compliant*
14.	Number of sentinel events during the six-month period per 1,000 Medicaid beneficiaries served, by the following populations: adults with mental illness, children with mental illness, persons with developmental disabilities not on the HSW, persons on the HSW, and persons with substance abuse disorder.		*Fully Compliant*

Strengths

Southwest Affiliation and the community mental health service programs (CMHSPs) demonstrated a collaborative working relationship for performance measure reporting and discussed quality improvement issues in regular meetings. The PIHP performed quarterly validation audits of encounter data to ensure accurate, complete, and consistent data across the affiliation. Automated processes at the PIHP level addressed possible manual data errors.

Recommendations

Southwest Affiliation should continue the transition of the present claims/encounter data processing system to the Avatar system and document the process and any issues encountered. The PIHP should consider conducting audits on the processes for generating performance indicators to add validity to the reported rates.

Summary Assessment Related to Quality, Timeliness, and Access

Southwest Affiliation's performance indicators related to **quality** were *Fully Compliant* with MDCH specifications. The PIHP met or exceeded four of the five contractually required performance standards related to **quality** of services provided by the PIHP, missing the MDCH benchmark for one indicator by less than 1 percentage point. For the remaining indicators in the **quality** domain, **Southwest Affiliation** achieved the following results: The PIHP's HSW rate of 98 percent exceeded the statewide rate. The rates for MI and DD adults who were employed competitively and the rates of MI and DD adults who earned minimum wage were higher than the statewide rates. Performance indicators related to **timeliness** of and **access** to services were *Fully Compliant* with MDCH specifications. **Southwest Affiliation** met or exceeded the contractually required performance standards for six of the seven performance measures related to **timeliness** of and **access** to services provided by the PIHP. The PIHP's penetration rate of 6 percent equaled the statewide rate. **Southwest Affiliation** demonstrated strong performance across all three domains of **quality**, **timeliness**, and **access** and met the minimum performance standard for a total of eight of the nine indicators.

Thumb Alliance PIHP

Findings

Table 3-35 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2008 Validation of Performance Measures Report for **Thumb Alliance PIHP** includes additional details of the validation results.

Table 3-35—2007–2008 Performance Measure Results *for* Thumb Alliance PIHP

	Indicator	Reported Rate	Audit Designation
1.	Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children: 100% Adults: 100%	*Fully Compliant*
2.	Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	98.92%	*Fully Compliant*
3.	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional.	97.82%	*Fully Compliant*
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children: 100% Adults: 100%	*Fully Compliant*
4b.	Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	89.47%	*Fully Compliant*
5.	Percentage of Medicaid recipients having received PIHP-managed services (penetration rate).	7.35%	*Fully Compliant*
8.	Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination (HSW rate).	100%	*Fully Compliant*
10.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who are employed competitively.	MI Adults: 11.62% DD Adults: 4.99%	*Fully Compliant*
11.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who earned minimum wage or more from any employment activities.	MI Adults: 35.48% DD Adults: 10.12%	*Fully Compliant*
12.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children: 0.00% Adults:11.86%	*Fully Compliant*
13.	Annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by the PIHPs.		*Fully Compliant*
14.	Number of sentinel events during the six-month period per 1,000 Medicaid beneficiaries served, by the following populations: adults with mental illness, children with mental illness, persons with developmental disabilities not on the HSW, persons on the HSW, and persons with substance abuse disorder.		*Fully Compliant*

Strengths

Thumb Alliance PIHP continued to demonstrate a strong commitment to complete and accurate service and quality improvement data and performance measure reporting. The PIHP demonstrated best practices in the areas of the "Data Management Workgroup" and the document, Review of Data Accuracy and Completeness, which addressed the overall assessment of data completeness. **Thumb Alliance PIHP** continued to prepare and share with the CMHCs numerous reports that evaluate data completeness and assess data accuracy.

Recommendations

Thumb Alliance PIHP should continue the integration of data from the CA into the Outcome and Assessment Information Set (OASIS) system. The PIHP should continue to increase the percentage of providers (including hospitals) that enter services directly into the OASIS system.

Summary Assessment Related to Quality, Timeliness, and Access

Thumb Alliance PIHP's performance indicators related to **quality** were *Fully Compliant* with MDCH specifications. The PIHP met or exceeded four of the five contractually required performance standards related to **quality** of services provided by the PIHP. For the remaining indicators in the **quality** domain, **Thumb Alliance PIHP** demonstrated the following results: The PIHP's HSW rate of 100 percent exceeded the statewide rate. The rate for MI adults who were employed competitively was higher than the statewide rate, while the rate for DD adults who were employed competitively and the rates of MI and DD adults who earned minimum wage were lower than the statewide rates. Performance indicators related to **timeliness** of and **access** to services were *Fully Compliant* with MDCH specifications. **Thumb Alliance PIHP** met or exceeded the contractually required performance standards for six of the seven performance measures related to **timeliness** of and **access** to services provided by the PIHP. The PIHP's penetration rate of 7 percent exceeded the statewide rate. **Thumb Alliance PIHP** demonstrated strong performance across all three domains of **quality**, **timeliness**, and **access** and met the minimum performance standard for a total of eight of the nine indicators.

Venture Behavioral Health

Findings

Table 3-36 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2008 Validation of Performance Measures Report for **Venture Behavioral Health** includes additional details of the validation results.

Table 3-36—2007–2008 Performance Measure Results *for* Venture Behavioral Health

	Indicator	Reported Rate	Audit Designation
1.	Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children: 100% Adults: 100%	*Fully Compliant*
2.	Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	98.34%	*Fully Compliant*
3.	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional.	96.68%	*Fully Compliant*
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children: 100% Adults: 100%	*Fully Compliant*
4b.	Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	100%	*Fully Compliant*
5.	Percentage of Medicaid recipients having received PIHP-managed services (penetration rate).	6.26%	*Fully Compliant*
8.	Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination (HSW rate).	97.78%	*Fully Compliant*
10.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who are employed competitively.	MI Adults: 11.96% DD Adults: 7.78%	*Fully Compliant*
11.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who earned minimum wage or more from any employment activities.	MI Adults: 25.33% DD Adults: 13.99%	*Fully Compliant*
12.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children: 0.00% Adults: 4.11%	*Fully Compliant*
13.	Annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by the PIHPs.		*Fully Compliant*
14.	Number of sentinel events during the six-month period per 1,000 Medicaid beneficiaries served, by the following populations: adults with mental illness, children with mental illness, persons with developmental disabilities not on the HSW, persons on the HSW, and persons with substance abuse disorder.		*Fully Compliant*

Strengths

Venture Behavioral Health implemented the PracticeManagement and CareManagement data systems, which enhanced data collection and reporting of encounter and performance indicator data. The PIHP and CMHCs met monthly to review performance indicator and encounter data and took action when necessary to follow up on outliers or inconsistent data prior to submitting data to MDCH. The PIHP implemented a special project for limiting data entry to MDCH-required options by adding drop-down fields in the PracticeManagement system to improve consistency among the CMHCs in collecting State-reported data.

Recommendations

Venture Behavioral Health should implement front-end edits to ensure entry of required data elements and add the Missing Quality Improvement Indicators Report to the dashboard to provide feedback to providers on a regular basis. The PIHP should continue to work with the CMHCs on efforts to decrease the lag time for entering paper claims. **Venture Behavioral Health** should continue to work with the CA to receive substance abuse data on a more regular and real-time basis.

Summary Assessment Related to Quality, Timeliness, and Access

Venture Behavioral Health's performance indicators related to **quality** were *Fully Compliant* with MDCH specifications. The PIHP met or exceeded all contractually required performance standards related to **quality** of services provided by the PIHP. For the remaining indicators in the **quality** domain, **Venture Behavioral Health** demonstrated the following results: The PIHP's HSW rate of 98 percent exceeded the statewide rate. The rate for MI adults who were employed competitively was higher than the statewide rate, while the rate for DD adults who were employed competitively and the rates of MI and DD adults who earned minimum wage were lower than the statewide rates. Performance indicators related to **timeliness** of and **access** to services were *Fully Compliant* with MDCH specifications. **Venture Behavioral Health** met or exceeded the contractually required performance standards for all performance measures related to **timeliness** of and **access** to services provided by the PIHP. The PIHP's penetration rate of 6 percent equaled the statewide rate. **Venture Behavioral Health** demonstrated exceptional performance across all three domains of **quality**, **timeliness**, and **access** and met the minimum performance standard for all nine indicators.

Validation of Performance Improvement Projects

This section of the report presents the results of the validation of PIPs. For the 2007–2008 validation, the PIHPs continued with the study topic, *Ongoing Service Within 14 Days of Nonemergent Assessment*, to target the lowest-scoring of the five population groups (adults with mental illness, adults with developmental disabilities, children with mental illness, children with developmental disabilities, or beneficiaries with a substance abuse disorder) for each PIHP. Two PIHPs, **Thumb Alliance PIHP** and **Southwest Affiliation**, continued with their own topic as they had met the performance standard for ongoing services. PIHPs differed in how far their study had progressed. Consequently, some of the activities of the CMS PIP Protocol were not assessed for all PIHPs. The validation of PIPs addresses the validity and reliability of the PIHP's processes for conducting valid PIPs. Therefore, for the purpose of the EQR technical report, HSAG assigned all PIPs to the **quality** domain.

Access Alliance of Michigan

Findings

Table 3–37 and Table 3–38 show **Access Alliance of Michigan**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2007–2008 PIP Validation Report for **Access Alliance of Michigan**. Validation of Activities I through IX resulted in a validation status of *Met,* with an overall score of 94 percent and a score of 100 percent for critical elements.

Table 3–37—PIP Validation Scores
for ***Ongoing Service Within 14 Days of Nonemergent Assessment***
for **Access Alliance of Michigan**

		All Evaluation Elements (Including Critical Elements)					Critical Elements				
Review Activity		Total	*M*	*PM*	*NM*	*NA*	Total	*M*	*PM*	*NM*	*NA*
I.	Appropriate Study Topic	6	6	0	0	0	1	1	0	0	0
II.	Clearly Defined, Answerable Study Question	2	2	0	0	0	2	2	0	0	0
III.	Clearly Defined Study Indicator(s)	7	5	0	0	2	3	3	0	0	0
IV.	Correctly Identified Study Population	3	2	0	0	1	2	2	0	0	0
V.	Valid Sampling Techniques	6	0	0	0	6	1	0	0	0	1
VI.	Accurate/Complete Data Collection	11	6	0	0	5	1	0	0	0	1
VII.	Appropriate Improvement Strategies	4	3	0	0	1	1	1	0	0	0
VIII.	Sufficient Data Analysis and Interpretation	9	7	1	0	1	2	1	0	0	1
IX.	Real Improvement Achieved	4	3	0	1	0	No Critical Elements				
X.	Sustained Improvement Achieved	1	Not Assessed				No Critical Elements				
Totals for All Activities		**53**	**34**	**1**	**1**	**16**	**13**	**10**	**0**	**0**	**3**

M *= Met,* ***PM*** *= Partially Met,* ***NM*** *= Not Met,* ***NA*** *= Not Applicable*

Table 3–38—PIP Validation Status
for ***Ongoing Service Within 14 Days of Nonemergent Assessment***
for **Access Alliance of Michigan**

Percentage Score of Evaluation Elements *Met*	**94%**
Percentage Score of Critical Elements *Met*	**100%**
Validation Status	***Met***

Strengths

Access Alliance of Michigan's PIP was validated through nine activities and HSAG's assessment determined confidence in the results. The PIHP provided comprehensive background information for the study topic and a thorough explanation of the study population. The description of the data collection methodology and staff members performing data collection was complete. Improvement strategies were related to causes/barriers identified through data analysis and addressed system changes that were likely to produce permanent change. **Access Alliance of Michigan**'s data analysis was conducted according to the analysis plan in the study and presented data in a clear and easily understood format. There was documented improvement—though not statistically significant—in the study indicator that appeared to be the result of the planned interventions.

Recommendations

HSAG identified the following areas for improvement for **Access Alliance of Michigan**:

The PIP identified statistical differences using the two-tailed Fisher's Exact test; however, HSAG could not replicate the reported *p* values. The improvement noted from baseline to the first remeasurement period failed to reach statistical significance using the Fisher's Exact test. For the activities related to the study topic, data collection, and improvement strategies, HSAG identified additional *Points of Clarification* to strengthen the study.

Summary Assessment Related to Quality, Timeliness, and Access

Access Alliance of Michigan recognized that the study provided an opportunity to improve the timeliness of access to care and services across health care delivery systems for its beneficiaries. The focus of the study was to improve the percentage of new cases of children with serious emotional disturbance (SED) starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional. **Access Alliance of Michigan** documented improved performance from baseline to remeasurement. As **Access Alliance of Michigan** progresses in the study, assessment of the impact of the PIP on the **quality** of care and services will continue.

CMH Affiliation of Mid-Michigan

Findings

Table 3–39 and Table 3–40 show **CMH Affiliation of Mid-Michigan**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2007–2008 PIP Validation Report for **CMH Affiliation of Mid-Michigan**. Validation of Activities I through IX resulted in a validation status of *Met,* with an overall score of 95 percent and a score of 100 percent for critical elements.

Table 3–39—PIP Validation Scores
for ***Ongoing Service Within 14 Days of Nonemergent Assessment***
for **CMH Affiliation of Mid-Michigan**

		All Evaluation Elements (Including Critical Elements)					Critical Elements				
Review Activity		Total	*M*	*PM*	*NM*	*NA*	Total	*M*	*PM*	*NM*	*NA*
I.	Appropriate Study Topic	6	6	0	0	0	1	1	0	0	0
II.	Clearly Defined, Answerable Study Question	2	2	0	0	0	2	2	0	0	0
III.	Clearly Defined Study Indicator(s)	7	5	0	0	2	3	3	0	0	0
IV.	Correctly Identified Study Population	3	2	0	0	1	2	2	0	0	0
V.	Valid Sampling Techniques	6	0	0	0	6	1	0	0	0	1
VI.	Accurate/Complete Data Collection	11	4	0	2	5	1	0	0	0	1
VII.	Appropriate Improvement Strategies	4	4	0	0	0	1	1	0	0	0
VIII.	Sufficient Data Analysis and Interpretation	9	8	0	0	1	2	1	0	0	1
IX.	Real Improvement Achieved	4	4	0	0	0	No Critical Elements				
X.	Sustained Improvement Achieved	1	Not Assessed				No Critical Elements				
Totals for All Activities		**53**	**35**	**0**	**2**	**15**	**13**	**10**	**0**	**0**	**3**

M *= Met,* ***PM*** *= Partially Met,* ***NM*** *= Not Met,* ***NA*** *= Not Applicable*

Table 3–40—PIP Validation Status
for ***Ongoing Service Within 14 Days of Nonemergent Assessment***
for **CMH Affiliation of Mid-Michigan**

Percentage Score of Evaluation Elements *Met*	**95%**
Percentage Score of Critical Elements *Met*	**100%**
Validation Status	***Met***

Strengths

CMH Affiliation of Mid-Michigan Michigan's PIP was validated through nine activities and HSAG's assessment determined high confidence in the results. The selected study population captured all beneficiaries to whom the study question applied. The PIHP's improvement strategies were based on a causal/barrier analysis and addressed system changes that were likely to produce permanent change. **CMH Affiliation of Mid-Michigan Michigan** revised interventions based on findings from data analysis and quality improvement processes. There was documented improvement in the study indicator, with statistical evidence that observed improvement was true improvement.

Recommendations

HSAG identified the following areas for improvement for **CMH Affiliation of Mid-Michigan**:

CMH Affiliation of Mid-Michigan should include a description of the systematic processes used to collect baseline and remeasurement data and a discussion of the administrative data collection process used in the production of the study indicators. Future PIP submissions should also address the process used to calculate the percentage for the estimated degree of administrative data completeness. For activities related to the study topic and the study population, HSAG identified additional *Points of Clarification* to strengthen the study.

Summary Assessment Related to Quality, Timeliness, and Access

CMH Affiliation of Mid-Michigan recognized that the study provided an opportunity to improve the timeliness of access to care and services across health care delivery systems for its beneficiaries. The focus of the study was to improve the percentage of new cases of persons with substance abuse disorder starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional. **CMH Affiliation of Mid-Michigan** demonstrated improvement in the percentage of beneficiaries who received timely, ongoing services despite the statistically nonsignificant declines in the last two remeasurement periods.

CMH for Central Michigan

Findings

Table 3–41 and Table 3–42 show **CMH for Central Michigan**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2007–2008 PIP Validation Report for **CMH for Central Michigan**. Validation of Activities I through IX resulted in a validation status of *Partially Met,* with an overall score of 75 percent and a score of 90 percent for critical elements.

Table 3–41—PIP Validation Scores
for ***Ongoing Service Within 14 Days of Nonemergent Assessment***
for **CMH for Central Michigan**

		All Evaluation Elements (Including Critical Elements)					Critical Elements				
Review Activity		Total	*M*	*PM*	*NM*	*NA*	Total	*M*	*PM*	*NM*	*NA*
I.	Appropriate Study Topic	6	6	0	0	0	1	1	0	0	0
II.	Clearly Defined, Answerable Study Question	2	2	0	0	0	2	2	0	0	0
III.	Clearly Defined Study Indicator(s)	7	5	0	0	2	3	3	0	0	0
IV.	Correctly Identified Study Population	3	2	0	0	1	2	2	0	0	0
V.	Valid Sampling Techniques	6	0	0	0	6	1	0	0	0	1
VI.	Accurate/Complete Data Collection	11	6	0	0	5	1	0	0	0	1
VII.	Appropriate Improvement Strategies	4	0	2	1	1	1	0	1	0	0
VIII.	Sufficient Data Analysis and Interpretation	9	4	1	3	1	2	1	0	0	1
IX.	Real Improvement Achieved	4	2	0	2	0	No Critical Elements				
X.	Sustained Improvement Achieved	1	Not Assessed				No Critical Elements				
Totals for All Activities		**53**	**27**	**3**	**6**	**16**	**13**	**9**	**1**	**0**	**3**
M *= Met,* ***PM*** *= Partially Met,* ***NM*** *= Not Met,* ***NA*** *= Not Applicable*											

Table 3–42—PIP Validation Status
for ***Ongoing Service Within 14 Days of Nonemergent Assessment***
for **CMH for Central Michigan**

Percentage Score of Evaluation Elements *Met*	**75%**
Percentage Score of Critical Elements *Met*	**90%**
Validation Status	***Partially Met***

Strengths

CMH for Central Michigan provided a detailed and complete description of the data collection methodology. The PIHP conducted data analysis according to the analysis plan in the study. There was documented improvement in the study indicator that appeared to be the result of the planned interventions.

Recommendations

HSAG identified the following areas for improvement for **CMH for Central Michigan**:

CMH for Central Michigan should include a discussion about the type of causal/barrier analysis or quality improvement process used to identify the reported barriers. The PIP documentation should include information regarding the procedures used in the absence of the quality analyst. **CMH for Central Michigan** should include a discussion about standardization of the interventions and monitoring for ongoing success. Future submissions of the PIP should include a discussion regarding factors that threaten the internal or external validity of the data findings and factors that affect the ability to compare measurement periods. Data provided in the PIP should be clear, accurate, and easily understood, and statistical testing should be performed to show statistical significance between measurement periods. The methodology used for remeasurement should be the same as the baseline methodology. If the methodology has changed, the PIP should provide an explanation supporting the change. For activities related to the study topic, the study population, and data collection, HSAG identified additional *Points of Clarification* to strengthen the study.

Summary Assessment Related to Quality, Timeliness, and Access

CMH for Central Michigan recognized that the study provided an opportunity to improve the timeliness of access to care and services across health care delivery systems for its beneficiaries. The focus of the study was to improve the percentage of new cases of persons with substance abuse disorder starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional. **CMH for Central Michigan** reported baseline and first remeasurement results; however, the measurement periods for the baseline period and the remeasurement period were not the same, and there was a gap of missing data points in between the two measurements.

CMH Partnership of Southeastern Michigan

Findings

Table 3–43 and Table 3–44 show **CMH Partnership of Southeastern Michigan**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2007–2008 PIP Validation Report for **CMH Partnership of Southeastern Michigan**. Validation of Activities I through IX resulted in a validation status of *Met,* with an overall score of 100 percent and a score of 100 percent for critical elements.

Table 3–43—PIP Validation Scores
for ***Ongoing Service Within 14 Days of Nonemergent Assessment***
for **CMH Partnership of Southeastern Michigan**

		All Evaluation Elements (Including Critical Elements)					Critical Elements				
Review Activity		Total	*M*	*PM*	*NM*	*NA*	Total	*M*	*PM*	*NM*	*NA*
I.	Appropriate Study Topic	6	6	0	0	0	1	1	0	0	0
II.	Clearly Defined, Answerable Study Question	2	2	0	0	0	2	2	0	0	0
III.	Clearly Defined Study Indicator(s)	7	5	0	0	2	3	3	0	0	0
IV.	Correctly Identified Study Population	3	2	0	0	1	2	2	0	0	0
V.	Valid Sampling Techniques	6	0	0	0	6	1	0	0	0	1
VI.	Accurate/Complete Data Collection	11	6	0	0	5	1	0	0	0	1
VII.	Appropriate Improvement Strategies	4	3	0	0	1	1	1	0	0	0
VIII.	Sufficient Data Analysis and Interpretation	9	8	0	0	1	2	1	0	0	1
IX.	Real Improvement Achieved	4	4	0	0	0	No Critical Elements				
X.	Sustained Improvement Achieved	1	Not Assessed				No Critical Elements				
Totals for All Activities		**53**	**36**	**0**	**0**	**16**	**13**	**10**	**0**	**0**	**3**

M *= Met,* ***PM*** *= Partially Met,* ***NM*** *= Not Met,* ***NA*** *= Not Applicable*

Table 3–44—PIP Validation Status
for ***Ongoing Service Within 14 Days of Nonemergent Assessment***
for **CMH Partnership of Southeastern Michigan**

Percentage Score of Evaluation Elements *Met*	**100%**
Percentage Score of Critical Elements *Met*	**100%**
Validation Status	***Met***

Strengths

CMH Partnership of Southeastern Michigan's PIP was validated through nine activities and HSAG's assessment determined high confidence in the results. The PIHP provided comprehensive background information for the study topic and a detailed explanation of the study population. The PIHP based the selected interventions on a causal/barrier analysis and linked the interventions with identified barriers. **CMH Partnership of Southeastern Michigan** conducted complete and thorough data analysis and interpretation of study results according to the data analysis plan in the study. There was documented improvement in the study indicator, with statistical evidence that improvement was true improvement.

Recommendations

There were no opportunities for improvement identified during this validation cycle. For activities related to the study topic, the study indicators, and data analysis and interpretation, HSAG identified *Points of Clarification* to strengthen the study.

Summary Assessment Related to Quality, Timeliness, and Access

CMH Partnership of Southeastern Michigan recognized that the study provided an opportunity to improve the timeliness of access to care and services across health care delivery systems for its beneficiaries. The focus of the study was to improve the percentage of new cases of adults with developmental disabilities starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional. **CMH Partnership of Southeastern Michigan** reported data for baseline and one remeasurement, showing statistically significant improvement in the percentage of beneficiaries who received timely, ongoing services.

Detroit-Wayne County CMH Agency

Findings

Table 3–45 and Table 3–46 show **Detroit-Wayne County CMH Agency**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2007–2008 PIP Validation Report for **Detroit-Wayne County CMH Agency**. Validation of Activities I through IX resulted in a validation status of *Partially Met,* with an overall score of 80 percent and a score of 91 percent for critical elements.

Table 3–45—PIP Validation Scores
for ***Ongoing Service Within 14 Days of Nonemergent Assessment***
for **Detroit-Wayne County CMH Agency**

		All Evaluation Elements (Including Critical Elements)					Critical Elements				
Review Activity		Total	M	PM	NM	NA	Total	M	PM	NM	NA
I.	Appropriate Study Topic	6	6	0	0	0	1	1	0	0	0
II.	Clearly Defined, Answerable Study Question	2	2	0	0	0	2	2	0	0	0
III.	Clearly Defined Study Indicator(s)	7	5	0	0	2	3	3	0	0	0
IV.	Correctly Identified Study Population	3	2	0	0	1	2	2	0	0	0
V.	Valid Sampling Techniques	6	0	0	0	6	1	0	0	0	1
VI.	Accurate/Complete Data Collection	11	9	0	2	0	1	1	0	0	0
VII.	Appropriate Improvement Strategies	4	2	0	0	2	1	1	0	0	0
VIII.	Sufficient Data Analysis and Interpretation	9	5	3	0	1	2	0	1	0	1
IX.	Real Improvement Achieved	4	1	3	0	0	No Critical Elements				
X.	Sustained Improvement Achieved	1	Not Assessed				No Critical Elements				
Totals for All Activities		**53**	**32**	**6**	**2**	**12**	**13**	**10**	**1**	**0**	**2**

M *= Met,* ***PM*** *= Partially Met,* ***NM*** *= Not Met,* ***NA*** *= Not Applicable*

Table 3–46—PIP Validation Status
for ***Ongoing Service Within 14 Days of Nonemergent Assessment***
for **Detroit-Wayne County CMH Agency**

Percentage Score of Evaluation Elements *Met*	**80%**
Percentage Score of Critical Elements *Met*	**91%**
Validation Status	***Partially Met***

Strengths

Detroit-Wayne County CMH Agency provided a complete definition of the revised study population that captured all beneficiaries to whom the study question applied. The PIP documentation included a complete description of the data collection methodology. Improvement strategies were related to a causal/barrier analysis and addressed system changes that were likely to produce permanent change. The data analysis was conducted according to the data analysis plan in the study. The remeasurement methodology was the same as the baseline methodology.

Recommendations

HSAG identified the following areas for improvement for **Detroit-Wayne County CMH Agency**:

Detroit-Wayne County CMH Agency should document the qualifications, training, experience, and education for each person collecting manual data and provide the estimated degree of administrative data completeness and the process used to calculate this percentage. The data analysis plan in the PIP documentation should discuss the type of statistical testing that will be used to determine statistical significance between measurement periods. The data analysis presented in the PIP should be clear, accurate, and easily understood. The p values should be consistent throughout the PIP documentation. Statistically significant improvement should occur across all study indicators for all measurement periods. Interventions should be analyzed and revised to achieve the desired outcomes of the study. For the activity related to the study topic, HSAG identified an additional *Point of Clarification* to strengthen the study.

Summary Assessment Related to Quality, Timeliness, and Access

Detroit-Wayne County CMH Agency recognized that the study provided an opportunity to improve the timeliness of access to care and services across health care delivery systems for its beneficiaries. The focus of the study was to improve the percentage of new cases of persons with developmental disabilities starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional. **Detroit-Wayne County CMH Agency** reported data for baseline and five quarterly remeasurements, showing nonsignificant declines for most of the remeasurement periods and a statistically significant increase for the third remeasurement period. As **Detroit-Wayne County CMH Agency** moves forward in the PIP, the assessment of the impact of the PIP on the **quality** of care and services will continue.

Genesee County CMH

Findings

Table 3–47 and Table 3–48 show **Genesee County CMH**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2007–2008 PIP Validation Report for **Genesee County CMH**. Validation of Activities I through X resulted in a validation status of *Met,* with an overall score of 100 percent and a score of 100 percent for critical elements.

Table 3–47—PIP Validation Scores
for ***Ongoing Service Within 14 Days of Nonemergent Assessment***
for **Genesee County CMH**

		All Evaluation Elements (Including Critical Elements)					Critical Elements				
Review Activity		Total	*M*	*PM*	*NM*	*NA*	Total	*M*	*PM*	*NM*	*NA*
I.	Appropriate Study Topic	6	6	0	0	0	1	1	0	0	0
II.	Clearly Defined, Answerable Study Question	2	2	0	0	0	2	2	0	0	0
III.	Clearly Defined Study Indicator(s)	7	6	0	0	1	3	3	0	0	0
IV.	Correctly Identified Study Population	3	2	0	0	1	2	2	0	0	0
V.	Valid Sampling Techniques	6	0	0	0	6	1	0	0	0	1
VI.	Accurate/Complete Data Collection	11	6	0	0	5	1	0	0	0	1
VII.	Appropriate Improvement Strategies	4	3	0	0	1	1	1	0	0	0
VIII.	Sufficient Data Analysis and Interpretation	9	8	0	0	1	2	1	0	0	1
IX.	Real Improvement Achieved	4	3	0	0	1	No Critical Elements				
X.	Sustained Improvement Achieved	1	1	0	0	0	No Critical Elements				
Totals for All Activities		**53**	**37**	**0**	**0**	**16**	**13**	**10**	**0**	**0**	**3**

M *= Met,* ***PM*** *= Partially Met,* ***NM*** *= Not Met,* ***NA*** *= Not Applicable*

Table 3–48—PIP Validation Status
for ***Ongoing Service Within 14 Days of Nonemergent Assessment***
for **Genesee County CMH**

Percentage Score of Evaluation Elements *Met*	**100%**
Percentage Score of Critical Elements *Met*	**100%**
Validation Status	***Met***

Strengths

Genesee County CMH's PIP was validated through all 10 activities and HSAG's assessment determined high confidence in the results. The PIHP provided comprehensive background information for the study topic. The method for identifying the study population was completely defined and captured all beneficiaries to whom the study question applied. The PIP documentation included a comprehensive description of the data collection methodology. The PIHP determined appropriate interventions through a causal/barrier analysis and selected improvement strategies that were likely to produce permanent change. **Genesee County CMH** conducted complete and thorough data analysis and interpretation of study results, showing improvement in the study indicator.

Recommendations

There were no opportunities for improvement identified during this validation cycle. For activities related to the study population, data collection, and data analysis and interpretation, HSAG identified *Points of Clarification* to strengthen the study.

Summary Assessment Related to Quality, Timeliness, and Access

Genesee County CMH recognized that the study provided an opportunity to improve the timeliness of access to care and services across health care delivery systems for its beneficiaries. The focus of the study was to improve the percentage of new cases of children with SED starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional. **Genesee County CMH** reported data for baseline and seven quarterly remeasurement periods. There was statistical evidence that improvement in the percentage of beneficiaries who received timely, ongoing services from the first remeasurement to the second was true improvement. Due to the high compliance rate and the small numbers for the numerators and denominators, HSAG determined that it was statistically and numerically impossible for **Genesee County CMH** to achieve statistically significant improvement for all remeasurement periods.

Lakeshore Behavioral Health Alliance

Findings

Table 3–49 and Table 3–50 show **Lakeshore Behavioral Health Alliance**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2007–2008 PIP Validation Report for **Lakeshore Behavioral Health Alliance**. Validation of Activities I through IX resulted in a validation status of *Partially Met,* with an overall score of 91 percent and a score of 90 percent for critical elements.

Table 3–49—PIP Validation Scores
for ***Ongoing Service Within 14 Days of Nonemergent Assessment***
for **Lakeshore Behavioral Health Alliance**

		All Evaluation Elements (Including Critical Elements)					Critical Elements				
Review Activity		Total	*M*	*PM*	*NM*	*NA*	Total	*M*	*PM*	*NM*	*NA*
I.	Appropriate Study Topic	6	6	0	0	0	1	1	0	0	0
II.	Clearly Defined, Answerable Study Question	2	2	0	0	0	2	2	0	0	0
III.	Clearly Defined Study Indicator(s)	7	5	0	0	2	3	3	0	0	0
IV.	Correctly Identified Study Population	3	2	0	0	1	2	2	0	0	0
V.	Valid Sampling Techniques	6	0	0	0	6	1	0	0	0	1
VI.	Accurate/Complete Data Collection	11	6	0	0	5	1	0	0	0	1
VII.	Appropriate Improvement Strategies	4	1	2	0	1	1	0	1	0	0
VIII.	Sufficient Data Analysis and Interpretation	9	7	0	1	1	2	1	0	0	1
IX.	Real Improvement Achieved	4	3	0	0	1	No Critical Elements				
X.	Sustained Improvement Achieved	1	Not Assessed				No Critical Elements				
Totals for All Activities		**53**	**32**	**2**	**1**	**17**	**13**	**9**	**1**	**0**	**3**
M *= Met,* ***PM*** *= Partially Met,* ***NM*** *= Not Met,* ***NA*** *= Not Applicable*											

Table 3–50—PIP Validation Status
for ***Ongoing Service Within 14 Days of Nonemergent Assessment***
for **Lakeshore Behavioral Health Alliance**

Percentage Score of Evaluation Elements *Met*	**91%**
Percentage Score of Critical Elements *Met*	**90%**
Validation Status	***Partially Met***

Strengths

Lakeshore Behavioral Health Alliance provided a comprehensive description of the administrative data collection methodology and selected improvement strategies that were likely to produce permanent change. The PIHP conducted the data analysis according to the data analysis plan in the study. There was improvement in the study indicator. The remeasurement methodology was the same as the baseline methodology.

Recommendations

HSAG identified the following areas for improvement for **Lakeshore Behavioral Health Alliance:**

The PIP study documentation should include the data analysis, causal/barrier analysis, or quality improvement processes used by the PIHP to determine the reported barriers. A discussion about whether or not the interventions were standardized and monitored for continued success should be included. *T* tests and *z* tests were used for statistical testing. This information should be part of the data analysis plan. However, preferred tests are Chi-square or Fisher's Exact. Future submissions should make this correction and include discussion of factors that could affect the ability to compare measurement periods. For activities related to the study topic, study population, data collection, and real improvement achieved, HSAG identified additional *Points of Clarification* to strengthen the study.

Summary Assessment Related to Quality, Timeliness, and Access

Lakeshore Behavioral Health Alliance recognized that the study provided an opportunity to improve the timeliness of access to care and services across health care delivery systems for its beneficiaries. The focus of the study was to improve the percentage of new cases of adults with developmental disabilities starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional. **Lakeshore Behavioral Health Alliance** reported documented improvement in the percentage of beneficiaries who received timely, ongoing services. However, HSAG recognized that it was statistically and numerically impossible to achieve statistical significance for all measurement periods due to high compliance rates and small numbers for the numerators and denominators.

LifeWays

Findings

Table 3–51 and Table 3–52 show **LifeWays**' scores based on HSAG's PIP evaluation. For additional details, refer to the 2007–2008 PIP Validation Report for **LifeWays**. Validation of Activities I through IX resulted in a validation status of *Met,* with an overall score of 94 percent and a score of 100 percent for critical elements.

Table 3–51—PIP Validation Scores
for ***Ongoing Service Within 14 Days of Nonemergent Assessment***
for **LifeWays**

		All Evaluation Elements (Including Critical Elements)					Critical Elements				
Review Activity		Total	*M*	*PM*	*NM*	*NA*	Total	*M*	*PM*	*NM*	*NA*
I.	Appropriate Study Topic	6	6	0	0	0	1	1	0	0	0
II.	Clearly Defined, Answerable Study Question	2	2	0	0	0	2	2	0	0	0
III.	Clearly Defined Study Indicator(s)	7	5	0	0	2	3	3	0	0	0
IV.	Correctly Identified Study Population	3	2	0	0	1	2	2	0	0	0
V.	Valid Sampling Techniques	6	0	0	0	6	1	0	0	0	1
VI.	Accurate/Complete Data Collection	11	6	0	0	5	1	0	0	0	1
VII.	Appropriate Improvement Strategies	4	3	0	0	1	1	1	0	0	0
VIII.	Sufficient Data Analysis and Interpretation	9	6	2	0	1	2	1	0	0	1
IX.	Real Improvement Achieved	4	3	0	0	1	No Critical Elements				
X.	Sustained Improvement Achieved	1	Not Assessed				No Critical Elements				
Totals for All Activities		**53**	**33**	**2**	**0**	**17**	**13**	**10**	**0**	**0**	**3**

M *= Met,* ***PM*** *= Partially Met,* ***NM*** *= Not Met,* ***NA*** *= Not Applicable*

Table 3–52—PIP Validation Status
for ***Ongoing Service Within 14 Days of Nonemergent Assessment***
for **LifeWays**

Percentage Score of Evaluation Elements *Met*	**94%**
Percentage Score of Critical Elements *Met*	**100%**
Validation Status	***Met***

Strengths

LifeWays's PIP was validated through nine activities and HSAG's assessment determined confidence in the results. The PIHP included comprehensive background information for the study topic in the PIP documentation and provided a detailed description of the administrative data collection methodology. Improvement strategies were related to causes/barriers identified through data analysis and addressed system changes that were likely to produce permanent change. The data analysis was conducted according to the data analysis plan in the study. There was documented improvement in the study indicator that appeared to be the result of the planned interventions.

Recommendations

HSAG identified the following areas for improvement for **LifeWays**:

The PIHP reported that the *f* test was used for statistical testing. The preferred statistical tests are Chi-square or Fisher's Exact. The *p* values could not be replicated by the HSAG PIP Review Team using the Chi-square test. Future PIP submissions should compare fiscal year to fiscal year instead of quarter to quarter. For activities related to the study topic, study indicators, study population, and data collection, HSAG identified additional *Points of Clarification* to strengthen the study.

Summary Assessment Related to Quality, Timeliness, and Access

LifeWays recognized that the study provided an opportunity to improve the timeliness of access to care and services across health care delivery systems for its beneficiaries. The focus of the study was to improve the percentage of new cases of persons with substance abuse disorder starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional. **LifeWays** reported baseline and four quarterly remeasurement periods. There was statistical evidence that observed improvement in the percentage of beneficiaries who received timely, ongoing services was true improvement from baseline to the first remeasurement period. HSAG determined that it was statistically and numerically impossible to achieve statistical significance for all remaining measurement periods due to the small numbers for the numerators and denominators.

Macomb County CMH Services

Findings

Table 3–53 and Table 3–54 show **Macomb County CMH Services**' scores based on HSAG's PIP evaluation. For additional details, refer to the 2007–2008 PIP Validation Report for **Macomb County CMH Services**. Validation of Activities I through IX resulted in a validation status of *Met,* with an overall score of 91 percent and a score of 100 percent for critical elements.

Table 3–53—PIP Validation Scores
for ***Ongoing Service Within 14 Days of Nonemergent Assessment***
for **Macomb County CMH Services**

		All Evaluation Elements (Including Critical Elements)					Critical Elements				
Review Activity		Total	*M*	*PM*	*NM*	*NA*	Total	*M*	*PM*	*NM*	*NA*
I.	Appropriate Study Topic	6	6	0	0	0	1	1	0	0	0
II.	Clearly Defined, Answerable Study Question	2	2	0	0	0	2	2	0	0	0
III.	Clearly Defined Study Indicator(s)	7	5	0	0	2	3	3	0	0	0
IV.	Correctly Identified Study Population	3	2	0	0	1	2	2	0	0	0
V.	Valid Sampling Techniques	6	0	0	0	6	1	0	0	0	1
VI.	Accurate/Complete Data Collection	11	6	0	0	5	1	0	0	0	1
VII.	Appropriate Improvement Strategies	4	2	0	0	2	1	1	0	0	0
VIII.	Sufficient Data Analysis and Interpretation	9	7	1	0	1	2	1	0	0	1
IX.	Real Improvement Achieved	4	2	0	2	0	No Critical Elements				
X.	Sustained Improvement Achieved	1	Not Assessed				No Critical Elements				
Totals for All Activities		**53**	**32**	**1**	**2**	**17**	**13**	**10**	**0**	**0**	**3**
M = *Met*, ***PM*** = *Partially Met*, ***NM*** = *Not Met*, ***NA*** = *Not Applicable*											

Table 3–54—PIP Validation Status
for ***Ongoing Service Within 14 Days of Nonemergent Assessment***
for **Macomb County CMH Services**

Percentage Score of Evaluation Elements *Met*	**91%**
Percentage Score of Critical Elements *Met*	**100%**
Validation Status	***Met***

Strengths

Macomb County CMH Service's PIP was validated through nine activities and HSAG's assessment determined confidence in the results. The PIHP provided comprehensive background information for the study topic and a detailed explanation of the study population. The PIHP described the data collection methodology in depth. Improvement strategies were related to causes/barriers identified through data analysis and addressed system changes that were likely to produce permanent change. The data analysis was conducted according to the data analysis plan in the study. There was documented improvement in the study indicator that appeared to be the result of the planned interventions.

Recommendations

HSAG identified the following areas for improvement for **Macomb County CMH Services**:

Future submissions of the PIP should use the preferred Chi-square test to show statistical significance. Measurement periods should be comparable time periods, and an explanation for any gaps should be provided. The data should be presented in a clear, accurate, and easily understood format. The remeasurement and baseline methodologies should be the same. If they are not the same, the PIP should provide an explanation for the change. The improvement noted from baseline to first remeasurement was not statistically significant. The PIHP should consider revising existing interventions or implementing new interventions to achieve the desired outcomes. For activities related to the study indicators and data collection, HSAG identified additional *Points of Clarification* to strengthen the study.

Summary Assessment Related to Quality, Timeliness, and Access

Macomb County CMH Services recognized that the study provided an opportunity to improve the timeliness of access to care and services across health care delivery systems for its beneficiaries. The focus of the study was to improve the percentage of new cases of children with SED starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional. **Macomb County CMH Services** reported baseline and first remeasurement data that reflected improvement in the percentage of beneficiaries who received timely, ongoing services. As **Macomb County CMH Services** progresses in the study, assessment of the impact of the PIP on the **quality** of care and services will continue.

network180

Findings

Table 3–55 and Table 3–56 show **network180**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2007–2008 PIP Validation Report for **network180**. Validation of Activities I through IX resulted in a validation status of *Met,* with an overall score of 91 percent and a score of 100 percent for critical elements.

Table 3–55—PIP Validation Scores
for ***Ongoing Service Within 14 Days of Nonemergent Assessment***
for **network180**

		All Evaluation Elements (Including Critical Elements)					Critical Elements				
Review Activity		**Total**	***M***	***PM***	***NM***	***NA***	**Total**	***M***	***PM***	***NM***	***NA***
I.	Appropriate Study Topic	6	6	0	0	0	1	1	0	0	0
II.	Clearly Defined, Answerable Study Question	2	2	0	0	0	2	2	0	0	0
III.	Clearly Defined Study Indicator(s)	7	5	0	0	2	3	3	0	0	0
IV.	Correctly Identified Study Population	3	2	0	0	1	2	2	0	0	0
V.	Valid Sampling Techniques	6	0	0	0	6	1	0	0	0	1
VI.	Accurate/Complete Data Collection	11	6	0	0	5	1	0	0	0	1
VII.	Appropriate Improvement Strategies	4	2	0	0	2	1	1	0	0	0
VIII.	Sufficient Data Analysis and Interpretation	9	8	0	0	1	2	1	0	0	1
IX.	Real Improvement Achieved	4	1	3	0	0	No Critical Elements				
X.	Sustained Improvement Achieved	1	Not Assessed				No Critical Elements				
Totals for All Activities		**53**	**32**	**3**	**0**	**17**	**13**	**10**	**0**	**0**	**3**

M *= Met,* ***PM*** *= Partially Met,* ***NM*** *= Not Met,* ***NA*** *= Not Applicable*

Table 3–56—PIP Validation Status
for ***Ongoing Service Within 14 Days of Nonemergent Assessment***
for **network180**

Percentage Score of Evaluation Elements *Met*	**91%**
Percentage Score of Critical Elements *Met*	**100%**
Validation Status	***Met***

Strengths

network180's PIP was validated through nine activities and HSAG's assessment determined confidence in the results. The PIHP provided a comprehensive description of the administrative data collection methodology. Improvement strategies were related to causes/barriers identified through data analysis and addressed system changes that were likely to produce permanent change. The data analysis was conducted according to the data analysis plan in the study.

Recommendations

HSAG identified the following areas for improvement for **network180**:

Results demonstrated declines, though not statistically significant, from the first to the second remeasurement and from the third to the fourth remeasurement. The improvement noted for some of the remeasurement periods appeared to be the result of planned interventions. For activities related to appropriate improvement strategies and data analysis and interpretation, HSAG identified additional *Points of Clarification* to strengthen the study.

Summary Assessment Related to Quality, Timeliness, and Access

network180 recognized that the study provided an opportunity to improve the timeliness of access to care and services across health care delivery systems for its beneficiaries. The focus of the study was to improve the percentage of new cases of children with SED starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional. **network180** reported quarterly data for baseline and four remeasurement periods that reflected improvement in the percentage of beneficiaries who received timely, ongoing services between baseline and the first remeasurement and from the second to the third remeasurement. A decline, though not statistically significant, was observed for the fourth remeasurement; however, the rate for the fourth remeasurement remained above the baseline rate.

NorthCare

Findings

Table 3–57 and Table 3–58 show **NorthCare**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2007–2008 PIP Validation Report for **NorthCare**. Validation of Activities I through IX resulted in a validation status of *Met,* with an overall score of 88 percent and a score of 100 percent for critical elements.

Table 3–57—PIP Validation Scores
for ***Ongoing Service Within 14 Days of Nonemergent Assessment***
for **NorthCare**

Review Activity		All Evaluation Elements (Including Critical Elements)					Critical Elements				
		Total	*M*	*PM*	*NM*	*NA*	Total	*M*	*PM*	*NM*	*NA*
I.	Appropriate Study Topic	6	6	0	0	0	1	1	0	0	0
II.	Clearly Defined, Answerable Study Question	2	2	0	0	0	2	2	0	0	0
III.	Clearly Defined Study Indicator(s)	7	5	0	0	2	3	3	0	0	0
IV.	Correctly Identified Study Population	3	2	0	0	1	2	2	0	0	0
V.	Valid Sampling Techniques	6	0	0	0	6	1	0	0	0	1
VI.	Accurate/Complete Data Collection	11	9	1	1	0	1	1	0	0	0
VII.	Appropriate Improvement Strategies	4	2	1	0	1	1	1	0	0	0
VIII.	Sufficient Data Analysis and Interpretation	9	7	0	1	1	2	1	0	0	1
IX.	Real Improvement Achieved	4	3	0	1	0	No Critical Elements				
X.	Sustained Improvement Achieved	1	Not Assessed				No Critical Elements				
Totals for All Activities		**53**	**36**	**2**	**3**	**11**	**13**	**11**	**0**	**0**	**2**

M *= Met,* ***PM*** *= Partially Met,* ***NM*** *= Not Met,* ***NA*** *= Not Applicable*

Table 3–58—PIP Validation Status
for ***Ongoing Service Within 14 Days of Nonemergent Assessment***
for **NorthCare**

Percentage Score of Evaluation Elements *Met*	**88%**
Percentage Score of Critical Elements *Met*	**100%**
Validation Status	***Met***

Strengths

NorthCare's PIP was validated through nine activities and HSAG's assessment determined confidence in the results. The PIHP provided comprehensive background information for the study topic and a detailed description of the administrative data collection methodology. Improvement strategies were related to causes/barriers identified through data analysis and addressed system changes that were likely to produce permanent change. The data analysis was conducted according to the data analysis plan in the study. There was documented improvement in the study indicator that appeared to be the result of the planned interventions.

Recommendations

HSAG identified the following areas for improvement for **NorthCare**:

NorthCare should include in the study documentation the qualifications and experience of each staff member involved in the manual data collection process. The written instructions for the manual data collection tool should include an overview of the study. The PIHP should perform statistical testing to show statistical significance between measurement periods. The complete *p* value and the statistical analysis should be documented in the PIP. For the activity related to the study topic, HSAG identified additional *Points of Clarification* to strengthen the study.

Summary Assessment Related to Quality, Timeliness, and Access

NorthCare recognized that the study provided an opportunity to improve the timeliness of access to care and services across health care delivery systems for its beneficiaries. The focus of the study was to improve the percentage of new cases of children with developmental disabilities starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional. **NorthCare** reported data for baseline and four quarterly remeasurement periods. The PIHP, however, did not perform statistical testing that would demonstrate whether or not the improvement in the percentage of beneficiaries who received timely, ongoing services was statistically significant.

Northern Affiliation

Findings

Table 3–59 and Table 3–60 show **Northern Affiliation**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2007–2008 PIP Validation Report for **Northern Affiliation**. Validation of Activities I through IX resulted in a validation status of *Met,* with an overall score of 86 percent and a score of 100 percent for critical elements.

Table 3–59—PIP Validation Scores
for ***Ongoing Service Within 14 Days of Nonemergent Assessment***
for **Northern Affiliation**

		All Evaluation Elements (Including Critical Elements)					Critical Elements				
Review Activity		Total	*M*	*PM*	*NM*	*NA*	Total	*M*	*PM*	*NM*	*NA*
I.	Appropriate Study Topic	6	6	0	0	0	1	1	0	0	0
II.	Clearly Defined, Answerable Study Question	2	2	0	0	0	2	2	0	0	0
III.	Clearly Defined Study Indicator(s)	7	5	0	0	2	3	3	0	0	0
IV.	Correctly Identified Study Population	3	2	0	0	1	2	2	0	0	0
V.	Valid Sampling Techniques	6	0	0	0	6	1	0	0	0	1
VI.	Accurate/Complete Data Collection	11	6	0	0	5	1	0	0	0	1
VII.	Appropriate Improvement Strategies	4	3	0	0	1	1	1	0	0	0
VIII.	Sufficient Data Analysis and Interpretation	9	6	2	0	1	2	1	0	0	1
IX.	Real Improvement Achieved	4	1	2	1	0	No Critical Elements				
X.	Sustained Improvement Achieved	1	Not Assessed				No Critical Elements				
Totals for All Activities		**53**	**31**	**4**	**1**	**16**	**13**	**10**	**0**	**0**	**3**

M *= Met,* ***PM*** *= Partially Met,* ***NM*** *= Not Met,* ***NA*** *= Not Applicable*

Table 3–60—PIP Validation Status
for ***Ongoing Service Within 14 Days of Nonemergent Assessment***
for **Northern Affiliation**

Percentage Score of Evaluation Elements *Met*	**86%**
Percentage Score of Critical Elements *Met*	**100%**
Validation Status	***Met***

Strengths

Northern Affiliation's PIP was validated through nine activities and HSAG's assessment determined confidence in the results. The PIHP provided a detailed description of the administrative data collection methodology and a comprehensive data analysis plan. Improvement strategies were related to causes/barriers identified through data analysis and addressed system changes that were likely to produce permanent change. Original interventions were revised based on data analysis. The data analysis was conducted according to the data analysis plan in the study. The remeasurement methodology was the same as the baseline methodology.

Recommendations

HSAG identified the following areas for improvement for **Northern Affiliation**:

Northern Affiliation should present data in a clear, accurate, and easily understood format. While there was documented improvement in the study indicator for the first three measurement periods, results were trending down from the fourth to the sixth remeasurement periods. There was no statistical evidence that demonstrated improvement was true improvement. For activities related to the study topic and study indicator, HSAG identified additional *Points of Clarification* to strengthen the study.

Summary Assessment Related to Quality, Timeliness, and Access

Northern Affiliation recognized that the study provided an opportunity to improve the timeliness of access to care and services across health care delivery systems for its beneficiaries. The focus of the study was to improve the percentage of new cases of persons with substance abuse disorder starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional. **Northern Affiliation** provided quarterly data for baseline and seven remeasurement periods. There was documented improvement in the percentage of beneficiaries who received timely, ongoing services from baseline through the first four measurement periods.

Northwest CMH Affiliation

Findings

Table 3–61 and Table 3–62 show **Northwest CMH Affiliation**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2007–2008 PIP Validation Report for **Northwest CMH Affiliation**. Validation of Activities I through IX resulted in a validation status of *Not Met,* with an overall score of 63 percent and a score of 82 percent for critical elements.

Table 3–61—PIP Validation Scores
for ***Ongoing Service Within 14 Days of Nonemergent Assessment***
for **Northwest CMH Affiliation**

		All Evaluation Elements (Including Critical Elements)					Critical Elements				
Review Activity		Total	*M*	*PM*	*NM*	*NA*	Total	*M*	*PM*	*NM*	*NA*
I.	Appropriate Study Topic	6	6	0	0	0	1	1	0	0	0
II.	Clearly Defined, Answerable Study Question	2	2	0	0	0	2	2	0	0	0
III.	Clearly Defined Study Indicator(s)	7	5	0	0	2	3	3	0	0	0
IV.	Correctly Identified Study Population	3	2	0	0	1	2	2	0	0	0
V.	Valid Sampling Techniques	6	0	0	0	6	1	0	0	0	1
VI.	Accurate/Complete Data Collection	11	1	3	7	0	1	0	0	1	0
VII.	Appropriate Improvement Strategies	4	1	2	0	1	1	0	1	0	0
VIII.	Sufficient Data Analysis and Interpretation	9	6	2	0	1	2	1	0	0	1
IX.	Real Improvement Achieved	4	3	0	1	0	No Critical Elements				
X.	Sustained Improvement Achieved	1	Not Assessed				No Critical Elements				
Totals for All Activities		**53**	**26**	**7**	**8**	**11**	**13**	**9**	**1**	**1**	**2**

M *= Met,* ***PM*** *= Partially Met,* ***NM*** *= Not Met,* ***NA*** *= Not Applicable*

Table 3–62—PIP Validation Status
for ***Ongoing Service Within 14 Days of Nonemergent Assessment***
for **Northwest CMH Affiliation**

Percentage Score of Evaluation Elements *Met*	**63%**
Percentage Score of Critical Elements *Met*	**82%**
Validation Status	***Not Met***

Strengths

Northwest CMH Affiliation's study documentation included the method for identifying the study population. The improvement strategies were likely to produce permanent change. The data analysis was conducted according to the data analysis plan in the study. There was documented improvement in the study indicator that appeared to be the result of the planned interventions.

Recommendations

HSAG identified the following areas for improvement for **Northwest CMH Affiliation**:

Future PIP submissions should address all requirements related to accurate and complete data collection, including a copy of the manual data collection tool with written instructions, qualifications and training of manual data collection personnel, and descriptions of the processes for administrative data collection and for estimating the degree of data completeness. The causal/barrier analysis and/or quality improvement processes used to identify the barriers should be discussed in the PIP documentation. Once successful, interventions should be standardized and monitored for ongoing success. Data should be presented in a clear, accurate, and easily understood format. Measurement periods should include complete date ranges. For statistical testing, the Chi-square or Fisher's Exact tests are the preferred methods. The PIP should demonstrate statistically significant improvement. For activities related to the study topic and study indicator, HSAG identified additional *Points of Clarification* to strengthen the study.

Summary Assessment Related to Quality, Timeliness, and Access

Northwest CMH Affiliation recognized that the study provided an opportunity to improve the timeliness of access to care and services across health care delivery systems for its beneficiaries. The focus of the study was to improve the percentage of new cases of children with SED starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional. **Northwest CMH Affiliation**'s PIP received a validation status of *Not Met,* indicating that the reported PIP results were not credible. As **Northwest CMH Affiliation** progresses in the study, assessment of the impact of the PIP on the **quality** of care and services will continue.

Oakland County CMH Authority

Findings

Table 3–63 and Table 3–64 show **Oakland County CMH Authority**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2007–2008 PIP Validation Report for **Oakland County CMH Authority**. Validation of Activities I through IX resulted in a validation status of *Met,* with an overall score of 93 percent and a score of 100 percent for critical elements.

Table 3–63—PIP Validation Scores
for ***Ongoing Service Within 14 Days of Nonemergent Assessment***
for **Oakland County CMH Authority**

		All Evaluation Elements (Including Critical Elements)					Critical Elements				
Review Activity		Total	*M*	*PM*	*NM*	*NA*	Total	*M*	*PM*	*NM*	*NA*
I.	Appropriate Study Topic	6	6	0	0	0	1	1	0	0	0
II.	Clearly Defined, Answerable Study Question	2	2	0	0	0	2	2	0	0	0
III.	Clearly Defined Study Indicator(s)	7	5	0	0	2	3	3	0	0	0
IV.	Correctly Identified Study Population	3	2	0	0	1	2	2	0	0	0
V.	Valid Sampling Techniques	6	0	0	0	6	1	0	0	0	1
VI.	Accurate/Complete Data Collection	11	11	0	0	0	1	1	0	0	0
VII.	Appropriate Improvement Strategies	4	2	0	1	1	1	1	0	0	0
VIII.	Sufficient Data Analysis and Interpretation	9	7	1	0	1	2	1	0	0	1
IX.	Real Improvement Achieved	4	3	1	0	0	No Critical Elements				
X.	Sustained Improvement Achieved	1	Not Assessed				No Critical Elements				
Totals for All Activities		**53**	**38**	**2**	**1**	**11**	**13**	**11**	**0**	**0**	**2**

M *= Met,* ***PM*** *= Partially Met,* ***NM*** *= Not Met,* ***NA*** *= Not Applicable*

Table 3–64—PIP Validation Status
for ***Ongoing Service Within 14 Days of Nonemergent Assessment***
for **Oakland County CMH Authority**

Percentage Score of Evaluation Elements *Met*	**93%**
Percentage Score of Critical Elements *Met*	**100%**
Validation Status	***Met***

Strengths

Oakland County CMH Authority's PIP was validated through nine activities and HSAG's assessment determined confidence in the results. The PIHP provided comprehensive background information for the study topic, a complete explanation of the study population and included in its study documentation a detailed description of the administrative data collection methodology. Improvement strategies were related to a causal/barrier analysis and addressed system changes that were likely to produce permanent change. The data analysis was conducted according to the data analysis plan in the study. The remeasurement methodology was the same as the baseline methodology. There was documented improvement in the study indicator that appeared to be the result of the planned interventions.

Recommendations

HSAG identified the following areas for improvement for **Oakland County CMH Authority**:

Activity VII of the PIP submission should include a discussion about the standardization and monitoring of the interventions once they produce improvement in services. Data analysis should use Chi-square or Fisher's Exact testing rather than the *t* test that the PIHP performed. Using the Chi-square test, the HSAG PIP Review Team determined that the improvement from baseline to the first remeasurement was not statistically significant.

Summary Assessment Related to Quality, Timeliness, and Access

Oakland County CMH Authority recognized that the study provided an opportunity to improve the timeliness of access to care and services across health care delivery systems for its beneficiaries. The focus of the study was to improve the percentage of new cases of adults with developmental disabilities starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional. **Oakland County CMH Authority** provided data for baseline and four quarterly remeasurement periods. There was documented, statistically significant improvement in the percentage of beneficiaries who received timely, ongoing services from baseline to the fourth remeasurement period.

Saginaw County CMH Authority

Findings

Table 3–65 and Table 3–66 show **Saginaw County CMH Authority**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2007–2008 PIP Validation Report for **Saginaw County CMH Authority**. Validation of Activities I through VI resulted in a validation status of *Met,* with an overall score of 100 percent and a score of 100 percent for critical elements.

Table 3–65—PIP Validation Scores
for ***Ongoing Service Within 14 Days of Nonemergent Assessment***
for **Saginaw County CMH Authority**

		All Evaluation Elements (Including Critical Elements)					Critical Elements				
Review Activity		Total	*M*	*PM*	*NM*	*NA*	Total	*M*	*PM*	*NM*	*NA*
I.	Appropriate Study Topic	6	6	0	0	0	1	1	0	0	0
II.	Clearly Defined, Answerable Study Question	2	2	0	0	0	2	2	0	0	0
III.	Clearly Defined Study Indicator(s)	7	5	0	0	2	3	3	0	0	0
IV.	Correctly Identified Study Population	3	2	0	0	1	2	2	0	0	0
V.	Valid Sampling Techniques	6	0	0	0	6	1	0	0	0	1
VI.	Accurate/Complete Data Collection	11	6	0	0	5	1	0	0	0	1
VII.	Appropriate Improvement Strategies	4	Not Assessed				1	Not Assessed			
VIII.	Sufficient Data Analysis and Interpretation	9	Not Assessed				2	Not Assessed			
IX.	Real Improvement Achieved	4	Not Assessed				No Critical Elements				
X.	Sustained Improvement Achieved	1	Not Assessed				No Critical Elements				
Totals for All Activities		**53**	**21**	**0**	**0**	**14**	**13**	**8**	**0**	**0**	**2**

M *= Met,* ***PM*** *= Partially Met,* ***NM*** *= Not Met,* ***NA*** *= Not Applicable*

Table 3–66—PIP Validation Status
for ***Ongoing Service Within 14 Days of Nonemergent Assessment***
for **Saginaw County CMH Authority**

Percentage Score of Evaluation Elements *Met*	**100%**
Percentage Score of Critical Elements *Met*	**100%**
Validation Status	***Met*** [3-1]

[3-1] Saginaw achieved a *Met* validation status based on evaluation activities that focused on PIP design. They have failed to demonstrate any substantial progress toward fully implementing this PIP.

Strengths

Saginaw County CMH Authority's PIP was again validated through six activities. HSAG's assessment determined high confidence that the study would produce valid results. The PIHP revised the PIP and developed a strong study design with which to move forward. The PIP documentation included a complete definition of the study population and a thorough description of the data collection methodology.

Recommendations

There were no opportunities for improvement identified during this validation cycle. For activities related to the study topic, study population, sampling techniques, and data collection, HSAG identified *Points of Clarification* to strengthen the study. For the 2007–2008 validation cycle, the PIP was again validated through six activities because the PIP had not yet reported baseline data results. During the review of benchmark data, the PIHP identified issues affecting the data collection methodology and time frame for the proposed interventions. Consequently, **Saginaw County CMH Authority** was unable to implement interventions prior to January 2008. The PIHP's current PIP submission did not include the minimum of three quarters of baseline data that HSAG would have expected based on the documented baseline time frame of October 1, 2006, through September 30, 2007. **Saginaw County CMH Authority** should address all *Points of Clarification* in the PIP validation tool, provide data with analysis of the results through the current measurement period, and report on implemented improvement strategies.

Summary Assessment Related to Quality, Timeliness, and Access

Saginaw County CMH Authority recognized that the study provided an opportunity to improve the timeliness of access to care and services across health care delivery systems for its beneficiaries. The focus of the study was to improve the percentage of new cases of children with SED starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional. **Saginaw County CMH Authority** had not progressed far enough in the study to begin assessing the impact of the PIP on the **quality** of care and services.

Southwest Affiliation

Findings

Table 3–67 and Table 3–68 show **Southwest Affiliation**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2007–2008 PIP Validation Report for **Southwest Affiliation**. Validation of Activities I through IX resulted in a validation status of *Met,* with an overall score of 94 percent and a score of 100 percent for critical elements.

Table 3–67—PIP Validation Scores
for ***Timely Access to Services: Request-to-Assessment for Nonemergency Substance Abuse Services***
for **Southwest Affiliation**

		All Evaluation Elements (Including Critical Elements)					Critical Elements				
Review Activity		Total	*M*	*PM*	*NM*	*NA*	Total	*M*	*PM*	*NM*	*NA*
I.	Appropriate Study Topic	6	6	0	0	0	1	1	0	0	0
II.	Clearly Defined, Answerable Study Question	2	2	0	0	0	2	2	0	0	0
III.	Clearly Defined Study Indicator(s)	7	5	0	0	2	3	3	0	0	0
IV.	Correctly Identified Study Population	3	2	0	0	1	2	2	0	0	0
V.	Valid Sampling Techniques	6	0	0	0	6	1	0	0	0	1
VI.	Accurate/Complete Data Collection	11	6	0	0	5	1	0	0	0	1
VII.	Appropriate Improvement Strategies	4	3	0	0	1	1	1	0	0	0
VIII.	Sufficient Data Analysis and Interpretation	9	7	0	1	1	2	1	0	0	1
IX.	Real Improvement Achieved	4	3	0	1	0	No Critical Elements				
X.	Sustained Improvement Achieved	1	Not Assessed				No Critical Elements				
Totals for All Activities		**53**	**34**	**0**	**2**	**16**	**13**	**10**	**0**	**0**	**3**

M *= Met,* ***PM*** *= Partially Met,* ***NM*** *= Not Met,* ***NA*** *= Not Applicable*

Table 3–68—PIP Validation Status
for ***Timely Access to Services: Request-to-Assessment for Nonemergency Substance Abuse Services***
for **Southwest Affiliation**

Percentage Score of Evaluation Elements *Met*	**94%**
Percentage Score of Critical Elements *Met*	**100%**
Validation Status	***Met***

Strengths

Southwest Affiliation's PIP was validated through nine activities and HSAG's assessment determined confidence in the results. The PIHP provided comprehensive background information for the study topic and a thorough explanation of the study population and the data collection methodology. Improvement strategies were related to causes/barriers identified through data analysis and addressed system changes that were likely to produce permanent change. The PIHP revised the original interventions based on the results of the data analysis. **Southwest Affiliation**'s data analysis was conducted according to the data analysis plan in the study. The remeasurement methodology was the same as the baseline methodology. There was documented improvement in the study indicator that appeared to be the result of the planned interventions.

Recommendations

HSAG identified the following areas for improvement for **Southwest Affiliation**:

Southwest Affiliation should perform statistical testing to determine the statistical significance of the results. For the activities related to the study topic and the study indicator, HSAG identified additional *Points of Clarification* to strengthen the study.

Summary Assessment Related to Quality, Timeliness, and Access

Southwest Affiliation selected a PIP study topic that provided an opportunity to improve the timeliness of access to care and services across health care delivery systems for its beneficiaries. The focus of the study was to improve the percentage of new cases of persons who request nonemergency substance abuse services and receive a face-to-face assessment with a professional within 14 days of the request. **Southwest Affiliation** collected data for the baseline and four quarterly remeasurement periods. The PIP documented improvement in the percentage of timely face-to-face assessments. However, statistical testing was not performed to determine whether this improvement was statistically significant.

Thumb Alliance PIHP

Findings

Table 3–69 and Table 3–70 show **Thumb Alliance PIHP**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2007–2008 PIP Validation Report for **Thumb Alliance PIHP**. Validation of Activities I through IX resulted in a validation status of *Met,* with an overall score of 96 percent and a score of 100 percent for critical elements.

Table 3–69—PIP Validation Scores *for* *Co-Occurring Disorders* *for* Thumb Alliance PIHP

		All Evaluation Elements (Including Critical Elements)					Critical Elements				
Review Activity		Total	*M*	*PM*	*NM*	*NA*	Total	*M*	*PM*	*NM*	*NA*
I.	Appropriate Study Topic	6	6	0	0	0	1	1	0	0	0
II.	Clearly Defined, Answerable Study Question	2	2	0	0	0	2	2	0	0	0
III.	Clearly Defined Study Indicator(s)	7	6	0	0	1	3	3	0	0	0
IV.	Correctly Identified Study Population	3	2	0	0	1	2	2	0	0	0
V.	Valid Sampling Techniques	6	6	0	0	0	1	1	0	0	0
VI.	Accurate/Complete Data Collection	11	8	0	1	2	1	1	0	0	0
VII.	Appropriate Improvement Strategies	4	1	0	0	3	1	0	0	0	1
VIII.	Sufficient Data Analysis and Interpretation	9	9	0	0	0	2	2	0	0	0
IX.	Real Improvement Achieved	4	3	1	0	0	No Critical Elements				
X.	Sustained Improvement Achieved	1	Not Assessed				No Critical Elements				
Totals for All Activities		**53**	**43**	**1**	**1**	**7**	**13**	**12**	**0**	**0**	**1**

M *= Met*, ***PM*** *= Partially Met*, ***NM*** *= Not Met*, ***NA*** *= Not Applicable*

Table 3–70—PIP Validation Status *for* *Co-Occurring Disorders* *for* Thumb Alliance PIHP

Percentage Score of Evaluation Elements *Met*	**96%**
Percentage Score of Critical Elements *Met*	**100%**
Validation Status	***Met***

Strengths

Thumb Alliance PIHP's PIP was validated through nine activities and HSAG's assessment determined high confidence in the results. The PIHP provided comprehensive background information for the study topic, a complete explanation of the study population, and included in its study documentation a detailed description of the data collection methodology. The PIHP changed the study methodology to include sampling and provided documentation that demonstrated the use of proper sampling techniques. The PIHP also restructured the study question and study indicator based on recommendations from the 2006–2007 PIP validation. Improvement strategies were related to a causal/barrier analysis and addressed system changes that were likely to produce permanent change. The data analysis was complete and thorough. There was documented improvement in the study indicator that appeared to be the result of the planned interventions.

Recommendations

HSAG identified the following areas for improvement for **Thumb Alliance PIHP**:

Thumb Alliance PIHP should include an overview (purpose) of the study in instructions for the manual data collection tool. There was statistical evidence that demonstrated true improvement for Indicator 1 from the second to the third remeasurement and for Indicator 2 from the first to the second and from the second to third remeasurement. However, there was no statistical evidence of true improvement for Indicator 3. For activities related to data collection and data analysis and interpretation, HSAG identified additional *Points of Clarification* to strengthen the study.

Summary Assessment Related to Quality, Timeliness, and Access

Thumb Alliance PIHP selected a PIP study topic that provided an opportunity to improve the timeliness of access to care and services across health care delivery systems for its beneficiaries. The focus of the study was to improve the number of beneficiaries with a serious mental illness diagnosis and a substance-related diagnosis (co-occurring disorder [COD] beneficiaries). **Thumb Alliance PIHP** collected data for the baseline and three quarterly remeasurement periods. While the study demonstrated significant improvement on two study indicators, improvement on the third indicator was not statistically significant. As **Thumb Alliance PIHP** progresses with the study, assessment of the impact of the PIP on the **quality** of care and services will continue.

Venture Behavioral Health

Findings

Table 3–71 and Table 3–72 show **Venture Behavioral Health**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2007–2008 PIP Validation Report for **Venture Behavioral Health**. Validation of Activities I through IX resulted in a validation status of *Partially Met,* with an overall score of 94 percent and a score of 90 percent for critical elements.

Table 3–71—PIP Validation Scores
for ***Ongoing Service Within 14 Days of Nonemergent Assessment***
for **Venture Behavioral Health**

		All Evaluation Elements (Including Critical Elements)					Critical Elements				
Review Activity		Total	*M*	*PM*	*NM*	*NA*	Total	*M*	*PM*	*NM*	*NA*
I.	Appropriate Study Topic	6	6	0	0	0	1	1	0	0	0
II.	Clearly Defined, Answerable Study Question	2	2	0	0	0	2	2	0	0	0
III.	Clearly Defined Study Indicator(s)	7	5	1	0	1	3	2	1	0	0
IV.	Correctly Identified Study Population	3	2	0	0	1	2	2	0	0	0
V.	Valid Sampling Techniques	6	0	0	0	6	1	0	0	0	1
VI.	Accurate/Complete Data Collection	11	6	0	0	5	1	0	0	0	1
VII.	Appropriate Improvement Strategies	4	2	1	0	1	1	1	0	0	0
VIII.	Sufficient Data Analysis and Interpretation	9	8	0	0	1	2	1	0	0	1
IX.	Real Improvement Achieved	4	3	0	0	1	No Critical Elements				
X.	Sustained Improvement Achieved	1	Not Assessed				No Critical Elements				
Totals for All Activities		**53**	**34**	**2**	**0**	**16**	**13**	**9**	**1**	**0**	**3**

M *= Met,* ***PM*** *= Partially Met,* ***NM*** *= Not Met,* ***NA*** *= Not Applicable*

Table 3–72—PIP Validation Status
for ***Ongoing Service Within 14 Days of Nonemergent Assessment***
for **Venture Behavioral Health**

Percentage Score of Evaluation Elements *Met*	**94%**
Percentage Score of Critical Elements *Met*	**90%**
Validation Status	***Partially Met***

Strengths

Venture Behavioral Health provided comprehensive background information for the study topic and a complete explanation of the method for identifying the study population. The PIHP included in its study documentation a detailed description of the data collection methodology. Improvement strategies were related to a causal/barrier analysis and addressed system changes that were likely to produce permanent change. The data analysis was complete and thorough. The remeasurement methodology was the same as the baseline methodology. There was documented improvement in the study indicator that appeared to be the result of the planned interventions.

Recommendations

HSAG identified the following areas for improvement for **Venture Behavioral Health**:

Venture Behavioral Health should add a study question to address first-service appointments within seven days, as Study Indicator 2 did not align with the study question. Future submissions of the PIP should include a discussion of how ongoing interventions will be standardized and monitored for continued success.

Summary Assessment Related to Quality, Timeliness, and Access

Venture Behavioral Health recognized that the study provided an opportunity to improve the timeliness of access to care and services across health care delivery systems for its beneficiaries. The focus of the study was to improve the percentage of new cases of child plan beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional. **Venture Behavioral Health** progressed to reporting baseline and four quarterly remeasurement periods for Study Indicator I and baseline with one remeasurement for Study Indicator 2. The PIP demonstrated statistically significant improvement in the percentage of children who received timely, ongoing services. Results for Study Indicator 2 (the proportion of first-service appointments that are scheduled within seven calendar days of a completed intake assessment with a professional) also demonstrated statistically significant improvement.

4. Assessment of PIHP Follow-up on Prior Recommendations

Introduction

This section of the report presents an assessment of the PIHPs' follow-up on prior recommendations for each of the three EQR activities: compliance monitoring, validation of performance measures, and validation of PIPs.

The 2007–2008 compliance monitoring reviews evaluated the PIHPs' progress in implementing corrective actions identified in the 2006–2007 initial review of compliance standards in the areas of Subcontracts and Delegation, Provider Network, Credentialing, Access and Availability, Coordination of Care, Appeals, and Advance Directives. The PIHP-specific segments of Section 3 of this report contain a more detailed description of the PIHPs' performance and recommendations for improvement.

The 2006–2007 recommendations for improvement addressed the PIHPs' processes related to the reporting of performance indicator data and oversight of subcontractors' performance indicator reporting activities. The assessment of the PIHPs' follow-up on these recommendations was, therefore, independent of any changes to the actual indicators that were included in the validation.

For the 2007–2008 validation, PIHPs submitted studies that were a continuation of the PIPs validated in 2006–2007. This section presents the results of the assessment of the PIHPs' follow-up on recommendations made during the 2006–2007 validation of the PIPs.

Access Alliance of Michigan

Compliance Monitoring

Table 4-1 shows the results for **Access Alliance of Michigan** from the 2006–2007 (initial) and 2007–2008 (follow-up) compliance monitoring reviews.

Table 4-1—Compliance Following Initial and Follow-Up Reviews *for* Access Alliance of Michigan				
Standard		Full Compliance		One or More Remaining Corrective Action(s)
		Achieved at Initial Review	Achieved After Follow-Up	
IX	Subcontracts and Delegation	✓		
X	Provider Network	✓		
XI	Credentialing			✓
XII	Access and Availability			✓
XIII	Coordination of Care	✓		
XIV	Appeals			✓
XV	Advance Directives	✓		

The 2006–2007 compliance monitoring review resulted in 22 recommendations for improvement in the following areas: Credentialing (15), Access and Availability (6), and Appeals (1). The PIHP addressed recommendations through corrective action plans and implemented improvements. Subsequent to the 2007–2008 follow-up review, **Access Alliance of Michigan** achieved full compliance on most elements addressed in the follow-up review, with five continuing recommendations for Credentialing (1), Access and Availability (3), and Appeals (1).

Validation of Performance Measures

Table 4-2 shows the recommendations for improvement for **Access Alliance of Michigan** from the 2006–2007 validation of performance measures and the status of the PIHP's follow-up on these recommendations at the time of the 2007–2008 EQR.

Table 4-2—Follow-Up on Prior Recommendations *for* Access Alliance of Michigan

2006–2007 Recommendation	2007–2008 Status
Reviewers recommended that **Access Alliance of Michigan** update any outdated policies and procedures and retrain CMHC staff regarding reporting requirements for Indicator 13. The reviewers encouraged the PIHP to formalize existing processes to review and monitor QI data to continue to improve completeness and accuracy of the data. The reviewers also recommended that the PIHP explore ways to encourage uniform methods for the CMHCs to submit updates of QI data.	The PIHP implemented an iterative approach to measure calculation and outlier identification, with subsequent distribution of the results to the affiliated CMHC boards for review and correction. **Access Alliance of Michigan** implemented a new requirement for the CMHCs whereby a written action plan is required when the completeness of QI data elements is below 95 percent. The collaborative development of the data completeness protocols by the data integrity group reinforced and reflected the positive collaborative management of the boards by **Access Alliance of Michigan**.

Access Alliance of Michigan addressed the recommendations for improvement.

Validation of Performance Improvement Projects

HSAG identified no opportunities for improvement for **Access Alliance of Michigan** during the 2006–2007 PIP validation.

CMH Affiliation of Mid-Michigan

Compliance Monitoring

Table 4-3 shows the results for **CMH Affiliation of Mid-Michigan** from the 2006–2007 (initial) and 2007–2008 (follow-up) compliance monitoring reviews.

Table 4-3—Compliance Following Initial and Follow-Up Reviews *for* CMH Affiliation of Mid-Michigan

Standard		Full Compliance		One or More Remaining Corrective Action(s)
		Achieved at Initial Review	Achieved After Follow-Up	
IX	Subcontracts and Delegation			✓
X	Provider Network			✓
XI	Credentialing		✓	
XII	Access and Availability		✓	
XIII	Coordination of Care	✓		
XIV	Appeals			✓
XV	Advance Directives			✓

The 2006–2007 compliance monitoring review resulted in 19 recommendations for improvement in the following areas: Subcontracts and Delegation (1), Provider Network (1), Credentialing (5), Access and Availability (5), Appeals (4), and Advance Directives (3). The PIHP addressed recommendations through corrective action plans and implemented improvements. Subsequent to the 2007–2008 follow-up review, **CMH Affiliation of Mid-Michigan** achieved full compliance on two additional standards (Credentialing and Access and Availability), with 8 continuing recommendations for Subcontracts and Delegation (1), Provider Network (1), Appeals (3), and Advance Directives (3).

Validation of Performance Measures

Table 4-4 shows the recommendations for improvement for **CMH Affiliation of Mid-Michigan** from the 2006–2007 validation of performance measures and the status of the PIHP's follow-up on these recommendations at the time of the 2007–2008 EQR.

Table 4-4—Follow-Up on Prior Recommendations *for* CMH Affiliation of Mid-Michigan

2006–2007 Recommendation	2007–2008 Status
The reviewers recommended that **CMH Affiliation of Mid-Michigan** continue to improve processes with the CA due to the low rates. Additionally, the reviewers recommended that the PIHP consider additional oversight of the recipient rights function and that the PIHP continue its efforts toward further automation for reporting this indicator.	The PIHP saw an increase in the CA's performance indicator rates, which was noted as a concern during the previous year's audit. **CMH Affiliation of Mid-Michigan** demonstrated an excellent process for reviewing each affiliate's encounter, QI, and performance indicator data, including feedback and requests for corrective action. The PIHP continued its efforts toward the goal of full automation of calculation of performance indicators.

CMH Affiliation of Mid-Michigan addressed the recommendations for improvement.

Validation of Performance Improvement Projects

Table 4-5 displays activities/elements scored *Partially Met* or *Not Met* for **CMH Affiliation of Mid-Michigan** during the 2006–2007 validation of PIPs and results of the assessment of these elements from the 2007–2008 EQR.

Table 4-5—Follow-Up on Prior Recommendations *for* CMH Affiliation of Mid-Michigan			
Activity/ Element	2006–2007 Score	2007–2008 Score	2007–2008 Comment
VI.3	*Not Met*	*Not Met*	The PIP documentation did not include a clearly defined, systematic process for collecting baseline and remeasurement data. The PIP referenced the ISCAT but the document was not provided.

CMH Affiliation of Mid-Michigan did not address the recommendation from the 2006–2007 PIP validation.

CMH for Central Michigan

Compliance Monitoring

Table 4-6 shows the results for **CMH for Central Michigan** from the 2006–2007 (initial) and 2007–2008 (follow-up) compliance monitoring reviews.

Table 4-6—Compliance Following Initial and Follow-Up Reviews *for* CMH for Central Michigan				
Standard		Full Compliance		One or More Remaining Corrective Action(s)
		Achieved at Initial Review	Achieved After Follow-Up	
IX	Subcontracts and Delegation		✓	
X	Provider Network		✓	
XI	Credentialing		✓	
XII	Access and Availability			✓
XIII	Coordination of Care		✓	
XIV	Appeals			✓
XV	Advance Directives		✓	

The 2006–2007 compliance monitoring review resulted in 33 recommendations for improvement across all standards: Subcontracts and Delegation (1), Provider Network (3), Credentialing (6), Access and Availability (6), Coordination of Care (1), Appeals (10), and Advance Directives (6). The PIHP addressed recommendations through corrective action plans and implemented improvements. Subsequent to the 2007–2008 follow-up review, **CMH for Central Michigan** achieved full compliance on five of the seven standards, with 5 continuing recommendations for Access and Availability (1) and Appeals (4).

Validation of Performance Measures

Table 4-7 shows the recommendations for improvement for **CMH for Central Michigan** from the 2006–2007 validation of performance measures and the status of the PIHP's follow-up on these recommendations at the time of the 2007–2008 EQR.

Table 4-7—Follow-Up on Prior Recommendations
***for* CMH for Central Michigan**

2006–2007 Recommendation	2007–2008 Status
CMH for Central Michigan should formalize its oversight of the CA. **CMH for Central Michigan** should bring the CA into its committee structure and involve the CA in discussions and reviews of the indicator data and results. Formal oversight in this manner can allow the PIHP to hold the CA to higher levels of accountability and performance. Although reviewers found no concerns with the preparation and submission of the encounter file to MDCH, reviewers encouraged **CMH for Central Michigan** to explore automated means for this process to enhance data accuracy.	A noted improvement from last year was an increase in the oversight of its CA. **CMH for Central Michigan** implemented additional oversight activities, including having regular telephone consultations with the CA and using SQL to review the data submitted in the 837 file. **CMH for Central Michigan** continued to explore automation for preparation and submission of the encounter file for MDCH.

CMH for Central Michigan addressed the recommendations for improvement.

Validation of Performance Improvement Projects

Table 4-8 displays activities/elements scored *Partially Met* or *Not Met* for **CMH for Central Michigan** during the 2006–2007 validation of PIPs and results of the assessment of these elements from the 2007–2008 EQR.

Table 4-8—Follow-Up on Prior Recommendations *for* CMH for Central Michigan			
Activity/ Element	**2006–2007 Score**	**2007–2008 Score**	**2007–2008 Comment**
VII.1	*Partially Met*	*Partially Met*	The PIP documentation provided a list of barriers with corresponding interventions. However, the PIP did not discuss the causal/barrier analysis process that took place to identify the documented barriers.
VII.2	*Partially Met*	*Partially Met*	In the 2006–2007 PIP Validation Tool, HSAG requested documentation to clarify the procedures to be used in the quality analyst's absences. The 2007–2008 PIP submission did not provide this information.
VII.4	*Not Met*	*Not Met*	The PIP did not include documentation regarding the standardization of the current interventions and how they would be monitored for success. This information is required once the study indicator demonstrates statistically significant improvement, as was the case with this PIP.
VIII.4	*Not Met*	*Not Met*	The PIP did not include a discussion regarding factors that could threaten the internal or external validity of the data findings.

CMH for Central Michigan did not demonstrate progress in addressing the recommendations from the 2006–2007 PIP validation.

CMH Partnership of Southeastern Michigan

Compliance Monitoring

Table 4-9 shows the results for **CMH Partnership of Southeastern Michigan** from the 2006–2007 (initial) and 2007–2008 (follow-up) compliance monitoring reviews.

Table 4-9—Compliance Following Initial and Follow-Up Reviews *for* CMH Partnership of Southeastern Michigan

Standard		Full Compliance		One or More Remaining Corrective Action(s)
		Achieved at Initial Review	Achieved After Follow-Up	
IX	Subcontracts and Delegation	✓		
X	Provider Network	✓		
XI	Credentialing		✓	
XII	Access and Availability		✓	
XIII	Coordination of Care	✓		
XIV	Appeals	✓		
XV	Advance Directives		✓	

The 2006–2007 compliance monitoring review resulted in 10 recommendations for improvement in the following areas: Credentialing (2), Access and Availability (7), and Advance Directives (1). The PIHP addressed recommendations through corrective action plans and implemented improvements. Subsequent to the 2007–2008 follow-up review, **CMH Partnership of Southeastern Michigan** achieved full compliance on all standards.

Validation of Performance Measures

Table 4-10 shows the recommendations for improvement for **CMH Partnership of Southeastern Michigan** from the 2006–2007 validation of performance measures and the status of the PIHP's follow-up on these recommendations at the time of the 2007–2008 EQR.

Table 4-10—Follow-Up on Prior Recommendations *for* CMH Partnership of Southeastern Michigan	
2006–2007 Recommendation	**2007–2008 Status**
CMH Partnership of Southeastern Michigan should consider looking at trends in encounter data submission to identify missing data more readily. The reviewers recommended that the PIHP move toward a more automated process to replace the current manual count processes for the recipient rights indicator. The PIHP should explore interpretation of the 90-day rule for new consumers and should provide training as appropriate. Additionally, the PIHP should continue tracking and training for identification of outlier hospital discharges.	The use of standardized processes across the affiliates, in conjunction with identical information systems at each affiliate, enhanced data accuracy and completeness. The availability of critical reports to the CMHCs also enhanced data accuracy. **CMH Partnership of Southeastern Michigan** continued its efforts to automate the recipient rights function and improved the HSW reconciliation process, which helped to improve rates for this year. Uniform data collection activities and ongoing monitoring ensured the comparability of data across the continuum of the data collection and reporting process.

CMH Partnership of Southeastern Michigan addressed all recommendations for improvement.

Validation of Performance Improvement Projects

HSAG identified no opportunities for improvement for **CMH Partnership of Southeastern Michigan** during the 2006–2007 PIP validation.

Detroit-Wayne County CMH Agency

Compliance Monitoring

Table 4-11 shows the results for **Detroit-Wayne County CMH Agency** from the 2006–2007 (initial) and 2007–2008 (follow-up) compliance monitoring reviews.

Table 4-11—Compliance Following Initial and Follow-Up Reviews *for* Detroit-Wayne County CMH Agency

Standard		Full Compliance		One or More Remaining Corrective Action(s)
		Achieved at Initial Review	Achieved After Follow-Up	
IX	Subcontracts and Delegation			✓
X	Provider Network		✓	
XI	Credentialing			✓
XII	Access and Availability			✓
XIII	Coordination of Care		✓	
XIV	Appeals			✓
XV	Advance Directives		✓	

The 2006–2007 compliance monitoring review resulted in 55 recommendations for improvement across all standards: Subcontracts and Delegation (3), Provider Network (2), Credentialing (22), Access and Availability (13), Coordination of Care (1), Appeals (12), and Advance Directives (2). The PIHP addressed recommendations through corrective action plans and implemented improvements. Subsequent to the 2007–2008 follow-up review, **Detroit-Wayne County CMH Agency** achieved full compliance on three standards (Provider Network, Coordination of Care, and Advance Directives), with 19 continuing recommendations for Subcontracts and Delegation (1), Credentialing (3), Access and Availability (10), and Appeals (5).

Validation of Performance Measures

Table 4-12 shows the recommendations for improvement for **Detroit-Wayne County CMH Agency** from the 2006–2007 validation of performance measures and the status of the PIHP's follow-up on these recommendations at the time of the 2007–2008 EQR.

Table 4-12—Follow-Up on Prior Recommendations *for* Detroit-Wayne County CMH Agency	
2006–2007 Recommendation	**2007–2008 Status**
Detroit-Wayne County CMH Agency should continue to improve its oversight of data from the MCPNs and the CA through increased documentation and formalization of current oversight activities. **Detroit-Wayne County CMH Agency** should expand the documentation of its data completeness assessment activities, considering overall data completeness as well as assessments at the MCPN level.	The collaborative relationship between the **Detroit-Wayne County CMH Agency** and the MCPNs has greatly improved over the past 18 months. Rather than punitive mandates or other less-positive approaches, all parties have improved their communication and have focused on working collaboratively. **Detroit-Wayne County CMH Agency** needs to continue its efforts to improve the completeness of the QI data elements— specifically, minimum wage and employment.

Detroit-Wayne County CMH Agency demonstrated progress toward implementing the recommendations for improvement.

Validation of Performance Improvement Projects

Table 4-13 displays activities/elements scored *Partially Met* or *Not Met* for **Detroit-Wayne County CMH Agency** during the 2006–2007 validation of PIPs and results of the assessment of these elements from the 2007–2008 EQR.

Table 4-13—Follow-Up on Prior Recommendations *for* Detroit-Wayne County CMH Agency

Activity/ Element	2006–2007 Score	2007–2008 Score	2007–2008 Comment
IV.1	*Partially Met*	*Met*	The PIP documentation included a complete and accurate description of the method used to identify the eligible study population.

Detroit-Wayne County CMH Agency successfully addressed the recommendation from the 2006–2007 PIP validation.

Genesee County CMH

Compliance Monitoring

Table 4-14 shows the results for **Genesee County CMH** from the 2006–2007 (initial) and 2007–2008 (follow-up) compliance monitoring reviews.

Table 4-14—Compliance Following Initial and Follow-Up Reviews *for* Genesee County CMH				
Standard		Full Compliance		One or More Remaining Corrective Action(s)
		Achieved at Initial Review	Achieved After Follow-Up	
IX	Subcontracts and Delegation	*NA*		
X	Provider Network	✓		
XI	Credentialing		✓	
XII	Access and Availability		✓	
XIII	Coordination of Care	✓		
XIV	Appeals	✓		
XV	Advance Directives		✓	

The 2006–2007 compliance monitoring review resulted in 10 recommendations for improvement in the following areas: Credentialing (2), Access and Availability (7), and Advance Directives (1). The Subcontracts and Delegation standard received a score of *NA* because the PIHP's only delegated function (Utilization Management) had been reviewed previously. The PIHP addressed recommendations through corrective action plans and implemented improvements. Subsequent to the 2007–2008 follow-up review, **Genesee County CMH** achieved full compliance on all applicable standards.

Validation of Performance Measures

Table 4-15 shows the recommendations for improvement for **Genesee County CMH** from the 2006–2007 validation of performance measures and the status of the PIHP's follow-up on these recommendations at the time of the 2007–2008 EQR.

Table 4-15—Follow-Up on Prior Recommendations *for* Genesee County CMH	
2006–2007 Recommendation	**2007–2008 Status**
Genesee County CMH should continue to focus on ways to improve data completeness and should continue to automate as many processes as possible. Due to the PIHP's concerns with the limitations of the CareNet system, **Genesee County CMH** should continue to explore development of a custom-built application to replace CareNet.	The contest for QI data implemented by **Genesee County CMH** represented an innovative way of improving QI data completeness. The multidisciplinary data certification committee reviewed data on a monthly basis, which also ensured ongoing review of data completeness. The PIHP had not taken any steps to implement a replacement for CareNet at the time of the review.

Genesee County CMH demonstrated progress toward implementing the recommendations for improvement.

Validation of Performance Improvement Projects

HSAG identified no opportunities for improvement for **Genesee County CMH** during the 2006–2007 PIP validation.

Lakeshore Behavioral Health Alliance

Compliance Monitoring

Table 4-16 shows the results for **Lakeshore Behavioral Health Alliance** from the 2006–2007 (initial) and 2007–2008 (follow-up) compliance monitoring reviews.

Table 4-16—Compliance Following Initial and Follow-Up Reviews *for* Lakeshore Behavioral Health Alliance

Standard		Full Compliance		One or More Remaining Corrective Action(s)
		Achieved at Initial Review	Achieved After Follow-Up	
IX	Subcontracts and Delegation		✓	
X	Provider Network	✓		
XI	Credentialing		✓	
XII	Access and Availability		✓	
XIII	Coordination of Care	✓		
XIV	Appeals			✓
XV	Advance Directives	✓		

The 2006–2007 compliance monitoring review resulted in 12 recommendations for improvement in the following areas: Subcontracts and Delegation (1), Credentialing (6), Access and Availability (3), and Appeals (2). The PIHP addressed recommendations through corrective action plans and implemented improvements. Subsequent to the 2007–2008 follow-up review, **Lakeshore Behavioral Health Alliance** achieved full compliance on six of the seven standards, with one continuing recommendation for Appeals.

Validation of Performance Measures

Table 4-17 shows the recommendations for improvement for **Lakeshore Behavioral Health Alliance** from the 2006–2007 validation of performance measures and the status of the PIHP's follow-up on these recommendations at the time of the 2007–2008 EQR.

Table 4-17—Follow-Up on Prior Recommendations *for* Lakeshore Behavioral Health Alliance

2006–2007 Recommendation	2007–2008 Status
The reviewers recommended that the PIHP formalize a validation process for a review of the PI data entry prior to the submission of data to MDCH. **Lakeshore Behavioral Health Alliance** should continue to work with the Avatar system to ensure that the system can report encounter data to MDCH. Additionally, reviewers encouraged the PIHP to continue working on automating the performance indicator generation processes.	The reviewers identified excellent oversight by **Lakeshore Behavioral Health Alliance** of the affiliates' and CA's data prior to reporting to MDCH. The HSAG reviewers noted that the PIHP used multiple committees and work groups to help maintain consistent interpretation of indicators and uniform collection of performance indicator data. At the time of the on-site review, one of the PIHP's affiliates, Community Mental Health Services of Muskegon County, was having ongoing challenges with extracting complete encounter data from Avatar. The reviewers noted that the PIHP was working with the affiliate to assist in getting this issue resolved. The PIHP continued to work toward automating generation of the performance indicator rates.

Lakeshore Behavioral Health Alliance successfully addressed several recommendations for improvement.

Validation of Performance Improvement Projects

HSAG identified no opportunities for improvement for **Lakeshore Behavioral Health Alliance** during the 2006–2007 PIP validation.

LifeWays

Compliance Monitoring

Table 4-18 shows the results for **LifeWays** from the 2006–2007 (initial) and 2007–2008 (follow-up) compliance monitoring reviews.

Table 4-18—Compliance Following Initial and Follow-Up Reviews *for* LifeWays				
Standard		Full Compliance		One or More Remaining Corrective Action(s)
		Achieved at Initial Review	Achieved After Follow-Up	
IX	Subcontracts and Delegation		✓	
X	Provider Network			✓
XI	Credentialing			✓
XII	Access and Availability		✓	
XIII	Coordination of Care	✓		
XIV	Appeals			✓
XV	Advance Directives	✓		

The 2006–2007 compliance monitoring review resulted in 29 recommendations for improvement across most standards: Subcontracts and Delegation (1), Provider Network (1), Credentialing (9), Access and Availability (8), and Appeals (10). The PIHP addressed recommendations through corrective action plans and implemented improvements. Subsequent to the 2007–2008 follow-up review, **LifeWays** achieved full compliance on two additional standards (Subcontracts and Delegation and Access and Availability), with 6 continuing recommendations for Provider Network (1), Credentialing (1), and Appeals (4).

Validation of Performance Measures

Table 4-19 shows the recommendations for improvement for **LifeWays** from the 2006–2007 validation of performance measures and the status of the PIHP's follow-up on these recommendations at the time of the 2007–2008 EQR.

Table 4-19—Follow-Up on Prior Recommendations *for* LifeWays	
2006–2007 Recommendation	**2007–2008 Status**
LifeWays should continue toward automation of performance measure calculation to minimize potential calculation errors inherent to a manual system. The PIHP should also consider using only standard claims forms, such as UB92 and CMS 1500 forms, and eliminate the use of nonstandard proprietary forms to ensure collection of all necessary data to support performance measure reporting.	The implementation of automated collection for some of the data used for performance indicator calculations improved the processes for reporting these measures. **LifeWays**' providers entered all data directly into a proprietary system, which captures all elements necessary for claims and encounter data reporting (which includes CMS 1500/UB92/UB04 formats).

LifeWays successfully addressed the recommendations for improvement.

Validation of Performance Improvement Projects

HSAG identified no opportunities for improvement for **LifeWays** during the 2006–2007 PIP validation.

Macomb County CMH Services

Compliance Monitoring

Table 4-20 shows the results for **Macomb County CMH Services** from the 2006–2007 (initial) and 2007–2008 (follow-up) compliance monitoring reviews.

Table 4-20—Compliance Following Initial and Follow-Up Reviews *for* Macomb County CMH Services				
Standard		Full Compliance		One or More Remaining Corrective Action(s)
		Achieved at Initial Review	Achieved After Follow-Up	
IX	Subcontracts and Delegation		✓	
X	Provider Network		✓	
XI	Credentialing		✓	
XII	Access and Availability			✓
XIII	Coordination of Care	✓		
XIV	Appeals			✓
XV	Advance Directives		✓	

The 2006–2007 compliance monitoring review resulted in 26 recommendations for improvement across most standards: Subcontracts and Delegation (2), Provider Network (1), Credentialing (3), Access and Availability (4), Appeals (14), and Advance Directives (2). The PIHP addressed recommendations through corrective action plans and implemented improvements. Subsequent to the 2007–2008 follow-up review, **Macomb County CMH Services** achieved full compliance on five of the seven standards, with 9 continuing recommendations for Access and Availability (4) and Appeals (5).

Validation of Performance Measures

Table 4-21 shows the recommendations for improvement for **Macomb County CMH Services** from the 2006–2007 validation of performance measures and the status of the PIHP's follow-up on these recommendations at the time of the 2007–2008 EQR.

Table 4-21—Follow-Up on Prior Recommendations *for* Macomb County CMH Services

2006–2007 Recommendation	2007–2008 Status
Reviewers encouraged **Macomb County CMH Services** to continue to transition providers from paper submission to direct entry of claims, potentially for the hospitals.	**Macomb County CMH Services**' strong efforts with its provider community have led to more than 98 percent electronic submission of service data (including hospital data).
The reviewers suggested that the PIHP investigate methods of automating the recipient rights measure and process for capturing these data.	**Macomb County CMH Services** should continue its efforts to automate the recipient rights measure.
Macomb County CMH Services should also consider a systematic, but secure, process for tracking sentinel event data.	The PIHP implemented a work group/ committee review approach for tracking and reporting of sentinel event data. The group performed root-cause analysis based on its findings.

Macomb County CMH Services demonstrated progress in the implementation of the recommendations for improvement.

Validation of Performance Improvement Projects

HSAG identified no opportunities for improvement for **Macomb County CMH Services** during the 2006–2007 PIP validation.

network180

Compliance Monitoring

Table 4-22 shows the results for **network180** from the 2006–2007 (initial) and 2007–2008 (follow-up) compliance monitoring reviews.

Table 4-22—Compliance Following Initial and Follow-Up Reviews *for* network180				
Standard		Full Compliance		One or More Remaining Corrective Action(s)
		Achieved at Initial Review	Achieved After Follow-Up	
IX	Subcontracts and Delegation			✓
X	Provider Network	✓		
XI	Credentialing			✓
XII	Access and Availability			✓
XIII	Coordination of Care	✓		
XIV	Appeals			✓
XV	Advance Directives			✓

The 2006–2007 compliance monitoring review resulted in 34 recommendations for improvement across most standards: Subcontracts and Delegation (1), Credentialing (20), Access and Availability (5), Appeals (4), and Advance Directives (4). The PIHP addressed recommendations through corrective action plans and implemented improvements. Subsequent to the 2007–2008 follow-up review, **network180** achieved full compliance on many elements addressed in the follow-up review, with 18 continuing recommendations for Subcontracts and Delegation (1), Credentialing (7), Access and Availability (3), Appeals (4), and Advance Directives (3).

Validation of Performance Measures

Table 4-23 shows the recommendations for improvement for **network180** from the 2006–2007 validation of performance measures and the status of the PIHP's follow-up on these recommendations at the time of the 2007–2008 EQR.

Table 4-23—Follow-Up on Prior Recommendations *for* network180	
2006–2007 Recommendation	**2007–2008 Status**
Reviewers encouraged **network180** to explore the possibilities of facilitating more complete encounter data and encouraging its providers to submit data electronically. Additionally, the reviewers recommended validation of the entry of recipient rights data.	The PIHP used incentives and other creative means to encourage complete encounter data submission from its providers. **network180** incorporated informal oversight of data entry into the recipient rights database; however, this process should be formalized.

network180 demonstrated progress in the implementation of the recommendations for improvement.

Validation of Performance Improvement Projects

HSAG identified no opportunities for improvement for **network180** during the 2006–2007 PIP validation.

NorthCare

Compliance Monitoring

Table 4-24 shows the results for **NorthCare** from the 2006–2007 (initial) and 2007–2008 (follow-up) compliance monitoring reviews.

Table 4-24—Compliance Following Initial and Follow-Up Reviews *for* NorthCare				
Standard		Full Compliance		One or More Remaining Corrective Action(s)
		Achieved at Initial Review	Achieved After Follow-Up	
IX	Subcontracts and Delegation	✓		
X	Provider Network	✓		
XI	Credentialing		✓	
XII	Access and Availability			✓
XIII	Coordination of Care	✓		
XIV	Appeals	✓		
XV	Advance Directives		✓	

The 2006–2007 compliance monitoring review resulted in 14 recommendations for improvement in the following areas: Credentialing (8), Access and Availability (5), and Advance Directives (1). The PIHP addressed recommendations through corrective action plans and implemented improvements. Subsequent to the 2007–2008 follow-up review, **NorthCare** achieved full compliance on all standards except one, with 1 continued recommendation for Access and Availability.

Validation of Performance Measures

Table 4-25 shows the recommendations for improvement for **NorthCare** from the 2006–2007 validation of performance measures and the status of the PIHP's follow-up on these recommendations at the time of the 2007–2008 EQR.

Table 4-25—Follow-Up on Prior Recommendations *for* NorthCare	
2006–2007 Recommendation	**2007–2008 Status**
NorthCare should continue its process for selecting and implementing a standardized data system across the PIHP. The PIHP should document its processes for auditing claims and encounter data and develop quality control flow charts to explain how the PIHP ensures data accuracy. The reviewers suggested that the PIHP consider reviewing the Medicaid performance audits performed by the CMHCs. **NorthCare** should document the review process for monthly performance indicator data. Reviewers also suggested that meeting minutes from the Data Warehouse Committee include a more detailed discussion of the data oversight process.	**NorthCare** selected a standardized data system across the PIHP and was in the process of implementing it across all CMHCs. The PIHP fully documented its process for claims and encounter audits, which are now performed at the PIHP level. **NorthCare**'s Medicaid verification audit reports included corrective actions for affiliate boards to follow up on, ensuring a continuous quality improvement loop within the organization. Additionally, the PIHP implemented a process to review the performance indicator data at the quality improvement committee meetings. The PIHP required that CMHC boards that under-perform for two consecutive quarters submit a corrective action plan.

NorthCare successfully addressed all recommendations for improvement.

Validation of Performance Improvement Projects

Table 4-26 displays activities/elements scored *Partially Met* or *Not Met* for **NorthCare** during the 2006–2007 validation of PIPs and results of the assessment of these elements from the 2007–2008 EQR.

Table 4-26—Follow-Up on Prior Recommendations *for* NorthCare

Activity/ Element	2006–2007 Score	2007–2008 Score	2007–2008 Comment
VI.5	*Partially Met*	*Partially Met*	The PIP documentation and attachments did not include all required components for manual data collection personnel. The qualifications, credentials, education, experience, and training for each manual data collection staff member should be included in the PIP documentation.
VI.9	*Partially Met*	*Not Met*	An overview of the study was not included in the written instructions for the manual data collection tool.

NorthCare did not address the recommendations from the 2006–2007 PIP validation.

Northern Affiliation

Compliance Monitoring

Table 4-27 shows the results for **Northern Affiliation** from the 2006–2007 (initial) and 2007–2008 (follow-up) compliance monitoring reviews.

Table 4-27—Compliance Following Initial and Follow-Up Reviews *for* Northern Affiliation

Standard		Full Compliance		One or More Remaining Corrective Action(s)
		Achieved at Initial Review	Achieved After Follow-Up	
IX	Subcontracts and Delegation		✓	
X	Provider Network	✓		
XI	Credentialing		✓	
XII	Access and Availability			✓
XIII	Coordination of Care		✓	
XIV	Appeals			✓
XV	Advance Directives		✓	

The 2006–2007 compliance monitoring review resulted in 21 recommendations for improvement across most standards: Subcontracts and Delegation (1), Credentialing (6), Access and Availability (3), Coordination of Care (1), Appeals (7), and Advance Directives (3). The PIHP addressed recommendations through corrective action plans and implemented numerous improvements. Subsequent to the 2007–2008 follow-up review, **Northern Affiliation** achieved full compliance on most standards, with 3 continuing recommendations for Access and Availability (2) and Appeals (1).

Validation of Performance Measures

Table 4-28 shows the recommendations for improvement for **Northern Affiliation** from the 2006–2007 validation of performance measures and the status of the PIHP's follow-up on these recommendations at the time of the 2007–2008 EQR.

Table 4-28—Follow-Up on Prior Recommendations *for* Northern Affiliation

2006–2007 Recommendation	2007–2008 Status
Northern Affiliation should continue its comprehensive oversight of the CA performance indicator data and should move to a more programmatic approach to performance indicator calculation. Reviewers recommended, as they did last year, that audit and verification processes be more formally documented. To assess data completeness further, **Northern Affiliation** should expand the current medical record review documentation process to include audits that compare medical records to the claims/encounter system. The PIHP should perform data entry checks on the paper forms entered into the data entry screen for the performance indicators.	**Northern Affiliation** continued its oversight of the CA data. The PIHP was working toward a more programmatic approach to performance indicator calculation. The PIHP continued to develop formal documentation of its audit and verification processes. The performance measure team demonstrated a proactive approach to performance indicator reporting and was receptive to suggestions for improvement. The PIHP demonstrated continued improvement in its performance measure reporting process over time. **Northern Affiliation** incorporated a comparison of medical records to claims/encounter data into its Medicaid verification audit. The PIHP continued to work toward data entry checks on all paper forms entered for the performance indicators.

Northern Affiliation demonstrated progress toward implementation of the recommendations for improvement.

Validation of Performance Improvement Projects

Table 4-29 displays activities/elements scored *Partially Met* or *Not Met* for **Northern Affiliation** during the 2006–2007 validation of PIPs and results of the assessment of these elements from the 2007–2008 EQR.

Table 4-29—Follow-Up on Prior Recommendations *for* Northern Affiliation			
Activity/ Element	2006–2007 Score	2007–2008 Score	2007–2008 Comment
I.1	*Not Met*	*Met*	The study documentation indicated that MDCH selected the study topic, which reflected high-risk conditions.
I.2	*Not Met*	*Met*	The study documentation reflected that MDCH selected the study topic based on collection and analysis of data.
I.6	*Not Met*	*Met*	MDCH selected the study topic, which had the potential to affect beneficiaries' health and functional status. The PIP should address the following *Point of Clarification* in future submissions: Activity I should include information about how the selected study topic has the potential to affect beneficiaries' health and functional status.
VIII.3	*Partially Met*	*Met*	The PIP identified factors that could threaten the internal and external validity of the data findings.
VIII.8	*Not Met*	*Met*	The PIP identified factors that could affect the ability to compare measurement periods.
VIII.9	*Partially Met*	*Met*	An interpretation of the extent to which the study was successful was included in the PIP documentation.

Northern Affiliation successfully addressed all recommendations from the 2006–2007 PIP validation.

Northwest CMH Affiliation

Compliance Monitoring

Table 4-30 shows the results for **Northwest CMH Affiliation** from the 2006–2007 (initial) and 2007–2008 (follow-up) compliance monitoring reviews.

Table 4-30—Compliance Following Initial and Follow-Up Reviews *for* Northwest CMH Affiliation

Standard		Full Compliance		One or More Remaining Corrective Action(s)
		Achieved at Initial Review	Achieved After Follow-Up	
IX	Subcontracts and Delegation		✓	
X	Provider Network		✓	
XI	Credentialing			✓
XII	Access and Availability			✓
XIII	Coordination of Care	✓		
XIV	Appeals		✓	
XV	Advance Directives		✓	

The 2006–2007 compliance monitoring review resulted in 15 recommendations for improvement across most standards: Subcontracts and Delegation (1), Provider Network (3), Credentialing (1), Access and Availability (6), Appeals (1), and Advance Directives (3). The PIHP addressed recommendations through corrective action plans and implemented improvements. Subsequent to the 2007–2008 follow-up review, **Northwest CMH Affiliation** achieved full compliance on five of the seven standards, with 4 continuing recommendations for Credentialing (1) and Access and Availability (3).

Validation of Performance Measures

Table 4-31 shows the recommendations for improvement for **Northwest CMH Affiliation** from the 2006–2007 validation of performance measures and the status of the PIHP's follow-up on these recommendations at the time of the 2007–2008 EQR.

Table 4-31—Follow-Up on Prior Recommendations *for* Northwest CMH Affiliation	
2006–2007 Recommendation	**2007–2008 Status**
Although reviewers found that **Northwest CMH Affiliation** had increased collaboration with the CA, reviewers encouraged the PIHP to continue to monitor CA data to reinforce the importance of timely data submission. **Northwest CMH Affiliation** should also continue to encourage thorough documentation of exclusions for performance indicators and should continue efforts to move toward further automation for performance indicator reporting.	The auditors noted that **Northwest CMH Affiliation** continued to improve its oversight of and communication with the CA. The Northern Lakes Community Mental Health Data Assumptions document provided evidence of the PIHP/CMHC collaboration. The detailed document included the CMHCs' assumptions for each of the MDCH performance indicators, including exclusions, helping to ensure consistency in understanding between the CMHCs. Both CMHCs have also demonstrated improvement in the automation of day-to-day processes and performance measure reporting.

Northwest CMH Affiliation demonstrated progress toward implementing the recommendations for improvement.

Validation of Performance Improvement Projects

HSAG identified no opportunities for improvement for **Northwest CMH Affiliation** during the 2006–2007 PIP validation.

Oakland County CMH Authority

Compliance Monitoring

Table 4-32 shows the results for **Oakland County CMH Authority** from the 2006–2007 (initial) and 2007–2008 (follow-up) compliance monitoring reviews.

Table 4-32—Compliance Following Initial and Follow-Up Reviews *for* Oakland County CMH Authority

Standard		Full Compliance		One or More Remaining Corrective Action(s)
		Achieved at Initial Review	Achieved After Follow-Up	
IX	Subcontracts and Delegation	✓		
X	Provider Network	✓		
XI	Credentialing		✓	
XII	Access and Availability		✓	
XIII	Coordination of Care	✓		
XIV	Appeals			✓
XV	Advance Directives		✓	

The 2006–2007 compliance monitoring review resulted in 9 recommendations for improvement in the following areas: Credentialing (4), Access and Availability (2), Appeals (2), and Advance Directives (1). The PIHP addressed recommendations through corrective action plans and implemented improvements. Subsequent to the 2007–2008 follow-up review, **Oakland County CMH Authority** achieved full compliance on all standards except one, with 2 continued recommendations for Appeals.

Validation of Performance Measures

Table 4-33 shows the recommendations for improvement for **Oakland County CMH Authority** from the 2006–2007 validation of performance measures and the status of the PIHP's follow-up on these recommendations at the time of the 2007–2008 EQR.

Table 4-33—Follow-Up on Prior Recommendations *for* Oakland County CMH Authority	
2006–2007 Recommendation	**2007–2008 Status**
Reviewers encouraged the PIHP to continue efforts to automate data collection for performance indicator reporting.	**Oakland County CMH Authority** continued to work on the automation of performance indicator calculation and reporting.
Due to some providers changing information systems, **Oakland County CMH Authority** should continue close monitoring and oversight of the system conversion process.	Reviewers identified no issues related to system conversion. The unified system used by the majority of providers ensured accurate and complete data. The PIHP had multiple processes to ensure the completeness of service data reported by its providers, including a trending analysis based on charges and service codes.

Oakland County CMH Authority demonstrated progress in addressing the recommendation for improvement.

Validation of Performance Improvement Projects

Table 4-34 displays activities/elements scored *Partially Met* or *Not Met* for **Oakland County CMH Authority** during the 2006–2007 validation of PIPs and results of the assessment of these elements from the 2007–2008 EQR.

Table 4-34—Follow-Up on Prior Recommendations *for* Oakland County CMH Authority			
Activity/ Element	**2006–2007 Score**	**2007–2008 Score**	**2007–2008 Comment**
VI.5	*Partially Met*	*Met*	The PIP documentation outlined the qualifications, education, experience, and training of the manual data collection staff.
VI.8	*Partially Met*	*Met*	The PIP submission included written instructions on the use of the manual data collection tool.

Oakland County CMH Authority successfully addressed all recommendations from the 2006–2007 PIP validation.

Saginaw County CMH Authority

Compliance Monitoring

Table 4-35 shows the results for **Saginaw County CMH Authority** from the 2006–2007 (initial) and 2007–2008 (follow-up) compliance monitoring reviews.

Table 4-35—Compliance Following Initial and Follow-Up Reviews *for* Saginaw County CMH Authority

Standard		Full Compliance		One or More Remaining Corrective Action(s)
		Achieved at Initial Review	Achieved After Follow-Up	
IX	Subcontracts and Delegation		✓	
X	Provider Network	✓		
XI	Credentialing			✓
XII	Access and Availability			✓
XIII	Coordination of Care	✓		
XIV	Appeals			✓
XV	Advance Directives	✓		

The 2006–2007 compliance monitoring review resulted in 26 recommendations for improvement in the following areas: Subcontracts and Delegation (1), Credentialing (11), Access and Availability (12), and Appeals (2). The PIHP addressed recommendations through corrective action plans and implemented improvements. Subsequent to the 2007–2008 follow-up review, **Saginaw County CMH Authority** achieved full compliance on one additional standard (Subcontracts and Delegation), with 10 continued recommendations for Credentialing (1), Access and Availability (8), and Appeals (1).

Validation of Performance Measures

Table 4-36 shows the recommendations for improvement for **Saginaw County CMH Authority** from the 2006–2007 validation of performance measures and the status of the PIHP's follow-up on these recommendations at the time of the 2007–2008 EQR.

Table 4-36—Follow-Up on Prior Recommendations *for* Saginaw County CMH Authority	
2006–2007 Recommendation	**2007–2008 Status**
The PIHP did not formally validate data for Indicator 13 prior to submission to MDCH; therefore, the reviewers recommended that **Saginaw County CMH Authority** implement a validation process for performance indicator reporting in the future. The reviewers also recommended further automation of the system to help to account for exceptions for other indicators, eliminating the need for manual follow-up.	**Saginaw County CMH Authority** staff performed formal data entry for Indicator 13. The PIHP should continue the rigorous verification of performance measure data. The performance measure reporting staff continued its efforts toward increasing automation of the measure calculation process.

Saginaw County CMH Authority demonstrated progress toward addressing the recommendations for improvement.

Validation of Performance Improvement Projects

Table 4-37 displays activities/elements scored *Partially Met* or *Not Met* for **Saginaw County CMH Authority** during the 2006–2007 validation of PIPs and results of the assessment of these elements from the 2007–2008 EQR.

Table 4-37—Follow-Up on Prior Recommendations *for* Saginaw County CMH Authority			
Activity/ Element	**2006–2007 Score**	**2007–2008 Score**	**2007–2008 Comment**
III.1	*Partially Met*	*Met*	The study indicators were well defined, objective, and measurable.
III.3	*Not Met*	*Met*	The study indicator allowed for the study question to be answered.
III.4	*Not Met*	*Met*	The study indicator measured changes in beneficiary health and functional status.
VI.3	*Not Met*	*Met*	The PIP documentation provided a clearly defined and systematic process for collecting baseline and remeasurement data.
VI.10	*Not Met*	*Met*	The PIP documentation included a discussion of the administrative data collection process.

Saginaw County CMH Authority successfully addressed all recommendations from the 2006–2007 PIP validation. However, **Saginaw County CMH Authority** failed to demonstrate any substantial progress in implementing the PIP beyond the status achieved the previous year.

Southwest Affiliation

Compliance Monitoring

Table 4-38 shows the results for **Southwest Affiliation** from the 2006–2007 (initial) and 2007–2008 (follow-up) compliance monitoring reviews.

Table 4-38—Compliance Following Initial and Follow-Up Reviews *for* Southwest Affiliation				
Standard		Full Compliance		One or More Remaining Corrective Action(s)
		Achieved at Initial Review	Achieved After Follow-Up	
IX	Subcontracts and Delegation			✓
X	Provider Network		✓	
XI	Credentialing			✓
XII	Access and Availability			✓
XIII	Coordination of Care	✓		
XIV	Appeals		✓	
XV	Advance Directives		✓	

The 2006–2007 compliance monitoring review resulted in 27 recommendations for improvement across most standards: Subcontracts and Delegation (1), Provider Network (1), Credentialing (16), Access and Availability (4), Appeals (2), and Advance Directives (3). The PIHP addressed recommendations through corrective action plans and implemented improvements. Subsequent to the 2007–2008 follow-up review, **Southwest Affiliation** achieved full compliance on three additional standards (Provider Network, Appeals, and Advance Directives), with 7 continuing recommendations for Subcontracts and Delegation (1), Credentialing (4) and Access and Availability (2).

Validation of Performance Measures

Table 4-39 shows the recommendations for improvement for **Southwest Affiliation** from the 2006–2007 validation of performance measures and the status of the PIHP's follow-up on these recommendations at the time of the 2007–2008 EQR.

Table 4-39—Follow-Up on Prior Recommendations *for* Southwest Affiliation

2006–2007 Recommendation	2007–2008 Status
Southwest Affiliation should document oversight of the CMHSPs' performance indicator calculation by developing formal policies and procedures and audit processes. In addition to the format and volume verification processes currently in place, **Southwest Affiliation** should consider checks of encounter data accuracy at the PIHP level before submitting data to MDCH. For co-occurring cases of MI and DD disorders, **Southwest Affiliation** should develop a consistent approach and definition across all affiliates for determining the disorder under which members will be reported.	The PIHP and CMHSPs demonstrated a collaborative and committed working relationship for performance measure reporting and service delivery to members. **Southwest Affiliation** continued to develop documentation related to the performance measure reporting process. The encounter data validation audits performed by **Southwest Affiliation** on a quarterly basis helped to ensure that the encounter data reflected the services provided. The audits also helped to ensure the consistent collection and reporting of encounter data across the CMHSPs. The automated electronic processes at the PIHP level alleviated the possibility of manual data errors. **Southwest Affiliation** continued to develop uniform definitions for the MI and DD population across its affiliates.

Southwest Affiliation addressed the recommendations for improvement.

Validation of Performance Improvement Projects

Table 4-40 displays activities/elements scored *Partially Met* or *Not Met* for **Southwest Affiliation** during the 2006–2007 validation of PIPs and results of the assessment of these elements from the 2007–2008 EQR.

Table 4-40—Follow-Up on Prior Recommendations *for* Southwest Affiliation

Activity/ Element	2006–2007 Score	2007–2008 Score	2007–2008 Comment
1.5	*Not Met*	*Met*	The study did not exclude beneficiaries with special health care needs. The PIP should address the following *Point of Clarification* in future PIP submissions: The PIP reported in Activity IV that beneficiaries requesting nonemergency substance abuse services, regardless of any special health care needs identified, were included in the study. The PIP should also document this information in Activity I for the eligible population.

Southwest Affiliation successfully addressed the recommendation from the 2006–2007 PIP validation.

Thumb Alliance PIHP

Compliance Monitoring

Table 4-41 shows the results for **Thumb Alliance PIHP** from the 2006–2007 (initial) and 2007–2008 (follow-up) compliance monitoring reviews.

Table 4-41—Compliance Following Initial and Follow-Up Reviews *for* Thumb Alliance PIHP

Standard		Full Compliance		One or More Remaining Corrective Action(s)
		Achieved at Initial Review	Achieved After Follow-Up	
IX	Subcontracts and Delegation	✓		
X	Provider Network	✓		
XI	Credentialing	✓		
XII	Access and Availability		✓	
XIII	Coordination of Care	✓		
XIV	Appeals	✓		
XV	Advance Directives		✓	

The 2006–2007 compliance monitoring review resulted in 3 recommendations for improvement in the following areas: Access and Availability (1) and Advance Directives (2). The PIHP addressed recommendations through corrective action plans and implemented improvements. Subsequent to the 2007–2008 follow-up review, **Thumb Alliance PIHP** achieved full compliance on all standards.

Validation of Performance Measures

Table 4-42 shows the recommendations for improvement for **Thumb Alliance PIHP** from the 2006–2007 validation of performance measures and the status of the PIHP's follow-up on these recommendations at the time of the 2007–2008 EQR.

Table 4-42—Follow-Up on Prior Recommendations *for* Thumb Alliance PIHP

2006–2007 Recommendation	2007–2008 Status
Thumb Alliance PIHP staff should continue the CA data integration process, ensuring that these data are as complete and accurate as the PIHP data. **Thumb Alliance PIHP** should also continue its activities toward automation of the performance measure calculation process, including investigation of methods for automating the recipient rights measure. The PIHP should consider expanding the data warehouse to include all data sources to facilitate additional exploratory analysis.	**Thumb Alliance PIHP** should continue the integration of its data by moving the CA data into the OASIS system. The PIHP continued its efforts toward automation of the performance measure calculation process. **Thumb Alliance PIHP** continued its efforts to expand the data warehouse to include all data sources to facilitate additional analysis.

Thumb Alliance PIHP demonstrated progress toward addressing the recommendations for improvement.

Validation of Performance Improvement Projects

Table 4-43 displays activities/elements scored *Partially Met* or *Not Met* for **Thumb Alliance PIHP** during the 2006–2007 validation of PIPs and results of the assessment of these elements from the 2007–2008 EQR.

Table 4-43—Follow-Up on Prior Recommendations *for* Thumb Alliance PIHP			
Activity/ Element	2006–2007 Score	2007–2008 Score	2007–2008 Comment
II.2	*Partially Met*	*Met*	The PIHP restructured the study question to be answerable.
III.1	*Partially Met*	*Met*	The study indicators were well defined, objective, and measurable.
III.4	*Partially Met*	*Met*	The study indicators measured changes in beneficiary health and functional status and valid process alternatives.

Thumb Alliance PIHP successfully addressed all recommendations from the 2006–2007 PIP validation.

Venture Behavioral Health

Compliance Monitoring

Table 4-44 shows the results for **Venture Behavioral Health** from the 2006–2007 (initial) and 2007–2008 (follow-up) compliance monitoring reviews.

Table 4-44—Compliance Following Initial and Follow-Up Reviews *for* Venture Behavioral Health

Standard		Full Compliance		One or More Remaining Corrective Action(s)
		Achieved at Initial Review	Achieved After Follow-Up	
IX	Subcontracts and Delegation		✓	
X	Provider Network		✓	
XI	Credentialing		✓	
XII	Access and Availability			✓
XIII	Coordination of Care	✓		
XIV	Appeals		✓	
XV	Advance Directives		✓	

The 2006–2007 compliance monitoring review resulted in 15 recommendations for improvement across most standards: Subcontracts and Delegation (1), Provider Network (1), Credentialing (1), Access and Availability (9), Appeals (2), and Advance Directives (1). The PIHP addressed recommendations through corrective action plans and implemented improvements. Subsequent to the 2007–2008 follow-up review, **Venture Behavioral Health** achieved full compliance on all standards except one, with 2 continuing recommendations for Access and Availability.

Validation of Performance Measures

Table 4-45 shows the recommendations for improvement for **Venture Behavioral Health** from the 2006–2007 validation of performance measures and the status of the PIHP's follow-up on these recommendations at the time of the 2007–2008 EQR.

Table 4-45—Follow-Up on Prior Recommendations *for* Venture Behavioral Health	
2006–2007 Recommendation	**2007–2008 Status**
Venture Behavioral Health should undertake a more formal assessment of data completeness to ensure that the PIHP includes relevant data in performance measure calculations and that it submits all claims/encounters to MDCH (i.e., comparison of claims/encounter submissions to historical benchmarks). The PIHP should work to ensure that the affiliates develop appropriate oversight processes for entry of external paper claims. PIHP should also increase its oversight of CA data. **Venture Behavioral Health** should continue the progress it has made in the automation of receipt and entry of performance indicator data elements.	The implementation of the PracticeManagement and the CareManagement data systems enhanced the data collection and reporting of encounter and performance indicator data. These systems offered nearly real-time access to the data and enabled the PIHP to monitor timeliness, penetration, and service delivery. **Venture Behavioral Health** continued to formalize the oversight of CA and affiliate data. **Venture Behavioral Health** continued its efforts to automate the receipt and entry of performance indicator data.

Venture Behavioral Health demonstrated progress toward implementing the recommendations for improvement.

Validation of Performance Improvement Projects

Table 4-46 displays activities/elements scored *Partially Met* or *Not Met* for **Venture Behavioral Health** during the 2006–2007 validation of PIPs and results of the assessment of these elements from the 2007–2008 EQR.

Table 4-46—Follow-Up on Prior Recommendations *for* Venture Behavioral Health			
Activity/ Element	**2006–2007 Score**	**2007–2008 Score**	**2007–2008 Comment**
III.2	*Partially Met*	*Met*	MDCH defined Study Indicator 1, which was based on practice guidelines. The PIHP added Study Indicator 2 in 2007–2008.
III.7	*Partially Met*	*Met*	MDCH defined Study Indicator 1. The PIP documentation provided the basis for the development of Study Indicator 2.

Venture Behavioral Health successfully addressed all recommendations from the 2006–2007 PIP validation.

Appendix A. Summary Tables of External Quality Review Activity Results

Introduction

This section of the report presents two-year comparison tables for statewide and PIHP scores for the validation of performance measures and the validation of PIPs, as well as results for all 15 compliance monitoring standards reviewed over the last four years.

Results for Compliance Monitoring

The following tables and graphs present the results from the compliance monitoring reviews in Years I through IV to provide an overview of the PIHP and statewide performance on all 15 compliance monitoring standards assessed.

Compliance Monitoring Standards

Figure A-1 through Figure A-15 present compliance scores for each of the 18 PIHPs as well as the statewide score for each of the 15 compliance monitoring standards:

Figure A-1—Standard I: QAPIP

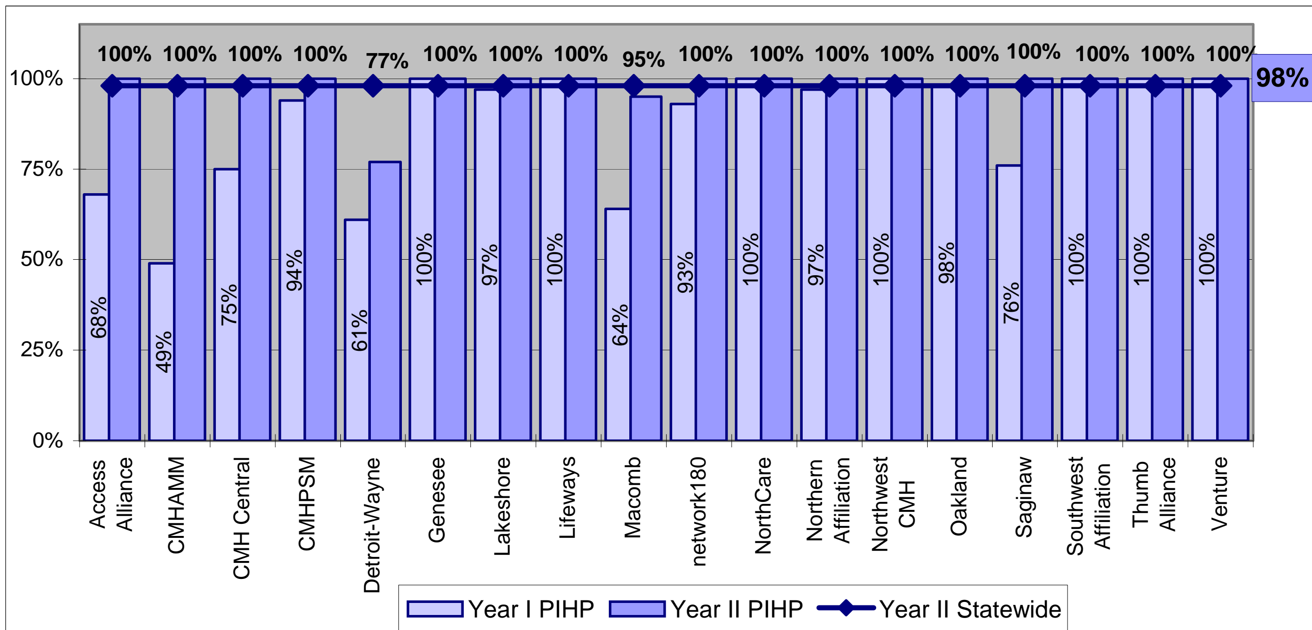


Figure A-2—Standard II: Performance Improvement and Measurement

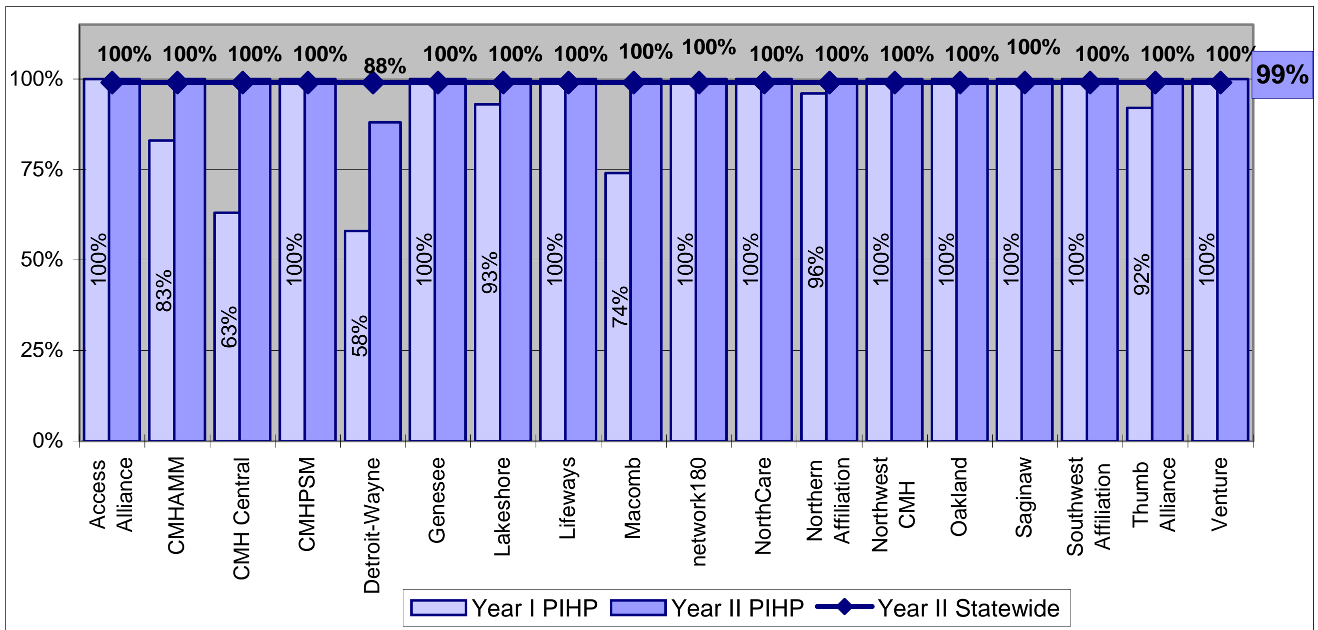


Figure A-3—Standard III: Practice Guidelines

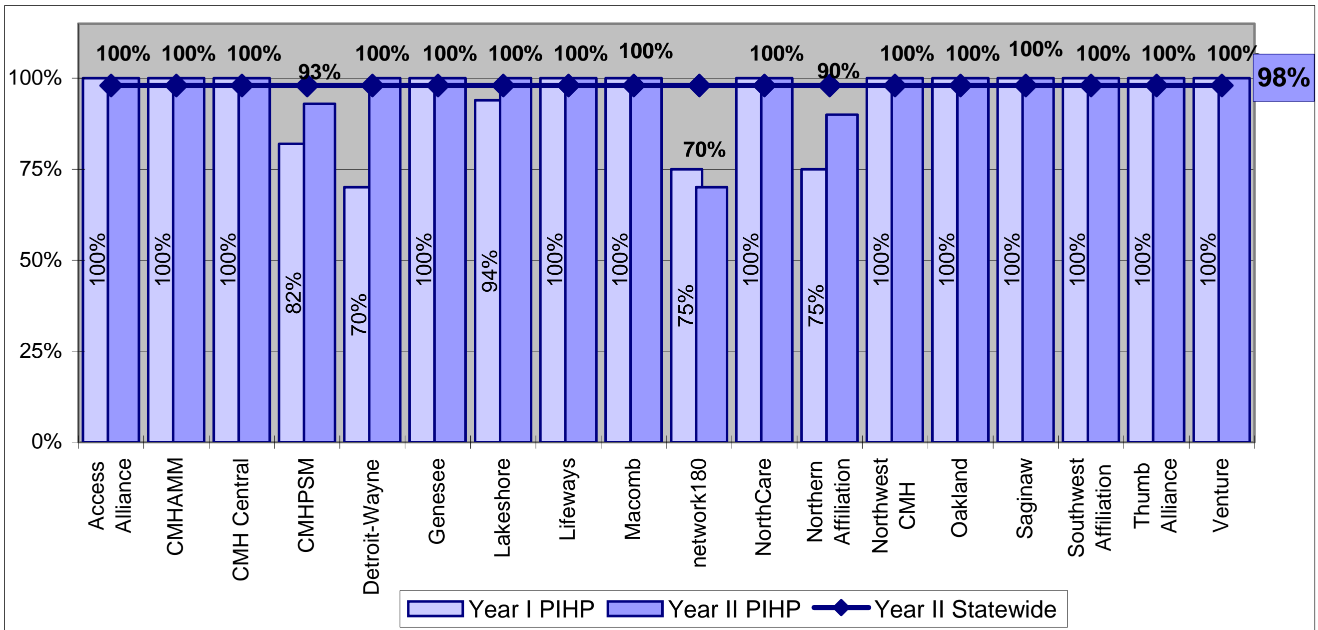


Figure A-4—Standard IV: Staff Qualifications and Training

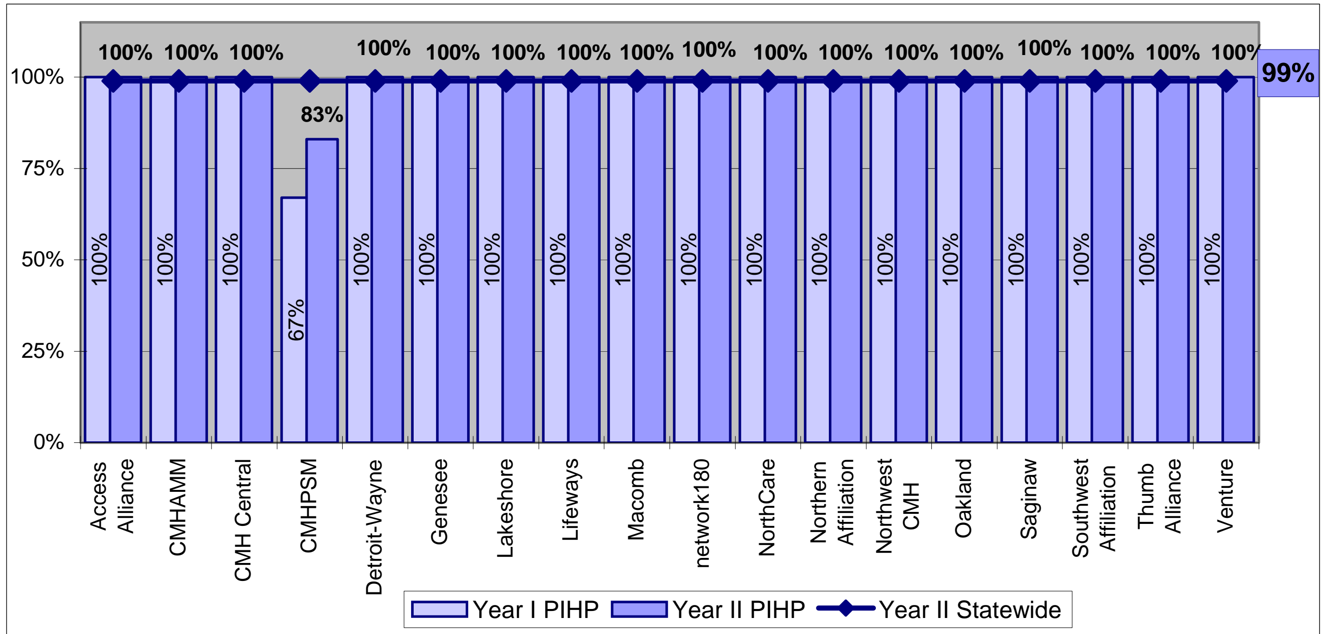


Figure A-5—Standard V: Utilization Management

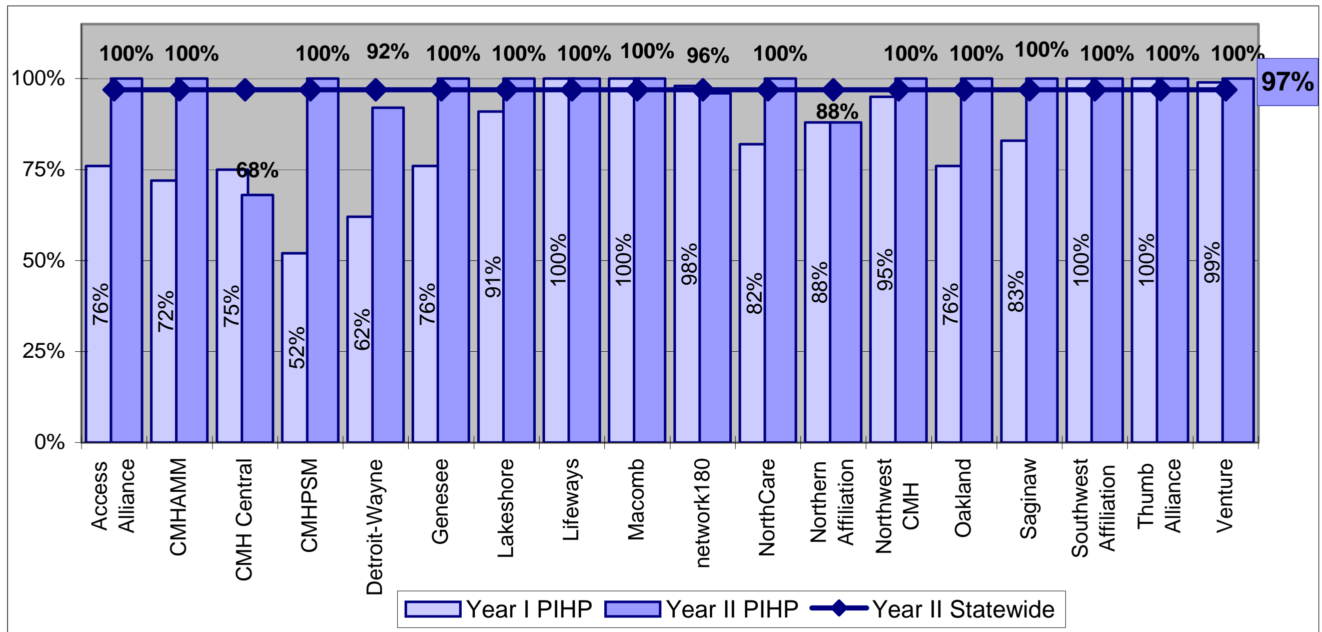


Figure A-6—Standard VI: Customer Service

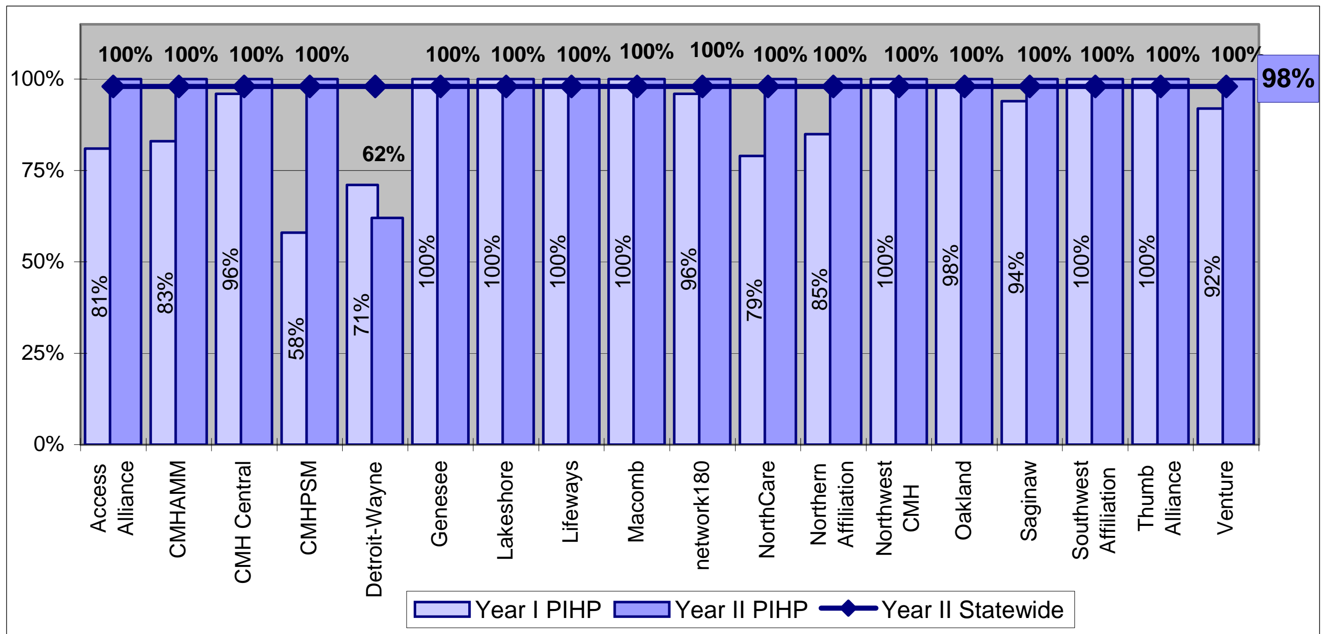


Figure A-7—Standard VII: Recipient Grievance Process

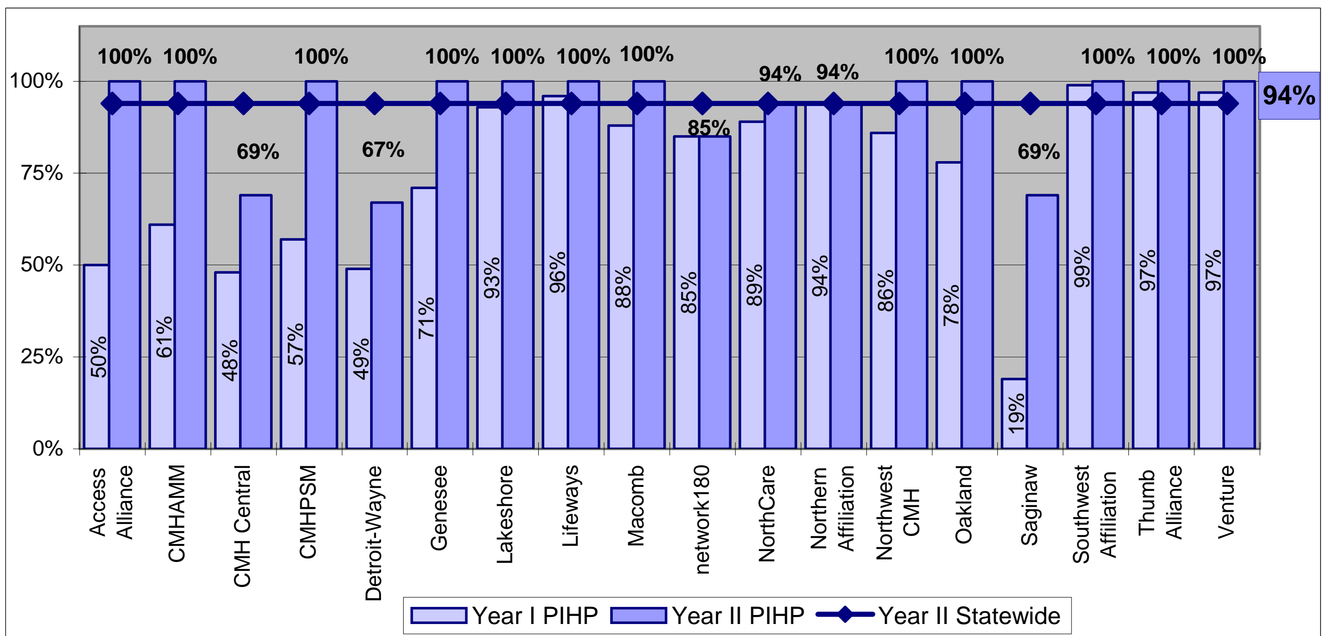


Figure A-8—Standard VIII: Recipient Rights and Protections

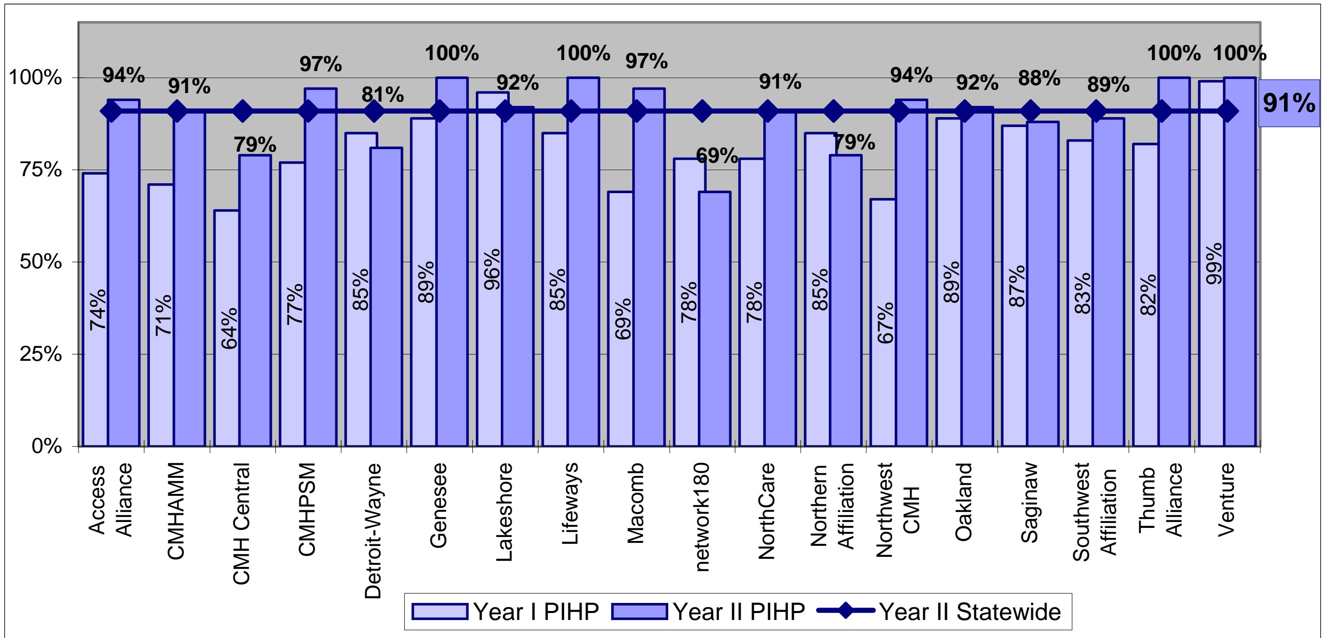


Figure A-9—Standard IX: Subcontracts and Delegation

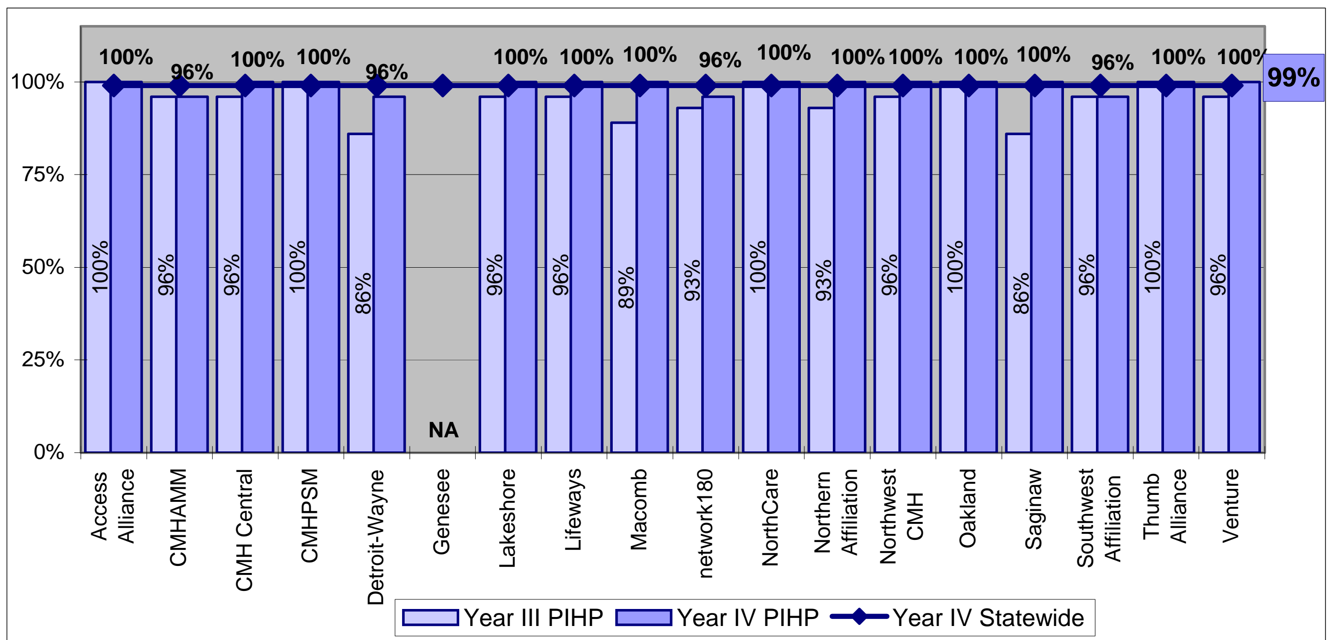


Figure A-10—Standard X: Provider Network

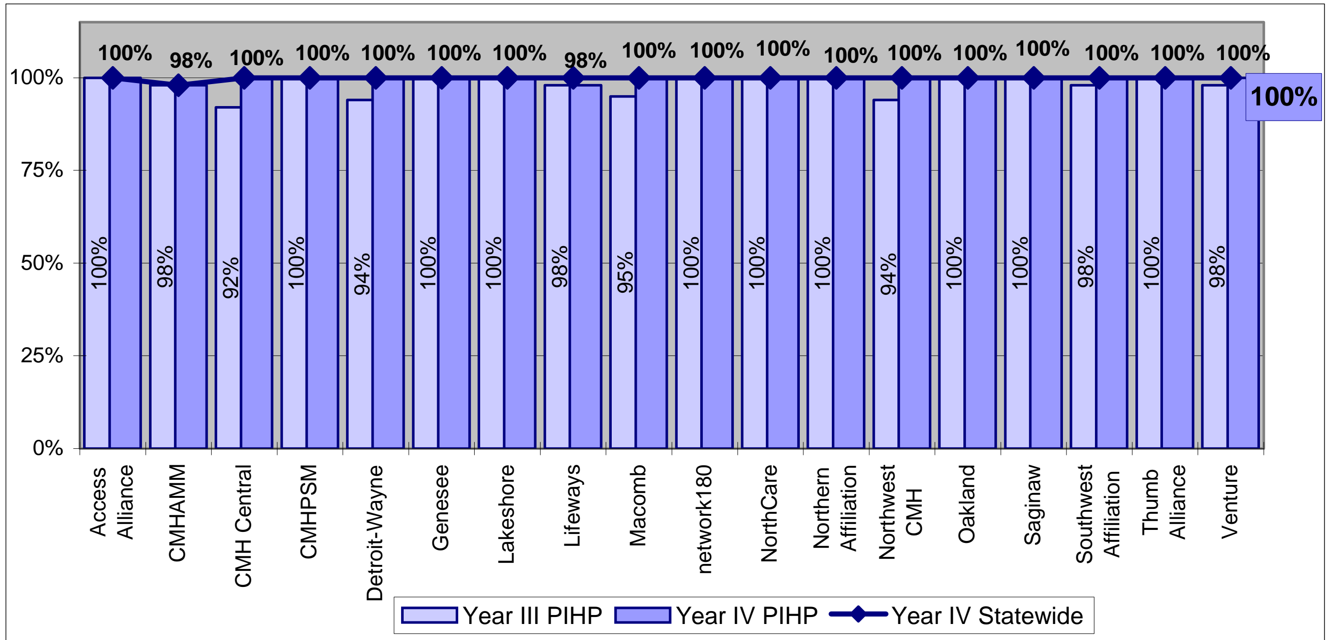


Figure A-11—Standard XI: Credentialing

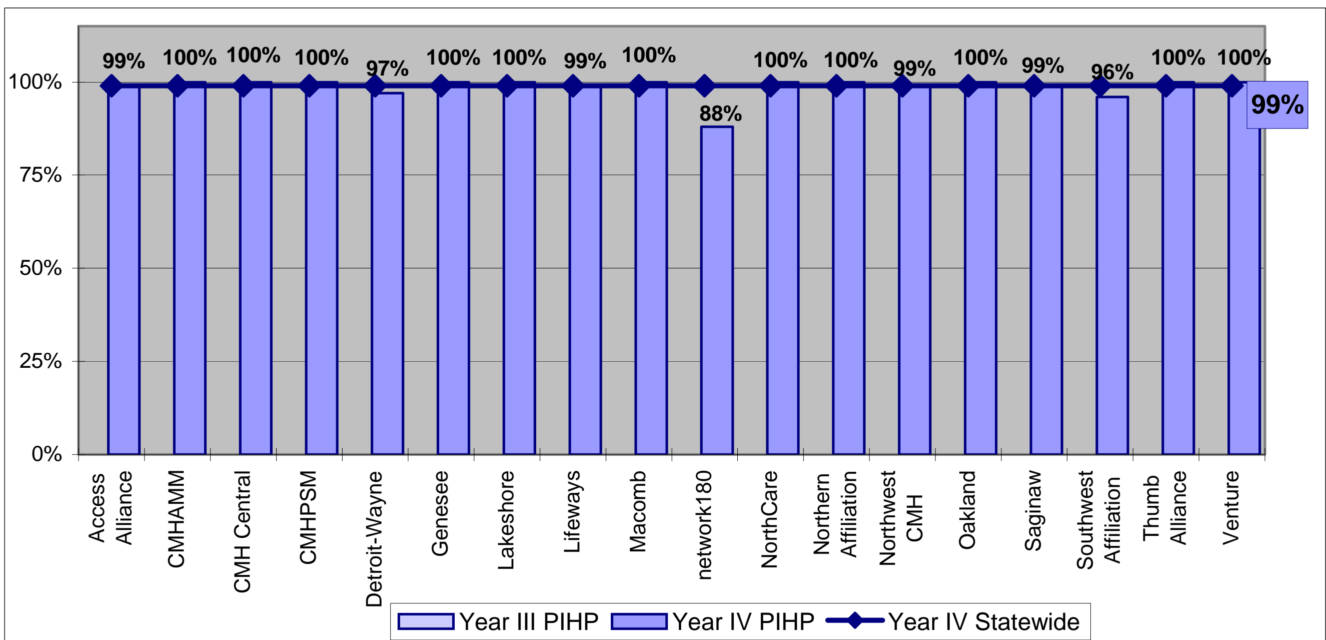


Figure A-12—Standard XII: Access and Availability

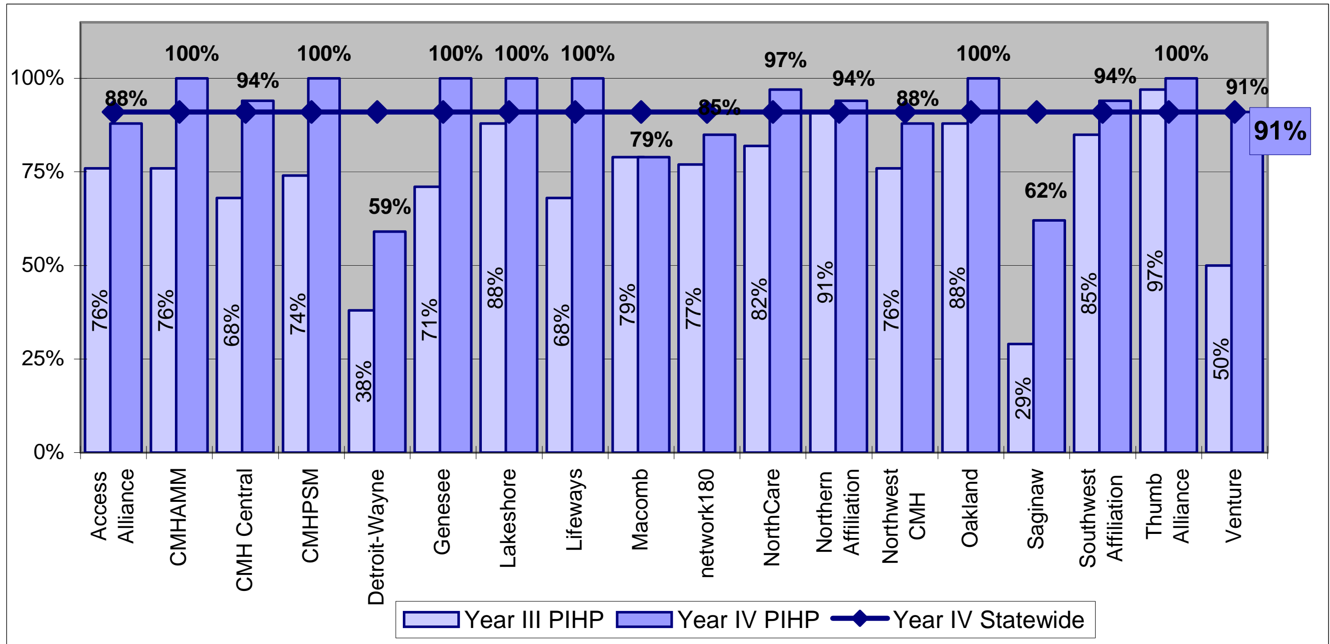


Figure A-13—Standard XIII: Coordination of Care

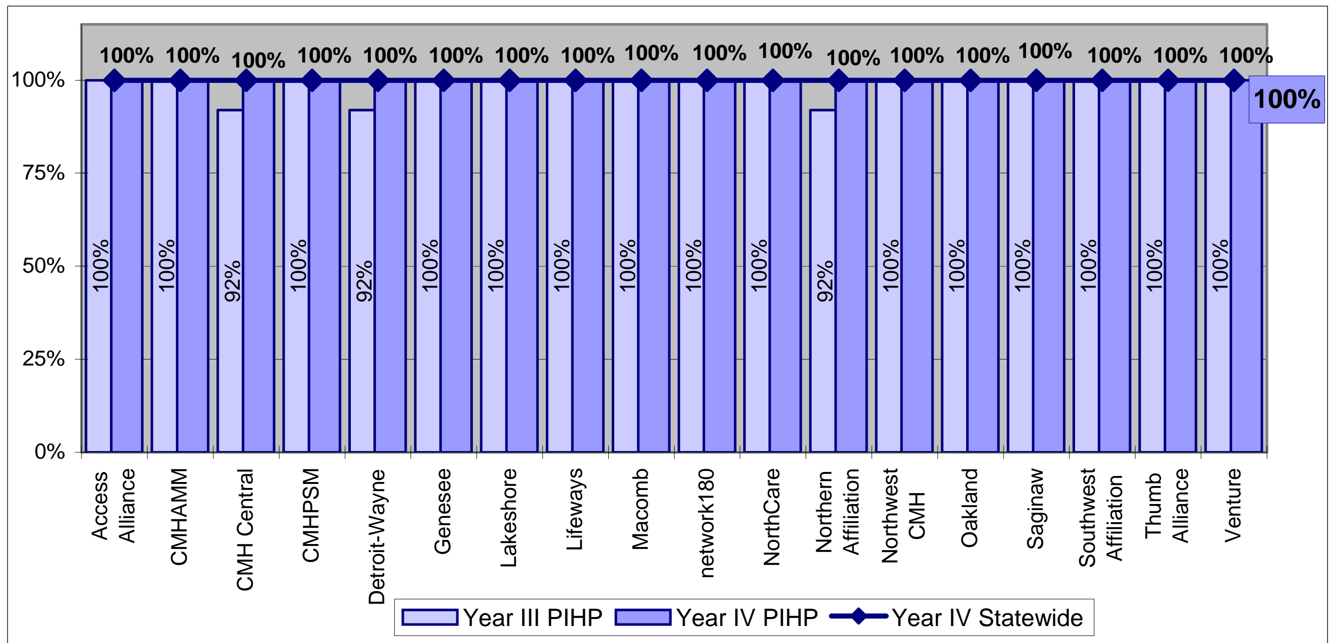


Figure A-14—Standard XIV: Appeals

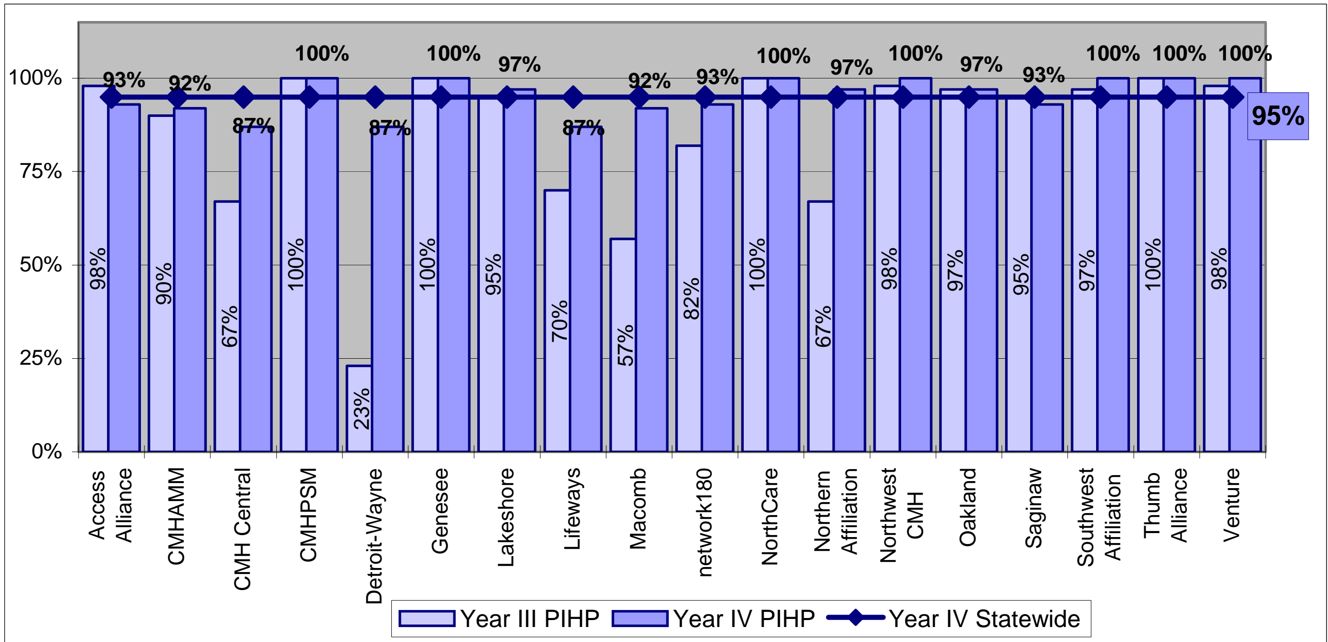
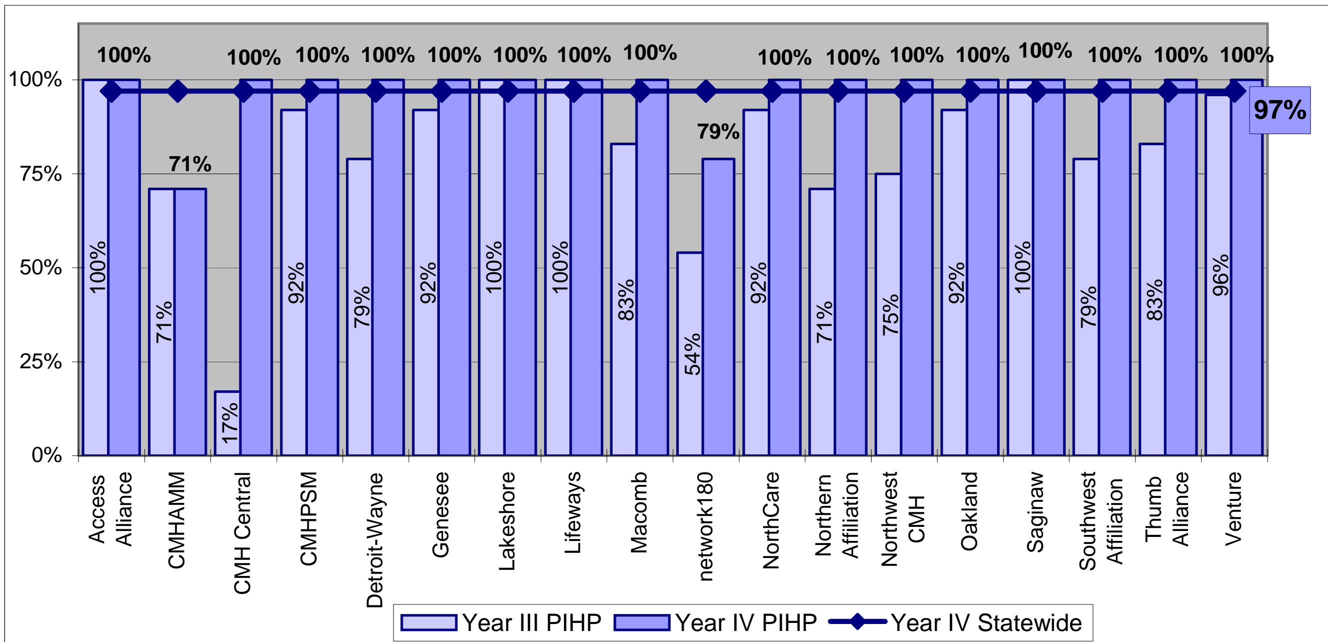


Figure A-15—Standard XV: Advance Directives



PIHP Compliance after Follow-Up Review

Table A-1 presents the compliance scores for all 18 PIHPs on the 15 compliance monitoring standards. Percentages represent the level of compliance after the follow-up review on each standard.

Table A-1—Summary of PIHP Compliance Scores After Follow-Up Reviews

PIHP	Year I and Year II								Year III and Year IV						
	I. QAPIP	II. Performance Measurement	III. Practice Guidelines	IV. Staff Qualifications	V. Utilization Management	VI. Customer Service	VII. Recipient Grievance Process	VIII. Recipient Rights	IX. Subcontracts	X. Provider Network	XI. Credentialing	XII. Access	XIII. Coordination of Care	XIV. Appeals	XV. Advance Directives
Access Alliance	100%	100%	100%	100%	100%	100%	100%	94%	100%	100%	99%	88%	100%	93%	100%
CMHAMM	100%	100%	100%	100%	100%	100%	100%	91%	96%	98%	100%	100%	100%	92%	71%
CMH Central	100%	100%	100%	100%	68%	100%	69%	79%	100%	100%	100%	94%	100%	87%	100%
CMHPSM	100%	100%	93%	83%	100%	100%	100%	97%	100%	100%	100%	100%	100%	100%	100%
Detroit-Wayne	77%	88%	100%	100%	92%	62%	67%	81%	96%	100%	97%	59%	100%	87%	100%
Genesee	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%	100%	100%	100%	100%	100%
Lakeshore	100%	100%	100%	100%	100%	100%	100%	92%	100%	100%	100%	100%	100%	97%	100%
LifeWays	100%	100%	100%	100%	100%	100%	100%	100%	100%	98%	99%	100%	100%	87%	100%
Macomb	95%	100%	100%	100%	100%	100%	100%	97%	100%	100%	100%	79%	100%	92%	100%
network180	100%	100%	70%	100%	96%	100%	85%	69%	96%	100%	88%	85%	100%	93%	79%
NorthCare	100%	100%	100%	100%	100%	100%	94%	91%	100%	100%	100%	97%	100%	100%	100%
Northern Affiliation	100%	100%	90%	100%	88%	100%	94%	79%	100%	100%	100%	94%	100%	97%	100%
Northwest CMH	100%	100%	100%	100%	100%	100%	100%	94%	100%	100%	99%	88%	100%	100%	100%
Oakland	100%	100%	100%	100%	100%	100%	100%	92%	100%	100%	100%	100%	100%	97%	100%
Saginaw	100%	100%	100%	100%	100%	100%	69%	88%	100%	100%	99%	62%	100%	93%	100%
Southwest Affiliation	100%	100%	100%	100%	100%	100%	100%	89%	96%	100%	96%	94%	100%	100%	100%
Thumb Alliance	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Venture	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	91%	100%	100%	100%
Statewide Score	**98%**	**99%**	**98%**	**99%**	**97%**	**98%**	**94%**	**91%**	**99%**	**100%**	**99%**	**91%**	**100%**	**95%**	**97%**

Note: Shaded cells show performance below the statewide score.

PIHP-Specific Compliance Monitoring Results

Table A-2—Compliance Monitoring
Initial (Years I and III) and Follow-Up Review (Years II and IV) Scores
for **Access Alliance of Michigan**

Standard		Year	# M	# SM	# PM	# NM	# NA	Compliance Score (After Follow-Up)
I	QAPIP	I	14	0	2	6	1	100%
		II	8					
II	Performance Improvement	I	26	0	0	0	1	100%
		II	No follow-up review required for this standard.					
III	Practice Guidelines	I	14	0	0	0	6	100%
		II	No follow-up review required for this standard.					
IV	Staff Qualifications and Training	I	6	0	0	0	0	100%
		II	No follow-up review required for this standard.					
V	Utilization Management	I	13	1	9	1	2	100%
		II	11					
VI	Customer Service	I	8	0	5	0	0	100%
		II	5					
VII	Recipient Grievance Process	I	4	0	9	4	2	100%
		II	13					
VIII	Recipient Rights and Protections	I	18	1	13	2	7	94%
		II	13					
IX	Subcontracts and Delegation	III	7	0	0	0	0	100%
		IV	No follow-up review required for this standard.					
X	Provider Network	III	12	0	0	0	0	100%
		IV	No follow-up review required for this standard.					
XI	Credentialing	III	9	8	4	3	1	99%
		IV	14	1	0	0	0	
XII	Access and Availability	III	11		4	2	0	88%
		IV	3		2	1	0	
XIII	Coordination of Care	III	3	0	0	0	0	100%
		IV	No follow-up review required for this standard.					
XIV	Appeals	III	14	1	0	0	0	93%
		IV	0	0	0	1	0	
XV	Advance Directives	III	6	0	0	0	0	100%
		IV	No follow-up review required for this standard.					

M *= Met,* ***SM*** *= Substantially Met,* ***PM*** *= Partially Met,* ***NM*** *= Not Met,* ***NA*** *= Not Applicable*

Compliance Score: The overall percentages were calculated by adding the number of elements that received a score of *Met* (initial and follow-up review combined) 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* from the follow-up review, then dividing this total by the total number of applicable elements.

Note: For the Year II follow-up reviews, scores of *Substantially Met* and *Partially Met* were not applicable to any standard, nor were scores of *Substantially Met* for Standard XII in Years III and IV (cells shaded in gray).

Table A-3—Compliance Monitoring
Initial (Years I and III) and Follow-Up Review (Years II and IV) Scores
***for* CMH Affiliation of Mid-Michigan**

Standard		Year	# M	# SM	# PM	# NM	# NA	Compliance Score (After Follow-Up)
I	QAPIP	I	9	1	2	10	1	100%
		II	13					
II	Performance Improvement	I	15	2	2	2	6	100%
		II	6					
III	Practice Guidelines	I	10	0	0	0	10	100%
		II	No follow-up review required for this standard.					
IV	Staff Qualifications and Training	I	6	0	0	0	0	100%
		II	No follow-up review required for this standard.					
V	Utilization Management	I	11	6	5	3	1	100%
		II	14					
VI	Customer Service	I	10	1	0	2	0	100%
		II	3					
VII	Recipient Grievance Process	I	5	4	6	3	1	100%
		II	13					
VIII	Recipient Rights and Protections	I	19	6	4	7	5	91%
		II	13					
IX	Subcontracts and Delegation	III	6	1	0	0	0	96%
		IV	0	1	0	0	0	
X	Provider Network	III	11	1	0	0	0	98%
		IV	0	1	0	0	0	
XI	Credentialing	III	17	1	4	0	3	100%
		IV	5	0	0	0	0	
XII	Access and Availability	III	12		2	3	0	100%
		IV	5		0	0	0	
XIII	Coordination of Care	III	3	0	0	0	0	100%
		IV	No follow-up review required for this standard.					
XIV	Appeals	III	11	2	2	0	0	92%
		IV	1	1	2	0	0	
XV	Advance Directives	III	3	1	1	1	0	71%
		IV	0	1	1	1	0	

***M** = Met, **SM** = Substantially Met, **PM** = Partially Met, **NM** = Not Met, **NA** = Not Applicable*

Compliance Score: The overall percentages were calculated by adding the number of elements that received a score of *Met* (initial and follow-up review combined) 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* from the follow-up review, then dividing this total by the total number of applicable elements.

Note: For the Year II follow-up reviews, scores of *Substantially Met* and *Partially Met* were not applicable to any standard, nor were scores *of Substantially Met* for Standard XII in Years III and IV (cells shaded in gray).

Table A-4—Compliance Monitoring
Initial (Years I and III) and Follow-Up Review (Years II and IV) Scores
***for* CMH for Central Michigan**

	Standard	Year	# M	# SM	# PM	# NM	# NA	Compliance Score (After Follow-Up)
I	QAPIP	I	12	1	0	4	6	100%
		II	5					
II	Performance Improvement	I	12	1	1	7	6	100%
		II	9					
III	Practice Guidelines	I	10	0	0	0	10	100%
		II	No follow-up review required for this standard.					
IV	Staff Qualifications and Training	I	6	0	0	0	0	100%
		II	No follow-up review required for this standard.					
V	Utilization Management	I	13	1	1	4	7	68%
		II	0					
VI	Customer Service	I	12	0	1	0	0	100%
		II	1					
VII	Recipient Grievance Process	I	2	1	7	3	6	69%
		II	7					
VIII	Recipient Rights and Protections	I	13	4	5	7	12	79%
		II	10					
IX	Subcontracts and Delegation	III	6	1	0	0	0	100%
		IV	1	0	0	0	0	
X	Provider Network	III	9	2	1	0	0	100%
		IV	3	0	0	0	0	
XI	Credentialing	III	18	5	1	0	1	100%
		IV	6	0	0	0	0	
XII	Access and Availability	III	11		1	5	0	94%
		IV	5		0	1	0	
XIII	Coordination of Care	III	2	1	0	0	0	100%
		IV	1	0	0	0	0	
XIV	Appeals	III	5	0	10	0	0	87%
		IV	6	0	4	0	0	
XV	Advance Directives	III	0	0	2	4	0	100%
		IV	6	0	0	0	0	

***M** = Met, **SM** = Substantially Met, **PM** = Partially Met, **NM** = Not Met, **NA** = Not Applicable*

Compliance Score: The overall percentages were calculated by adding the number of elements that received a score of *Met* (initial and follow-up review combined) 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* from the follow-up review, then dividing this total by the total number of applicable elements.

Note: For the Year II follow-up reviews, scores of *Substantially Met* and *Partially Met* were not applicable to any standard, nor were scores of *Substantially Met* for Standard XII in Years III and IV (cells shaded in gray).

Table A-5—Compliance Monitoring
Initial (Years I and III) and Follow-Up Review (Years II and IV) Scores
***for* CMH Partnership of Southeastern Michigan**

Standard		Year	# *M*	# *SM*	# *PM*	# *NM*	# *NA*	Compliance Score (After Follow-Up)
I	QAPIP	I	20	1	0	1	1	100%
		II	2					
II	Performance Improvement	I	26	0	0	0	1	100%
		II	No follow-up review required for this standard.					
III	Practice Guidelines	I	9	0	5	0	6	93%
		II	4					
IV	Staff Qualifications and Training	I	3	0	2	1	0	83%
		II	2					
V	Utilization Management	I	9	2	4	9	2	100%
		II	15					
VI	Customer Service	I	5	0	5	3	0	100%
		II	8					
VII	Recipient Grievance Process	I	6	1	7	4	1	100%
		II	12					
VIII	Recipient Rights and Protections	I	17	3	9	2	10	97%
		II	12					
IX	Subcontracts and Delegation	III	7	0	0	0	0	100%
		IV	No follow-up review required for this standard.					
X	Provider Network	III	12	0	0	0	0	100%
		IV	No follow-up review required for this standard.					
XI	Credentialing	III	21	1	1	0	2	100%
		IV	2	0	0	0	0	
XII	Access and Availability	III	10		5	2	0	100%
		IV	7		0	0	0	
XIII	Coordination of Care	III	3	0	0	0	0	100%
		IV	No follow-up review required for this standard.					
XIV	Appeals	III	15	0	0	0	0	100%
		IV	No follow-up review required for this standard.					
XV	Advance Directives	III	5	0	1	0	0	100%
		IV	1	0	0	0	0	

M *= Met*, ***SM*** *= Substantially Met*, ***PM*** *= Partially Met*, ***NM*** *= Not Met*, ***NA*** *= Not Applicable*

Compliance Score: The overall percentages were calculated by adding the number of elements that received a score of *Met* (initial and follow-up review combined) 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* from the follow-up review, then dividing this total by the total number of applicable elements.

Note: For the Year II follow-up reviews, scores of *Substantially Met* and *Partially Met* were not applicable to any standard, nor were scores of *Substantially Met* for Standard XII in Years III and IV (cells shaded in gray).

Table A-6—Compliance Monitoring Initial (Years I and III) and Follow-Up Review (Years II and IV) Scores *for* Detroit-Wayne County CMH Agency								
Standard		Year	# *M*	# *SM*	# *PM*	# *NM*	# *NA*	Compliance Score (After Follow-Up)
I	QAPIP	I	9	4	3	6	1	77%
		II	8					
II	Performance Improvement	I	12	2	3	9	1	88%
		II	11					
III	Practice Guidelines	I	8	1	2	3	6	100%
		II	6					
IV	Staff Qualifications and Training	I	6	0	0	0	0	100%
		II	No follow-up review required for this standard.					
V	Utilization Management	I	9	2	10	4	1	92%
		II	14					
VI	Customer Service	I	7	1	3	2	0	62%
		II	1					
VII	Recipient Grievance Process	I	4	3	5	6	1	67%
		II	8					
VIII	Recipient Rights and Protections	I	29	3	2	4	3	81%
		II	1					
IX	Subcontracts and Delegation	III	4	2	1	0	0	96%
		IV	2	1	0	0	0	
X	Provider Network	III	10	1	1	0	0	100%
		IV	2	0	0	0	0	
XI	Credentialing	III	2	1	4	17	1	97%
		IV	19	3	0	0	0	
XII	Access and Availability	III	4		5	8	0	59%
		IV	3		6	4	0	
XIII	Coordination of Care	III	2	1	0	0	0	100%
		IV	1	0	0	0	0	
XIV	Appeals	III	3	0	1	11	0	87%
		IV	7	4	0	1	0	
XV	Advance Directives	III	4	1	0	1	0	100%
		IV	2	0	0	0	0	

M *= Met*, ***SM*** *= Substantially Met*, ***PM*** *= Partially Met*, ***NM*** *= Not Met*, ***NA*** *= Not Applicable*

Compliance Score: The overall percentages were calculated by adding the number of elements that received a score of *Met* (initial and follow-up review combined) 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* from the follow-up review, then dividing this total by the total number of applicable elements.

Note: For the Year II follow-up reviews, scores of *Substantially Met* and *Partially Met* were not applicable to any standard, nor were scores of *Substantially Met* for Standard XII in Years III and IV (cells shaded in gray).

Table A-7—Compliance Monitoring
Initial (Years I and III) and Follow-Up Review (Years II and IV) Scores
***for* Genesee County CMH**

Standard		Year	# *M*	# *SM*	# *PM*	# *NM*	# *NA*	Compliance Score (After Follow-Up)
I	QAPIP	I	17	0	0	0	6	100%
		II	No follow-up review required for this standard.					
II	Performance Improvement	I	21	0	0	0	6	100%
		II	No follow-up review required for this standard.					
III	Practice Guidelines	I	14	0	0	0	6	100%
		II	No follow-up review required for this standard.					
IV	Staff Qualifications and Training	I	6	0	0	0	0	100%
		II	No follow-up review required for this standard.					
V	Utilization Management	I	12	2	2	3	7	100%
		II	7					
VI	Customer Service	I	13	0	0	0	0	100%
		II	No follow-up review required for this standard.					
VII	Recipient Grievance Process	I	7	1	3	2	6	100%
		II	6					
VIII	Recipient Rights and Protections	I	24	4	1	2	10	100%
		II	6					
IX	Subcontracts and Delegation	III	0	0	0	0	7	NA
		IV	No follow-up review required for this standard.					
X	Provider Network	III	12	0	0	0	0	100%
		IV	No follow-up review required for this standard.					
XI	Credentialing	III	21	0	1	1	2	100%
		IV	2	0	0	0	0	
XII	Access and Availability	III	10		4	3	0	100%
		IV	7		0	0	0	
XIII	Coordination of Care	III	3	0	0	0	0	100%
		IV	No follow-up review required for this standard.					
XIV	Appeals	III	15	0	0	0	0	100%
		IV	No follow-up review required for this standard.					
XV	Advance Directives	III	5	0	1	0	0	100%
		IV	1	0	0	0	0	

***M** = Met, **SM** = Substantially Met, **PM** = Partially Met, **NM** = Not Met, **NA** = Not Applicable*

Compliance Score: The overall percentages were calculated by adding the number of elements that received a score of *Met* (initial and follow-up review combined) 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* from the follow-up review, then dividing this total by the total number of applicable elements.

Note: For the Year II follow-up reviews, scores of *Substantially Met* and *Partially Met* were not applicable to any standard, nor were scores of *Substantially Met* for Standard XII in Years III and IV (cells shaded in gray).

Table A-8—Compliance Monitoring
Initial (Years I and III) and Follow-Up Review (Years II and IV) Scores
***for* Lakeshore Behavioral Health Alliance**

	Standard	Year	# *M*	# *SM*	# *PM*	# *NM*	# *NA*	Compliance Score (After Follow-Up)
I	QAPIP	I	20	3	0	0	0	100%
		II	3					
II	Performance Improvement	I	23	2	1	1	0	100%
		II	4					
III	Practice Guidelines	I	18	1	0	1	0	100%
		II	2					
IV	Staff Qualifications and Training	I	6	0	0	0	0	100%
		II	No follow-up review required for this standard.					
V	Utilization Management	I	22	1	2	1	0	100%
		II	4					
VI	Customer Service	I	13	0	0	0	0	100%
		II	No follow-up review required for this standard.					
VII	Recipient Grievance Process	I	15	3	1	0	0	100%
		II	4					
VIII	Recipient Rights and Protections	I	32	6	0	0	3	92%
		II	2					
IX	Subcontracts and Delegation	III	6	1	0	0	0	100%
		IV	1	0	0	0	0	
X	Provider Network	III	12	0	0	0	0	100%
		IV	No follow-up review required for this standard.					
XI	Credentialing	III	17	1	4	1	2	100%
		IV	6	0	0	0	0	
XII	Access and Availability	III	14		2	1	0	100%
		IV	3		0	0	0	
XIII	Coordination of Care	III	3	0	0	0	0	100%
		IV	No follow-up review required for this standard.					
XIV	Appeals	III	13	1	1	0	0	97%
		IV	1	0	1	0	0	
XV	Advance Directives	III	6	0	0	0	0	100%
		IV	No follow-up review required for this standard.					

M *= Met*, ***SM*** *= Substantially Met*, ***PM*** *= Partially Met*, ***NM*** *= Not Met*, ***NA*** *= Not Applicable*

Compliance Score: The overall percentages were calculated by adding the number of elements that received a score of *Met* (initial and follow-up review combined) 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* from the follow-up review, then dividing this total by the total number of applicable elements.

Note: For the Year II follow-up reviews, scores of *Substantially Met* and *Partially Met* were not applicable to any standard, nor were scores of *Substantially Met* for Standard XII in Years III and IV (cells shaded in gray).

Table A-9—Compliance Monitoring
Initial (Years I and III) and Follow-Up Review (Years II and IV) Scores
for **LifeWays**

Standard		Year	# *M*	# *SM*	# *PM*	# *NM*	# *NA*	Compliance Score (After Follow-Up)
I	QAPIP	I	17	0	0	0	6	100%
		II	No follow-up review required for this standard.					
II	Performance Improvement	I	21	0	0	0	6	100%
		II	No follow-up review required for this standard.					
III	Practice Guidelines	I	14	0	0	0	6	100%
		II	No follow-up review required for this standard.					
IV	Staff Qualifications and Training	I	6	0	0	0	0	100%
		II	No follow-up review required for this standard.					
V	Utilization Management	I	25	0	0	0	1	100%
		II	No follow-up review required for this standard.					
VI	Customer Service	I	13	0	0	0	0	100%
		II	No follow-up review required for this standard.					
VII	Recipient Grievance Process	I	11	2	0	0	6	100%
		II	2					
VIII	Recipient Rights and Protections	I	24	3	2	3	9	100%
		II	7					
IX	Subcontracts and Delegation	III	6	1	0	0	0	100%
		IV	1	0	0	0	0	
X	Provider Network	III	11	1	0	0	0	98%
		IV	0	1	0	0	0	
XI	Credentialing	III	14	8	1	0	2	99%
		IV	8	1	0	0	0	
XII	Access and Availability	III	9		5	3	0	100%
		IV	8		0	0	0	
XIII	Coordination of Care	III	3	0	0	0	0	100%
		IV	No follow-up review required for this standard.					
XIV	Appeals	III	5	4	5	1	0	87%
		IV	6	2	1	1	0	
XV	Advance Directives	III	6	0	0	0	0	100%
		IV	No follow-up review required for this standard.					

M *= Met,* ***SM*** *= Substantially Met,* ***PM*** *= Partially Met,* ***NM*** *= Not Met,* ***NA*** *= Not Applicable*

Compliance Score: The overall percentages were calculated by adding the number of elements that received a score of *Met* (initial and follow-up review combined) 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* from the follow-up review, then dividing this total by the total number of applicable elements.

Note: For the Year II follow-up reviews, scores of *Substantially Met* and *Partially Met* were not applicable to any standard, nor were scores of *Substantially Met* for Standard XII in Years III and IV (cells shaded in gray).

Table A-10—Compliance Monitoring
Initial (Years I and III) and Follow-Up Review (Years II and IV) Scores
***for* Macomb County CMH Services**

Standard		Year	# M	# SM	# PM	# NM	# NA	Compliance Score (After Follow-Up)
I	QAPIP	I	13	0	2	7	1	95%
		II	8					
II	Performance Improvement	I	18	1	1	6	1	100%
		II	8					
III	Practice Guidelines	I	10	0	0	0	10	100%
		II	No follow-up review required for this standard.					
IV	Staff Qualifications and Training	I	6	0	0	0	0	100%
		II	No follow-up review required for this standard.					
V	Utilization Management	I	25	0	0	0	1	100%
		II	No follow-up review required for this standard.					
VI	Customer Service	I	13	0	0	0	0	100%
		II	No follow-up review required for this standard.					
VII	Recipient Grievance Process	I	8	4	1	0	6	100%
		II	5					
VIII	Recipient Rights and Protections	I	18	4	2	8	9	97%
		II	12					
IX	Subcontracts and Delegation	III	5	1	1	0	0	100%
		IV	2	0	0	0	0	
X	Provider Network	III	10	0	1	0	1	100%
		IV	1	0	0	0	0	
XI	Credentialing	III	19	2	1	0	3	100%
		IV	3	0	0	0	0	
XII	Access and Availability	III	13		1	3	0	79%
		IV	0		1	3	0	
XIII	Coordination of Care	III	3	0	0	0	0	100%
		IV	No follow-up review required for this standard.					
XIV	Appeals	III	1	4	9	1	0	92%
		IV	9	5	0	0	0	
XV	Advance Directives	III	4	0	2	0	0	100%
		IV	2	0	0	0	0	

***M** = Met, **SM** = Substantially Met, **PM** = Partially Met, **NM** = Not Met, **NA** = Not Applicable*

Compliance Score: The overall percentages were calculated by adding the number of elements that received a score of *Met* (initial and follow-up review combined) 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* from the follow-up review, then dividing this total by the total number of applicable elements.

Note: For the Year II follow-up reviews, scores of *Substantially Met* and *Partially Met* were not applicable to any standard, nor were scores of *Substantially Met* for Standard XII in Years III and IV (cells shaded in gray).

Table A-11—Compliance Monitoring
Initial (Years I and III) and Follow-Up Review (Years II and IV) Scores
***for* network180**

	Standard	Year	# M	# SM	# PM	# NM	# NA	Compliance Score (After Follow-Up)
I	QAPIP	I	13	3	1	0	6	100%
		II	4					
II	Performance Improvement	I	21	0	0	0	6	100%
		II	No follow-up review required for this standard.					
III	Practice Guidelines	I	7	0	1	2	10	70%
		II	0					
IV	Staff Qualifications and Training	I	6	0	0	0	0	100%
		II	No follow-up review required for this standard.					
V	Utilization Management	I	24	0	1	0	1	96%
		II	0					
VI	Customer Service	I	12	0	1	0	0	100%
		II	1					
VII	Recipient Grievance Process	I	10	0	2	1	6	85%
		II	1					
VIII	Recipient Rights and Protections	I	19	4	3	4	11	69%
		II	1					
IX	Subcontracts and Delegation	III	6	0	1	0	0	96%
		IV	0	1	0	0	0	
X	Provider Network	III	12	0	0	0	0	100%
		IV	No follow-up review required for this standard.					
XI	Credentialing	III	3	2	18	0	2	88%
		IV	13	3	4	0	0	
XII	Access and Availability	III	12		2	3	0	85%
		IV	2		1	2	0	
XIII	Coordination of Care	III	3	0	0	0	0	100%
		IV	No follow-up review required for this standard.					
XIV	Appeals	III	11	1	1	2	0	93%
		IV	0	4	0	0	0	
XV	Advance Directives	III	2	1	1	2	0	79%
		IV	1	1	2	0	0	

***M** = Met, **SM** = Substantially Met, **PM** = Partially Met, **NM** = Not Met, **NA** = Not Applicable*

Compliance Score: The overall percentages were calculated by adding the number of elements that received a score of *Met* (initial and follow-up review combined) 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* from the follow-up review, then dividing this total by the total number of applicable elements.

Note: For the Year II follow-up reviews, scores of *Substantially Met* and *Partially Met* were not applicable to any standard, nor were scores of *Substantially Met* for Standard XII in Years III and IV (cells shaded in gray).

Table A-12—Compliance Monitoring
Initial (Years I and III) and Follow-Up Review (Years II and IV) Scores
***for* NorthCare**

	Standard	Year	# M	# SM	# PM	# NM	# NA	Compliance Score (After Follow-Up)
I	QAPIP	I	22	0	0	0	1	100%
		II	No follow-up review required for this standard.					
II	Performance Improvement	I	26	0	0	0	1	100%
		II	No follow-up review required for this standard.					
III	Practice Guidelines	I	19	0	0	0	1	100%
		II	No follow-up review required for this standard.					
IV	Staff Qualifications and Training	I	6	0	0	0	0	100%
		II	No follow-up review required for this standard.					
V	Utilization Management	I	18	0	5	2	1	100%
		II	7					
VI	Customer Service	I	9	1	1	2	0	100%
		II	4					
VII	Recipient Grievance Process	I	14	2	1	1	1	94%
		II	3					
VIII	Recipient Rights and Protections	I	24	1	5	5	6	91%
		II	8					
IX	Subcontracts and Delegation	III	7	0	0	0	0	100%
		IV	No follow-up review required for this standard.					
X	Provider Network	III	12	0	0	0	0	100%
		IV	No follow-up review required for this standard.					
XI	Credentialing	III	15	0	5	3	2	100%
		IV	8	0	0	0	0	
XII	Access and Availability	III	12		4	1	0	97%
		IV	4		1	0	0	
XIII	Coordination of Care	III	3	0	0	0	0	100%
		IV	No follow-up review required for this standard.					
XIV	Appeals	III	15	0	0	0	0	100%
		IV	No follow-up review required for this standard.					
XV	Advance Directives	III	5	0	1	0	0	100%
		IV	1	0	0	0	0	

M *= Met,* ***SM*** *= Substantially Met,* ***PM*** *= Partially Met,* ***NM*** *= Not Met,* ***NA*** *= Not Applicable*

Compliance Score: The overall percentages were calculated by adding the number of elements that received a score of *Met* (initial and follow-up review combined) 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* from the follow-up review, then dividing this total by the total number of applicable elements.

Note: For the Year II follow-up reviews, scores of *Substantially Met* and *Partially Met* were not applicable to any standard, nor were scores of *Substantially Met* for Standard XII in Years III and IV (cells shaded in gray).

Table A-13—Compliance Monitoring
Initial (Years I and III) and Follow-Up Review (Years II and IV) Scores
***for* Northern Affiliation**

	Standard	Year	# M	# SM	# PM	# NM	# NA	Compliance Score (After Follow-Up)
I	QAPIP	I	19	3	0	0	1	100%
		II	3					
II	Performance Improvement	I	25	0	0	1	1	100%
		II	1					
III	Practice Guidelines	I	5	0	5	0	10	90%
		II	4					
IV	Staff Qualifications and Training	I	6	0	0	0	0	100%
		II	No follow-up review required for this standard.					
V	Utilization Management	I	19	0	4	1	2	88%
		II	2					
VI	Customer Service	I	11	0	0	2	0	100%
		II	2					
VII	Recipient Grievance Process	I	15	2	1	0	1	94%
		II	2					
VIII	Recipient Rights and Protections	I	26	3	3	3	6	79%
		II	1					
IX	Subcontracts and Delegation	III	6	0	1	0	0	100%
		IV	1	0	0	0	0	
X	Provider Network	III	12	0	0	0	0	100%
		IV	No follow-up review required for this standard.					
XI	Credentialing	III	18	3	0	3	1	100%
		IV	6	0	0	0	0	
XII	Access and Availability	III	14		3	0	0	94%
		IV	1		2	0	0	
XIII	Coordination of Care	III	2	1	0	0	0	100%
		IV	1	0	0	0	0	
XIV	Appeals	III	8	2	1	4	0	97%
		IV	6	0	1	0	0	
XV	Advance Directives	III	3	1	1	1	0	100%
		IV	3	0	0	0	0	

***M** = Met, **SM** = Substantially Met, **PM** = Partially Met, **NM** = Not Met, **NA** = Not Applicable*

Compliance Score: The overall percentages were calculated by adding the number of elements that received a score of *Met* (initial and follow-up review combined) 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* from the follow-up review, then dividing this total by the total number of applicable elements.

Note: For the Year II follow-up reviews, scores of *Substantially Met* and *Partially Met* were not applicable to any standard, nor were scores of *Substantially Met* for Standard XII in Years III and IV (cells shaded in gray).

Table A-14—Compliance Monitoring
Initial (Years I and III) and Follow-Up Review (Years II and IV) Scores
***for* Northwest CMH Affiliation**

Standard		Year	# M	# SM	# PM	# NM	# NA	Compliance Score (After Follow-Up)
I	QAPIP	I	22	0	0	0	1	100%
		II	No follow-up review required for this standard.					
II	Performance Improvement	I	26	0	0	0	1	100%
		II	No follow-up review required for this standard.					
III	Practice Guidelines	I	14	0	0	0	6	100%
		II	No follow-up review required for this standard.					
IV	Staff Qualifications and Training	I	6	0	0	0	0	100%
		II	No follow-up review required for this standard.					
V	Utilization Management	I	21	3	1	0	1	100%
		II	4					
VI	Customer Service	I	13	0	0	0	0	100%
		II	No follow-up review required for this standard.					
VII	Recipient Grievance Process	I	10	6	2	0	1	100%
		II	8					
VIII	Recipient Rights and Protections	I	22	1	4	10	4	94%
		II	12					
IX	Subcontracts and Delegation	III	6	1	0	0	0	100%
		IV	1	0	0	0	0	
X	Provider Network	III	9	3	0	0	0	100%
		IV	3	0	0	0	0	
XI	Credentialing	III	22	1	0	0	2	99%
		IV	0	1	0	0	0	
XII	Access and Availability	III	11		4	2	0	88%
		IV	3		2	1	0	
XIII	Coordination of Care	III	3	0	0	0	0	100%
		IV	No follow-up review required for this standard.					
XIV	Appeals	III	14	1	0	0	0	100%
		IV	1	0	0	0	0	
XV	Advance Directives	III	3	0	3	0	0	100%
		IV	3	0	0	0	0	

***M** = Met, **SM** = Substantially Met, **PM** = Partially Met, **NM** = Not Met, **NA** = Not Applicable*

Compliance Score: The overall percentages were calculated by adding the number of elements that received a score of *Met* (initial and follow-up review combined) 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* from the follow-up review, then dividing this total by the total number of applicable elements.

Note: For the Year II follow-up reviews, scores of *Substantially Met* and *Partially Met* were not applicable to any standard, nor were scores of *Substantially Met* for Standard XII in Years III and IV (cells shaded in gray).

Table A-15—Compliance Monitoring
Initial (Years I and III) and Follow-Up Review (Years II and IV) Scores
***for* Oakland County CMH Authority**

Standard		Year	# *M*	# *SM*	# *PM*	# *NM*	# *NA*	Compliance Score (After Follow-Up)
I	QAPIP	I	20	2	0	0	1	100%
		II	2					
II	Performance Improvement	I	26	0	0	0	1	100%
		II	No follow-up review required for this standard.					
III	Practice Guidelines	I	14	0	0	0	6	100%
		II	No follow-up review required for this standard.					
IV	Staff Qualifications and Training	I	6	0	0	0	0	100%
		II	No follow-up review required for this standard.					
V	Utilization Management	I	12	6	5	2	1	100%
		II	13					
VI	Customer Service	I	12	1	0	0	0	100%
		II	1					
VII	Recipient Grievance Process	I	11	2	3	2	1	100%
		II	7					
VIII	Recipient Rights and Protections	I	30	3	1	3	4	92%
		II	3					
IX	Subcontracts and Delegation	III	7	0	0	0	0	100%
		IV	No follow-up review required for this standard.					
X	Provider Network	III	12	0	0	0	0	100%
		IV	No follow-up review required for this standard.					
XI	Credentialing	III	18	1	0	3	3	100%
		IV	4	0	0	0	0	
XII	Access and Availability	III	15		0	2	0	100%
		IV	2		0	0	0	
XIII	Coordination of Care	III	3	0	0	0	0	100%
		IV	No follow-up review required for this standard.					
XIV	Appeals	III	13	2	0	0	0	97%
		IV	0	2	0	0	0	
XV	Advance Directives	III	5	0	1	0	0	100%
		IV	1	0	0	0	0	

M *= Met*, ***SM*** *= Substantially Met*, ***PM*** *= Partially Met*, ***NM*** *= Not Met*, ***NA*** *= Not Applicable*

Compliance Score: The overall percentages were calculated by adding the number of elements that received a score of *Met* (initial and follow-up review combined) 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* from the follow-up review, then dividing this total by the total number of applicable elements.

Note: For the Year II follow-up reviews, scores of *Substantially Met* and *Partially Met* were not applicable to any standard, nor were scores of *Substantially Met* for Standard XII in Years III and IV (cells shaded in gray).

Table A-16—Compliance Monitoring Initial (Years I and III) and Follow-Up Review (Years II and IV) Scores *for* Saginaw County CMH Authority								
Standard		Year	# *M*	# *SM*	# *PM*	# *NM*	# *NA*	Compliance Score (After Follow-Up)
I	QAPIP	I	13	0	0	4	6	100%
		II	4					
II	Performance Improvement	I	21	0	0	0	6	100%
		II	No follow-up review required for this standard.					
III	Practice Guidelines	I	14	0	0	0	6	100%
		II	No follow-up review required for this standard.					
IV	Staff Qualifications and Training	I	6	0	0	0	0	100%
		II	No follow-up review required for this standard.					
V	Utilization Management	I	14	1	2	2	7	100%
		II	5					
VI	Customer Service	I	11	1	1	0	0	100%
		II	2					
VII	Recipient Grievance Process	I	1	0	3	9	6	69%
		II	8					
VIII	Recipient Rights and Protections	I	26	3	1	3	8	88%
		II	2					
IX	Subcontracts and Delegation	III	6	0	0	1	0	100%
		IV	1	0	0	0	0	
X	Provider Network	III	12	0	0	0	0	100%
		IV	No follow-up review required for this standard.					
XI	Credentialing	III	13	8	3	0	1	99%
		IV	10	1	0	0	0	
XII	Access and Availability	III	5		0	12	0	62%
		IV	4		3	5	0	
XIII	Coordination of Care	III	3	0	0	0	0	100%
		IV	No follow-up review required for this standard.					
XIV	Appeals	III	13	1	1	0	0	93%
		IV	1	0	0	1	0	
XV	Advance Directives	III	6	0	0	0	0	100%
		IV	No follow-up review required for this standard.					

M *= Met,* ***SM*** *= Substantially Met,* ***PM*** *= Partially Met,* ***NM*** *= Not Met,* ***NA*** *= Not Applicable*

Compliance Score: The overall percentages were calculated by adding the number of elements that received a score of *Met* (initial and follow-up review combined) 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* from the follow-up review, then dividing this total by the total number of applicable elements.

Note: For the Year II follow-up reviews, scores of *Substantially Met* and *Partially Met* were not applicable to any standard, nor were scores of *Substantially Met* for Standard XII in Years III and IV (cells shaded in gray).

Table A-17—Compliance Monitoring
Initial (Years I and III) and Follow-Up Review (Years II and IV) Scores
***for* Southwest Affiliation**

Standard		Year	# *M*	# *SM*	# *PM*	# *NM*	# *NA*	Compliance Score (After Follow-Up)
I	QAPIP	I	22	0	0	0	1	100%
		II	No follow-up review required for this standard.					
II	Performance Improvement	I	26	0	0	0	1	100%
		II	No follow-up review required for this standard.					
III	Practice Guidelines	I	14	0	0	0	6	100%
		II	No follow-up review required for this standard.					
IV	Staff Qualifications and Training	I	6	0	0	0	0	100%
		II	No follow-up review required for this standard.					
V	Utilization Management	I	25	0	0	0	1	100%
		II	No follow-up review required for this standard.					
VI	Customer Service	I	13	0	0	0	0	100%
		II	No follow-up review required for this standard.					
VII	Recipient Grievance Process	I	17	1	0	0	1	100%
		II	1					
VIII	Recipient Rights and Protections	I	29	2	2	5	3	89%
		II	4					
IX	Subcontracts and Delegation	III	6	1	0	0	0	96%
		IV	0	1	0	0	0	
X	Provider Network	III	11	1	0	0	0	100%
		IV	1	0	0	0	0	
XI	Credentialing	III	8	14	1	1	1	96%
		IV	12	4	0	0	0	
XII	Access and Availability	III	13		3	1	0	94%
		IV	2		2	0	0	
XIII	Coordination of Care	III	3	0	0	0		100%
		IV	No follow-up review required for this standard.					
XIV	Appeals	III	13	2	0	0	0	100%
		IV	2	0	0	0	0	
XV	Advance Directives	III	3	1	2	0	0	100%
		IV	3	0	0	0	0	

M *= Met*, ***SM*** *= Substantially Met*, ***PM*** *= Partially Met*, ***NM*** *= Not Met*, ***NA*** *= Not Applicable*

Compliance Score: The overall percentages were calculated by adding the number of elements that received a score of *Met* (initial and follow-up review combined) 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* from the follow-up review, then dividing this total by the total number of applicable elements.

Note: For the Year II follow-up reviews, scores of *Substantially Met* and *Partially Met* were not applicable to any standard, nor were scores of *Substantially Met* for Standard XII in Years III and IV (cells shaded in gray).

Table A-18—Compliance Monitoring
Initial (Years I and III) and Follow-Up Review (Years II and IV) Scores
***for* Thumb Alliance PIHP**

Standard		Year	# M	# SM	# PM	# NM	# NA	Compliance Score (After Follow-Up)
I	QAPIP	I	17	0	0	0	6	100%
		II	No follow-up review required for this standard.					
II	Performance Improvement	I	18	1	1	1	6	100%
		II	3					
III	Practice Guidelines	I	14	0	0	0	6	100%
		II	No follow-up review required for this standard.					
IV	Staff Qualifications and Training	I	6	0	0	0	0	100%
		II	No follow-up review required for this standard.					
V	Utilization Management	I	25	0	0	0	1	100%
		II	No follow-up review required for this standard.					
VI	Customer Service	I	13	0	0	0	0	100%
		II	No follow-up review required for this standard.					
VII	Recipient Grievance Process	I	16	2	0	0	1	100%
		II	2					
VIII	Recipient Rights and Protections	I	29	0	4	5	3	100%
		II	8					
IX	Subcontracts and Delegation	III	7	0	0	0	0	100%
		IV	No follow-up review required for this standard.					
X	Provider Network	III	12	0	0	0	0	100%
		IV	No follow-up review required for this standard.					
XI	Credentialing	III	23	0	0	0	2	100%
		IV	No follow-up review required for this standard.					
XII	Access and Availability	III	16		1	0	0	100%
		IV	1		0	0	0	
XIII	Coordination of Care	III	3	0	0	0	0	100%
		IV	No follow-up review required for this standard.					
XIV	Appeals	III	15	0	0	0	0	100%
		IV	No follow-up review required for this standard.					
XV	Advance Directives	III	4	0	2	0	0	100%
		IV	2	0	0	0	0	

***M** = Met, **SM** = Substantially Met, **PM** = Partially Met, **NM** = Not Met, **NA** = Not Applicable*

Compliance Score: The overall percentages were calculated by adding the number of elements that received a score of *Met* (initial and follow-up review combined) 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* from the follow-up review, then dividing this total by the total number of applicable elements.

Note: For the Year II follow-up reviews, scores of *Substantially Met* and *Partially Met* were not applicable to any standard, nor were scores of *Substantially Met* for Standard XII in Years III and IV (cells shaded in gray).

Table A-19—Compliance Monitoring
Initial (Years I and III) and Follow-Up Review (Years II and IV) Scores
***for* Venture Behavioral Health**

	Standard	Year	# M	# SM	# PM	# NM	# NA	Compliance Score (After Follow-Up)
I	QAPIP	I	22	0	0	0	1	100%
		II	No follow-up review required for this standard.					
II	Performance Improvement	I	26	0	0	0	1	100%
		II	No follow-up review required for this standard.					
III	Practice Guidelines	I	10	0	0	0	10	100%
		II	No follow-up review required for this standard.					
IV	Staff Qualifications and Training	I	6	0	0	0	0	100%
		II	No follow-up review required for this standard.					
V	Utilization Management	I	24	1	0	0	1	100%
		II	1					
VI	Customer Service	I	12	0	0	1	0	100%
		II	1					
VII	Recipient Grievance Process	I	17	0	1	0	1	100%
		II	1					
VIII	Recipient Rights and Protections	I	36	1	0	0	4	100%
		II	1					
IX	Subcontracts and Delegation	III	6	1	0	0	0	100%
		IV	1	0	0	0	0	
X	Provider Network	III	11	1	0	0	0	100%
		IV	1	0	0	0	0	
XI	Credentialing	III	23	0	0	1	1	100%
		IV	1	0	0	0	0	
XII	Access and Availability	III	8		1	8	0	91%
		IV	7		1	1	0	
XIII	Coordination of Care	III	3	0	0	0	0	100%
		IV	No follow-up review required for this standard.					
XIV	Appeals	III	13	2	0	0	0	100%
		IV	2	0	0	0	0	
XV	Advance Directives	III	5	1	0	0	0	100%
		IV	1	0	0	0	0	

M *= Met,* ***SM*** *= Substantially Met,* ***PM*** *= Partially Met,* ***NM*** *= Not Met,* ***NA*** *= Not Applicable*

Compliance Score: The overall percentages were calculated by adding the number of elements that received a score of *Met* (initial and follow-up review combined) 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* from the follow-up review, then dividing this total by the total number of applicable elements.

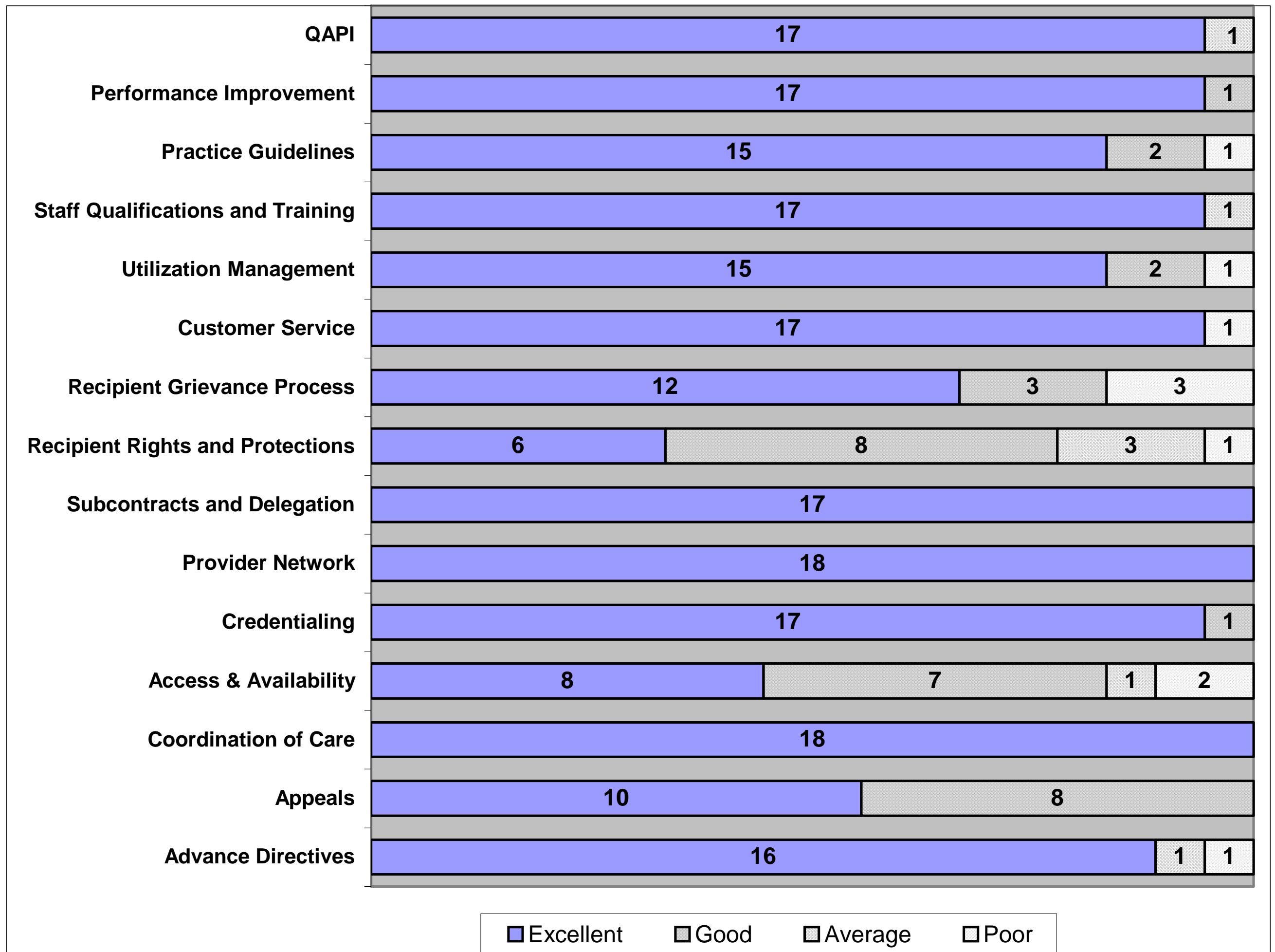
Note: For the Year II follow-up reviews, scores of *Substantially Met* and *Partially Met* were not applicable to any standard, nor were scores of *Substantially Met* for Standard XII in Years III and IV (cells shaded in gray).

PIHP Compliance Scores

Compliance monitoring scores had the following ratings: scores ranging from 95 to 100 percent were *Excellent*, scores from 85 to 94 percent were *Good*, scores from 75 to 84 percent were *Average*, and scores of 74 percent and lower were *Poor*.

Figure A-16 presents the number of PIHPs receiving *Excellent/Good/Average/Poor* compliance scores after follow-up review for each of the 15 standards.

Figure A-16—Number of PIHPs Receiving *Excellent/Good/Average/Poor* Compliance Scores



Results for Validation of Performance Measures

Table A-20 shows the overall statewide PIHP compliance with the MDCH codebook specifications for performance indicators validated by HSAG in 2006–2007 and 2007–2008.

Table A-20—Degree of Compliance for Performance Measures

	Indicator	Percent of PIHPs					
		Fully Compliant		Substantially Compliant		Not Valid	
		2006–2007	2007–2008	2006–2007	2007–2008	2006–2007	2007–2008
1.	Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	100%	89%	0%	11%	0%	0%
2.	Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	100%	100%	0%	0%	0%	0%
3.	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional.	100%	100%	0%	0%	0%	0%
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	100%	100%	0%	0%	0%	0%
4b.	Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	100%	100%	0%	0%	0%	0%
5.	Percentage of Medicaid recipients having received PIHP-managed services (penetration rate).	94%	94%	0%	0%	6%	6%
8.	Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination (HSW rate).	100%	100%	0%	0%	0%	0%
10.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who are employed competitively.		94%		6%		0%
11.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who earned minimum wage or more from any employment activities.		94%		6%		0%
12.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	100%	100%	0%	0%	0%	0%
13.	Annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by the PIHPs.	83%	100%	17%	0%	0%	0%
14.	Number of sentinel events during the six-month period per 1,000 Medicaid beneficiaries served, by the following populations: adults with mental illness, children with mental illness, persons with developmental disabilities not on the HSW, persons on the HSW, and persons with substance abuse disorder.	100%	100%	0%	0%	0%	0%

Note: Indicators 10 and 11 were not included in the 2006–2007 validation of performance measures.

Table A-21 and Table A-22 present a two-year comparison of the statewide results for the validated performance indicators. The tables only include indicators reported for both periods.

Table A-21—Performance Measure Results			
Indicator		Reported Rate	
		2006–2007	2007–2008
1.	Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours. Children	98%	99%
	Adults	98%	96%
2.	Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	98%	98%
3.	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional.	96%	97%
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days. Children	92%	95%
	Adults	91%	89%
4b.	Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	95%	98%
5.	Percentage of Medicaid recipients having received PIHP-managed services (penetration rate).	6%	6%
8.	Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination (HSW rate).	94%	97%
12.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge. Children	8%	7%
	Adults	12%	13%

Table A-22—PIHP Performance Measure Results for 2006–2007 (Year III) and 2007–2008 (Year IV)												
PIHP	Year	Preadmission Screening—Children	Preadmission Screening—Adults	Face-to-Face Assessment Within 14 Days	Initiate Ongoing Service Within 14 Days	7-Day Psychiatric Follow-Up—Children	7-Day Psychiatric Follow-Up—Adults	7-Day Detox Follow-Up	Penetration Rate	HSW Rate	30-Day Readmission Rate—Children	30-Day Readmission Rate—Adults
Access Alliance	III	100%	98.10%	97.97%	97.55%	100%	100%	90.91%	7.26%	94.95%	4.76%	10.00%
	IV	100%	98.90%	99.43%	97.70%	96.15%	92.93%	100%	6.94%	97.38%	3.57%	18.92%
CMHAMM	III	100%	96.50%	99.40%	97.51%	100%	95.45%	100%	5.77%	97.05%	7.69%	11.43%
	IV	100%	97.54%	99.78%	98.90%	100%	96.36%	100%	5.82%	98.92%	0.00%	13.56%
CMH Central	III	100%	100%	94.58%	92.16%	88.89%	100%	100%	7.95%	97.16%	11.11%	8.33%
	IV	97.22%	100%	100%	98.10%	100%	97.78%	100%	8.12%	99.45%	0.00%	0.00%
CMHPSM	III	98.90%	99.70%	100%	99.00%	100%	96.88%	100%	6.28%	85.03%	0.00%	1.39%
	IV	100%	100%	98.03%	98.97%	100%	98.51%	100%	5.83%	96.97%	6.06%	5.95%
Detroit-Wayne	III	98.06%	96.83%	94.40%	86.51%	94.85%	86.36%	96.92%	4.57%	89.51%	2.20%	12.55%
	IV	99.07%	89.30%	92.00%	93.94%	89.42%	74.88%	100%	5.08%	93.93%	6.82%	13.41%
Genesee	III	97.50%	96.98%	99.42%	96.86%	96.55%	95.45%	100%	4.67%	96.07%	24.39%	11.76%
	IV	98.11%	97.46%	97.33%	97.12%	96.00%	97.04%	100%	5.04%	97.38%	3.13%	12.12%
Lakeshore	III	97.14%	100%	98.80%	94.21%	100%	98.00%	90.91%	NV	97.78%	5.88%	11.67%
	IV	96.30%	99.12%	95.08%	94.48%	100%	100%	100%	NV	98.25%	0.00%	8.33%
LifeWays	III	100%	99.00%	97.78%	97.59%	100%	96.23%	100%	5.70%	91.97%	7.14%	14.55%
	IV	100%	100%	100%	98.57%	100%	100%	100%	6.27%	99.26%	9.09%	33.33%
Macomb	III	97.10%	99.11%	96.95%	94.68%	66.67%	64.20%	92.31%	5.78%	98.31%	21.74%	13.58%
	IV	100%	99.61%	98.85%	94.51%	100%	98.08%	100%	6.67%	98.76%	15.38%	12.65%
network180	III	97.30%	98.25%	97.78%	88.94%	100%	95.24%	100%	5.44%	95.81%	8.51%	13.39%
	IV	94.55%	98.17%	99.37%	94.62%	94.74%	99.01%	80.00%	5.40%	100%	4.88%	9.38%
NorthCare	III	98.53%	99.16%	97.94%	98.50%	100%	96.55%	100%	6.57%	95.69%	23.08%	25.00%
	IV	100%	100%	98.29%	98.09%	92.86%	98.00%	100%	6.24%	96.46%	4.55%	17.86%
Northern Affiliation	III	100%	98.24%	94.46%	96.37%	100%	100%	100%	6.74%	94.43%	0.00%	6.67%
	IV	100%	100%	99.28%	97.70%	100%	97.73%	100%	6.99%	97.94%	8.33%	12.50%
Northwest CMH	III	97.83%	99.26%	98.38%	98.80%	81.25%	95.77%	100%	7.16%	93.89%	5.13%	5.95%
	IV	100%	100%	94.88%	97.81%	87.50%	91.18%	100%	7.47%	96.11%	21.05%	13.70%
Oakland	III	96.81%	96.59%	97.45%	98.45%	100%	96.61%	100%	7.59%	98.28%	10.71%	18.06%
	IV	97.27%	96.30%	99.14%	98.67%	100%	98.75%	100%	7.33%	98.62%	3.45%	12.90%
Saginaw	III	100%	100%	100%	94.77%	83.33%	80.77%	47.37%	4.07%	83.19%	21.43%	15.15%
	IV	100%	99.55%	100%	97.40%	100%	100%	70.00%	4.44%	95.65%	0.00%	15.22%
Southwest Alliance	III	100%	99.55%	98.15%	96.41%	100%	98.25%	100%	6.66%	94.85%	4.17%	6.33%
	IV	98.90%	98.83%	99.69%	98.04%	100%	95.74%	94.44%	6.21%	98.05%	12.50%	5.26%
Thumb Alliance	III	100%	100%	100%	99.53%	100%	98.28%	100%	7.02%	99.66%	12.50%	20.00%
	IV	100%	100%	98.92%	97.82%	100%	100%	89.47%	7.35%	100%	0.00%	11.86%
Venture	III	100%	100%	97.07%	98.20%	80.00%	86.57%	100%	5.33%	91.02%	9.09%	7.32%
	IV	100%	100%	98.34%	96.68%	100%	100%	100%	6.26%	97.78%	0.00%	4.11%

Results for Validation of Performance Improvement Projects

Table A-23 presents a two-year comparison of the PIHPs' PIP validation status.

Table A-23—Comparison of PIHPs' PIP Validation Status		
Validation Status	Number of PIHPs	
	2006–2007	2007–2008
Met	13	13
Partially Met	3	4
Not Met	2	1

Table A-24 presents a two-year comparison of statewide PIP validation results, showing how many of the PIPs that were reviewed for each activity met all evaluation or critical elements.

Table A-24—Summary of Data From Validation of Performance Improvement Projects				
Validation Activity	Number of PIPs Meeting All Evaluation Elements/ Number Reviewed		Number of PIPs Meeting All Critical Elements/ Number Reviewed	
	2006–2007	2007–2008	2006–2007	2007–2008
I. Appropriate Study Topic	16/18	18/18	17/18	18/18
II. Clearly Defined, Answerable Study Question	17/18	18/18	17/18	18/18
III. Clearly Defined Study Indicator(s)	15/18	17/18	16/18	17/18
IV. Correctly Identified Study Population	17/18	18/18	17/18	18/18
V. Valid Sampling Techniques*	18/18	18/18	18/18	18/18
VI. Accurate/Complete Data Collection	13/17	13/18	17/17	17/18
VII. Appropriate Improvement Strategies	10/11	11/17	10/11	14/17
VIII. Sufficient Data Analysis and Interpretation	8/10	6/17	10/10	16/17
IX. Real Improvement Achieved	2/2	6/17	*NA*	*NA*
X. Sustained Improvement Achieved	1/1	1/1	*NA*	*NA*

*For 2006–2007, HSAG scored all evaluation elements for Activity V. Valid Sampling Techniques *NA* for all PIPs as the studies did not use sampling. In 2007–2008, only one PIHP used sampling.

Table A-25 presents a two-year comparison of PIP scores for each PIHP.

Table A-25—Comparison of PIHP PIP Validation Scores

PIHP	% of All Evaluation Elements *Met*		% of All Critical Elements *Met*		Validation Status	
	2006–2007	2007–2008	2006–2007	2007–2008	2006–2007	2007–2008
Access Alliance	100%	94%	100%	100%	*Met*	*Met*
CMHAMM	96%	95%	100%	100%	*Met*	*Met*
CMH Central	89%	75%	90%	90%	*Partially Met*	*Partially Met*
CMHPSM	100%	100%	100%	100%	*Met*	*Met*
Detroit-Wayne	94%	80%	88%	91%	*Partially Met*	*Partially Met*
Genesee	100%	100%	100%	100%	*Met*	*Met*
Lakeshore	100%	91%	100%	90%	*Met*	*Partially Met*
LifeWays	100%	94%	100%	100%	*Met*	*Met*
Macomb	100%	91%	100%	100%	*Met*	*Met*
network180	100%	91%	100%	100%	*Met*	*Met*
NorthCare	94%	88%	100%	100%	*Met*	*Met*
Northern Affiliation	83%	86%	90%	100%	*Not Met*	*Met*
Northwest CMH	100%	63%	100%	82%	*Met*	*Not Met*
Oakland	94%	93%	100%	100%	*Met*	*Met*
Saginaw	76%	100%	75%	100%	*Not Met*	*Met* [A-1]
Southwest Alliance	96%	94%	100%	100%	*Met*	*Met*
Thumb Alliance	90%	96%	80%	100%	*Partially Met*	*Met*
Venture	93%	94%	100%	90%	*Met*	*Partially Met*

[A-1] Saginaw achieved a *Met* validation status based on evaluation activities that focused on PIP design. They have failed to demonstrate any substantial progress toward fully implementing this PIP.

Appendix B. Compliance Monitoring Tool

The compliance monitoring tool appendix follows this cover page.

HSAG customized the 2007–2008 compliance monitoring tool for each PIHP based on the corrective action plan template that included only those elements that scored less than *Met* in the 2006–2007 review. For each PIHP, the tool included the 2006–2007 findings and scores, a section for the PIHP to describe any corrective actions taken since the last review and list supporting documentation, and a section for the current year findings and score.

The following section presents the instructions cover page and a complete set of elements for the seven standards addressed in the 2007–2008 follow-up compliance review.

Instructions for Completing the Tool

Please complete the sections "2007–2008 PIHP Corrective Actions" and "2007–2008 Documentation as Submitted by the PIHP" for each element listed as detailed as possible to provide comprehensive information about what actions the PIHP has taken to address findings from the 2006–2007 compliance monitoring review, and list the supporting documentation that is being submitted to demonstrate that the corrective actions have been implemented (e.g., revised policies, forms, or contract sections; newly developed documents; meeting minutes, etc.). Please be specific so that the documents can be easily identified among the documents posted to the FTP site. Page references, when applicable, are appreciated.

2007–2008 Compliance Review		
2007–2008 PIHP Corrective Actions	**2007–2008 Documentation as Submitted by the PIHP**	**2007–2008 Follow-Up Score**
To be completed by the PIHP **Describe any corrective actions taken to address the findings from the 2006-07 review and achieve compliance with the requirement(s):** For example: ◆ (PIHP) revised its credentialing policy to include all of the MDCH credentialing requirements. ◆ Affiliate CMHSPs and the CA have adopted the revised PIHP credentialing policy.	**To be completed by the PIHP** **List the documentation that provides evidence that the PIHP has implemented the corrective action(s):** For example: ◆ Revised Credentialing Policy, revision date 5/5/07. ◆ Board meeting minutes from 6/1/07, agenda item #3 (reflecting policy approval). ◆ Network Committee meeting minutes from 6/15/07, agenda item #6 (reflecting that the PIHP required Affiliates/CA to adopt the PIHP credentialing policy by 7/1/07). ◆ Network Committee meeting minutes from 7/15/07, agenda items #5–11 (reflecting that all Affiliates/CA have completed adoption of the PIHP credentialing policy).	☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable** **To be completed by HSAG**
2007–2008 Follow-Up Findings and Recommendations		
To be completed by HSAG		

Example

Standard IX—Subcontracts and Delegation

The PIHP oversees and is accountable for any functions and responsibilities that it delegates to any subcontractor.

438.230(a)(1)

Some contracts/delegation agreements were reviewed in Year I in association with Standard I—QAPIP; Standard II—Performance Measurement and Improvement; Standard III—Practice Guidelines; Standard V—Utilization Management; Standard VII—Grievance Process; and Standard VIII—Recipient (Beneficiary) Rights and Protections. Contracts/agreements previously reviewed will not be re-reviewed. Other delegated functions and/or agreements will be the subject of review for this standard, i.e., coordinating agency contracts, data processing services, etc.

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
1. Predelegation Assessment Prior to entering into delegation subcontracts or agreements, the PIHP evaluates the proposed subcontractor's ability to perform the activities to be delegated. 438.230(b)		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings		

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
2. Written Agreements The PIHP has a written agreement with each delegated subcontractor. 438.230(b)(2)		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings		

Standard IX—Subcontracts and Delegation

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
3. Content of Agreement—Activities The written agreement specifies the activities delegated to the subcontractor. 438.230(b)(2)(i) MDCH 6.4.2		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings		

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
4. Content of Agreement—Reports The written agreement specifies the report responsibilities delegated to the subcontractor. 438.230(b)(2)(i) MDCH 6.4.2		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings		

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
5. Content of Agreement—Revocation/Sanctions The written agreement includes provisions for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate. 438.230(b)(2)(ii)		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings		

Standard IX—Subcontracts and Delegation

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
6. Monitoring of Delegates The PIHP monitors the performance of the subcontractor on an ongoing basis and subjects it to formal review according to a periodic schedule. 438.230(b)(3) MDCH 6.4.3		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings		

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
7. Corrective Action If the PIHP identifies deficiencies or areas for improvement, the PIHP and the subcontractor take corrective action. 438.230(b)(4) MDCH 6.4.3		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings		

Standard X—Provider Network

The PIHP maintains and monitors a network of appropriate providers supported by written agreements sufficient to provide adequate access to all services. §438.206(b)(1)

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
1. Provider Written Agreements The PIHP maintains a network of providers supported by written agreements. 438.206(b)(1)		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings		

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
2. Sufficiency of Agreements Written agreements provide adequate access to all services covered under the contract. 438.206(b)(1)		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings		

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
3. Content of Agreements Written agreements ensure that beneficiaries are not held liable when the PIHP does not pay the health care provider furnishing services under the contract. 438.106(b)(2)		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings		

Standard X—Provider Network

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
4. Content of Agreements Written agreements ensure that beneficiaries are not held liable for payment of covered services furnished under the contract if those payments are in excess of the amount that the beneficiary would owe if the PIHP provided the service directly. 438.106(c)		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings		

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
5. Delivery Network In establishing and maintaining the network, the PIHP considers: anticipated Medicaid enrollment, expected utilization, numbers and types of providers required, number of network providers who are not accepting new beneficiaries, geographic location of providers and beneficiaries, distance, travel time, and transportation availability, including physical access for beneficiaries with disabilities. 438.206(b)(1)(i-v)		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings		

Standard X—Provider Network

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
6. Geographic Access for Mental Health and Substance Abuse Services The PIHP ensures geographic access to covered, alternative, and allowable supports and services in accordance with the following standards: For office or site-based services, the PIHP's primary service providers (e.g., case managers, psychiatrists, primary therapists) must be: ◆ Within 30 miles or 30 minutes of the recipient's residence in urban areas ◆ Within 60 miles or 60 minutes in rural areas. MDCH 3.1		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
7. Excluded Providers The PIHP does not employ or contract with providers excluded from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act. 438.214(d)		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Standard X—Provider Network

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
8. Reason For Decision To Decline If the PIHP declines to include individual providers or groups of providers in its network, it gives the affected providers written notice of the reason for its decision. 438.12 MDCH 6.4.1		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings		

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
9. Network Changes The PIHP notifies MDCH within seven days of any significant changes to the provider network composition that affect adequate capacity and services. 438.207(c)(2) MDCH 6.4(F)		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings		

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
10. Out-Of-Network Services If a necessary service covered under the contract is unavailable within the network, the PIHP adequately and timely covers the service out of network for as long as the PIHP is unable to provide it. 438.206(b)(4) MDCH 3.4.6		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings		

Standard X—Provider Network

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
11. Requirements Related to Payment The PIHP requires out-of-network providers to coordinate with the PIHP regarding payment and ensures that any cost to the beneficiary is no greater than it would be if the services were furnished within the network. 438.206(b)(5)		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
12. Second Opinion The PIHP provides for a second opinion from a qualified health care professional within the network or arranges for the beneficiary to obtain one outside the network at no cost to the beneficiary. 438.206(b)(3) MDCH 3.4.5		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Standard XI—Credentialing

The PIHP demonstrates that its providers are credentialed as required by Sec. 438.214.
438.206(b)(6)
Each State must establish a uniform credentialing and recredentialing policy that each PIHP must follow.
438.214(b)(1)

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
1. Credentialing The PIHP follows a documented process consistent with State policy for credentialing and recredentialing of providers who are employed by or have signed contracts or participation agreements with the PIHP. 438.214(b)(2) MDCH 6.4.3		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings		

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
2. Health Care Professionals The PIHP's processes for credentialing and recredentialing are conducted and documented for at least the following health care professionals: ◆ Physicians (MDs or DOs) ◆ Physician assistants ◆ Psychologists (licensed, limited license, or temporary license) ◆ Social workers (licensed master's, licensed bachelor's, limited license, or registered social service technicians) ◆ Licensed professional counselors ◆ Nurse practitioners, registered nurses, or licensed practical nurses ◆ Occupational therapists or occupational therapist assistants ◆ Physical therapists or physical therapist assistants ◆ Speech pathologists		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XI—Credentialing

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
3. Written Policy—Criteria, Scope, Timeline, and Process The credentialing policy reflects the scope, criteria, timeliness, and process for credentialing and recredentialing providers.		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
4. Provider Discrimination The PIHP has processes to ensure: ◆ That the credentialing and recredentialing processes do not discriminate against: ▪ A health care professional solely on the basis of license, registration, or certification. ▪ A health care professional who serves high-risk populations or who specializes in the treatment of conditions that require costly treatment. ◆ Compliance with Federal Requirements that prohibit employment or contracts with providers excluded from participation under either Medicare or Medicaid. 438.12 and 438.214(c) MDCH 6.4.1 and Credentialing Policy		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Findings

Standard XI—Credentialing

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
5. Written Policy—Authorities The PIHP’s credentialing policy was approved by the PIHP's governing body and identifies the PIHP administrative staff member responsible for oversight of the process.		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings		

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
6. Written Policy—Responsibility The PIHP’s policy identifies the administrative staff member and entity (e.g., credentialing committee) responsible for oversight and implementation of the process and delineates their role.		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings		

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
7. Written Policy—Documentation The policy describes the methodology to document that each credentialing or recredentialing file was complete and reviewed prior to presentation to the credentialing committee for evaluation.		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings		

Standard XI—Credentialing

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
8. Written Policy—Integration With QAPIP The credentialing policy describes how findings of the PIHP's Quality Assessment and Performance Improvement Program (QAPIP) are incorporated into the recredentialing process.		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings		

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
9. Written Policy—Provider Role The policy describes any use of participating providers in making credentialing decisions.		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings		

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
10. Credentialing Files The PIHP's processes require that an individual file be maintained for each credentialed provider and that each file include: ◆ The initial credentialing and all subsequent recredentialing applications. ◆ Information gained through primary source verification. ◆ Any other pertinent information used in determining whether or not the provider met the PIHP's credentialing standards.		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings		

Standard XI—Credentialing

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
11. Initial Credentialing—Application The PIHP's policy and procedures require that the written application is completed, signed, and dated by the applicant and attests to the following elements: ◆ Lack of present illegal drug use ◆ Any history of loss of license and/or felony convictions ◆ Any history of loss or limitation of privileges or disciplinary action ◆ Attestation by the applicant of the correctness and completeness of the application		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
12. Initial Credentialing—Requirements The PIHP's policy and procedures require that the initial credentialing of an applicant include: ◆ An evaluation of the applicant's work history for the past five years. ◆ Primary source verification of licensure or certification. ◆ Primary source verification of board certification or highest level of credentials attained, if applicable, or completion of any required internships/residency programs or other postgraduate training. ◆ Documentation of graduation from an accredited school. ◆ A National Practitioner Data Bank (NPDB) query, or, in lieu of an NPDB query, verification of all of the following: ▪ A minimum five-year history of professional liability claims resulting in a judgment or settlement ▪ Disciplinary status with a regulatory board or agency ▪ A Medicare/Medicaid sanctions query		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Standard XI—Credentialing

Note: If the individual practitioner undergoing credentialing is a physician, then the physician profile information obtained from the American Medical Association may be used to satisfy the primary source verification of the first three items above.		
Findings		

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
13. Temporary/Provisional Credentialing of Individual Practitioners		
a. Policies and Limitations The PIHP has a policy and procedures to address granting of temporary or provisional credentials and the policy and procedures require that the temporary or provisional credentials are not granted for more than 150 days.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
b. Application The PIHP's policy and procedures require that, at a minimum, a provider must complete a signed application that includes the following items: ◆ Lack of present illegal drug use ◆ History of loss of license, registration, or certification and/or felony convictions ◆ History of loss or limitation of privileges or disciplinary action ◆ A summary of the provider's work history for the prior five years ◆ Attestation by the applicant of the correctness and completeness of the application		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Standard XI—Credentialing

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
c. Review and Primary Source Verification The PIHP's designee reviews the information obtained and determines whether to grant provisional credentials. If approved, the PIHP conducts primary source verification of the following: ◆ Licensure or certification ◆ Board certification, if applicable, or the highest level of credential attained ◆ Medicare/Medicaid sanctions		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
d. Timeliness of the PIHP Decision The PIHP's policy and procedures require that the PIHP has up to 31 days from the receipt of a complete application and the minimum required documents within which to render a decision regarding temporary or provisional credentialing.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
14. Recredentialing—Timelines The PIHP's policy requires recredentialing of physicians and other licensed, registered, or certified health care providers at least every two years.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Standard XI—Credentialing

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
15. Recredentialing Requirements for Individual Practitioners The PIHP's policy and procedures for recredentialing require, at a minimum: ◆ An update of information obtained during the initial credentialing. ◆ A process for ongoing monitoring, and intervention when appropriate, of provider sanctions, complaints, and quality issues pertaining to the provider, which must include, at a minimum, a review of: ▪ Medicare/Medicaid sanctions. ▪ State sanctions or limitations on licensure, registration, or certification. ▪ Beneficiary concerns, which include grievances (complaints) and appeals information. ▪ PIHP quality issues		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
16. Delegation of PIHP Responsibilities for Credentialing/ Recredentialing If responsibilities for credentialing/recredentialing are delegated by the PIHP, the PIHP: ◆ Retains the right to approve, suspend, or terminate providers selected by the entity. ◆ Must meet all requirements associated with the delegation. ◆ Specifies in the delegation agreement/subcontract the functions that are delegated and those that are retained. ◆ Is responsible for oversight of delegated credentialing or recredentialing decisions.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Standard XI—Credentialing

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
17. Credentialing Organizational Providers The PIHP must validate, and revalidate at least every two years, that an organizational provider is licensed as necessary to operate within the State and has not been excluded from Medicaid or Medicare.		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
18. Organizational Providers—Delegation of Credentialing for Individuals Employed by, or Contracted with, an Organizational Provider If the PIHP delegates to another entity any of the responsibilities of credentialing/recredentialing or selection of providers, the PIHP: ◆ Retains the right to approve, suspend, or terminate a provider selected by that entity. ◆ Must meet all requirements associated with the delegation of PIHP functions. ◆ Is responsible for oversight regarding delegated credentialing or re-credentialing decisions.		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Findings

Standard XI—Credentialing

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
19. Deeming If the PIHP accepts the credentialing decision of another PIHP for an individual or organizational provider, it maintains copies of the current credentialing PIHP's decision in its administrative records.		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings		

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
20. Notification of Adverse Credentialing Decision The PIHP's policy and procedures address the requirement for the PIHP to inform an individual or organizational provider in writing of the reasons for the PIHP's adverse credentialing decisions.		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings		

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
21. Provider Appeals The PIHP's policy and procedures address the PIHP's appeal process (consistent with State and federal regulations) that is available to providers for instances when the PIHP denies, suspends, or terminates a provider for any reason other than lack of need.		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings		

Standard XI—Credentialing

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
22. Reporting Requirements The PIHP has procedures for reporting, to appropriate authorities (i.e., MDCH, the provider's regulatory board or agency, the Attorney General, etc.), improper known organizational provider or individual practitioner conduct which results in suspension of termination from the PIHP's provider network. The procedures are consistent with current federal and State requirements, including those specified in the MDCH Medicaid Managed Specialty Supports and Services Contract.		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Findings

Standard XII—Access And Availability

The PIHP meets and 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)

Findings were derived from the Michigan Mission-Based Performance Indicator System—Access Domain, Indicators 1 through 4.b.

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 (10/01/05)	MDCH will provide data directly to HSAG (in the first, second, and third quarters of 2005-2006).	☐ **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		☐ **Met** ☐ **Partially Met** ☐ **Not Met**
b. Adult		☐ **Met** ☐ **Partially Met** ☐ **Not Met**
Findings		

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		☐ **Met** ☐ **Partially Met** ☐ **Not Met**
b. Adult		☐ **Met** ☐ **Partially Met** ☐ **Not Met**
c. Developmentally Disabled—Children		☐ **Met** ☐ **Partially Met** ☐ **Not Met**
d. Developmentally Disabled—Adult		☐ **Met** ☐ **Partially Met** ☐ **Not Met**
e. Substance Abuse		☐ **Met** ☐ **Partially Met** ☐ **Not Met**
Findings		

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		☐ **Met** ☐ **Partially Met** ☐ **Not Met**
b. Mentally Ill—Adult		☐ **Met** ☐ **Partially Met** ☐ **Not Met**
c. Developmentally Disabled—Children		☐ **Met** ☐ **Partially Met** ☐ **Not Met**
d. Developmentally Disabled—Adult		☐ **Met** ☐ **Partially Met** ☐ **Not Met**
e. Substance Abuse		☐ **Met** ☐ **Partially Met** ☐ **Not Met**
Findings		

Standard XII—Access And Availability

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		☐ **Met** ☐ **Partially Met** ☐ **Not Met**
b. Adults		☐ **Met** ☐ **Partially Met** ☐ **Not Met**
Findings		

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.		☐ **Met** ☐ **Partially Met** ☐ **Not Met**
Findings		

Standard XII—Access And Availability

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)		☐ Met ☐ Partially Met ☐ Not Met
Findings		

Standard XIII—Coordination of Care

The PIHP must coordinate the services it furnishes to beneficiaries with other services the beneficiary receives.
438.208(b)(2)

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
1. Coordination Procedures/Primary Care Providers The PIHP has procedures to ensure that coordination occurs between primary care physicians and the PIHP and/or its network. MDCH 6.4.4 and 6.8.3		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings		

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
2. Coordination With Other MCOs and PIHPs PIHP procedures ensure that the services the PIHP furnishes to the beneficiary are coordinated with the services the beneficiary receives from other MCOs and PIHPs. 438.208(b)(2)		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings		

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
3. Results of Assessments Shared With MCOs and PIHPs PIHP procedures ensure that results of beneficiary assessments performed by the PIHP are shared with other MCOs and PIHPs serving the beneficiary in order to prevent duplication of services. 438.208(b)(3)		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings		

Standard XIV—Appeals

Each PIHP must have a system that includes an appeal process and access to the State's fair hearing system.
§438.402

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.		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
b) The method for a beneficiary to obtain a hearing.		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
c) The beneficiary's right to file appeals.		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
d) The requirements and time frames for filing appeals.		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Findings

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		☐ 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		☐ 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		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings		

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		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings		

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		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings		

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		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

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)		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

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		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

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		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

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		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings		

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		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings		

Standard XV—Advance Directives

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
1. Written Policy and Procedures The PIHP has a written advance directives policy and procedures. 438.6(i) 422.128		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings		

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
2. Documentation in the Beneficiary's Record The policy requires that there is documentation in a prominent part of the beneficiary's current medical record as to whether or not the beneficiary has executed an advance directive. 422.128		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings		

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
3. Education of Staff The PIHP provides for education of staff concerning its policies and procedures on advance directives. 422(a)(2)(H)		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings		

Standard XV—Advance Directives

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
4. Subcontracts PIHP subcontracts, as applicable, contain advance directive requirements appropriate to the subcontract. 438.6(l)		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings		

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
5. Information for Adult Beneficiaries The PIHP provides all adult beneficiaries with written information on advance directive policies, including a description of applicable State laws. This includes information on the beneficiary's right to make decisions concerning his or her medical care, including the right to accept or refuse treatment, and the right to formulate advance directives. 438.6(i)(3) 422.128		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings		

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
6. Changes in State Law The information provided to adult beneficiaries must reflect changes in State law as soon as possible, but no later than 90 days after the effective date of the change. 438.6(i)(4)		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings		

Appendix C. Performance Measure Validation Tool

The performance measure validation tool appendix follows this cover page.

The PIHPs were given the Information Systems Capabilities Assessment Tool (ISCAT) to complete and submit as a part of the performance measure validation process. A modified, abbreviated version of the ISCAT (mini-ISCAT) was submitted by PIHP subcontractors as well.

HSAG HEALTH SERVICES ADVISORY GROUP

Appendix C. Information Systems Capabilities Assessment (ISCA) Michigan Department of Community Health for Prepaid Inpatient Health Plans (PIHPs)

I. GENERAL INFORMATION

Please provide the following general information:

Note: When completing this ISCA, answer the questions in the context of the performance indicators reported to MDCH, and the QI and encounter data submitted to MDCH only. If a question does not apply whatsoever to the performance indicator calculation and reporting, QI data, or encounter data submission, enter an N/A response. Coordinating Agencies (CAs) should be considered a subcontractor, on the same level as a Community Mental Health Service Provider (CMHSP) or a Managed Comprehensive Provider Network (MCPN).
ITEMS HIGHLIGHTED IN YELLOW INDICATE CHANGES FROM LAST YEAR'S VERSION.

A. Contact Information

Please insert (or verify the accuracy of) the PIHP identification information below, including the PIHP name, PIHP contact name and title, mailing address, telephone and fax numbers, and e-mail address, if applicable.

PIHP Name: ______
Contact Name and Title: ______
Mailing Address: ______
Phone Number: ______
Fax Number: ______
E-Mail Address: ______
Chief Information Officer (CIO) Name and Title: ______
Phone Number: ______
E-Mail Address: ______

I. GENERAL INFORMATION

B. PIHP Model Type

Please indicate model type (if other, please specify):

☐ PIHP – stand alone

☐ PIHP – affiliation

☐ PIHP – MCPN Network

☐ PIHP – other (describe): _____

PIHP Structure

Please indicate general structure (if other, please specify):

☐ Centralized (All information system functions are performed by the PIHP)

☐ Mixed (Some information system functions are delegated to other entities)

☐ Delegated (All information system functions are delegated to other entities)

☐ Other (describe): _____

C. Please provide a brief narrative description of any changes that were made to your organization within the last year, including organization structure, information systems, key staff, or other significant changes: _____

D. Unduplicated Count of Medicaid Consumers Receiving Services as of:

June 2007 _____

July 2007 _____

August 2007 _____

September 2007 _____

October 2007 _____

November 2007 _____

December 2007_____

I. GENERAL INFORMATION

E. Has your organization ever undergone a formal IS capabilities assessment (other than the performance measure validation activity performed by the EQRO)? A formal IS capabilities assessment must have been performed by an external reviewer.

Note: CARF/JCHO reviews would not apply as they do not get to the level of detail necessary to meet CMS protocols.

☐ Yes

☐ No

If *yes*, who performed the assessment? ______

When was the assessment completed? ______

F. In an attachment to the ISCA, please describe how your PIHP's data process flow is configured for its entire network. Label as Attachment 8.

This will likely require a multi-dimensional presentation and data flow chart. Please include any IS functions that have been delegated downstream to the Community Mental Health Service Providers (CMHSPs), MCPNs (if applicable), the Coordinating Agency (CA) office, and sub-panel contract agencies of both the CA/CMHSPs. Identify which entity-level is responsible for which kind of data collection and submission, which entity has overall data validation responsibilities, and the data validation process involved. A typical response should generally be a two-to-three-page write-up, with some graphical flow charts attached. This description will help immensely with the reviewers' understanding of your PIHP and will help make the validation process run smoothly and efficiently.

II. INFORMATION SYSTEMS: DATA PROCESSING PROCEDURES AND PERSONNEL

1. What database management system (DBMS) or systems does your organization use to store Medicaid claims and encounter (service) data?

______

2. How would you characterize this/these DBMSs? *(Check all that apply.)*

- ☐ Relational
- ☐ Hierarchical
- ☐ Indexed
- ☐ Other
- ☐ Network
- ☐ Flat File
- ☐ Proprietary
- ☐ Don't Know

3. Into what DBMS(s), if any, do you extract relevant Medicaid encounter/service/eligibility detail for analytic reporting purposes?

______

4. How would you characterize this/these DBMS(s)? *(Check all that apply.)*

- ☐ Relational
- ☐ Hierarchical
- ☐ Indexed
- ☐ Other
- ☐ Network
- ☐ Flat File
- ☐ Proprietary
- ☐ Don't Know

II. INFORMATION SYSTEMS: DATA PROCESSING PROCEDURES AND PERSONNEL

5. **What programming languages do your programmers use to create Medicaid data extracts or analytic reports?** A *programmer* is defined as an individual who develops and/or runs computer programs or queries to manipulate data for submission to MDCH (QI data and encounter data) or performance indicator reporting.

The intent of this question is to help the reviewers understand how the performance indicators are calculated by your PIHP.

______

How many programmers (internal staff or external vendors) are trained and capable of modifying these programs?

______

6. **Approximately what percentage of your organization's programming work is outsourced?**

This question pertains to the programming work necessary for the calculation of the performance measures reported to MDCH, and to the submission of encounter data to MDCH.

______%

7. **What is the average experience, in years, of programmers in your organization?**

______ years

8. **What steps are necessary to meet performance indicator and encounter data reporting requirements? Your response should address the steps necessary to prepare and submit encounter data to MDCH.**

If your PIHP has this information already documented, please submit the documentation or notate that you will make the documentation available to the reviewers during the site visit.

______

II. INFORMATION SYSTEMS: DATA PROCESSING PROCEDURES AND PERSONNEL

9. What is the process for version control when computer programming code is revised?

This question applies to internal programmers or vendors who develop and/or run computer programming to manipulate data for encounter data submission or performance indicator reporting.

_____

10. Who is responsible for your organization meeting the State Medicaid reporting requirements, as certified on file with MDCH? *(Check all that apply)*

- ☐ **CEO/Executive Director**
- ☐ **CFO/Director of Administrative Services/Finance**
- ☐ **COO**
- ☐ **Other:** _____

11. Staffing

11a. Describe the Medicaid claims and/or service/encounter data processing organization in terms of staffing and their expected productivity goals. What is the overall daily, monthly, and annual productivity of the department and of each processor? Productivity is defined as the volume of claims/encounters that are processed during a pre-established interval (i.e. per day, or per week).

_____

11b. Describe claims and/or service/encounter data processor training from new hire to refresher courses for seasoned processors:

_____

11c. What is the average tenure of the staff? _____

11d. What is the annual turnover? _____

II. INFORMATION SYSTEMS: DATA PROCESSING PROCEDURES AND PERSONNEL

12. Security (Note: The intent of this section is to ensure that your PIHP has adequate systems and protocols in place to ensure data are secure. Voluminous documentation is not necessary. Simply identify the type of security products that are used and have backup documentation available for review.)

12a. How is the loss of Medicaid claim and service/encounter data prevented in the event of system failure?

_____

How frequently are system back-ups performed? _____

Where are back-up data stored? _____

12b. What is done to minimize the corruption of Medicaid data due to system failure or program error?

_____

12c. Describe the controls used to assure all Medicaid claims data entered into the system are fully accounted for (e.g., batch control sheets). This question is asking how you ensure that for each service that is provided, an encounter is generated within your system.

_____

12d. Describe the provisions in place for physical security of the computer system and manual files:

_____

- Premises/Computer Facilities _____
- Documents (Any documents that contain PHI) _____
- Database access and levels of security _____

12e. What other individuals have access to your computer system that contains performance indicator data?

☐ Consumers

☐ Providers

Describe their access and the security that is maintained restricting or controlling such access.

_____

III. DATA ACQUISITION CAPABILITIES

The purpose of this section is to obtain a high-level understanding of how you collect and maintain claims/encounters, enrollment information, and data on ancillary services.

A. Administrative Data (Claims and Encounter Data, and other Administrative Data Sources)

For the purposes of this ISCA, a *claim* is defined as a service for which direct reimbursement is made (FFS). An *encounter* is defined as a capitated service, in which no direct reimbursement for the service is provided—rather, the provider receives a capitation payment based on member panels. The intent of these questions is to provide the reviewers with an understanding of the data elements and data flow for the two different payment arrangements. If your PIHP does not utilize one or the other, enter N/A anywhere that claims and encounters are broken out for the non-applicable payment arrangement. **Consider daily appointments/service data as encounter data when responding to the following questions.**

This section requests information on input data sources (e.g., paper and electronic claims) and on the transaction system(s) you use.

1. Do you use standard claims or encounter forms (either paper or electronic format) for the following?

Please specify the type of form used (e.g., CMS1500, UB 92, or service activity log) in the table below.

DATA SOURCE	No	Yes	Please specify the type of form used
CMH/MCPN (for direct-run providers)	☐	☐	_____
Sub-Panel Provider (for a CMH contract agency)	☐	☐	_____
Off-Panel Provider (for out-of-network providers, incl. COFR	☐	☐	_____
Hospital	☐	☐	_____
Other: _____	☐	☐	_____
Other: _____	☐	☐	_____

III. DATA ACQUISITION CAPABILITIES

2. **We would like to understand how claims or service/encounter data are submitted to your plan**. We are also interested in an estimate of what percentage (if any) of services provided to your consumers by all providers serving your Medicaid enrollees are NOT submitted as claims or encounters and therefore are not represented in your administrative data. For example, your PIHP may collect encounter data from a system where service activity is gathered, but the data are never formatted for submission (a UB-92/CMS-1500 or 837 P format).

Please fill in the following table with the appropriate percentages:

MEDIUM	CMH/MCPN (for direct-run providers)	Sub-Panel Provider (for a CMH contract agency)	Off-Panel Provider (for out-of-network providers, incl. COFR)	Hospital	Other
Claims/Encounters Submitted Electronically	___%	___%	___%	___%	___%
Claims/Encounters Submitted on Paper	___%	___%	___%	___%	___%
Services Not Submitted as Claims or Encounters	___%	___%	___%	___%	___%
TOTAL	100%	100%	100%	100%	100%

Comments: ______

III. DATA ACQUISITION CAPABILITIES

3. Please document whether the following data elements (data fields) are required by you for providers, and/or delegated entities, for each of the types of Medicaid claims/encounters identified below.

If required, enter an "R" in the appropriate box. Where the requirements differ, please indicate by entering an "R/P" for paper required elements, or an "R/E" for electronic required elements. For professional submissions (non-institutional), "First Date of Service" means "Date of Service," and "Last Date of Service" should be entered as "N/A."

DATA ELEMENTS	CMH/MCPN (for direct-run providers)	Sub-Panel Provider (for a CMH contract agency)	Off-Panel Provider (for out-of-network providers, incl. COFR)	Hospital	Other
Consumer DOB/Age	_____	_____	_____	_____	_____
Diagnosis	_____	_____	_____	_____	_____
Procedure	_____	_____	_____	_____	_____
First Date of Service	_____	_____	_____	_____	_____
Last Date of Service	_____	_____	_____	_____	_____
# of Units	_____	_____	_____	_____	_____
Revenue Code	_____	_____	_____	_____	_____
Provider ID	_____	_____	_____	_____	_____
Place of Service	_____	_____	_____	_____	_____

III. DATA ACQUISITION CAPABILITIES

4. Please describe how each new consumer is assigned a diagnosis, the maximum number of diagnoses maintained per consumer within the master client file, and how often the diagnoses are updated within the system. _____

4a. How many diagnoses and procedures are captured on each claim? On each encounter?

This question is asking how many diagnoses or procedure codes the claims processing system is capable of capturing. For example, if four diagnosis codes can be submitted on a claim, can the system capture all four, or more?

CLAIM—Institutional Data		ENCOUNTER—Institutional Data	
Diagnoses: ___	Procedures: ___	Diagnoses: ___	Procedures: ___
CLAIM—Professional Data		**ENCOUNTER—Professional Data**	
Diagnoses: ___	Procedures: ___	Diagnoses: ___	Procedures: ___

5. Principal and Secondary Diagnoses

5a. Can your system distinguish between principal (primary) and secondary diagnoses?

☐ Yes

☐ No

5b. If *yes* to 5a, above, how do you distinguish between principal (primary) and secondary diagnoses?

_____

6. Please explain what happens if a Medicaid claims/encounter is submitted and one or more required fields are missing, incomplete, or invalid. For example, if the procedure is not coded, is the claims examiner required by the system to use an online software product like AutoCoder to determine the correct CPT code?

Institutional Data: _____

Professional Data: _____

III. DATA ACQUISITION CAPABILITIES

7. Under what circumstances can claims processors change Medicaid claims/encounter or service information?

______

8. Identify any instance where the content of a field is intentionally different from the description or intended use of the field. For example, if the dependent's Social Security Number (SSN) is unknown, do you enter the consumer's SSN instead?

______

9. Medicaid Claims/Encounters

9a. How are Medicaid claims/encounters received?

Note: An *intermediary* is defined as an entity that accepts service data (claims/encounter) and converts or aggregates the data into a standard submission format. These are sometimes referred to as *data clearinghouses*.

SOURCE	Received Directly	Submitted Through an Intermediary
CMH/MCPN (for direct-run providers)	☐	☐
Sub-Panel Provider (for a CMH contract agency)	☐	☐
Off-Panel Provider (for out-of-network providers, incl. COFR)	☐	☐
Hospital	☐	☐
Other: ______	☐	☐

9b. If the data are received through an intermediary, what changes, if any, are made to the data?

______

III. DATA ACQUISITION CAPABILITIES

10. Please estimate the percentage of coding types provided by setting (institutional/inpatient or professional/outpatient) using the following coding schemes (When more than one coding scheme is used, the total may be more than 100 percent.)

	INSTITUTIONAL		PROFESSIONAL	
CODING SCHEME	Inpatient Diagnosis	Inpatient Procedure	Ambulatory/ Outpatient Diagnosis	Ambulatory/ Outpatient Procedure
ICD-9-CM	___%	___%	___%	___%
CPT-4		___%		___%
HCPCS		___%		___%
DSM-IV	___%		___%	
Internally Developed	___%	___%	___%	___%
Other (Specify)	___%	___%	___%	___%
Not Required	___%	___%	___%	___%
TOTAL	100%	100%	100%	100%

11. Please identify all information systems through which service and utilization data for the Medicaid population are processed. Describe the flow of a claim/encounter or service data from the point of service, through any external vendors, to the point it reaches your PIHP.

Your response should start with the systems used by those who handle data after a service is performed, through the point where your PIHP receives the data (or the performance indicator results). Use the "mini-ISCAT" and have your subcontractors complete their sections; then you will only need to respond with regard to your PIHP.

_____

III. DATA ACQUISITION CAPABILITIES

12. Please check the appropriate box(es) to indicate any major systems changes/updates that have taken place in the last three years in your Medicaid claims or encounter system. If you check a box, please provide a description of the change and the specific dates on which changes were implemented.

☐ New system purchased and installed to replace old system.

Description/implementation dates _____

☐ New system purchased and installed to replace most of old system; old system still used.

Description/implementation dates _____

☐ Major enhancements made to old system. (If *yes*: Please describe the enhancements.)

Description/implementation dates _____

☐ New product line adjudicated (processed) on old system.

Description/implementation dates _____

☐ Conversion of a product line from one system to another.

Description/implementation dates _____

Comments: _____

III. DATA ACQUISITION CAPABILITIES

13. Have any of these changes influenced, even temporarily, the quality and/or completeness of the Medicaid data that are collected? If so, how and when?

______

14. How many years of Medicaid data are retained online? How are historical Medicaid data accessed when needed?

______

15. How much volume of Medicaid data is processed online versus batch? Batch processing refers to collecting claims/encounters/service data and processing them in bulk on a pre-determined schedule. ______

If batch, how often is it run? ______

16. How complete are the Medicaid data three months after the close of a reporting period (i.e. a quarter)?

______

How is completeness estimated? How is completeness defined?

______

17. What is your policy regarding Medicaid claims/encounter audits? Are any audits performed evaluating the data submitted compared with the consumer record?

______

Are Medicaid encounters audited regularly? Randomly?

______

18. What are the standards regarding timeliness of processing? Within what timeframe must claims/encounters or service data be entered?

______

III. DATA ACQUISITION CAPABILITIES

19. Are diagnostic and procedure codes edited for validity? Please provide detail on system edits that are targeted to field content and consistency.

This question is to help reviewers get a sense of how accurate and valid your claims/encounter data are. If you have an existing document that identifies what edits you have in place, you may submit it as an attachment, or make it available for the reviewers on-site. If you do the latter, please note that in your response.

III. DATA ACQUISITION CAPABILITIES

20. Please complete the following table for Medicaid claims and encounter data and other Medicaid administrative data that is used for performance indicator reporting, or submitted to MDCH as QI or encounter data. For the purposes of this ISCA, a *claim* is defined as a service for which direct reimbursement is made (FFS). An *encounter* is defined as a capitated service, in which no direct reimbursement for the service is provided—rather, the provider receives a capitation payment based on member panels. *Administrative data* is defined as any service data that is housed electronically in a database that is not represented in claims or encounters. Examples would include Sub-Element Cost Report (CMHs), authorization systems, consumer surveys, etc.

Provide any documentation that should be reviewed to explain the data that are being submitted.

	Claims	Encounters	QI Data
Percent of Total Service Volume	___%	___%	
Percent Complete	___%	___%	___%
Other Administrative Data (list types)	_____		
How Are the Above Statistics Quantified?	_____		
Incentives for Data Submission	_____		

Comments: _____

21. Describe the Medicaid claims/encounter suspend ("pend") process, including timeliness of reconciling pended services.

For example, indicate how the pend happens, how it is communicated to providers, and how long something can be pended before it is rejected.

_____

22. Describe how Medicaid claims are suspended/pended for review, for non-approval due to missing authorization code(s), or for other reasons.

What triggers a processor to follow up on "pended" claims? How frequent are these triggers?

_____

III. DATA ACQUISITION CAPABILITIES

23. If any Medicaid services/providers are capitated, have you performed studies on the completeness of the information collected on capitated services? If no providers are paid via capitation, how do you ensure that all services are represented within the information system?

For example, reviewing the encounters reported and following up with providers to ensure completeness of data would be an appropriate response.

☐ Yes

☐ No

If *yes*, what were the results?

______

24. Claims/Encounters Systems

24a. If multiple systems are used to process performance indicator data (i.e., each CMHSP has its own IS system to process data), document how the performance data are ultimately merged into one PIHP rate.

______

With what frequency are performance indicator data merged?

______

24b. Beginning with receipt of a Medicaid claim or encounter in-house, describe the claim/encounter handling, logging, and processes that precede adjudication.

When are Medicaid claims/encounters assigned a document control number and logged or scanned into the system? When are Medicaid claims/encounters microfilmed? If there is a delay in microfilming, how do processors access a claim/encounter that is logged into the system, but is not yet filmed?

Note: This question should only be answered by those entities that receive paper claims and process them manually.

______

III. DATA ACQUISITION CAPABILITIES

24c. Discuss which decisions in processing a Medicaid claim and encounter (service data) are automated, which are prompted by automated messages appearing on the screen, and which are manual. Document the opportunities a processor has for overriding the system manually.

Is there a report documenting overrides or "exceptions" generated on each processor and reviewed by the claim supervisor? Please describe this report.

The intent of this question is to understand how much manual intervention is required to either data-enter a claim/encounter or to adjudicate a claim. The less manual intervention there is, the less room there is for error.

III. DATA ACQUISITION CAPABILITIES

24d. Are there any outside parties or contractors used to complete adjudication, including but not limited to:

- Bill auditors (hospital claims, claims over a certain dollar amount)

  ☐ Yes

  ☐ No

- Peer or medical reviewers

  ☐ Yes

  ☐ No

- Sources for additional charge data (usual and customary)

  ☐ Yes

  ☐ No

- Bill "re-pricing" for any services provided

  ☐ Yes

  ☐ No

How are these data incorporated into your organization's data?

______

24e. Describe the system's editing capabilities that assure that Medicaid claims and encounters (service data) are processed correctly.

Keep your responses only in the context of the data used for performance indicator reporting. Keep your responses fairly general (i.e., listing the following edits: valid diagnosis and procedure codes, valid recipient ID, valid date of service, mandatory fields, etc.). If your documentation is voluminous, please simply make it available to the reviewers during the site visit.

Provide a list of the specific edits that are performed on claims as they are adjudicated, and note:

1. Whether the edits are performed pre- or post-payment, and
2. Which are manual and which are automated functions.

______

III. DATA ACQUISITION CAPABILITIES

24f. Please describe how Medicaid eligibility files are updated before providing services, how frequently they updated for ongoing clients, and who has "change" authority. How and when does Medicaid eligibility verification take place (prior to beginning services, monthly, semi-annually, etc.)?

______

24g. Describe how your systems and procedures handle validation and payment of Medicaid claims and encounters (service data) when procedure codes are not provided.

______

24h. Where does the system-generated output (EOBs, remittance advices, pend/rejection reports, etc.) reside?

☐ In-house?

☐ In a separate facility?

If located elsewhere, how is such work tracked and accounted for?

______

25. Describe all performance monitoring standards for Medicaid claims/encounters processing and recent actual performance results.

This question addresses only those staff who are involved with data entry of claims/encounters and/or adjudication of claims.

______

26. Describe processor-specific performance goals and supervision of actual versus target performance. Do processors have to meet goals for processing speed? Do they have to meet goals for accuracy?

Again, this question addresses those staff who are involved with data entry of claims/encounters and/or adjudication of claims.

______

III. DATA ACQUISITION CAPABILITIES

27. Other Administrative Data Used for Performance Indicator Reporting

27a. Identify other administrative data sources used. Include all data sources that are utilized to calculate performance measures by your PIHP: (*check all that apply)*

- ☐ Sub-Element Cost Report (CMHSPs) or Legislative Boiler Plate Report (CAs)
- ☐ QI Data
- ☐ Appointment/Access Database
- ☐ Consumer Surveys
- ☐ Preadmission Screening Data
- ☐ Case Management Authorization System
- ☐ Client Assessment Records
- ☐ Supported Employment Data
- ☐ Recipient Complaints
- ☐ Telephone Service Data
- ☐ Outcome Measurement Data
- ☐ Other: ______
- ☐ Other: ______

27b. For each data source identified above, describe the flow of data from the point of origin through the point of entry into an administrative database, data warehouse, or reporting system maintained by your PIHP. Dataflow diagrams may be included as an attachment.

______

27c. For each data source identified above, identify the data elements captured within the administrative database, data warehouse, or reporting system, and used for performance measure reporting. This may be included as a separate attachment and may be documentation of table structures or a data dictionary. If the documentation is voluminous, please make it available to the reviewers during the site visit and indicate this below:

______

27d. For each data source identified above, describe the validation activities performed by your PIHP to ensure the data in the administrative database are accurate.

______

III. DATA ACQUISITION CAPABILITIES

B. Eligibility System

1. **Please describe any major changes/updates that have taken place in the last three years in your Medicaid eligibility data system.** *(Be sure to identify specific dates on which changes were implemented.)*

   Examples:

   ☐ New **eligibility** system purchased and installed to replace old system

   ☐ New **eligibility** system purchased and installed to replace most of old system —old system still used

   ☐ Major enhancements to old system (please also explain the types)

   ☐ The use of a vendor-provided eligibility service/system

   ☐ Modifications to eligibility data due to organizational restructuring

2. **Have any of these changes influenced, even temporarily, the quality and/or completeness of the Medicaid data that are collected, including changes made by MDCH? If so, how and when?**

3. **How does your PIHP uniquely identify consumers?**

4. **How does your PIHP assign unique consumer IDs? Is this number assigned by the PIHP only or do your affiliate CMHSPs also assign unique consumer IDs?**

III. DATA ACQUISITION CAPABILITIES

5. How do you track consumer eligibility? Does the individual retain the same ID (unique consumer ID)?

______

6. Can your systems track consumers who switch from one payer source (e.g., Medicaid, commercial plan, federal block grant) to another?

☐ Yes

☐ No

6a. Can you track previous claims/encounter data for consumers who switch from one payer source to another?

☐ Yes

☐ No

6b. Are you able to link previous claims/encounter data across payer sources? For example, if a consumer received services under one payer source (e.g., state monies) and then additional services under another payer source (e.g., Medicaid), could the PIHP identify all the services rendered to the individual, regardless of the payer source?

☐ Yes

☐ No

7. Under what circumstances, if any, can a Medicaid member exist under more than one identification number within your PIHP's information management systems?

This applies to your internal ID, Medicaid ID, etc. How many numbers can one consumer have within your system?

Under what circumstances, if any, can a member's identification number change?

______

8. How often is Medicaid enrollment information updated (e.g., how often does your PIHP receive eligibility updates)?

______

9. Can you track and maintain Medicaid eligibility over time, including retro-active eligibility?

______

III. DATA ACQUISITION CAPABILITIES

C. Incorporating Data from Subcontractor Systems

Use this section to record information on stand-alone systems or benefits provided through subcontracts, such as CMHSPs, MCPNs, CAs, sub-contract agencies, and other organizational providers.

1. Does your PIHP incorporate data from subcontractors to calculate any of the following Medicaid quality measures? If so, which measures require subcontractor data?

Measure	Subcontractors
The percent of children and adults receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	______
The percent of new persons receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service.	______
The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional.	______
The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days. The percent of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	______ ______
The percent of Medicaid recipients having received PIHP managed services (this indicator is calculated by MDCH).	______
The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination. (This indicator is calculated by MDCH)	______
The percent of adults with mental illness and the percent of adults with developmental disabilities served by PIHPs who are in competitive employment. (This indicator is calculated by MDCH). The validation will focus on FY07 and the first quarter of FY08 for this indicator.	______

III. DATA ACQUISITION CAPABILITIES

	The percent of adults with mental illness and the percent of adults with developmental disabilities served by CMHSPs and PIHPs who earn minimum wage or more from employment activities (competitive, supported or self employment, or sheltered workshop). (This indicator is calculated by MDCH). The validation will focus on FY07 and the first quarter of FY08 for this indicator.	____	
	The percent of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	____	

III. DATA ACQUISITION CAPABILITIES

2. **Discuss any concerns you may have about the quality or completeness of any subcontractor data.**

3. **Please identify which PIHP mental health services are adjudicated through a separate system that belongs to a subcontractor.**

4. **Describe the kinds of information sources available to the PIHP from the subcontractor (e.g., monthly hard copy reports, full claims data).**

5. **Do you evaluate the quality of this information?**

   If so, how?

6. **Did you incorporate these subcontractor data into the creation of Medicaid-related studies or performance indicator reporting? If not, why not?**

III. DATA ACQUISITION CAPABILITIES

D. Integration and Control of Data for Performance Measure Reporting

This section requests information on how your PIHP integrates Medicaid claims, encounter/service, membership, provider, vendor, and other data to calculate performance rates. All questions relate to your current systems and processes, unless indicated otherwise.

File Consolidation

1. Provide a written description of the process used to calculate each performance indicator, including all data sources. This may be included as Attachment 5.

______

2. In consolidating data for Medicaid performance measurement, how are the data sets for each measure collected:

- By querying the processing systems online (claims/encounter, eligibility, etc.)?
  - ☐ Yes
  - ☐ No

- By using extract files created for analytical purposes (i.e., extracting or "freezing" the necessary data into a separate database for analysis)?
  - ☐ Yes
  - ☐ No

  If so, how frequently are the files updated? How do they account for claim and encounter submission and processing lags? How is the file creation process checked for accuracy?

  ______

- By using a separate relational database or data warehouse (i.e., a performance measure repository)?
  - ☐ Yes
  - ☐ No

  If so, is this the same system from which all other reporting is produced?

  ______

III. DATA ACQUISITION CAPABILITIES

3. Describe the procedure for consolidating Medicaid claims/encounter, member, provider, and other data for performance measure reporting (whether it be into a relational database or file extracts on a measure-by-measure basis).

3a. How many different types of data are merged together to create reports?

_____

3b. What control processes are in place to ensure data merges are accurate and complete? In other words, how do you ensure that the merges were done correctly?

_____

3c. What control processes are in place to ensure that no extraneous data are captured (e.g., lack of specificity in consumer identifiers may lead to inclusion of non-eligible members or to double-counting)?

_____

3d. Do you compare samples of data in the repository to raw data in transaction sets (such as the 837) to verify if all the required data are captured (e.g., were any members, providers, or services lost in the process)?

_____

3e. Describe your process(es) to monitor that the required level of coding detail is maintained (e.g., all significant digits and primary and secondary diagnoses remain) after data have been merged?

_____

4. Describe both the files accessed to create Medicaid performance measures and the fields from those files used for linking or analysis. Use either a schematic or text to respond.

_____

III. DATA ACQUISITION CAPABILITIES

5. Are any algorithms used to check the reasonableness of data integrated to report Medicaid performance measures?

☐ Yes

☐ No

If yes, please describe: ______

6. Are Medicaid reports created from a vendor software product?

☐ Yes

☐ No

If so, how frequently are the files updated? How are reports checked for accuracy?

______

7. Are data files used to report Medicaid performance measures archived and labeled with the performance period in question?

☐ Yes

☐ No

III. DATA ACQUISITION CAPABILITIES

Subcontractor Data Integration

8. **Information on several types of external encounter sources is requested. In the table on the following page, for each type of delegated service, please indicate the following:**

   - First column: Indicate the number of entities contracted (or subcontracted) to provide the mental health services. Include subcontractors that offer all or some of the services.
   - Second column: Indicate whether your PIHP receives member-level data for any Medicaid performance measure reporting from the subcontractors. Answer "Yes" only if all data received from contracted entities are at the member level. If *any* encounter-related data are received in aggregate form, you should answer "No." If type of service is not a covered benefit, indicate "N/A."
   - Third column: Indicate whether all data needed for Medicaid performance measure reporting are integrated, at the member-level, with PIHP administrative data.
   - Fourth and fifth columns: Rank the completeness and quality of the Medicaid data provided by the subcontractors. Consider data received from all sources when using the following data quality grades:
     - A. Data are complete or of high quality.
     - B. Data are generally complete or of good quality.
     - C. Data are incomplete or of poor quality.
   - In the sixth column, describe any concerns you have in ensuring completeness and quality of Medicaid data received from contracted entities. If measure is not being calculated because of no eligible members, please indicate "N/A."

Type of Delegated Service	Always Receive Member-Level Data From This Subcontractor? (Yes or No)	Integrate Subcontractor Data With PIHP Administrative Data? (Yes or No)	Completeness of Data (A, B, or C)	Quality of Data (A, B, or C)	Rationale for Rating/ Concerns With Data Collection
EXAMPLE: CMHSP #1—All mental health services for blank population	☒ Yes ☐ No	☒ Yes ☐ No	☐ A ☒ B ☐ C	☒ A ☐ B ☐ C	*Volumes of encounters not consistent from month to month.*
______	☐ Yes ☐ No	☐ Yes ☐ No	☐ A ☐ B ☐ C	☐ A ☐ B ☐ C	______
______	☐ Yes ☐ No	☐ Yes ☐ No	☐ A ☐ B ☐ C	☐ A ☐ B ☐ C	______
______	☐ Yes ☐ No	☐ Yes ☐ No	☐ A ☐ B ☐ C	☐ A ☐ B ☐ C	______
______	☐ Yes ☐ No	☐ Yes ☐ No	☐ A ☐ B ☐ C	☐ A ☐ B ☐ C	______
______	☐ Yes ☐ No	☐ Yes ☐ No	☐ A ☐ B ☐ C	☐ A ☐ B ☐ C	______
______	☐ Yes ☐ No	☐ Yes ☐ No	☐ A ☐ B ☐ C	☐ A ☐ B ☐ C	______
______	☐ Yes ☐ No	☐ Yes ☐ No	☐ A ☐ B ☐ C	☐ A ☐ B ☐ C	______

III. DATA ACQUISITION CAPABILITIES

Performance Measure Repository Structure

A *performance measure repository structure* is defined as a database that contains consumer-level data used to report performance indicators.

If your PIHP uses a performance measure repository, please answer the following question. Otherwise, skip to the Report Production section.

9. If your PIHP uses a performance measure repository for Medicaid performance measures, review the repository structure. Does it contain all the key information necessary for Medicaid performance measure reporting?

☐ Yes

☐ No

Report Production

10. Please describe your Medicaid report production logs and run controls. Please describe your Medicaid performance measure report generation process.

______

11. How are Medicaid report generation programs documented? Is there a type of version control in place?

______

12. Is testing completed on the development efforts used to generate Medicaid performance measure reports?

______

13. Are Medicaid performance measure reporting programs reviewed by supervisory staff?

______

III. DATA ACQUISITION CAPABILITIES

14. Do you have internal back-ups for performance measure programmers (i.e., do others know the programming language and the structure of the actual programs)? Is there documentation?

III. DATA ACQUISITION CAPABILITIES

E. Provider Data

Compensation Structure

The purpose of this section is to evaluate the Medicaid provider compensation structure, as this may influence the quality and completeness of data. Please identify the percentage for each category level listed. Each column should total 100%.

Payment Mechanism	CMH/MCPN (for direct run providers)	Sub-panel provider (for a CMH contract agency)	Off Panel Provider (for out of network providers, incl CORF)	Hospital
1. Fee-for-Service—no withhold or bonus	___%	___%	___%	___%
2. Fee-for-Service, with withhold. Please specify % withhold:	___%	___%	___%	___%
3. Fee-for-Service with bonus. Bonus range:	___%	___%	___%	___%
4. Capitated—no withhold or bonus	___%	___%	___%	___%
5. Capitated with withhold. Please specify % withhold:	___%	___%	___%	___%
6. Capitated with bonus. Bonus range:	___%	___%	___%	___%
7. Case Rate—with withhold or bonus	___%	___%	___%	___%
8. Case Rate—no withhold or bonus	___%	___%	___%	___%
9. Salaried – mental health center staff	___%	___%	___%	___%
10. Other	___%	___%	___%	___%
TOTAL	100%	100%	100%	100%

1. **How are Medicaid fee schedules and provider compensation rules maintained? Who has updating authority?**

   ______

2. **Are Medicaid fee schedules and contractual payment terms automated? Is payment against the schedules automated for all types of participating providers?**

   ______

Summary of Requested Documentation

The documentation requested in the previous questions is summarized in the table below. Please label all attached documentation as described in the table, and by the item number in the far right column. Remember—you are not limited to providing only the documentation listed below; you are encouraged to provide any additional documentation that helps clarify an answer or eliminates the need for a lengthy response.

Requested Document	Details	Label Number
Previous Medicaid Performance Measure Reports	Please attach final documentation from any previous Medicaid performance measure reporting calculated by your PIHP for the last 4 quarters.	**1.**
Organizational Chart	Please attach an organizational chart for your PIHP. The chart should make clear the relationship among key individuals/departments responsible for information management, including performance measure reporting.	**2.**
Data Integration Flow Chart	Please provide a flowchart that gives an overview of the structure of your management IS. Be sure to show how all claims, encounter, membership, provider, vendor, and other data are integrated for performance measure reporting.	**3.**
Performance Measure Repository File Structure (if applicable)	Provide a complete file structure, file format, and field definitions for the performance measure repository.	**4.**
Program/Query Language for Performance Measure Repository Reporting (if applicable)	Provide full documentation on the software programs or codes used to convert performance measure repository data to performance measures.	**5.**
Medicaid Claims Edits	List of specific edits performed on claims/encounters as they are adjudicated with notation of performance timing (pre- or post-payment) and whether they are manual or automated functions.	**6.**
Statistics on Medicaid claims/encounters and other administrative data	Documentation that explains statistics reported in the ISCA.	**7.**
Health Information System Configuration for Network	Attachment 8	**8.**
______	______	**9.**

Comments:______

Appendix D. Performance Improvement Project Validation Tool

The performance improvement project validation tool and summary form appendix follows this cover page.

Appendix D. Michigan 2007–2008 PIP Validation Tool: <PIP Topic> *for* <PIHP Full Name>

<table>
<tr><th colspan="4">DEMOGRAPHIC INFORMATION</th></tr>
<tr><td>Health Plan Name:</td><td colspan="3"><u><PIHP Full Name></u></td></tr>
<tr><td>Study Leader Name:</td><td>_____</td><td>Title:</td><td>_____</td></tr>
<tr><td>Telephone Number:</td><td>_____</td><td>E-mail Address:</td><td>_____</td></tr>
<tr><td>Name of Project/Study:</td><td colspan="3"><u><PIP Topic></u></td></tr>
<tr><td>Type of Study:</td><td colspan="3">☐ Clinical ☐ Nonclinical</td></tr>
<tr><td>Date of Study:</td><td>_____ to _____</td><td colspan="2"></td></tr>
<tr><td>Date of Delivery System:</td><td>PIHP</td><td colspan="2">Number of Medicaid Beneficiaries in PIHP: _________
Number of Medicaid Beneficiaries in Study: _________</td></tr>
<tr><td colspan="2">Section to be completed by HSAG
_________ Year 1 Validation _________ Initial Submission _________ Resubmission
_________ Year 2 Validation _________ Initial Submission _________ Resubmission
_________ Year 3 Validation _________ Initial Submission _________ Resubmission</td><td colspan="2"></td></tr>
</table>

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ACTIVITIES		EVALUATION ELEMENTS	SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation				
I.		**Appropriate Study Topic: Topics selected for the study should reflect the Medicaid enrollment in terms of demographic characteristics, prevalence of disease, and the potential consequences (risks) of the disease. Topics could also address the need for a specific service. The goal of the project should be to improve processes and outcomes of health care. The topic may be specified by the State Medicaid agency or on the basis of Medicaid beneficiary input.**		
	—	1. Reflects high-volume or high-risk conditions (or was selected by the State). **NA** is not applicable to this element for scoring.	☐ Met ☐ Partially Met ☐ Not Met ☐ NA	
	—	2. Is selected following collection and analysis of data (or was selected by the State). **NA** is not applicable to this element for scoring.	☐ Met ☐ Partially Met ☐ Not Met ☐ NA	
	—	3. Addresses a broad spectrum of care and services (or was selected by the State). The score for this element will be **Me**t or **Not Met.**	☐ Met ☐ Partially Met ☐ Not Met ☐ NA	
	—	4. Includes all eligible populations that meet the study criteria. **NA** is not applicable to this element for scoring.	☐ Met ☐ Partially Met ☐ Not Met ☐ NA	
	—	5. Does not exclude beneficiaries with special health care needs. The score for this element will be **Me**t or **Not Met.**	☐ Met ☐ Partially Met ☐ Not Met ☐ NA	
	C*	6. Has the potential to affect beneficiary health, functional status, or satisfaction. The score for this element will be **Me**t or **Not Met.**	☐ Met ☐ Partially Met ☐ Not Met ☐ NA	
Totals for Activity **I**	1**		☐ Met ☐ Partially Met ☐ Not Met ☐ NA	

* "C" in this column denotes a *critical* evaluation element.

** This number is a tally of the total number of *critical* evaluation elements for this review activity.

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ACTIVITIES		EVALUATION ELEMENTS	SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation				
II.	**Clearly Defined, Answerable Study Question: Stating the study question(s) helps maintain the focus of the PIP and sets the framework for data collection, analysis, and interpretation.**			
	C*	1. States the problem to be studied in simple terms. **NA** is not applicable to this element for scoring.	☐ Met ☐ Partially Met ☐ Not Met ☐ NA	
	C*	2. Is answerable: **NA** is not applicable to this element for scoring.	☐ Met ☐ Partially Met ☐ Not Met ☐ NA	
Totals for Activity II	2**		☐ Met ☐ Partially Met ☐ Not Met ☐ NA	

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ACTIVITIES		EVALUATION ELEMENTS	SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation				
III.		**Clearly Defined Study Indicator(s): A study indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event (e.g., an older adult has not received a flu shot in the last 12 months), or a status (e.g., a beneficiary's blood pressure is or is not below a specified level) that is to be measured. The selected indicators should track performance or improvement over time. The indicators should be objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research.**		
	C*	1. Are well-defined, objective, and measurable. **NA** is not applicable to this element for scoring.	☐ Met ☐ Partially Met ☐ Not Met ☐ NA	
	—	2. Are based on current evidence-based practice guidelines, pertinent peer review literature, or consensus expert panels.	☐ Met ☐ Partially Met ☐ Not Met ☐ NA	
	C*	3. Allow for the study question to be answered. **NA** is not applicable to this element for scoring.	☐ Met ☐ Partially Met ☐ Not Met ☐ NA	
	—	4. Measure changes (outcomes) in health or functional status, beneficiary satisfaction, or valid process alternatives. **NA** is not applicable to this element for scoring.	☐ Met ☐ Partially Met ☐ Not Met ☐ NA	
	C*	5. Have available data that can be collected on each indicator. **NA** is not applicable to this element for scoring.	☐ Met ☐ Partially Met ☐ Not Met ☐ NA	
	—	6. Are nationally recognized measures such as HEDIS specifications, when appropriate. The scoring for this element will be either **Met or NA.**	☐ Met ☐ Partially Met ☐ Not Met ☐ NA	
	—	7. Includes the basis on which each indicator(s) was adopted, if internally developed.	☐ Met ☐ Partially Met ☐ Not Met ☐ NA	
Totals for Activity III	3**		☐ Met ☐ Partially Met ☐ Not Met ☐ NA	

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ACTIVITIES		EVALUATION ELEMENTS	SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation				
IV.		**Correctly Identified Study Population: The selected topic should represent the entire eligible Medicaid enrollment population with systemwide measurement and improvement efforts to which the study indicators apply.**		
	C*	1. Is accurately and completely defined. **NA** is not applicable to this element for scoring.	☐ Met ☐ Partially Met ☐ Not Met ☐ NA	
	—	2. Includes requirements for the length of a beneficiary's enrollment in the PIHP.	☐ Met ☐ Partially Met ☐ Not Met ☐ NA	
	C*	3. Captures all beneficiaries to whom the study question applies. **NA** is not applicable to this element for scoring.	☐ Met ☐ Partially Met ☐ Not Met ☐ NA	
Totals for Activity IV	2**		☐ Met ☐ Partially Met ☐ Not Met ☐ NA	

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ACTIVITIES		EVALUATION ELEMENTS	SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation				
V.		**Valid Sampling Techniques: (This activity is only scored if sampling was used.) If sampling is to be used to select beneficiaries of the study, proper sampling techniques are necessary to provide valid and reliable information on the quality of care provided. The true prevalence or incidence rate for the event in the population may not be known the first time a topic is studied.**		
	—	1. Consider and specify the true or estimated frequency of occurrence.	☐ Met ☐ Partially Met ☐ Not Met ☐ NA	
	—	2. Identify the sample size.	☐ Met ☐ Partially Met ☐ Not Met ☐ NA	
	—	3. Specify the confidence level.	☐ Met ☐ Partially Met ☐ Not Met ☐ NA	
	—	4. Specify the acceptable margin of error.	☐ Met ☐ Partially Met ☐ Not Met ☐ NA	
	C*	5. Ensure a representative sample of the eligible population.	☐ Met ☐ Partially Met ☐ Not Met ☐ NA	
	—	6. Are in accordance with generally accepted principles of research design and statistical analysis.	☐ Met ☐ Partially Met ☐ Not Met ☐ NA	
Totals for Activity V	1**		☐ Met ☐ Partially Met ☐ Not Met ☐ NA	

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ACTIVITIES		EVALUATION ELEMENTS	SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation				
VI.	**Accurate/ Complete Data Collection: Data collection must ensure that the data collected on the study indicators are valid and reliable. Validity is an indication of the accuracy of the information obtained. Reliability is an indication of the repeatability or reproducibility of a measurement.**			
	—	1. The identification of data elements to be collected. **NA** is not applicable to this element for scoring.	☐ Met ☐ Partially Met ☐ Not Met ☐ NA	
	—	2. The identification of specified sources of data. **NA** is not applicable to this element for scoring.	☐ Met ☐ Partially Met ☐ Not Met ☐ NA	
	—	3. A defined and systematic process for collecting baseline and remeasurement data. **NA** is not applicable to this element for scoring.	☐ Met ☐ Partially Met ☐ Not Met ☐ NA	
	—	4. A timeline for the collection of baseline and remeasurement data. **NA** is not applicable to this element for scoring.	☐ Met ☐ Partially Met ☐ Not Met ☐ NA	
	—	5. Qualified staff and personnel to abstract manual data.	☐ Met ☐ Partially Met ☐ Not Met ☐ NA	
	C*	6. A manual data collection tool that ensures consistent and accurate collection of data according to indicator specifications.	☐ Met ☐ Partially Met ☐ Not Met ☐ NA	
	—	7. A manual data collection tool that supports interrater reliability.	☐ Met ☐ Partially Met ☐ Not Met ☐ NA	
	—	8. Clear and concise written instructions for completing the manual data collection tool.	☐ Met ☐ Partially Met ☐ Not Met ☐ NA	
	—	9. An overview of the study in written instructions.	☐ Met ☐ Partially Met ☐ Not Met ☐ NA	

* "C" in this column denotes a *critical* evaluation element.

** This number is a tally of the total number of *critical* evaluation elements for this review activity.

ACTIVITIES		EVALUATION ELEMENTS	SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation				
VI.	**Accurate/ Complete Data Collection: Data collection must ensure that the data collected on the study indicators are valid and reliable. Validity is an indication of the accuracy of the information obtained. Reliability is an indication of the repeatability or reproducibility of a measurement.**			
	—	10. Administrative data collection algorithms/flow charts that show activities in the production of indicators.	☐ Met ☐ Partially Met ☐ Not Met ☐ NA	
	—	11. An estimated degree of administrative data completeness. Met=80-100% Partially Met=50-79% Not Met=<50% or not provided	☐ Met ☐ Partially Met ☐ Not Met ☐ NA	
Totals for Activity VI	1**		☐ Met ☐ Partially Met ☐ Not Met ☐ NA	

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ACTIVITIES		EVALUATION ELEMENTS	SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation				
VII.	**Appropriate Improvement Strategies: Real, sustained improvements in care result from a continuous cycle of measuring and analyzing performance, and developing and implementing systemwide improvements in care. Interventions are designed to change behavior at an institutional, practitioner, or beneficiary level.**			
	C*	1. Related to causes/barriers identified through data analysis and quality improvement processes. **NA** is not applicable to this element for scoring.	☐ Met ☐ Partially Met ☐ Not Met ☐ NA	
	—	2. System changes that are likely to induce permanent change.	☐ Met ☐ Partially Met ☐ Not Met ☐ NA	
	—	3. Revised if the original interventions were not successful.	☐ Met ☐ Partially Met ☐ Not Met ☐ NA	
	—	4. Standardized and monitored if interventions were successful.	☐ Met ☐ Partially Met ☐ Not Met ☐ NA	
Totals for Activity VII	1**		☐ Met ☐ Partially Met ☐ Not Met ☐ NA	

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ACTIVITIES		EVALUATION ELEMENTS	SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation				
VIII.		**Sufficient Data Analysis and Interpretation: Describe the data analysis process on the selected clinical or nonclinical study indicators. Include the statistical analysis techniques used.**		
	C*	1. Is conducted according to the data analysis plan in the study design. **NA** is not applicable to this element for scoring.	☐ Met ☐ Partially Met ☐ Not Met ☐ NA	
	C*	2. Allows for generalization of results to the study population if a sample was selected. If sampling was not used, this score will be **NA.**	☐ Met ☐ Partially Met ☐ Not Met ☐ NA	
	—	3. Identifies factors that threaten internal or external validity of findings.	☐ Met ☐ Partially Met ☐ Not Met ☐ NA	
	—	4. Includes an interpretation of findings.	☐ Met ☐ Partially Met ☐ Not Met ☐ NA	
	—	5. Is presented in a way that provides accurate, clear, and easily understood information.	☐ Met ☐ Partially Met ☐ Not Met ☐ NA	
	—	6. Identifies initial measurement and remeasurement of study indicators.	☐ Met ☐ Partially Met ☐ Not Met ☐ NA	
	—	7. Identifies statistical differences between initial measurement and remeasurement.	☐ Met ☐ Partially Met ☐ Not Met ☐ NA	
	—	8. Identifies factors that affect the ability to compare initial measurement with remeasurement.	☐ Met ☐ Partially Met ☐ Not Met ☐ NA	
	—	9. Includes interpretation of the extent to which the study was successful.	☐ Met ☐ Partially Met ☐ Not Met ☐ NA	
Totals for Activity VIII	2**		☐ Met ☐ Partially Met ☐ Not Met ☐ NA	

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ACTIVITIES		EVALUATION ELEMENTS	SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation				
IX.	**Real Improvement Achieved: Describe any meaningful change in performance observed and demonstrated during baseline measurement. Discuss any random, year-to-year variation, population changes, and sampling error that may have occurred during the measurement process.**			
	—	1. Remeasurement methodology is the same as baseline methodology.	☐ Met ☐ Partially Met ☐ Not Met ☐ NA	
	—	2. There is documented improvement in processes or outcomes of care.	☐ Met ☐ Partially Met ☐ Not Met ☐ NA	
	—	3. The improvement appears to be the result of planned intervention(s).	☐ Met ☐ Partially Met ☐ Not Met ☐ NA	
	—	4. There is statistical evidence that observed improvement is true improvement.	☐ Met ☐ Partially Met ☐ Not Met ☐ NA	
Totals for Activity IX	0**		☐ Met ☐ Partially Met ☐ Not Met ☐ NA	

** This number is a tally of the total number of *critical* evaluation elements for this review activity.

ACTIVITIES		EVALUATION ELEMENTS	SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation				
X.	**Sustained Improvement Achieved: Describe any demonstrated improvement through repeated measurements over comparable time periods. Discuss any random, year-to-year variation, population changes, and sampling error that may have occurred during the remeasurement process.**			
	—	1. Repeated measurements over comparable time periods demonstrate sustained improvement, or that a decline in improvement is not statistically significant.	☐ Met ☐ Partially Met ☐ Not Met ☐ NA	
Totals for Activity X	0**		☐ Met ☐ Partially Met ☐ Not Met ☐ NA	

** This number is a tally of the total number of *critical* evaluation elements for this review activity.

Appendix D. Michigan 2007–2008 PIP Validation Tool: <PIP Topic> *for* <PIHP Full Name>

Table 3-1—2007–2008 PIP Validation Report Scores *for* <PIP Topic> *for* <PIHP Full Name>

Review Activity	Total Possible Evaluation Elements (Including Critical Elements)	Total *Met*	Total *Partially Met*	Total *Not Met*	Total *NA*	Total Possible Critical Elements	Total Critical Elements *Met*	Total Critical Elements *Partially Met*	Total Critical Elements *Not Met*	Total Critical Elements *NA*
I. Appropriate Study Topic	6					1				
II. Clearly Defined, Answerable Study Question	2					2				
III. Clearly Defined Study Indicator(s)	7					3				
IV. Correctly Identified Study Population	3					2				
V. Valid Sampling Techniques	6					1				
VI. Accurate/Complete Data Collection	11					1				
VII. Appropriate Improvement Strategies	4					1				
VIII. Sufficient Data Analysis and Interpretation	9					2				
IX. Real Improvement Achieved	4					No Critical Elements				
X. Sustained Improvement Achieved	1					No Critical Elements				
Totals for All Activities	**53**					**13**				

Table 3-2—2007–2008 PIP Validation Report Overall Scores *for* <PIP Topic> *for* <PIHP Full Name>

Percentage Score of Evaluation Elements Met*	%
Percentage Score of Critical Elements Met**	%
Validation Status***	*<Met/Partially Met/Not Met>*

* The percentage score is calculated by dividing the total *Met* by the sum of the total *Met, Partially Met*, and *Not Met*.

** The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

*** *Met* equals confidence/high confidence that the PIP was valid.
Partially Met equals low confidence that the PIP was valid.
Not Met equals reported PIP results that were not credible.

EVALUATION OF THE OVERALL VALIDITY AND RELIABILITY OF PIP/STUDY RESULTS
HSAG assessed the implications of the study's findings on the likely validity and reliability of the results based on CMS Protocols. HSAG also assessed whether the state should have confidence in the reported PIP findings.
***Met =** Confidence/high confidence in reported PIP results ****Partially Met =** Low confidence in reported PIP results *****Not Met =** Reported PIP results not credible
Summary of Aggregate Validation Findings *☐ ***Met** **☐ ***Partially Met*** ***☐ ***Not Met***

Summary statement on the validation findings: Activities xx through xx were assessed for this PIP Validation Report. Based on the validation of this study indicator, HSAG's assessment determined confidence in the results.

Appendix D. PIP Summary Form: <PIP Topic> *for* <PIHP Full Name>

DEMOGRAPHIC INFORMATION		
PIHP Name or ID:	<PIHP Full Name>	
Study Leader Name:	_____	Title: _____
Telephone Number:	_____	E-Mail Address: _____
Name of Project/Study:	*<PIP Topic>*	
Type of Study:	☐ Clinical	☐ Nonclinical

_____ Number of Medicaid Beneficiaries _____ Number of Medicaid Beneficiaries in Study	**Section to be completed by HSAG** _____ Year 1 Validation _____ Initial Submission _____ Resubmission _____ Year 2 Validation _____ Initial Submission _____ Resubmission _____ Year 3 Validation _____ Initial Submission _____ Resubmission
	Section to be completed by HSAG _____ Baseline Assessment _____ Remeasurement 1 _____ Remeasurement 2 _____ Remeasurement 3

HSAG HEALTH SERVICES ADVISORY GROUP

Appendix D. PIP Summary Form: <PIP Topic> *for* <PIHP Full Name>

A. Activity I: Choose the study topic. PIP topics should target improvement in relevant areas of services and reflect the population in terms of demographic characteristics, prevalence of disease, and the potential consequences (risks) of the disease. Topics may be derived from utilization data (ICD-9 or CPT coding data related to diagnoses and procedures; NDC codes for medications; HCPCS codes for medications, medical supplies, and medical equipment; adverse events; admissions; readmissions; etc.); grievances and appeals data; survey data; provider access or appointment availability data; beneficiary characteristics data such as race/ethnicity/language; other fee-for-service data; local or national data related to Medicaid risk populations; etc. The goal of the project should be to improve processes and outcomes of health care or services in order to have a potentially significant impact on beneficiary health, functional status, or satisfaction. The topic may be specified by the State Medicaid agency or CMS and be based on input from beneficiaries. Over time, topics must cover a broad spectrum of key aspects of beneficiary care and services, including clinical and nonclinical areas, and should include all enrolled populations (i.e., certain subsets of beneficiaries should not be consistently excluded from studies).
Study topic:

B. Activity II: Define the study question(s). Stating the question(s) helps maintain the focus of the PIP and sets the framework for data collection, analysis, and interpretation.
Study question:

Appendix D. PIP Summary Form: <PIP Topic> *for* <PIHP Full Name>

C. Activity III: Select the study indicator(s). A study indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event (e.g., an older adult has not received an influenza vaccination in the last twelve months), or a status (e.g., a beneficiaries blood pressure is/is not below a specified level) that is to be measured. The selected indicators should track performance or improvement over time. The indicators should be objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research.	
Study Indicator 1	**Describe rationale for selection of study indicator:**
Numerator	
Denominator	
First Measurement Period Dates	
Benchmark	
Source of Benchmark	
Baseline Goal	
Study Indicator 2	**Describe rationale for selection of study indicator:**
Numerator	
Denominator	
First Measurement Period Dates	
Benchmark	
Source of Benchmark	
Baseline Goal	

Appendix D. PIP Summary Form: <PIP Topic> *for* <PIHP Full Name>

C. Activity III: Select the study indicator(s). A study indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event (e.g., an older adult has not received an influenza vaccination in the last twelve months), or a status (e.g., a beneficiaries blood pressure is/is not below a specified level) that is to be measured. The selected indicators should track performance or improvement over time. The indicators should be objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research.	
Study Indicator 3	**Describe rationale for selection of study indicator:**
Numerator	
Denominator	
First Measurement Period Dates	
Benchmark	
Source of Benchmark	
Baseline Goal	

Use this area for the provision of additional information:

D. Activity IV: Identify the study population. The selected topic should represent the entire Medicaid enrolled population, with system wide measurement and improvement efforts to which the study indicators apply. Once the population is identified, a decision must be made whether to review data for the entire population or a sample of that population.
Study population:

E. Activity V: Use sound sampling methods. If sampling is to be used to select beneficiaries of the study, proper sampling techniques are necessary to provide valid and reliable information on the quality of care provided. The true prevalence or incidence rate for the event in the population may not be known the first time a topic is studied.

Measure	Sample Error and Confidence Level	Sample Size	Population	Method for Determining Size (*describe*)	Sampling Method (*describe*)

F. Activity VIa: Use valid and reliable data collection procedures. Data collection must ensure that the data collected on study indicators are valid and reliable. Validity is an indication of the accuracy of the information obtained. Reliability is an indication of the repeatability or reproducibility of a measurement.

Data Sources

[ ] Hybrid (medical/treatment records and administrative)

[ ] Medical/Treatment Record Abstraction

Record Type
- [ ] Outpatient
- [ ] Inpatient
- [ ] Other ______________________________

Other Requirements
- [ ] Data collection tool attached
- [ ] Data collection instructions attached
- [ ] Summary of data collection training attached
- [ ] IRR process and results attached

[ ] Other data

____

____

____

____

Description of data collection staff (include training, experience and qualifications):

____

____

____

____

[ ] Administrative Data

Data Source
- [ ] Programmed pull from claims/encounters
- [ ] Complaint/appeal
- [ ] Pharmacy data
- [ ] Telephone service data /call center data
- [ ] Appointment/access data
- [ ] Delegated entity/vendor data ______________________________
- [ ] Other ______________________________

Other Requirements
- [ ] Data completeness assessment attached
- [ ] Coding verification process attached

[ ] Survey Data

Fielding Method
- [ ] Personal interview
- [ ] Mail
- [ ] Phone with CATI script
- [ ] Phone with IVR
- [ ] Internet
- [ ] Other ______________________________

Other Requirements
- [ ] Number of waves ______________________________
- [ ] Response rate ______________________________
- [ ] Incentives used ______________________________

F. Activity VIb: Determine the data collection cycle.	**Determine the data analysis cycle.**
[ ] Once a year [ ] Twice a year [ ] Once a season [ ] Once a quarter [ ] Once a month [ ] Once a week [ ] Once a day [ ] Continuous [ ] Other (list and describe): __________ __________ __________	[ ] Once a year [ ] Once a season [ ] Once a quarter [ ] Once a month [ ] Continuous [ ] Other (list and describe): __________ __________ __________ __________ __________

F. Activity VIc. Data analysis plan and other pertinent methodological features. Complete only if needed.
Estimated percentage degree of administrative data completeness: ______ percent. **Supporting documentation:** __________ __________ __________ __________

G. Activity VIIa: Include improvement strategies (interventions for improvement as a result of analysis). List chronologically the interventions that have had the most impact on improving the measure. Describe only the interventions and provide quantitative details whenever possible (e.g., "Hired four customer service representatives" as opposed to "Hired customer service representatives"). Do not include intervention planning activities.

Date Implemented (MMYY)	Check if Ongoing	Interventions	Barriers That Interventions Address

G. Activity VIIb: Implement intervention and improvement strategies. Real, sustained improvements in care result from a continuous cycle of measuring and analyzing performance, and developing and implementing systemwide improvements in care. Describe interventions designed to change behavior at an institutional, practitioner, or beneficiary level.
Describe interventions: **Baseline to Remeasurement 1:** **Remeasurement 1 to Remeasurement 2:** **Remeasurement 2 to Remeasurement 3:**

H. Activity VIIIa. Data analysis: Describe the data analysis process in accordance with the analysis plan and any ad hoc analysis done on the selected clinical or nonclinical study indicators. Include the statistical analysis techniques used and *p* values.
Data analysis process: **Baseline Measurement:** **Remeasurement 1:** **Remeasurement 2:** **Remeasurement 3**

H. Activity VIIIb. Interpretation of study results: Describe the results of the statistical analysis, interpret the findings, discuss the successfulness of the study, and indicate follow-up activities. Also, identify any factors that could influence the measurement or validity of the findings.

Interpretation of study results:
Address factors that threaten internal or external validity of the findings for each measurement period.

Baseline Measurement:

Remeasurement 1:

Remeasurement 2:

Remeasurement 3:

Appendix D. PIP Summary Form: <PIP Topic> *for* <PIHP Full Name>

I. Activity IX: Report improvement. Describe any meaningful change in performance observed and demonstrated during baseline measurement.

Quantifiable Measure No. 1:

Time Period Measurement Covers	Baseline Project Indicator Measurement	Numerator	Denominator	Rate or Results	Industry Benchmark	Statistical Test and Significance* Test statistic and *p*-value
	Baseline:					
	Remeasurement 1					
	Remeasurement 2					
	Remeasurement 3					
	Remeasurement 4					
	Remeasurement 5					

Quantifiable Measure No. 2:

Time Period Measurement Covers	Baseline Project Indicator Measurement	Numerator	Denominator	Rate or Results	Industry Benchmark	Statistical Test and Significance* Test statistic and *p*-value
	Baseline:					
	Remeasurement 1					
	Remeasurement 2					
	Remeasurement 3					
	Remeasurement 4					
	Remeasurement 5					

Quantifiable Measure No. 3:

Time Period Measurement Covers	Baseline Project Indicator Measurement	Numerator	Denominator	Rate or Results	Industry Benchmark	Statistical Test and Significance* Test statistic and *p*-value
	Baseline:					
	Remeasurement 1					
	Remeasurement 2					
	Remeasurement 3					
	Remeasurement 4					
	Remeasurement 5					

* Specify the test, *p* value, and specific measurements (e.g., baseline to remeasurement 1, remeasurement #1 to remeasurement 2, etc., or baseline to final remeasurement) included in the calculations.

J. Activity X: Describe sustained improvement. Describe any demonstrated improvement through repeated measurements over comparable time periods. Discuss any random year-to-year variation, population changes, sampling error, or statistically significant declines that may have occurred during the remeasurement process
Sustained improvement: