Michigan Department of Community Health

MDCH

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2009–2010 External Quality Review Technical Report

for

Prepaid Inpatient Health Plans

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HSAG Health Services Advisory Group

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CONTENTS

ACKNOWLEDGMENTS AND COPYRIGHTS

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, as well as recommend improvements. Finally, the report must assess the degree to which the MCOs and PIHPs addressed any previous recommendations. To meet this requirement, the 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 PIHPs, as well as 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 2009–2010 compliance monitoring review was designed to determine the PIHPs' progress in achieving compliance with their contract and with State and federal regulations through review of performance in 14 compliance standards: Quality Assessment and Performance Improvement Program (QAPIP) Plan and Structure, Performance Measurement and Improvement, Practice Guidelines, Staff Qualifications and Training, Utilization Management, Customer Services, Enrollee Grievance Process, Enrollee Rights and Protections, Subcontracts and Delegation, Provider Network, Credentialing, Access and Availability, Coordination of Care, and Appeals. 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 2008–2009 reviews and determined the degree to which the PIHP had moved into compliance with the related requirements.
- **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.

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.

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 (i.e., compliance monitoring standards, performance measures, and PIP protocol steps) 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's 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.

[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.

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. Table 1-6 contains a detailed description of the performance measure indicators.

Table 1-1—Measures Assessing Quality					
Measure			Statewide Score	PIHP Low Score	PIHP High Score
Compliance Monitoring Standards					
Standard I.	QAPIP Plan and Structure		99%	94%	100%
Standard II.	Performance Measurement/Improvement		100%	99%	100%
Standard III.	Practice Guidelines		100%	100%	100%
Standard IV.	Staff Qualifications and Training		100%	100%	100%
Standard VI.	Customer Services		100%	95%	100%
Standard VII.	Enrollee Grievance Process		98%	92%	100%
Standard VIII.	Enrollee Rights and Protections		100%	98%	100%
Standard IX.	Subcontracts and Delegation		100%	100%	100%
Standard X.	Provider Network		100%	100%	100%
Standard XI.	Credentialing		100%	98%	100%
Standard XIII.	Coordination of Care		100%	100%	100%
Standard XIV.	Appeals		99%	93%	100%
Performance Measure Indicators					
Indicator 4a:	Follow-Up Care	Children	98%	85%	100%
		Adults	96%	92%	100%
Indicator 4b:	Follow-Up Care After Detox		96%	40%	100%
Indicator 8:	Habilitation Supports Waiver (HSW) Rate		90%	26%	99%
Indicator 10:	Competitive Employment	Adults With MI	11%	5%	15%
		Adults With DD	11%	3%	20%
		Adults With MI/DD	13%	5%	21%
Indicator 11:	Earning Minimum Wage	Adults With MI	72%	49%	97%
		Adults With DD	29%	6%	83%
		Adults With MI/DD	34%	16%	94%
Indicator 12†:	Readmission Rate	Children	11%	24%	4%
		Adults	11%	24%	2%
Indicator 13*:	Recipient Rights Complaints				
Indicator 14*:	Sentinel Events				
Performance Improvement Projects					
		All evaluation elements *Met*	85%	76%	97%
		Critical elements *Met*	96%	90%	100%

† Lower rates are better for this measure. *Reporting validation results only due to the sensitive nature of the indicator.
MI =mental illness DD =developmental disability MI/DD=dually diagnosed with mental illness and developmental disability

PIHP performance on the compliance monitoring standards in the domain of **quality** continued to be a statewide strength. For most of the standards, the statewide score was 100 percent. For three of the standards in this domain—QAPIP Plan and Structure, Enrollee Grievance Process, and Appeals—the statewide score was slightly lower, at 99 percent, 98 percent, and 99 percent respectively.

The EQR activities related to the validation of PIPs addressed the validity and reliability of the PIHPs' processes for conducting valid PIPs. Therefore, for the purposes of the EQR technical report, HSAG assigned all PIPs to the **quality** domain. The PIHPs continued their PIPs, *Improving the Penetration Rates for Children,* and progressed to the first remeasurement of the quality indicators selected for the study. For this validation cycle, HSAG validated Steps I through IX. The number of PIHPs that received a validation status of *Met* increased to 10. The findings indicated that for this second validation cycle of the study, 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 performance. Five of the eight indicators received validation ratings of *Fully Compliant* across all PIHPs. Indicator 8—HSW Rate was rated *Substantially Compliant* for 1 PIHP and *Not Valid* for 2 PIHPs. For 12 of the 18 PIHPs, Indicators 10 and 11 (Competitive Employment and Earning Minimum Wage) received validation ratings of *Substantially Compliant* due to low data completeness for the employment status and minimum wage data, resulting in understated rates for these measures. During the reporting period, several PIHPs as well as MDCH transitioned to new data systems, which may have affected data completeness. Statewide rates for the performance measures related to **quality** of care and services—timely follow-up care for beneficiaries discharged from a psychiatric inpatient or detox unit and 30-day readmission rates for children and adults discharged from a psychiatric inpatient unit—exceeded the minimum performance standard set by MDCH for all indicators in this domain. Seven PIHPs met all performance standards in the **quality** domain. Rates for two measures (Indicator 13—Recipient Rights Complaints and Indicator 14—Sentinel Events) were not included in this report as MDCH is still developing an approach for presenting this sensitive information. MDCH did not specify a minimum performance standard for the three remaining indicators related to **quality** of care (Indicators 8, 10, and 11, addressing the HSW rate, competitive employment, and minimum wage earners, respectively). The statewide HSW rate showed an increase over last year's rate, while the rate of adults with MI earning minimum wage decreased. The remaining rates showed little change.

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 II.	Performance Measurement/Improvement		100%	99%	100%
Standard V.	Utilization Management		99%	93%	100%
Standard VII.	Enrollee Grievance Process		98%	92%	100%
Standard XII.	Access and Availability		96%	71%	100%
Standard XIV.	Appeals		99%	93%	100%
Performance Measure Indicators					
Indicator 1:	Preadmission Screenings	Children	99%	96%	100%
		Adults	98%	97%	100%
Indicator 2:	Face-to-Face Assessments		98%	93%	100%
Indicator 3:	Initiation of Ongoing Service		96%	89%	100%
Indicator 4a:	Follow-Up Care	Children	98%	85%	100%
		Adults	96%	92%	100%
Indicator 4b:	Follow-Up Care After Detox		96%	40%	100%

Statewide performance on compliance monitoring standards in the **timeliness** domain was strong, with scores ranging from a low of 96 percent for Access and Availability to a high of 100 percent for Performance Measurement and Improvement. However, the five compliance monitoring standards assessing **timeliness** of care and services provided by the PIHPs continued to include the four lowest statewide scores, the lowest PIHP scores, and the lowest number of PIHPs achieving 100 percent compliance. Even though the PIHPs overall demonstrated high levels of compliance in this domain, statewide more than one-fourth of the standards assessed in the **timeliness** domain resulted in continuing recommendations, primarily in the areas of grievances, beneficiary appeals, and timely access to services. Eighty percent of all recommendations identified in the 2009–2010 reviews addressed this domain, indicating continuing statewide opportunities for improvement.

Timeliness, as addressed by the validation of performance measures, reflected a statewide strength. The PIHPs demonstrated compliance with technical requirements and specifications in their collection and reporting of performance indicators. All PIHPs received validation scores of *Fully Compliant* for all indicators related to **timeliness** of care and services for this validation cycle. All of the seven measures related to **timeliness** of care and services continued to achieve statewide averages that exceeded the minimum performance level as specified by MDCH. The statewide rates for timely preadmission screenings for children and adults, timely face-to-face assessments with a professional, and follow-up care for beneficiaries discharged from a psychiatric inpatient or detox unit were above the 95 percent benchmark. Eleven PIHPs met all minimum performance standards in the **timeliness** domain.

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 V.	Utilization Management		99%	93%	100%
Standard VI.	Customer Services		100%	95%	100%
Standard X.	Provider Network		100%	100%	100%
Standard XII.	Access and Availability		96%	71%	100%
Standard XIII.	Coordination of Care		100%	100%	100%
Performance Measure Indicators					
Indicator 1:	Preadmission Screenings	Children	99%	96%	100%
		Adults	98%	97%	100%
Indicator 2:	Face-to-Face Assessments		98%	93%	100%
Indicator 3:	Initiation of Ongoing Service		96%	89%	100%
Indicator 4a:	Follow-Up Care	Children	98%	85%	100%
		Adults	96%	92%	100%
Indicator 4b:	Follow-Up Care After Detox		96%	40%	100%
Indicator 5:	Penetration Rate		6%	5%	8%

Overall, PIHP performance on the compliance monitoring standards in the domain of **access** continued to indicate another statewide strength. Statewide scores for the five **access**-related standards ranged from a low of 96 percent for the Access and Availability standard to a high of 100 percent for the Customer Services, Provider Network, and Coordination of Care standards. Most PIHPs achieved full compliance on the standards assessing **access** to care and services.

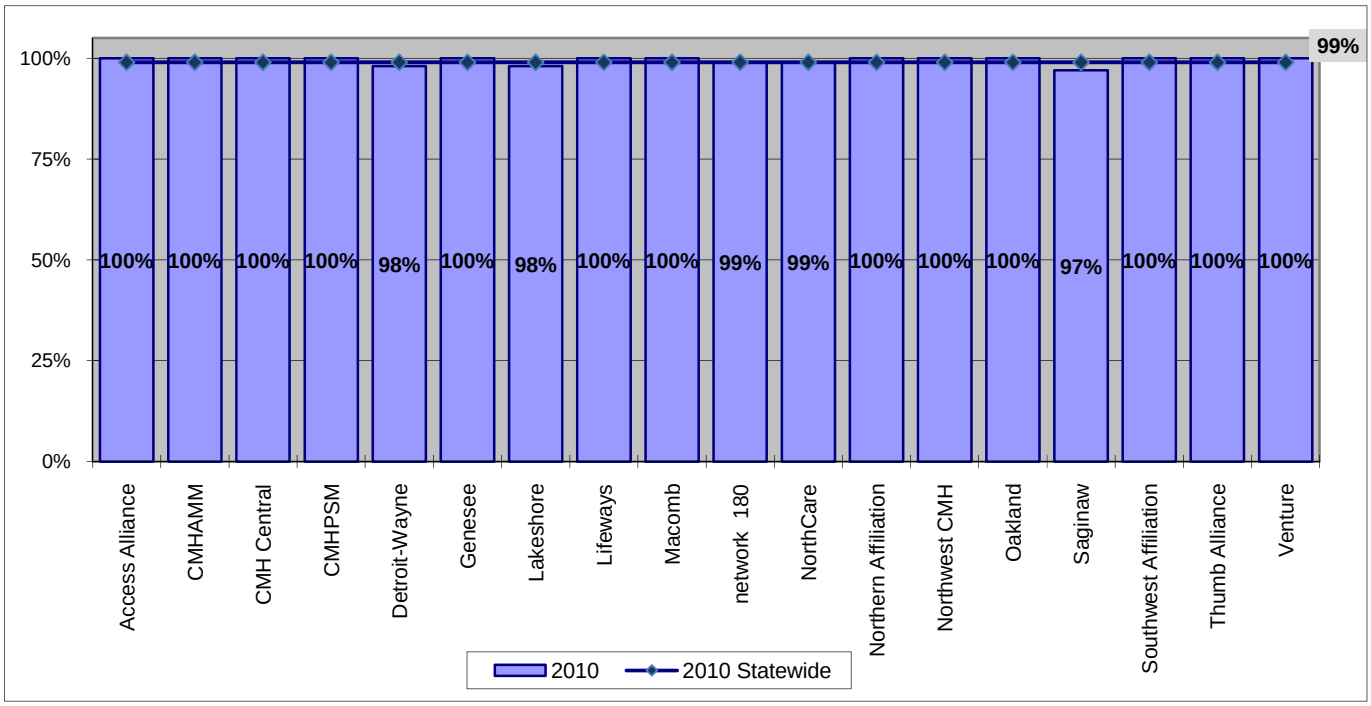
Access, as assessed by the validation of performance measures, indicated a statewide strength. Fifteen PIHPs received a validation score of *Fully Compliant* for all six indicators related to **access** to care and services. Indicator 5 —Penetration Rate was rated *Substantially Compliant* for one PIHP and *Not Valid* for two PIHPs. Statewide rates exceeded the minimum performance standard for all indicators, reflecting that PIHPs provided timely preadmission screenings, face-to-face assessments, access to ongoing services, and follow-up care after discharge from a psychiatric inpatient or detox unit. Eleven PIHPs met all minimum performance standards in the **access** domain. The statewide penetration rate showed a slight decrease from the corrected 2008–2009 penetration rate of 7 percent.

Findings for the 2009–2010 Compliance Monitoring Reviews

The regulatory provisions addressed in this sixth review year included Quality Assessment and Performance Improvement Program (42 CFR 438.240); Practice Guidelines (42 CFR 438.236); Quality Assessment and Performance Improvement, coverage and authorization of services (438.210); Grievance System (42 CFR 438.228, 438.400–408, 438.414, and 438.416); Enrollee Rights and Information Requirements (42 CFR 438.100, 438.10, and 438.218); Provider Network (42 CFR 438.106, 438.12, 438.206, 438.207, and 438.214); Credentialing (42 CFR 438.12 and 438.214); Access and Availability (42 CFR 438.206); Appeals (42 CFR 438.402, 438.406, 438.408, and 438.410); and two standards from the MDCH contract that were not specific to BBA regulations—Customer Services and Staff Qualifications and Training. The individual PIHP follow-up compliance reviews included only those standards that had received a compliance score of less than 100 percent during the review in 2008–2009 and only those elements that had received an initial score of less than *Met*. None of the PIHPs required a follow-up review for the Subcontracts and Delegation (42 CFR 438.230) or Coordination of Care (42 CFR 438.208) standards as all PIHPs had demonstrated full compliance with all related requirements during the 2008–2009 review cycle.

The overall compliance rating across all standards for the 18 PIHPs was 99 percent, with individual PIHP scores ranging from 97 percent to 100 percent. Scores ranging from 95 percent to 100 percent were rated *Excellent*, scores ranging from 85 percent to 94 percent were rated *Good*, scores ranging from 75 percent 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. All 18 PIHPs performed at an overall *Excellent* level, with 13 PIHPs receiving overall compliance scores of 100 percent. None of the PIHPs performed at the *Good*, *Average*, or *Poor* level.

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



PIHPs demonstrated high levels of compliance with federal and contractual requirements in all areas assessed. The PIHPs' performance was strongest in the Practice Guidelines, Staff Qualifications and Training, Subcontracts and Delegation, Provider Network, and Coordination of Care standards, with all 18 PIHPs receiving a compliance score of 100 percent.

Other standards for which all PIHPs performed at the *Excellent* level included Performance Measurement and Improvement, Customer Services, Enrollee Rights and Protections, and Credentialing. Only one-third or fewer of the PIHPs required follow-up review on these standards: six PIHPs had a follow-up review on the standards for Customer Services and Enrollee Rights, four PIHPs had follow-up for Performance Measurement and Improvement, and one PIHP had follow-up on the Credentialing standard. Most PIHPs achieved full compliance after the follow-up review.

QAPIP Plan and Structure and Utilization Management were also areas of strong performance, with 17 PIHPs receiving scores in the *Excellent* range, one PIHP receiving a score in the *Good* range and most PIHPs (14 and 15 PIHPs, respectively) receiving scores of 100 percent. The follow-up review on these standards primarily addressed review of data from the behavior treatment committee and utilization management procedures and determined that in most cases, the PIHPs had implemented corrective actions and achieved compliance.

PIHP performance on the standards, Enrollee Grievance Process and Appeals, reflected improvement. After the follow-up review, 17 PIHPs scored in the *Excellent* range and 1 PIHP performed at the *Good* level. Most PIHPs received scores of 100 percent. Almost all PIHPs required follow-up on these standards. PIHPs demonstrated that they had successfully addressed recommendations related to providing information about the grievance and appeal processes to beneficiaries and providers, maintaining logs of appeals, and most aspects of handling grievances and beneficiary appeals. Continuing recommendations primarily addressed requirements for the content and timeliness of the notice of disposition for grievances and appeals.

For the Access and Availability standard, the PIHPs demonstrated improved performance. The follow-up review excluded any element that received a score of *Met* for the 2008–2009 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 14, with 13 PIHPs receiving scores of 100 percent compliance. Two PIHPs performed in the *Good* range. Only one PIHP scored in the *Average* range and one PIHP's score was in the *Poor* range. Overall, PIHPs improved compliance with the requirements for timely preadmission screenings, face-to-face assessments, and follow-up care after discharge from a psychiatric inpatient or detox unit. Most continued recommendations addressed timely access to ongoing services, primarily for mentally ill and developmentally disabled adults and children with a serious emotional disturbance.

Table 1-4 presents the PIHPs' 2009–2010 compliance monitoring scores (percentage of compliance) on the 14 standards reviewed as well as an overall compliance score across all standards.

Table 1-4—Summary of PIHP Compliance Monitoring Scores (Percentage of Compliance)

PIHP	I. QAPIP Plan and Structure	II. Performance Measurement and Improvement	III. Practice Guidelines	IV. Staff Qualifications and Training	V. Utilization Management	VI. Customer Services	VII. Enrollee Grievance Process	VIII. Enrollee Rights and Protections	IX. Subcontracts and Delegation	X. Provider Network	XI. Credentialing	XII. Access and Availability	XIII. Coordination of Care	XIV. Appeals	Overall
Access Alliance	*100*	*100*	*100*	*100*	**100**	*100*	**100**	**100**	*100*	*100*	*100*	**100**	*100*	*100*	**100**
CMHAMM	**100**	**100**	**100**	**100**	*100*	**100**	**100**	*100*	*100*	**100**	*100*	*100*	*100*	**100**	**100**
CMH Central	*100*	*100*	*100*	*100*	*100*	**100**	**100**	*100*	*100*	*100*	*100*	*100*	*100*	**100**	**100**
CMHPSM	**99**	*100*	*100*	*100*	*100*	*100*	**100**	*100*	*100*	*100*	*100*	*100*	*100*	**98**	**100**
Detroit-Wayne	**99**	*100*	*100*	*100*	**100**	**100**	**96**	*100*	*100*	*100*	*100*	**79**	*100*	**98**	**98**
Genesee	*100*	*100*	*100*	*100*	*100*	*100*	**100**	*100*	*100*	*100*	*100*	**100**	*100*	*100*	**100**
Lakeshore	**94**	**99**	*100*	*100*	**93**	**100**	**96**	**99**	*100*	*100*	*100*	**100**	*100*	**98**	**98**
LifeWays	*100*	*100*	*100*	*100*	*100*	*100*	**98**	**100**	*100*	*100*	*100*	*100*	*100*	**97**	**100**
Macomb	*100*	*100*	*100*	*100*	*100*	**95**	**100**	*100*	*100*	*100*	*100*	**100**	*100*	**98**	**100**
network180	*100*	*100*	*100*	*100*	*100*	*100*	**96**	*100*	*100*	*100*	**98**	**91**	*100*	**98**	**99**
NorthCare	*100*	**100**	**100**	*100*	*100*	*100*	**96**	**100**	*100*	*100*	*100*	**100**	*100*	**93**	**99**
Northern Affiliation	*100*	*100*	*100*	*100*	**100**	*100*	**100**	*100*	*100*	*100*	*100*	**94**	*100*	**100**	**100**
Northwest CMH	**100**	*100*	*100*	**100**	**96**	**100**	**96**	*100*	*100*	*100*	*100*	**100**	*100*	**100**	**100**
Oakland	*100*	*100*	*100*	*100*	*100*	*100*	*100*	**100**	*100*	*100*	*100*	*100*	*100*	*100*	**100**
Saginaw	**97**	*100*	*100*	*100*	**100**	*100*	**92**	**98**	*100*	*100*	*100*	**71**	*100*	**100**	**97**
Southwest Affiliation	**100**	*100*	*100*	*100*	*100*	*100*	**100**	*100*	*100*	*100*	*100*	**97**	*100*	**100**	**100**
Thumb Alliance	*100*	**100**	*100*	*100*	*100*	*100*	**100**	*100*	*100*	*100*	*100*	**100**	*100*	**97**	**100**
Venture	**100**	**99**	*100*	*100*	**99**	*100*	*100*	*100*	*100*	*100*	*100*	**100**	*100*	**100**	**100**
Statewide Score	**99**	**100**	**100**	**100**	**99**	**100**	**98**	**100**	**100**	**100**	**100**	**96**	**100**	**99**	**99**

Note: *Scores* in italics show that no follow-up review was required. Scores in bold reflect performance after the 2009–2010 follow-up review.
Shaded cells show PIHP performance below the statewide score.

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

Findings for the 2009–2010 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 code book specifications.

HSAG assessed 12 performance indicators 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	186	86%
Substantially Compliant	26	12%
Not Valid	4	2%
Total	**216**	**100%**

Table 1-6 shows overall PIHP compliance with the MDCH codebook specifications for each of the 12 performance indicators validated by HSAG. Eight of the 12 measures were *Fully Compliant* for all PIHPs. For Indicators 5 and 8, one PIHP received a validation finding of *Substantially Compliant* and two PIHPs received validation findings of *Not Valid*. Twelve PIHPs received a score of *Substantially Compliant* on Indicators 10 and 11. Almost all PIHPs were required to implement corrective actions to address incomplete quality improvement (QI) data for the first quarter of the 2010 state fiscal year. These findings reflected lower levels of completeness for QI data than in the previous validation cycle, primarily related to data elements for adult beneficiaries' employment status and minimum wage earners. The State's transition to the new eligibility system, CHAMPS, as well as a lack of understanding of specific requirements for completion of the data fields may have contributed to the decline in data completeness. Additional documentation and technical assistance regarding data field requirements, as well as a process to allow for corrections by the PIHPs before reporting the data completeness results could assist in receiving more accurate and complete data in a timely manner and reduce the need for further corrective actions. All PIHPs demonstrated that they had adequate processes in place for data integration, data control, and documentation of performance indicator calculations. Oversight by the PIHPs of their affiliates and coordinating agencies was another statewide strength. The PIHPs provided close monitoring of QI, encounter, and performance indicator data and required corrective actions for rates that fell below the minimum performance standard of 95 percent. Many PIHPs implemented quality initiatives and new processes to improve the completeness of their QI data. Several PIHPs transitioned to new data systems, increasing uniformity and integrity of the data and enhancing their reporting capabilities.

Some PIHPs implemented additional reports to monitor data quality and completeness and to track, trend, and monitor services provided to beneficiaries, some of which were best practices. Statewide, the amount of claims and encounters received electronically increased, resulting in better data accuracy and completeness. Recommendations for improvement primarily addressed the need to improve the completeness of QI data files, particularly for the employment status and minimum wage data elements. Several PIHPs should continue efforts to provide detailed instructions and documentation related to the processes of calculating performance indicators and preparing and submitting encounter files, or the transition to a new data or electronic medical record (EMR) system. Statewide, PIHPs should continue monitoring of performance indicator rates as well as completeness of encounter and QI data.

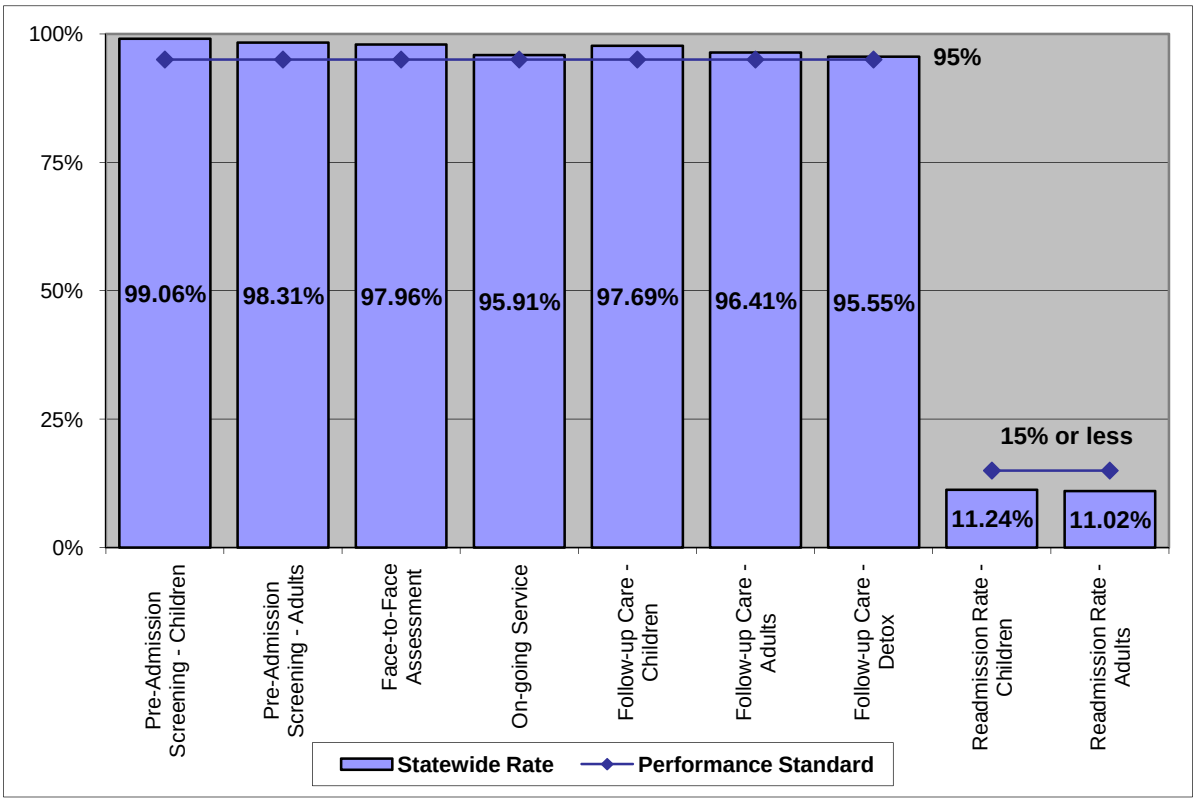
Table 1-6—Degree of Compliance Across all PIHPs

Performance Measure Indicator		Percentage 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.	100%	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%	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).	83%	6%	11%
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).	83%	6%	11%
10.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of adults dually diagnosed with mental illness/developmental disability served by the PIHPs who are employed competitively.	33%	67%	0%
11.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of adults dually diagnosed with mental illness/developmental disability served by the PIHPs who earned minimum wage or more from any employment activities.	33%	67%	0%
12.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	100%	0%	0%

Table 1-6—Degree of Compliance Across all PIHPs				
Performance Measure Indicator		Percentage of PIHPs		
		Fully Compliant	*Substantially Compliant*	*Not Valid*
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%

Statewide performance exceeded the MDCH-established minimum performance standards for all 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). This calculation excluded any *Not Valid* rates. MDCH did not specify a standard for Indicators 5, 8, 10, and 11. While HSAG validated Indicators 13 and 14, due to the sensitive nature of these indicators, actual rates for PIHP performance were not included in this report.

Figure 1-2—Statewide Rates for Performance Measures



Continued strong performance resulted in statewide rates that exceeded the MDCH benchmark for all measures. Indicator 1, Preadmission Screenings, continued to show the highest statewide rate (99 percent for children and 98 percent for adults) and was the only indicator for which all 18 PIHPs met or exceeded the MDCH performance standard.

Table 1-7 displays the 2009–2010 PIHP results for the validated performance indicators. Most indicators (Indicators 1 through 5, 8, and 12) were reported and validated for the first quarter of state fiscal year (SFY) 2010. For Indicators 10 and 11—reported and validated for SFY 2009—MDCH for the first time reported rates for adults dually diagnosed with mental illness and developmental disability in addition to rates for adults diagnosed with a mental illness and adults diagnosed with a developmental disability.

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.

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

PIHP	1. Pre-Admission 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 MI	Adults With DD	Adults With Dual Diagnosis	Adults With MI	Adults With DD	Adults With Dual Diagnosis	Children	Adults
Access Alliance	98.68	98.99	99.79	98.50	93.10	98.57	100	8.34	95.87	12.10	12.52	14.13	78.01	39.58	40.59	6.67	11.90
CMHAMM	100	99.65	99.79	97.03	84.62	91.67	100	5.82	97.37	10.05	13.36	12.95	82.55	49.51	52.76	5.88	13.85
CMH Central	97.87	98.46	98.24	98.65	100	95.00	100	8.37	97.30	11.71	14.84	10.00	87.17	28.95	37.78	10.00	5.00
CMHPSM	100	100	98.44	98.17	100	96.81	92.47	5.75	87.30	11.08	16.16	17.65	87.35	73.09	81.25	8.33	9.01
Detroit-Wayne	100	96.54	92.65	88.62	98.87	95.58	96.11	4.70	86.79	15.28	2.80	7.89	55.34	6.37	15.79	7.32	7.69
Genesee	98.73	98.95	97.39	99.20	95.56	96.12	96.88	4.89	25.71	4.59	5.52	10.17	70.32	21.39	50.00	7.69	15.24
Lakeshore	100	99.19	99.33	97.33	100	100	100	5.25	94.47	7.28	14.34	13.85	76.64	35.63	30.88	10.53	10.00
LifeWays	100	99.27	93.97	100	100	100	100	NV	NV	8.75	10.84	5.49	76.81	76.47	80.95	11.76	11.54
Macomb	99.29	99.78	98.76	99.73	95.83	97.44	100	5.01	97.99	9.83	8.61	7.72	58.03	20.56	16.67	19.70	24.31
network180	100	98.82	99.89	93.61	97.30	95.74	100	5.89	97.63	7.26	14.68	19.01	73.49	21.62	18.72	12.50	16.88
NorthCare	100	98.48	98.46	97.24	95.45	97.50	100	6.52	95.93	14.05	13.80	17.58	73.14	46.15	40.63	19.23	18.00
Northern Affiliation	100	100	100	100	100	100	100	6.23	93.61	9.99	20.03	21.27	70.22	45.76	55.95	4.17	14.52
Northwest CMH	96.30	96.97	99.74	97.89	100	100	100	7.51	92.47	11.65	18.09	13.44	96.62	82.84	94.26	11.54	3.28
Oakland	95.91	96.71	98.15	98.18	96.49	96.74	100	7.43	98.85	8.27	18.69	19.44	65.30	27.11	19.74	23.91	11.54
Saginaw	100	100	99.54	91.30	100	91.67	40.00	5.14	95.87	6.38	13.98	8.70	80.43	19.35	33.33	10.53	18.60
Southwest Affiliation	100	98.21	96.77	98.36	100	97.73	100	NV	NV	9.17	14.73	16.32	84.57	72.92	86.36	9.68	16.36
Thumb Alliance	100	99.35	100	99.47	100	98.31	100	6.91	97.65	9.75	5.44	5.15	49.29	19.02	17.11	4.35	18.67
Venture	98.08	97.51	98.70	97.25	100	98.48	100	5.72	94.74	10.79	13.77	14.48	59.09	29.49	40.00	14.29	2.30
Statewide Rate	**99.06**	**98.31**	**97.96**	**95.91**	**97.69**	**96.41**	**95.55**	**5.74**	**90.18**	**10.70**	**11.48**	**13.30**	**72.50**	**28.77**	**33.86**	**11.24**	**11.02**
MDCH Standard	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	NA	NA	NA	NA	NA	NA	NA	NA	≤15%	≤15%

Notes: Shaded cells indicate performance not meeting the MDCH minimum performance standard. NV: Rate is not valid NA: Not Applicable
Time period for the data: First quarter of SFY 2010 for Indicators 1 through 5, 8, and 12; SFY 2009 for Indicators 10 and 11.

Findings for the 2009–2010 Validation of Performance Improvement Projects

For each PIHP, HSAG validated one PIP based on CMS' protocol. For the current validation cycle, all PIHPs continued with the mandated study topic from 2008–2009, improving penetration rates for children. Table 1-8 presents a summary of the PIPs' validation status results. Most PIPs received a *Met* validation status, and no PIP received a validation status of *Not Met*. All 10 PIPs that had received a *Not Met* validation status in 2008–2009 showed improvement and received a validation status of *Met* (4 PIPs) or *Partially Met* (6 PIPs) in 2009–2010, reflecting improvement in the quality of the studies.

Table 1-8—PIP Validation Status

Validation Status	Number of PIHPs
Met	10
Partially Met	8
Not Met	0

Table 1-9 presents a statewide summary of the PIHPs' PIP validation results for each of the CMS PIP protocol activities. HSAG validated Steps I through IX. All of the PIPs demonstrated full compliance with the critical and noncritical evaluation elements for Steps I through VI, with one exception in Step I. All PIPs received a rating of *NA* in two steps; for all elements in Step V, as the studies did not use sampling; and for the critical element in Step VI, as the studies did not use a manual data collection tool. All PIHPs had progressed to collecting the first remeasurement data. However, no PIHP had collected the second remeasurement data; therefore, HSAG did not assess Step X in this validation cycle.

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

Validation Step		Number of PIPs Meeting All Evaluation Elements/ Number Reviewed	Number of PIPs Meeting All Critical Elements/ Number Reviewed
I.	Review the Selected Study Topic(s)	17/18	18/18
II.	Review the Study Question(s)	18/18	18/18
III.	Review the Selected Study Indicator(s)	18/18	18/18
IV.	Review the Identified Study Population	18/18	18/18
V.	Review Sampling Methods	18/18*	18/18*
VI.	Review Data Collection Procedures	18/18	18/18*
VII.	Assess Improvement Strategies	9/18	16/18
VIII.	Review Data Analysis and Study Results	1/18	13/18
IX.	Assess for Real Improvement	4/18	NA
X.	Assess for Sustained Improvement	0/0	NA

*HSAG scored all elements *Not Applicable* for all PIPs.

The PIHPs demonstrated compliance with CMS PIP protocol requirements in the areas of the study questions, study indicators, study population, and data collection procedures. While almost all PIHPs identified improvement strategies that related to causes or barriers identified through data analysis and quality improvement processes and that involved system changes that are likely to induce permanent change, few PIHPs showed in Step VII that the interventions were standardized and monitored. Most PIHPs conducted the data analysis according to the data analysis plan, identified factors that could threaten the validity of the findings, and identified the initial and repeat measurement of the study indicators. For all but one of the PIPs, HSAG identified opportunities for improvement in Step VIII that addressed primarily the interpretation and presentation of the study findings and statistical testing between measurement periods. In Step IX, all PIHPs demonstrated compliance with the requirement for the remeasurement to use the same methodology as the baseline measurement. About one-half of the PIHPs demonstrated improvement in processes or outcomes of care and documented that the observed improvements were consistent with the planned and implemented interventions, as assessed in Step IX. However, most PIPs did not show statistically significant improvement in the study indicators.

Table 1-10 presents the results of the 2009–2010 PIP validation.

Table 1-10—PIP Validation Results by PIHP

PIHP	% of All Elements *Met*	% of All Critical Elements *Met*	Validation Status
Access Alliance	91%	100%	*Met*
CMHAMM	76%	90%	*Partially Met*
CMH Central	85%	100%	*Met*
CMHPSM	97%	100%	*Met*
Detroit-Wayne	91%	90%	*Partially Met*
Genesee	82%	100%	*Met*
Lakeshore	76%	100%	*Partially Met*
LifeWays	82%	100%	*Met*
Macomb	85%	100%	*Met*
network180	91%	100%	*Met*
NorthCare	82%	90%	*Partially Met*
Northern Affiliation	76%	90%	*Partially Met*
Northwest CMH	76%	90%	*Partially Met*
Oakland	85%	100%	*Met*
Saginaw	82%	90%	*Partially Met*
Southwest Affiliation	79%	90%	*Partially Met*
Thumb Alliance	97%	100%	*Met*
Venture	91%	100%	*Met*

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 2009–2010 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 strong performance and high levels of compliance with federal, State, and contractual requirements related to the provision of care to beneficiaries.

Results from the compliance monitoring follow-up review reflected high levels of compliance across all standards. The number of PIHPs in full compliance with all requirements increased for the standards addressed in the follow-up. The PIHPs demonstrated that they implemented corrective actions to address recommendations from the 2008–2009 compliance review. The findings indicated that overall, the PIHPs demonstrated compliance with the federal and State requirements addressed in this review cycle.

For the second validation cycle for the PIP on improving penetration rates for children, the PIHPs demonstrated much improved levels of compliance with the requirements of the CMS PIP protocol, resulting in mostly valid PIPs that gave confidence in the reported results and could achieve 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. However, for this validation cycle, low levels of data completeness for some QI data elements affected the validation finding for some indicators for most PIHPs. Performance indicator rates reflected that overall, the PIHPs maintained improvements achieved in prior years, and for this validation cycle, all statewide rates exceeded the MDCH minimum performance standard.

2. External Quality Review Activities

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 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, a state or its EQRO must conduct a review within a three-year period to determine the PIHPs' compliance with standards for access to care, structure and operations, and quality measurement and improvement. 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 2009–2010 compliance monitoring reviews evaluated the PIHPs' compliance with federal and State regulations and with contractual requirements related to the following standards:

- Standard I. QAPIP 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 Services
- Standard VII. Grievance Process
- Standard VIII. Enrollee Rights and Protections
- 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

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 current performance processes.
- Plan and initiate activities to sustain and enhance current performance processes.

This is the sixth 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 2009–2010 follow-up compliance reviews, the tools were customized for each PIHP, based on their performance in 2008–2009, to include only those standards for which the PIHP had scored less than 100 percent and only those elements for which the PIHP had 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 2008–2009 review (policies, member materials, subcontracts, etc.) and the customized comprehensive EQR compliance review tool. The focus of the desk review was to identify compliance with BBA and MDCH contractual rules and regulations.
- HSAG developed record review tools for the review of utilization management (UM) denials, grievances, and beneficiary appeals. HSAG requested audit samples based on data files supplied by each PIHP. These files included logs of UM denials, grievances, and beneficiary appeals for the period of October 1, 2009, through the date of HSAG's request for the pre-review documentation. From each of these logs HSAG selected samples of files for review. The follow-up reviews addressed only those criteria for which the PIHP scored less than *Met* on the related element during the 2006–2007 compliance review.
- **Compliance Monitoring Reviews:** The 2009–2010 compliance monitoring reviews were conducted either via telephone conference calls between key PIHP staff members and the HSAG review team or as a one-day site visit (for the two PIHPs with the lowest overall scores in 2008–2009). The on-site reviews included an entrance conference, document and record reviews using the HSAG compliance monitoring and record review tools, and interviews with key PIHP staff. During the exit conference at the conclusion of the on-site reviews, the HSAG review team provided a summary of preliminary findings and recommendations. Telephonic

reviews included an opening statement to detail the review process and objectives, followed by discussions with key PIHP staff to evaluate the implementation of the corrective action plans and the degree of compliance for each of the standards and elements included in the follow-up review, a discussion of findings from the record reviews, and a closing statement.

- **Compliance Monitoring Report:** After completing the review, analysis, and scoring of the information obtained from the desk audit and the on-site or telephonic reviews, HSAG prepared a 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 that was not fully compliant. 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 QAPIP 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 UM denials, grievances, and beneficiary appeals.

Interviews with PIHP staff (e.g., PIHP leadership, customer services 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
Record Reviews	October 1, 2009, to Date of Documentation Request
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 record review tools to document findings regarding PIHP compliance with the standards. Results of the record reviews 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 reported quarterly performance data to MDCH. MDCH provided data directly to HSAG for the third and fourth quarters of FY 2008–2009.

HSAG evaluated and scored each element addressed in the compliance monitoring review as *Met (M)*, *Substantially Met (SM)*, *Partially Met (PM)*, *Not Met (NM)*, or *Not Applicable (NA)*, except that *Substantially Met* was not applicable to the Access and Availability standard. HSAG determined the overall score for each of the 14 standards by totaling the number of *Met* elements from both the 2008–2009 and 2009–2010 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. Using the same methodology, HSAG determined the overall score across all standards 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
I.	QAPIP Plan and Structure	✓		
II.	Performance Measurement and Improvement	✓	✓	
III.	Practice Guidelines	✓		
IV.	Staff Qualifications and Training	✓		
V.	Utilization Management		✓	✓
VI.	Customer Services	✓		✓
VII.	Enrollee Grievance Process	✓	✓	
VIII.	Enrollee Rights and Protections	✓		
IX.	Subcontracts and Delegation	✓		
X.	Provider Network	✓		✓
XI.	Credentialing	✓		
XII.	Access and Availability		✓	✓
XIII.	Coordination of Care	✓		✓
XIV.	Appeals	✓	✓	

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 7 of these indicators quarterly, with the remaining 5 calculated by MDCH. The majority of the performance indicators were reported and validated for the first quarter of the Michigan SFY, which began October 1, 2009, and ended December 31, 2009, as shown in Table 2-4.

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-audit Strategy**
  - HSAG obtained a list of the indicators that were selected by MDCH for validation. Indicator definitions and reporting templates were also provided by MDCH for review by the HSAG validation team. Based on the indicator definitions and reporting guidelines, HSAG developed indicator-specific work sheets derived from Attachment I of the CMS performance measure validation protocol.
  - HSAG prepared a documentation request, which consisted of the Information Systems Capabilities Assessment Tool (ISCAT), Appendix Z of the CMS performance measure validation protocol. Working in collaboration with MDCH and PIHP participants, HSAG customized the ISCAT to collect the necessary data consistent with Michigan's mental health service delivery model. The ISCAT was forwarded to each PIHP with a timetable for completion and instructions for submission. HSAG fielded ISCAT-related questions directly from the PIHPs during the pre-on-site phase.
  - HSAG prepared an agenda describing all on-site visit activities and indicating the type of staff needed for each session. The agendas were forwarded to the respective PIHPs approximately one month prior to the on-site visit. When requested, HSAG conducted pre-on-site conference calls with the PIHPs to discuss any outstanding ISCAT questions and on-site visit activities.

- **On-site Activities**
  - HSAG conducted on-site visits to each PIHP. Information was collected using several methods, including interviews, system demonstration, review of data output files, primary source verification, observation of data processing, and review of data reports. The on-site visit activities are described as follows:
    a. **Opening meetings**—included introductions of the validation team and key PIHP staff involved in the performance indicator activities. The review purpose, the required documentation, basic meeting logistics, and queries to be performed were discussed.
    b. **Evaluation of system compliance**—included a review of the information systems assessment, focusing on the processing of claims and encounter data, patient data, and provider data. Additionally, the review evaluated the processes used to collect and calculate the performance indicators, including accurate numerator and denominator identification, and algorithmic compliance (which evaluated whether rate calculations were performed correctly, all data were combined appropriately, and numerator events were counted accurately).
    c. **Review of ISCAT and supporting documentation**—included a review of the processes used for collecting, storing, validating, and reporting performance indicator data. This session was designed to be interactive with key PIHP staff so that the review team could obtain a complete picture of all the steps taken to generate the performance indicators. The goal of the session was to obtain a complete picture of the degree of compliance with written documentation. Interviews were used to confirm findings from the documentation review, expand or clarify outstanding issues, and ascertain that written policies and procedures were used and followed in daily practice.
    d. **Overview of data integration and control procedures**—included discussion and observation of source code logic and a review of how all data sources were combined and how the analytic file was produced for the reporting of selected performance indicators. Primary source verification was performed to further validate the output files. Backup documentation on data integration was reviewed. Data control and security procedures were also addressed during this session.
    e. **Closing conference**—summarized preliminary findings based on the review of the ISCAT and the on-site visit, and revisited the documentation requirements for any postvisit 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)	SFY 2009
Source Code (Programming Language) for Performance Measures (From MDCH)	SFY 2009
Previous Performance Measure Reports (From PIHPs)	SFY 2009
Performance Measure Reports (From PIHPs and MDCH)	First Quarter of SFY 2010
Supporting Documentation (From PIHPs and MDCH)	First Quarter of SFY 2010
On-site Interviews and Demonstrations (From PIHPs and MDCH)	First Quarter of SFY 2010

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 2010
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 2010
3.	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional.	PIHP	First Quarter SFY 2010
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	PIHP	First Quarter SFY 2010

Table 2-4—List of Performance Indicators for PIHPs			
Indicator		Calculation by:	Validation Review Period
4b.	Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	PIHP	First Quarter SFY 2010
5.	Percentage of Medicaid recipients having received PIHP-managed services (penetration rate).	MDCH	First Quarter SFY 2010
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 2010
10.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of adults dually diagnosed with mental illness/developmental disability served by the PIHPs who are employed competitively.	MDCH	SFY 2009
11.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of adults dually diagnosed with mental illness/developmental disability served by the PIHPs who earned minimum wage or more from any employment activities.	MDCH	SFY 2009
12.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	PIHP	First Quarter SFY 2010
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 2009
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 2009

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, the percentage of adults with developmental disabilities, and the percentage of adults dually diagnosed with mental illness/developmental disability served by the PIHPs who are employed competitively.	✓		
11.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of adults dually diagnosed with mental illness/developmental disability 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 QAPIP, 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 is expected to have a favorable effect 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. For the 2009–2010 validation cycle, all PIHPs continued with the PIP on improving penetration rates for children with a serious emotional disturbance (SED), children with a developmental disability (DD), and children who have both a serious emotional disturbance and a developmental disability.

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 steps:

- Step I. Review the Selected Study Topic(s)
- Step II. Review the Study Question(s)
- Step III. Review the Selected Study Indicator(s)
- Step IV. Review the Identified Study Population
- Step V. Review Sampling Methods

- Step VI. Review Data Collection Procedures
- Step VII. Assess the Health Plan's Improvement Strategies
- Step VIII. Review Data Analysis and the Interpretation of Study Results
- Step IX. Assess for Real Improvement
- Step X. Assess for Sustained Improvement

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 Steps 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)	SFY 2010

Data Aggregation, Analysis, and How Conclusions Were Drawn

HSAG used the following methodology to evaluate PIPs conducted by the PIHPs to determine if a PIP is valid and to rate the percentage of compliance with CMS' protocol for conducting PIPs.

Each PIP step consisted of critical and noncritical evaluation elements necessary for successful completion of a valid PIP. Each evaluation element was scored as *Met (M)*, *Partially Met (PM)*, *Not Met (NM)*, *Not Applicable (NA),* or *Not Assessed*.

The percentage score for all evaluation elements was calculated by dividing the number of elements (including critical elements) *Met* by the sum of evaluation elements *Met, Partially Met,* and *Not Met*. The percentage score for critical elements *Met* was calculated by dividing the number of critical elements *Met* by the sum of critical elements *Met, Partially Met,* and *Not Met.* The scoring methodology also included the *Not Applicable* designation for situations in which the evaluation element did not apply to the PIP. For example, in Step V, if the PIP did not use sampling techniques, HSAG would score the evaluation elements in Step V as *Not Applicable*. HSAG used the *Not Assessed* scoring designation when the PIP had not progressed to the remaining steps in the CMS protocol. HSAG used a *Point of Clarification* when 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 CMS protocols.

The validation status score was based on the percentage score and whether or not critical elements were *Met*, *Partially Met,* or *Not Met.* Due to the importance of critical elements, any critical element scored as *Not Met* would invalidate a PIP. Critical elements that were *Partially Met* and noncritical elements that were *Partially Met* or *Not Met* would not invalidate the PIP, but they would affect the

overall percentage score (which indicates the percentage of the PIP's compliance with CMS' protocol for conducting PIPs).

The scoring methodology was designed to ensure that critical elements are a must-pass step. If at least one critical element was *Not Met*, the overall validation status was *Not Met*. In addition, the methodology addressed the potential situation in which all critical elements were *Met*, but suboptimal performance was observed for noncritical elements. The final outcome would be based on the overall percentage score.

All PIPs were scored as follows:

- *Met*: All critical elements were *Met* and 80 percent to 100 percent of all evaluation elements were *Met* across all activities.
- *Partially Met*: All critical elements were *Met* and 60 percent 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*.

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 documented the findings and recommendations for each validated PIP. HSAG forwarded these completed PIP Validation Tools 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 2009–2010 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 on the standards listed in Table 3-1 that scored less than *Met* in the previous review. None of the PIHPs required follow-up on the Subcontracts and Delegation or Coordination of Care standards as all PIHPs had achieved 100 percent compliance during the 2008–2009 compliance reviews.

HSAG assigned the compliance standards to the domains of **quality**, **timeliness**, and **access** to care as follows:

Table 3-1—Standards

Standard		Quality	Timeliness	Access
I	QAPIP Plan and Structure	✓		
II	Performance Measurement and Improvement	✓	✓	
III	Practice Guidelines	✓		
IV	Staff Qualifications and Training	✓		
V	Utilization Management		✓	✓
VI	Customer Services	✓		✓
VII	Enrollee Grievance Process	✓	✓	
VIII	Enrollee Rights and Protections	✓		
IX	Subcontracts and Delegation	✓		
X	Provider Network	✓		✓
XI	Credentialing	✓		
XII	Access and Availability		✓	✓
XIII	Coordination of Care	✓		✓
XIV	Appeals	✓	✓	

Access Alliance of Michigan

Overall Compliance Monitoring Results

Table 3-2 presents the results from the initial review in 2008–2009 and the follow-up review in 2009–2010, showing the number of elements for each of the standards that received a score of *Met*, *Substantially Met*, *Partially Met*, *Not Met*, or *NA*. The table also shows total compliance scores after the follow-up review for each of the standards and across all standards. The 2009–2010 External Quality Review Compliance Monitoring Report for **Access Alliance of Michigan** contains details of the follow-up review.

Table 3-2—Summary of Compliance Scores
Prior Year (2008–2009) and Current Year (2009–2010)

Standard		Total Applicable Elements	Prior Year	Current Year					2009–2010 Total Compliance Score
			M	*M*	*SM*	*PM*	*NM*	*NA*	
I	QAPIP Plan and Structure	18	18	No follow-up review required					100%
II	Performance Measurement and Improvement	21	21	No follow-up review required					100%
III	Practice Guidelines	14	14	No follow-up review required					100%
IV	Staff Qualifications and Training	6	6	No follow-up review required					100%
V	Utilization Management	19	18	1	0	0	0	0	100%
VI	Customer Services	11	11	No follow-up review required					100%
VII	Enrollee Grievance Process	13	12	1	0	0	0	0	100%
VIII	Enrollee Rights and Protections	31	29	2	0	0	0	0	100%
IX	Subcontracts and Delegation	7	7	No follow-up review required					100%
X	Provider Network	12	12	No follow-up review required					100%
XI	Credentialing	25	25	No follow-up review required					100%
XII	Access and Availability	17	13	4	0	0	0	0	100%
XIII	Coordination of Care	3	3	No follow-up review required					100%
XIV	Appeals	15	15	No follow-up review required					100%
	Overall	212	204	8	0	0	0	0	100%

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

Total # of Applicable Elements: The total number of elements within each standard minus any elements that received a score of *NA*.

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* in the prior review plus the number of elements that received a score of *Met* in the current review to the weighted (multiplied by 0.75) number of elements that received a score of *Substantially Met* and the weighted (multiplied by 0.50) number that received a score of *Partially Met*, then dividing this total by the total number of applicable elements.

Strengths

Access Alliance of Michigan received an overall compliance score of 100 percent across all standards. In the 2008–2009 review, the PIHP had achieved 100 percent compliance on the following standards: QAPIP Plan and Structure, Performance Measurement and Improvement, Practice Guidelines, Staff Qualifications and Training, Customer Services, Subcontracts and Delegation, Provider Network, Credentialing, Coordination of Care, and Appeals. Therefore, no follow-up review was required for these standards. **Access Alliance of Michigan** successfully addressed all recommendations for improvement in the Utilization Management, Enrollee Grievance Process, Enrollee Rights and Protections, and Access and Availability standards.

Recommendations

The 2009–2010 follow-up review did not result in any recommendations for improvement as **Access Alliance of Michigan** achieved 100 percent compliance on all standards.

Summary Assessment Related to Quality, Timeliness, and Access

Access Alliance of Michigan demonstrated exceptional performance across the three domains of **quality**, **timeliness**, and **access**. The 2008–2009 compliance review resulted in full compliance on 10 of the 12 standards in the **quality** domain, 2 of the 5 standards in the t**imeliness** domain, and 3 of the 5 standards in the **access** domain. Standards included in the 2009–2010 follow-up review addressed all three domains. In the **quality** domain, the PIHP implemented corrective actions in the areas of grievances and enrollee rights, achieving 100 percent compliance after follow-up on these standards. Most of the opportunities for improvement identified in the 2008–2009 compliance review addressed the **timeliness** domain, where the PIHP demonstrated full compliance after the follow-up review on the Utilization Management, Enrollee Grievance Process, and Access and Availability standards. After the 2009–2010 follow-up review, **Access Alliance of Michigan** achieved 100 percent compliance on all standards across the three domains.

CMH Affiliation of Mid-Michigan

Overall Compliance Monitoring Results

Table 3-3 presents the results from the initial review in 2008–2009 and the follow-up review in 2009–2010, showing the number of elements for each of the standards that received a score of *Met*, *Substantially Met*, *Partially Met*, *Not Met*, or *NA*. The table also shows total compliance scores after the follow-up review for each of the standards and across all standards. The 2009–2010 External Quality Review Compliance Monitoring Report for **CMH Affiliation of Mid-Michigan** contains a more detailed description of the results.

Table 3-3—Summary of Compliance Scores
Prior Year (2008–2009) and Current Year (2009–2010)

Standard		Total Applicable Elements	Prior Year	Current Year					2009–2010 Total Compliance Score
			M	*M*	*SM*	*PM*	*NM*	*NA*	
I	QAPIP Plan and Structure	18	14	4	0	0	0	0	100%
II	Performance Measurement and Improvement	21	20	1	0	0	0	0	100%
III	Practice Guidelines	14	12	2	0	0	0	0	100%
IV	Staff Qualifications and Training	6	5	1	0	0	0	0	100%
V	Utilization Management	19	19	No follow-up review required					100%
VI	Customer Services	11	10	1	0	0	0	0	100%
VII	Enrollee Grievance Process	13	10	3	0	0	0	0	100%
VIII	Enrollee Rights and Protections	31	31	No follow-up review required					100%
IX	Subcontracts and Delegation	6	6	No follow-up review required					100%
X	Provider Network	11	10	1	0	0	0	0	100%
XI	Credentialing	23	23	No follow-up review required					100%
XII	Access and Availability	17	17	No follow-up review required					100%
XIII	Coordination of Care	3	3	No follow-up review required					100%
XIV	Appeals	15	10	5	0	0	0	0	100%
	Overall	208	190	18	0	0	0	0	100%

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

Total # of Applicable Elements: The total number of elements within each standard minus any elements that received a score of *NA*.

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* in the prior review plus the number of elements that received a score of *Met* in the current review to the weighted (multiplied by 0.75) number of elements that received a score of *Substantially Met* and the weighted (multiplied by 0.50) number that received a score of *Partially Met*, then dividing this total by the total number of applicable elements.

Strengths

CMH Affiliation of Mid-Michigan received an overall compliance score of 100 percent across all standards. In the 2008–2009 review, the PIHP had achieved 100 percent compliance on the following standards: Utilization Management, Enrollee Rights and Protections, Subcontracts and Delegation, Credentialing, Access and Availability, and Coordination of Care. Therefore, no follow-up review was required for these standards. **CMH Affiliation of Mid-Michigan** successfully addressed all recommendations for improvement in the QAPIP Plan and Structure, Performance Measurement and Improvement, Practice Guidelines, Staff Qualifications and Training, Customer Services, Enrollee Grievance Process, Provider Network, and Appeals standards.

Recommendations

The 2009–2010 follow-up review did not result in any recommendations for improvement as **CMH Affiliation of Mid-Michigan** achieved 100 percent compliance on all standards.

Summary Assessment Related to Quality, Timeliness, and Access

CMH Affiliation of Mid-Michigan demonstrated exceptional performance across the three domains of **quality**, **timeliness**, and **access**. The 2008–2009 compliance review resulted in full compliance on 4 of the 12 standards in the **quality** domain, 2 of the 5 standards in the **timeliness** domain, and 3 of the 5 standards in the **access** domain. Standards included in the 2009–2010 follow-up review addressed all three domains. The PIHP implemented corrective actions on two-thirds of the standards in the **quality** domain to achieve full compliance. The PIHP demonstrated the most marked improvement on the standards in this domain, which included nearly all of the opportunities for improvement identified in the 2009–2010 compliance review. In the **timeliness** and **access** domains, **CMH Affiliation of Mid-Michigan** implemented corrective actions on the Performance Measurement and Improvement, Customer Services, Enrollee Grievance Process, Provider Network, and Appeals standards. After the 2009–2010 follow-up review, **CMH Affiliation of Mid-Michigan** achieved 100 percent compliance on all standards across the three domains.

CMH for Central Michigan

Overall Compliance Monitoring Results

Table 3-4 presents the results from the initial review in 2008–2009 and the follow-up review in 2009–2010, showing the number of elements for each of the standards that received a score of *Met*, *Substantially Met*, *Partially Met*, *Not Met*, or *NA*. The table also shows total compliance scores after the follow-up review for each of the standards and across all standards. The 2009–2010 External Quality Review Compliance Monitoring Report for **CMH for Central Michigan** contains a more detailed description of the results.

Table 3-4—Summary of Compliance Scores
Prior Year (2008–2009) and Current Year (2009–2010)

Standard		Total Applicable Elements	Prior Year	Current Year					2009–2010 Total Compliance Score
			M	*M*	*SM*	*PM*	*NM*	*NA*	
I	QAPIP Plan and Structure	18	18	No follow-up review required					100%
II	Performance Measurement and Improvement	21	21	No follow-up review required					100%
III	Practice Guidelines	14	14	No follow-up review required					100%
IV	Staff Qualifications and Training	6	6	No follow-up review required					100%
V	Utilization Management	18	18	No follow-up review required					100%
VI	Customer Services	11	10	1	0	0	0	0	100%
VII	Enrollee Grievance Process	13	11	2	0	0	0	0	100%
VIII	Enrollee Rights and Protections	31	31	No follow-up review required					100%
IX	Subcontracts and Delegation	7	7	No follow-up review required					100%
X	Provider Network	12	12	No follow-up review required					100%
XI	Credentialing	25	25	No follow-up review required					100%
XII	Access and Availability	17	17	No follow-up review required					100%
XIII	Coordination of Care	3	3	No follow-up review required					100%
XIV	Appeals	15	14	1	0	0	0	0	100%
	Overall	211	207	4	0	0	0	0	100%

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

Total # of Applicable Elements: The total number of elements within each standard minus any elements that received a score of *NA*.

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* in the prior review plus the number of elements that received a score of *Met* in the current review to the weighted (multiplied by 0.75) number of elements that received a score of *Substantially Met* and the weighted (multiplied by 0.50) number that received a score of *Partially Met*, then dividing this total by the total number of applicable elements.

Strengths

CMH for Central Michigan received an overall compliance score of 100 percent across all standards. In the 2008–2009 review, the PIHP had achieved 100 percent compliance on the following standards: QAPIP Plan and Structure, Performance Measurement and Improvement, Practice Guidelines, Staff Qualifications and Training, Utilization Management, Enrollee Rights and Protections, Subcontracts and Delegation, Provider Network, Credentialing, Access and Availability, and Coordination of Care. Therefore, no follow-up review was required for these standards. **CMH for Central Michigan** successfully addressed all recommendations for improvement in the Customer Services, Enrollee Grievance Process, and Appeals standards.

Recommendations

The 2009–2010 follow-up review did not result in any recommendations for improvement as **CMH for Central Michigan** achieved 100 percent compliance on all standards.

Summary Assessment Related to Quality, Timeliness, and Access

CMH for Central Michigan demonstrated exceptional performance across the three domains of **quality**, **timeliness**, and **access**. The 2008–2009 compliance review resulted in full compliance on 9 of the 12 standards in the **quality** domain, 3 of the 5 standards in the **timeliness** domain, and 4 of the 5 standards in the **access** domain. Standards included in the 2009–2010 follow-up review addressed all three domains. The PIHP implemented corrective actions for the Enrollee Grievance Process and Appeals standards, which addressed the domains of **quality** and **timeliness**, and achieved 100 percent compliance after the follow-up review. Upon follow-up, the PIHP demonstrated full compliance on the Customer Services standard, which addressed the domains of **quality** and **access**. After the 2009–2010 follow-up review, **CMH for Central Michigan** achieved 100 percent compliance on all standards across the three domains.

CMH Partnership of Southeastern Michigan

Overall Compliance Monitoring Results

Table 3-5 presents the results from the initial review in 2008–2009 and the follow-up review in 2009–2010, showing the number of elements for each of the standards that received a score of *Met*, *Substantially Met*, *Partially Met*, *Not Met*, or *NA*. The table also shows total compliance scores after the follow-up review for each of the standards and across all standards. The 2009–2010 External Quality Review Compliance Monitoring Report for **CMH Partnership of Southeastern Michigan** contains a more detailed description of the results.

Table 3-5—Summary of Compliance Scores
Prior Year (2008–2009) and Current Year (2009–2010)

Standard		Total Applicable Elements	Prior Year	Current Year					2009–2010 Total Compliance Score
			M	*M*	*SM*	*PM*	*NM*	*NA*	
I	QAPIP Plan and Structure	18	17	0	1	0	0	0	99%
II	Performance Measurement and Improvement	21	21	No follow-up review required					100%
III	Practice Guidelines	14	14	No follow-up review required					100%
IV	Staff Qualifications and Training	6	6	No follow-up review required					100%
V	Utilization Management	19	19	No follow-up review required					100%
VI	Customer Services	11	11	No follow-up review required					100%
VII	Enrollee Grievance Process	13	11	2	0	0	0	0	100%
VIII	Enrollee Rights and Protections	31	31	No follow-up review required					100%
IX	Subcontracts and Delegation	7	7	No follow-up review required					100%
X	Provider Network	12	12	No follow-up review required					100%
XI	Credentialing	24	24	No follow-up review required					100%
XII	Access and Availability	17	17	No follow-up review required					100%
XIII	Coordination of Care	3	3	No follow-up review required					100%
XIV	Appeals	15	14	0	1	0	0	0	98%
	Overall	211	207	2	2	0	0	0	100%

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

Total # of Applicable Elements: The total number of elements within each standard minus any elements that received a score of *NA*.

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* in the prior review plus the number of elements that received a score of *Met* in the current review to the weighted (multiplied by 0.75) number of elements that received a score of *Substantially Met* and the weighted (multiplied by 0.50) number that received a score of *Partially Met*, then dividing this total by the total number of applicable elements.

Strengths

CMH Partnership of Southeastern Michigan received an overall compliance score of 100 percent across all standards. In the 2008–2009 review, the PIHP had achieved 100 percent compliance on the following standards: Performance Measurement and Improvement, Practice Guidelines, Staff Qualifications and Training, Utilization Management, Customer Services, Enrollee Rights and Protections, Subcontracts and Delegation, Provider Network, Credentialing, Access and Availability, and Coordination of Care. Therefore, no follow-up review was required for these standards. **CMH Partnership of Southeastern Michigan** successfully addressed all recommendations for improvement on the Enrollee Grievance Process standard.

Recommendations

Continued recommendations for improving **CMH Partnership of Southeast Michigan**'s performance addressed the QAPIP Plan and Structure and Appeals standards. The PIHP should continue efforts to ensure that data from the Behavior Treatment Review Committee for review by the QAPIP include the required elements and that notices of appeal resolutions provide all information specified in the MDCH technical requirement.

Summary Assessment Related to Quality, Timeliness, and Access

CMH Partnership of Southeast Michigan demonstrated excellent performance across the three domains of **quality**, **timeliness**, and **access.** The 2008–2009 compliance review resulted in full compliance on 9 of the 12 standards in the **quality** domain, 3 of the 5 standards in the **timeliness** domain, and all 5 standards in the **access** domain. Standards included in the 2009–2010 follow-up review addressed the **quality** and **timeliness** domains. The PIHP demonstrated its strongest performance in the **access** domain, with full compliance on all 5 standards in the 2008–2009 review. In the **quality** domain, **CMH Partnership of Southeast Michigan** achieved 100 percent compliance on the Enrollee Grievance Process standard, but had one continued recommendation each on the QAPIP and Appeals standards. Performance in the **timeliness** domain was also strong, with full compliance on the Enrollee Grievance Process and one continued recommendation related to appeals. After the 2009–2010 follow-up review, **CMH Partnership of Southeast Michigan**'s improved performance resulted in 100 percent compliance on all standards in the **access** domain, 10 of the 12 standards in the **quality** domain, and 4 of the 5 standards in the **timeliness** domain.

Detroit-Wayne County CMH Agency

Overall Compliance Monitoring Results

Table 3-6 presents the results from the initial review in 2008–2009 and the follow-up review in 2009–2010, showing the number of elements for each of the standards that received a score of *Met*, *Substantially Met*, *Partially Met*, *Not Met*, or *NA*. The table also shows total compliance scores after the follow-up review for each of the standards and across all standards. The 2009–2010 External Quality Review Compliance Monitoring Report for **Detroit-Wayne County CMH Agency** contains a more detailed description of the results.

Table 3-6—Summary of Compliance Scores
Prior Year (2008–2009) and Current Year (2009–2010)

Standard		Total Applicable Elements	Prior Year	Current Year					2009–2010 Total Compliance Score
			M	*M*	*SM*	*PM*	*NM*	*NA*	
I	QAPIP Plan and Structure	18	17	0	1	0	0	0	99%
II	Performance Measurement and Improvement	21	21	No follow-up review required					100%
III	Practice Guidelines	14	14	No follow-up review required					100%
IV	Staff Qualifications and Training	6	6	No follow-up review required					100%
V	Utilization Management	19	16	3	0	0	0	0	100%
VI	Customer Services	11	9	2	0	0	0	0	100%
VII	Enrollee Grievance Process	13	7	4	2	0	0	0	96%
VIII	Enrollee Rights and Protections	31	31	No follow-up review required					100%
IX	Subcontracts and Delegation	6	6	No follow-up review required					100%
X	Provider Network	12	12	No follow-up review required					100%
XI	Credentialing	25	25	No follow-up review required					100%
XII	Access and Availability	17	7	6	0	1	3	0	79%
XIII	Coordination of Care	3	3	No follow-up review required					100%
XIV	Appeals	15	11	3	1	0	0	0	98%
	Overall	211	185	18	4	1	3	0	98%

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

Total # of Applicable Elements: The total number of elements within each standard minus any elements that received a score of *NA*.

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* in the prior review plus the number of elements that received a score of *Met* in the current review to the weighted (multiplied by 0.75) number of elements that received a score of *Substantially Met* and the weighted (multiplied by 0.50) number that received a score of *Partially Met*, then dividing this total by the total number of applicable elements.

Strengths

Detroit-Wayne County CMH Agency received an overall compliance score of 98 percent across all standards. In the 2008–2009 review, the PIHP had achieved 100 percent compliance on the following standards: Performance Measurement, Practice Guidelines, Staff Qualifications, Enrollee Rights and Protections, Subcontracts and Delegation, Provider Network, Credentialing, and Coordination of Care. Therefore, no follow-up review was required for these standards. **Detroit-Wayne County CMH Agency** successfully addressed all recommendations for improvement on the Utilization Management and Customer Services standards.

Recommendations

Recommendations for improving **Detroit-Wayne County CMH Agency**'s performance addressed the QAPIP Plan and Structure, Enrollee Grievance Process, Access and Availability, and Appeals standards. The PIHP should continue efforts to ensure that the quarterly review of data from the Behavior Treatment Review Committee includes all required data elements and that grievances are resolved within the required time frame. **Detroit-Wayne County CMH Agency** should continue efforts to meet the minimum performance standard for the access to care measures that fell below the minimum performance standard and revise its policies and procedures for handling beneficiary appeals.

Summary Assessment Related to Quality, Timeliness, and Access

Detroit-Wayne County CMH Agency demonstrated improved performance across the three domains of **quality**, **timeliness**, and **access.** The 2008–2009 compliance review resulted in full compliance on 8 of the 12 standards in the **quality** domain, 1 of the 5 standards in the **timeliness** domain, and 2 of the 5 standards in the **access** domain. Standards included in the 2009–2010 follow-up review addressed all three domains. The PIHP demonstrated its strongest performance in the **access** domain, with full compliance on 4 of the 5 standards after successfully addressing all prior recommendations on the Utilization Management and Customer Services standards. **Detroit-Wayne County CMH Agency** achieved the largest increase in score from the previous review on the Access and Availability standard, which addressed the **access** and **timeliness** domains. Performance in the **quality** domain was also strong, with full compliance on the Customer Services standard after implementing corrective actions. In the **timeliness** domain, **Detroit-Wayne County CMH Agency** achieved 100 percent compliance on the Utilization Management standard, but had continued recommendations on the Enrollee Grievance Process, Access and Availability, and Appeals standards. After the 2009–2010 follow-up review, **Detroit-Wayne County CMH Agency**'s improved performance resulted in 100 percent compliance on 9 of the 12 standards in the **quality** domain, 2 of the 5 standards in the **timeliness** domain, and 4 of the 5 standards in the **access** domain.

Genesee County CMH

Overall Compliance Monitoring Results

Table 3-7 presents the results from the initial review in 2008–2009 and the follow-up review in 2009–2010, showing the number of elements for each of the standards that received a score of *Met*, *Substantially Met*, *Partially Met*, *Not Met*, or *NA*. The table also shows total compliance scores after the follow-up review for each of the standards and across all standards. The 2009–2010 External Quality Review Compliance Monitoring Report for **Genesee County CMH** contains a more detailed description of the results.

Table 3-7—Summary of Compliance Scores
Prior Year (2008–2009) and Current Year (2009–2010)

Standard		Total Applicable Elements	Prior Year	Current Year					2009–2010 Total Compliance Score
			M	*M*	*SM*	*PM*	*NM*	*NA*	
I	QAPIP Plan and Structure	18	18	No follow-up review required					100%
II	Performance Measurement and Improvement	21	21	No follow-up review required					100%
III	Practice Guidelines	14	14	No follow-up review required					100%
IV	Staff Qualifications and Training	6	6	No follow-up review required					100%
V	Utilization Management	19	19	No follow-up review required					100%
VI	Customer Services	11	11	No follow-up review required					100%
VII	Enrollee Grievance Process	13	12	1	0	0	0	0	100%
VIII	Enrollee Rights and Protections	31	31	No follow-up review required					100%
IX	Subcontracts and Delegation	7	7	No follow-up review required					100%
X	Provider Network	12	12	No follow-up review required					100%
XI	Credentialing	24	24	No follow-up review required					100%
XII	Access and Availability	17	16	1	0	0	0	0	100%
XIII	Coordination of Care	3	3	No follow-up review required					100%
XIV	Appeals	15	15	No follow-up review required					100%
	Overall	211	209	2	0	0	0	0	100%

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

Total # of Applicable Elements: The total number of elements within each standard minus any elements that received a score of *NA*.

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* in the prior review plus the number of elements that received a score of *Met* in the current review to the weighted (multiplied by 0.75) number of elements that received a score of *Substantially Met* and the weighted (multiplied by 0.50) number that received a score of *Partially Met*, then dividing this total by the total number of applicable elements.

Strengths

Genesee County CMH received an overall compliance score of 100 percent across all standards. In the 2008–2009 review, the PIHP had achieved 100 percent compliance on the following standards: QAPIP Plan and Structure, Performance Measurement and Improvement, Practice Guidelines, Staff Qualifications and Training, Utilization Management, Customer Services, Enrollee Rights and Protections, Subcontracts and Delegation, Provider Network, Credentialing, Coordination of Care, and Appeals. Therefore, no follow-up review was required for these standards. **Genesee County CMH** successfully addressed all recommendations for improvement on the Enrollee Grievance Process and Access and Availability standards.

Recommendations

The 2009–2010 follow-up review did not result in any recommendations for improvement as **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**. The 2008–2009 compliance review resulted in full compliance on 11 of the 12 standards in the **quality** domain, 3 of the 5 standards in the **timeliness** domain, and 4 of the 5 standards in the **access** domain. Both recommendations for improvement from the 2008–2009 review addressed the **timeliness** domain. Following the 2009–2010 compliance review, **Genesee County CMH** achieved full compliance on the Enrollee Grievance Process standard related to the **quality** and **timeliness** domains and the Access and Availability standard that addressed the **timeliness** and **access** domains. After the 2009–2010 follow-up review, **Genesee County CMH** achieved 100 percent compliance on all standards across the three domains.

Lakeshore Behavioral Health Alliance

Overall Compliance Monitoring Results

Table 3-8 presents the results from the initial review in 2008–2009 and the follow-up review in 2009–2010, showing the number of elements for each of the standards that received a score of *Met*, *Substantially Met*, *Partially Met*, *Not Met*, or *NA*. The table also shows total compliance scores after the follow-up review for each of the standards and across all standards. The 2009–2010 External Quality Review Compliance Monitoring Report for **Lakeshore Behavioral Health Alliance** contains a more detailed description of the results.

Table 3-8—Summary of Compliance Scores
Prior Year (2008–2009) and Current Year (2009–2010)

Standard		Total Applicable Elements	Prior Year	Current Year					2009–2010 Total Compliance Score
			M	*M*	*SM*	*PM*	*NM*	*NA*	
I	QAPIP Plan and Structure	18	12	5	0	0	1	0	94%
II	Performance Measurement and Improvement	21	18	2	1	0	0	0	99%
III	Practice Guidelines	14	14	No follow-up review required					100%
IV	Staff Qualifications and Training	6	6	No follow-up review required					100%
V	Utilization Management	19	4	10	5	0	0	0	93%
VI	Customer Services	11	10	1	0	0	0	0	100%
VII	Enrollee Grievance Process	13	10	2	0	1	0	0	96%
VIII	Enrollee Rights and Protections	31	30	0	1	0	0	0	99%
IX	Subcontracts and Delegation	7	7	No follow-up review required					100%
X	Provider Network	12	12	No follow-up review required					100%
XI	Credentialing	24	24	No follow-up review required					100%
XII	Access and Availability	17	13	4	0	0	0	0	100%
XIII	Coordination of Care	3	3	No follow-up review required					100%
XIV	Appeals	14	13	0	1	0	0	0	98%
	Overall	210	176	24	8	1	1	0	98%

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

Total # of Applicable Elements: The total number of elements within each standard minus any elements that received a score of *NA*.

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* in the prior review plus the number of elements that received a score of *Met* in the current review to the weighted (multiplied by 0.75) number of elements that received a score of *Substantially Met* and the weighted (multiplied by 0.50) number that received a score of *Partially Met*, then dividing this total by the total number of applicable elements.

Strengths

Lakeshore Behavioral Health Alliance received an overall compliance score of 98 percent across all standards. In the 2008–2009 review, the PIHP had achieved 100 percent compliance on the following standards: Practice Guidelines, Staff Qualifications and Training, Subcontracts and Delegation, Provider Network, Credentialing, and Coordination of Care. Therefore, no follow-up review was required for these standards. **Lakeshore Behavioral Health Alliance** successfully addressed all recommendations for improvement on the Customer Services and Access and Availability standards.

Recommendations

Recommendations for improving **Lakeshore Behavioral Health Alliance**'s performance addressed the QAPIP Plan and Structure, Performance Measurement and Improvement, Utilization Management, Enrollee Grievance Process, Enrollee Rights and Protections, and Appeals standards. The PIHP should ensure that it complies with all requirements related to the QAPIP and providing enrollee information, and continue efforts to ensure that its policies, procedures, and processes for utilization management, grievances, and beneficiary appeals are fully compliant with all contractual requirements.

Summary Assessment Related to Quality, Timeliness, and Access

Lakeshore Behavioral Health Alliance demonstrated mixed performance across the three domains of **quality**, **timeliness**, and **access**. The 2008–2009 compliance review resulted in full compliance on 6 of the 12 standards in the **quality** domain, none of the 5 standards in the t**imeliness** domain, and 2 of the 5 standards in the **access** domain. Standards included in the 2009–2010 follow-up review addressed all three domains. **Lakeshore Behavioral Health Alliance**'s strongest performance was in the **access** domain, with 4 of the 5 standards in full compliance after successfully addressing all prior recommendations on the Customer Services and Access and Availability standards. While the PIHP achieved the largest increase in score from the previous review on the Utilization Management standard related the **access** and **timeliness** domains, the 2009–2010 review resulted in several continued recommendations on this standard. The **timeliness** domain had the lowest performance, with only the Access and Availability standard in full compliance. Almost all continued recommendations addressed this domain. After the 2009–2010 follow-up review, **Lakeshore Behavioral Health Alliance**'s improved performance resulted in 100 percent compliance on 4 of the 5 standards in the **access** domain, 7 of the 12 standards in the **quality** domain, and 1 of the 5 standards in the **timeliness** domain.

LifeWays

Overall Compliance Monitoring Results

Table 3-9 presents the results from the initial review in 2008–2009 and the follow-up review in 2009–2010, showing the number of elements for each of the standards that received a score of *Met*, *Substantially Met*, *Partially Met*, *Not Met*, or *NA*. The table also shows total compliance scores after the follow-up review for each of the standards and across all standards. The 2009–2010 External Quality Review Compliance Monitoring Report for **LifeWays** contains a more detailed description of the results.

Table 3-9—Summary of Compliance Scores
Prior Year (2008–2009) and Current Year (2009–2010)

Standard		Total Applicable Elements	Prior Year	Current Year					2009–2010 Total Compliance Score
			M	*M*	*SM*	*PM*	*NM*	*NA*	
I	QAPIP Plan and Structure	18	18	No follow-up review required					100%
II	Performance Measurement and Improvement	21	21	No follow-up review required					100%
III	Practice Guidelines	14	14	No follow-up review required					100%
IV	Staff Qualifications and Training	6	6	No follow-up review required					100%
V	Utilization Management	19	19	No follow-up review required					100%
VI	Customer Services	11	11	No follow-up review required					100%
VII	Enrollee Grievance Process	13	10	2	1	0	0	0	98%
VIII	Enrollee Rights and Protections	31	30	1	0	0	0	0	100%
IX	Subcontracts and Delegation	7	7	No follow-up review required					100%
X	Provider Network	12	12	No follow-up review required					100%
XI	Credentialing	25	25	No follow-up review required					100%
XII	Access and Availability	17	17	No follow-up review required					100%
XIII	Coordination of Care	3	3	No follow-up review required					100%
XIV	Appeals	15	12	2	0	1	0	0	97%
	Overall	212	205	5	1	1	0	0	100%

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

Total # of Applicable Elements: The total number of elements within each standard minus any elements that received a score of *NA*.

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* in the prior review plus the number of elements that received a score of *Met* in the current review to the weighted (multiplied by 0.75) number of elements that received a score of *Substantially Met* and the weighted (multiplied by 0.50) number that received a score of *Partially Met*, then dividing this total by the total number of applicable elements.

Strengths

LifeWays received an overall compliance score of 100 percent across all standards. In the 2008–2009 review, the PIHP had achieved 100 percent compliance on the following standards: QAPIP Plan and Structure, Performance Measurement and Improvement, Practice Guidelines, Staff Qualifications and Training, Utilization Management, Customer Services, Subcontracts and Delegation, Provider Network, Credentialing, Access and Availability, and Coordination of Care. Therefore, no follow-up review was required for these standards. **LifeWays** successfully addressed all recommendations for improvement on the Enrollee Rights and Protections standard.

Recommendations

Recommendations for improving **LifeWays**' performance addressed the Enrollee Grievance Process and Appeals standards. The PIHP should ensure that its policies, procedures, and member materials related to grievances and beneficiary appeals are fully compliant with all contractual requirements.

Summary Assessment Related to Quality, Timeliness, and Access

LifeWays demonstrated strong performance across the three domains of **quality**, **timeliness**, and **access**. The 2008–2009 compliance review resulted in full compliance on 9 of the 12 standards in the **quality** domain, 3 of the 5 standards in the **timeliness** domain, and all 5 standards in the **access** domain. Standards included in the 2009–2010 follow-up review addressed the **quality** and **timeliness** domains. The PIHP demonstrated its strongest performance in the **access** domain, with full compliance on all 5 standards in the 2008–2009 review. The PIHP successfully addressed the prior recommendation on the Enrollee Rights and Protections standard, related to the **quality** domain. The follow-up review resulted in continuing recommendations on the Enrollee Grievance Process and Appeals standards, which addressed the domains of **quality** and **timeliness.** After the 2009–2010 follow-up review, **LifeWays**' improved performance resulted in 100 percent compliance on all standards in the **access** domain, 10 of the 12 standards in the **quality** domain, and 3 of the 5 standards in the **timeliness** domain.

Macomb County CMH Services

Overall Compliance Monitoring Results

Table 3-10 presents the results from the initial review in 2008–2009 and the follow-up review in 2009–2010, showing the number of elements for each of the standards that received a score of *Met*, *Substantially Met*, *Partially Met*, *Not Met*, or *NA*. The table also shows total compliance scores after the follow-up review for each of the standards and across all standards. The 2009–2010 External Quality Review Compliance Monitoring Report for **Macomb County CMH Services** contains a more detailed description of the results.

Table 3-10—Summary of Compliance Scores
Prior Year (2008–2009) and Current Year (2009–2010)

Standard		Total Applicable Elements	Prior Year	Current Year					2009–2010 Total Compliance Score
			M	*M*	*SM*	*PM*	*NM*	*NA*	
I	QAPIP Plan and Structure	18	18	No follow-up review required					100%
II	Performance Measurement and Improvement	21	21	No follow-up review required					100%
III	Practice Guidelines	10	10	No follow-up review required					100%
IV	Staff Qualifications and Training	6	6	No follow-up review required					100%
V	Utilization Management	19	19	No follow-up review required					100%
VI	Customer Services	11	8	1	2	0	0	0	95%
VII	Enrollee Grievance Process	13	12	1	0	0	0	0	100%
VIII	Enrollee Rights and Protections	31	31	No follow-up review required					100%
IX	Subcontracts and Delegation	7	7	No follow-up review required					100%
X	Provider Network	12	12	No follow-up review required					100%
XI	Credentialing	25	25	No follow-up review required					100%
XII	Access and Availability	17	13	4	0	0	0	0	100%
XIII	Coordination of Care	3	3	No follow-up review required					100%
XIV	Appeals	15	14	0	1	0	0	0	98%
	Overall	208	199	6	3	0	0	0	100%

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

Total # of Applicable Elements: The total number of elements within each standard minus any elements that received a score of *NA*.

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* in the prior review plus the number of elements that received a score of *Met* in the current review to the weighted (multiplied by 0.75) number of elements that received a score of *Substantially Met* and the weighted (multiplied by 0.50) number that received a score of *Partially Met*, then dividing this total by the total number of applicable elements.

Strengths

Macomb County CMH Services received an overall compliance score of 100 percent across all standards. In the 2008–2009 review, the PIHP had achieved 100 percent compliance on the following standards: QAPIP Plan and Structure, Performance Measurement and Improvement, Practice Guidelines, Staff Qualifications and Training, Utilization Management, Enrollee Rights and Protections, Subcontracts and Delegation, Provider Network, Credentialing, and Coordination of Care. Therefore, no follow-up review was required for these standards. **Macomb County CMH Services** successfully addressed all recommendations for improvement on the Enrollee Grievance Process and Access and Availability standards.

Recommendations

Recommendations for improving **Macomb County CMH Services**' performance addressed the Customer Services and Appeals standards. The PIHP should continue efforts to complete the revision and distribution of its member handbook as well as the implementation of the revised appeal notice of disposition.

Summary Assessment Related to Quality, Timeliness, and Access

Macomb County CMH Services demonstrated excellent performance across the three domains of **quality**, **timeliness**, and **access**. The 2008–2009 compliance review resulted in full compliance on 9 of the 12 standards in the **quality** domain, 2 of the 5 standards in the **timeliness** domain, and 3 of the 5 standards in the **access** domain. Standards included in the 2009–2010 follow-up review addressed all three domains. The PIHP's strongest performance was in the **quality** domain, with 10 of the 12 standards in full compliance after successfully addressing all prior recommendations on the Enrollee Grievance Process standard. In the **timeliness** and **access** domains, **Macomb County CMH Services** implemented corrective actions in the Access and Availability standard, resulting in 100 percent compliance. After the 2009–2010 follow-up review, **Macomb County CMH Services**' improved performance resulted in 100 percent compliance on 10 of the 12 standards in the **quality** domain, 4 of the 5 standards in the **timeliness** domain, and 4 of the 5 standards in the **access** domain.

network180

Overall Compliance Monitoring Results

Table 3-11 presents the results from the initial review in 2008–2009 and the follow-up review in 2009–2010, showing the number of elements for each of the standards that received a score of *Met*, *Substantially Met*, *Partially Met*, *Not Met*, or *NA*. The table also shows total compliance scores after the follow-up review for each of the standards and across all standards. The 2009–2010 External Quality Review Compliance Monitoring Report for **network180** contains a more detailed description of the results.

Table 3-11—Summary of Compliance Scores
Prior Year (2008–2009) and Current Year (2009–2010)

Standard		Total Applicable Elements	Prior Year	Current Year					2009–2010 Total Compliance Score
			M	*M*	*SM*	*PM*	*NM*	*NA*	
I	QAPIP Plan and Structure	18	18	No follow-up review required					100%
II	Performance Measurement and Improvement	21	21	No follow-up review required					100%
III	Practice Guidelines	10	10	No follow-up review required					100%
IV	Staff Qualifications and Training	6	6	No follow-up review required					100%
V	Utilization Management	19	19	No follow-up review required					100%
VI	Customer Services	11	11	No follow-up review required					100%
VII	Enrollee Grievance Process	13	10	2	0	1	0	0	96%
VIII	Enrollee Rights and Protections	31	31	No follow-up review required					100%
IX	Subcontracts and Delegation	7	7	No follow-up review required					100%
X	Provider Network	12	12	No follow-up review required					100%
XI	Credentialing	24	22	1	0	1	0	0	98%
XII	Access and Availability	17	14	1	0	1	1	0	91%
XIII	Coordination of Care	3	3	No follow-up review required					100%
XIV	Appeals	15	14	0	1	0	0	0	98%
	Overall	207	198	4	1	3	1	0	99%

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

Total # of Applicable Elements: The total number of elements within each standard minus any elements that received a score of *NA*.

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* in the prior review plus the number of elements that received a score of *Met* in the current review to the weighted (multiplied by 0.75) number of elements that received a score of *Substantially Met* and the weighted (multiplied by 0.50) number that received a score of *Partially Met*, then dividing this total by the total number of applicable elements.

Strengths

network180 received an overall compliance score of 99 percent across all standards. In the 2008–2009 review, the PIHP had achieved 100 percent compliance on the following standards: QAPIP Plan and Structure, Performance Measurement and Improvement, Practice Guidelines, Staff Qualifications and Training, Utilization Management, Customer Services, Enrollee Rights and Protections, Subcontracts and Delegation, Provider Network, and Coordination of Care. Therefore, no follow-up review was required for these standards. **network180** implemented corrective actions and demonstrated strong performance on the Enrollee Grievance Process, Credentialing, Access and Availability, and Appeals standards.

Recommendations

Recommendations for improving **network180**'s performance addressed the Enrollee Grievance Process, Credentialing, Access and Availability, and Appeals standards. The PIHP should complete the revisions of its grievance process, appeals, and credentialing policies and continue efforts to develop and implement enhanced monitoring of the delegated grievance function. **network180** should continue efforts to meet the minimum performance standards for access to ongoing services.

Summary Assessment Related to Quality, Timeliness, and Access

network180 demonstrated mixed performance across the three domains of **quality**, **timeliness**, and **access**. The 2008–2009 compliance review resulted in full compliance on 9 of the 12 standards in the **quality** domain, 2 of the 5 standards in the **timeliness** domain, and 4 of the 5 standards in the **access** domain. Standards included in the 2009–2010 follow-up review addressed all three domains. While the PIHP successfully addressed some of the prior recommendations, the 2009–2010 follow-up review resulted in continued recommendations on standards across all three domains. Most of the opportunities for improvement identified in the 2009–2010 review addressed the **quality** and **timeliness** domains. After the 2009–2010 follow-up review, **network180**'s performance resulted in 100 percent compliance on 9 of the 12 standards in the **quality** domain, 2 of the 5 standards in the **timeliness** domain, and 4 of the 5 standards in the **access** domain.

NorthCare

Overall Compliance Monitoring Results

Table 3-12 presents the results from the initial review in 2008–2009 and the follow-up review in 2009–2010, showing the number of elements for each of the standards that received a score of *Met*, *Substantially Met*, *Partially Met*, *Not Met*, or *NA*. The table also shows total compliance scores after the follow-up review for each of the standards and across all standards. The 2009–2010 External Quality Review Compliance Monitoring Report for **NorthCare** contains a more detailed description of the results.

Table 3-12—Summary of Compliance Scores
Prior Year (2008–2009) and Current Year (2009–2010)

Standard		Total Applicable Elements	Prior Year	Current Year					2009–2010 Total Compliance Score
			M	*M*	*SM*	*PM*	*NM*	*NA*	
I	QAPIP Plan and Structure	18	18	No follow-up review required					100%
II	Performance Measurement and Improvement	21	20	1	0	0	0	0	100%
III	Practice Guidelines	14	13	1	0	0	0	0	100%
IV	Staff Qualifications and Training	6	6	No follow-up review required					100%
V	Utilization Management	19	19	No follow-up review required					100%
VI	Customer Services	11	11	No follow-up review required					100%
VII	Enrollee Grievance Process	13	11	1	0	1	0	0	96%
VIII	Enrollee Rights and Protections	31	29	2	0	0	0	0	100%
IX	Subcontracts and Delegation	7	7	No follow-up review required					100%
X	Provider Network	12	12	No follow-up review required					100%
XI	Credentialing	25	25	No follow-up review required					100%
XII	Access and Availability	17	13	4	0	0	0	0	100%
XIII	Coordination of Care	3	3	No follow-up review required					100%
XIV	Appeals	15	12	1	0	2	0	0	93%
	Overall	212	199	10	0	3	0	0	99%

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

Total # of Applicable Elements: The total number of elements within each standard minus any elements that received a score of *NA*.

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* in the prior review plus the number of elements that received a score of *Met* in the current review to the weighted (multiplied by 0.75) number of elements that received a score of *Substantially Met* and the weighted (multiplied by 0.50) number that received a score of *Partially Met*, then dividing this total by the total number of applicable elements.

Strengths

NorthCare received an overall compliance score of 99 percent across all standards. In the 2008–2009 review, the PIHP had achieved 100 percent compliance on the following standards: QAPIP Plan and Structure, Staff Qualifications and Training, Utilization Management, Customer Services, Subcontracts and Delegation, Provider Network, Credentialing, and Coordination of Care. Therefore, no follow-up review was required for these standards. **NorthCare** successfully addressed all recommendations for improvement on the Performance Measurement and Improvement, Practice Guidelines, Enrollee Rights and Protections, and Access and Availability standards.

Recommendations

Recommendations for improving **NorthCare**'s performance addressed the Enrollee Grievance Process and Appeals standards. The PIHP should continue efforts to ensure that the disposition notices for grievances and beneficiary appeals include all required information.

Summary Assessment Related to Quality, Timeliness, and Access

NorthCare demonstrated strong performance across the three domains of **quality**, **timeliness**, and **access**. The 2008–2009 compliance review resulted in full compliance on 7 of the 12 standards in the **quality** domain, 1 of the 5 standards in the **timeliness** domain, and 4 of the 5 standards in the **access** domain. Standards included in the 2009–2010 follow-up review addressed all three domains. **NorthCare**'s strongest performance was in the **access** domain, where the PIHP implemented corrective actions on the Access and Availability standard, resulting in full compliance on all standards in this domain. In the **quality** domain, **NorthCare** successfully addressed all prior recommendations on the Performance Measurement and Improvement, Practice Guidelines, and Enrollee Rights and Protections standards. After the 2009–2010 follow-up review, **NorthCare**'s improved performance resulted in 100 percent compliance on all standards in the **access** domain, 10 of the 12 standards in the **quality** domain, and 3 of the 5 standards in the **timeliness** domain.

Northern Affiliation

Overall Compliance Monitoring Results

Table 3-13 presents the results from the initial review in 2008–2009 and the follow-up review in 2009–2010, showing the number of elements for each of the standards that received a score of *Met*, *Substantially Met*, *Partially Met*, *Not Met*, or *NA*. The table also shows total compliance scores after the follow-up review for each of the standards and across all standards. The 2009–2010 External Quality Review Compliance Monitoring Report for **Northern Affiliation** contains a more detailed description of the results.

Table 3-13—Summary of Compliance Scores
Prior Year (2008–2009) and Current Year (2009–2010)

Standard		Total Applicable Elements	Prior Year	Current Year					2009–2010 Total Compliance Score
			M	*M*	*SM*	*PM*	*NM*	*NA*	
I	QAPIP Plan and Structure	18	18	No follow-up review required					100%
II	Performance Measurement and Improvement	21	21	No follow-up review required					100%
III	Practice Guidelines	10	10	No follow-up review required					100%
IV	Staff Qualifications and Training	6	6	No follow-up review required					100%
V	Utilization Management	19	17	2	0	0	0	0	100%
VI	Customer Services	11	11	No follow-up review required					100%
VII	Enrollee Grievance Process	13	11	2	0	0	0	0	100%
VIII	Enrollee Rights and Protections	31	31	No follow-up review required					100%
IX	Subcontracts and Delegation	7	7	No follow-up review required					100%
X	Provider Network	12	12	No follow-up review required					100%
XI	Credentialing	25	25	No follow-up review required					100%
XII	Access and Availability	17	16	0	0	0	1	0	94%
XIII	Coordination of Care	3	3	No follow-up review required					100%
XIV	Appeals	15	14	1	0	0	0	0	100%
	Overall	208	202	5	0	0	1	0	100%

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

Total # of Applicable Elements: The total number of elements within each standard minus any elements that received a score of *NA*.

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* in the prior review plus the number of elements that received a score of *Met* in the current review to the weighted (multiplied by 0.75) number of elements that received a score of *Substantially Met* and the weighted (multiplied by 0.50) number that received a score of *Partially Met*, then dividing this total by the total number of applicable elements.

Strengths

Northern Affiliation received an overall compliance score of 100 percent across all standards. In the 2008–2009 review, the PIHP had achieved 100 percent compliance on the following standards: QAPIP Plan and Structure, Performance Measurement and Improvement, Practice Guidelines, Staff Qualifications and Training, Customer Services, Enrollee Rights and Protections, Subcontracts and Delegation, Provider Network, Credentialing, and Coordination of Care. Therefore, no follow-up review was required for these standards. **Northern Affiliation** successfully addressed all recommendations for improvement on the Utilization Management, Enrollee Grievance Process, and Appeals standards.

Recommendations

The recommendation for improving **Northern Affiliation**'s performance addressed the Access and Availability standard. The PIHP should continue its efforts to ensure timely access to ongoing services for adults with a developmental disability.

Summary Assessment Related to Quality, Timeliness, and Access

Northern Affiliation demonstrated excellent performance across the three domains of **quality**, **timeliness**, and **access**. The 2008–2009 compliance review resulted in full compliance on 10 of the 12 standards in the **quality** domain, 1 of the 5 standards in the **timeliness** domain, and 3 of the 5 standards in the **access** domain. Standards included in the 2009–2010 follow-up review addressed all three domains. The PIHP's strongest performance was in the **quality** domain, where **Northern Affiliation** successfully addressed all prior recommendations on the Enrollee Grievance Process and Appeals standards. In the **timeliness** and **access** domains, the PIHP implemented corrective actions for the Utilization Management standard, but had one continued recommendation in the Access and Availability standard. After the 2009–2010 follow-up review, **Northern Affiliation**'s improved performance resulted in 100 percent compliance on all standards in the **quality** domain, 4 of the 5 standards in the **timeliness** domain, and 4 of the 5 standards in the **access** domain.

Northwest CMH Affiliation

Overall Compliance Monitoring Results

Table 3-14 presents the results from the initial review in 2008–2009 and the follow-up review in 2009–2010, showing the number of elements for each of the standards that received a score of *Met*, *Substantially Met*, *Partially Met*, *Not Met*, or *NA*. The table also shows total compliance scores after the follow-up review for each of the standards and across all standards. The 2009–2010 External Quality Review Compliance Monitoring Report for **Northwest CMH Affiliation** contains a more detailed description of the results.

Table 3-14—Summary of Compliance Scores
Prior Year (2008–2009) and Current Year (2009–2010)

Standard		Total Applicable Elements	Prior Year	Current Year					2009–2010 Total Compliance Score
			M	*M*	*SM*	*PM*	*NM*	*NA*	
I	QAPIP Plan and Structure	18	17	1	0	0	0	0	100%
II	Performance Measurement and Improvement	21	21	No follow-up review required					100%
III	Practice Guidelines	14	14	No follow-up review required					100%
IV	Staff Qualifications and Training	6	4	2	0	0	0	0	100%
V	Utilization Management	19	16	2	1	0	0	0	99%
VI	Customer Services	11	10	1	0	0	0	0	100%
VII	Enrollee Grievance Process	13	12	0	0	1	0	0	96%
VIII	Enrollee Rights and Protections	31	31	No follow-up review required					100%
IX	Subcontracts and Delegation	7	7	No follow-up review required					100%
X	Provider Network	12	12	No follow-up review required					100%
XI	Credentialing	23	23	No follow-up review required					100%
XII	Access and Availability	17	13	4	0	0	0	0	100%
XIII	Coordination of Care	3	3	No follow-up review required					100%
XIV	Appeals	15	14	1	0	0	0	0	100%
	Overall	210	197	11	1	1	0	0	100%

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

Total # of Applicable Elements: The total number of elements within each standard minus any elements that received a score of *NA*.

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* in the prior review plus the number of elements that received a score of *Met* in the current review to the weighted (multiplied by 0.75) number of elements that received a score of *Substantially Met* and the weighted (multiplied by 0.50) number that received a score of *Partially Met*, then dividing this total by the total number of applicable elements.

Strengths

Northwest CMH Affiliation received an overall compliance score of 100 percent across all standards. In the 2008–2009 review, the PIHP had achieved 100 percent compliance on the following standards: Performance Measurement and Improvement, Practice Guidelines, Enrollee Rights and Protections, Subcontracts and Delegation, Provider Network, Credentialing, and Coordination of Care. Therefore, no follow-up review was required for these standards. **Northwest CMH Affiliation** successfully addressed all recommendations for improvement on the QAPIP Plan and Structure, Staff Qualifications and Training, Customer Services, Access and Availability, and Appeals standards.

Recommendations

Recommendations for improving **Northwest CMH Affiliation**'s performance addressed Utilization Management and the Enrollee Grievance Process. The PIHP should ensure compliance with the requirements related to notification of a denial and continue efforts to provide beneficiaries with a written disposition of their grievances that includes all required information.

Summary Assessment Related to Quality, Timeliness, and Access

Northwest CMH Affiliation demonstrated strong performance across the three domains of **quality**, **timeliness**, and **access**. The 2008–2009 compliance review resulted in full compliance on 7 of the 12 standards in the **quality** domain, 1 of the 5 standards in the **timeliness** domain, and 2 of the 5 standards in the **access** domain. Standards included in the 2009–2010 follow-up review addressed all three domains. The PIHP's strongest performance was in the **quality** domain, where **Northwest CMH Affiliation** successfully addressed all prior recommendations in the QAPIP Plan and Structure, Staff Qualifications and Training, Customer Services, and Appeals standards. In the **timeliness** and **access** domains, the PIHP implemented corrective actions and demonstrated full compliance on two additional standards in each domain. After the 2009–2010 follow-up review, **Northwest CMH Affiliation**'s improved performance resulted in 100 percent compliance on 11 of the 12 standards in the **quality** domain, 3 of the 5 standards in the **timeliness** domain, and 4 of the 5 standards in the **access** domain.

Oakland County CMH Authority

Overall Compliance Monitoring Results

Table 3-15 presents the results from the initial review in 2008–2009 and the follow-up review in 2009–2010, showing the number of elements for each of the standards that received a score of *Met*, *Substantially Met*, *Partially Met*, *Not Met*, or *NA*. The table also shows total compliance scores after the follow-up review for each of the standards and across all standards. The 2009–2010 External Quality Review Compliance Monitoring Report for **Oakland County CMH Authority** contains a more detailed description of the results.

Table 3-15—Summary of Compliance Scores
Prior Year (2008–2009) and Current Year (2009–2010)

Standard		Total Applicable Elements	Prior Year	Current Year					2009–2010 Total Compliance Score
			M	*M*	*SM*	*PM*	*NM*	*NA*	
I	QAPIP Plan and Structure	18	18	No follow-up review required					100%
II	Performance Measurement and Improvement	21	21	No follow-up review required					100%
III	Practice Guidelines	14	14	No follow-up review required					100%
IV	Staff Qualifications and Training	6	6	No follow-up review required					100%
V	Utilization Management	19	19	No follow-up review required					100%
VI	Customer Services	11	11	No follow-up review required					100%
VII	Enrollee Grievance Process	13	13	No follow-up review required					100%
VIII	Enrollee Rights and Protections	32	31	1	0	0	0	0	100%
IX	Subcontracts and Delegation	7	7	No follow-up review required					100%
X	Provider Network	12	12	No follow-up review required					100%
XI	Credentialing	23	23	No follow-up review required					100%
XII	Access and Availability	17	17	No follow-up review required					100%
XIII	Coordination of Care	3	3	No follow-up review required					100%
XIV	Appeals	15	15	No follow-up review required					100%
	Overall	211	210	1	0	0	0	0	100%

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

Total # of Applicable Elements: The total number of elements within each standard minus any elements that received a score of *NA*.

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* in the prior review plus the number of elements that received a score of *Met* in the current review to the weighted (multiplied by 0.75) number of elements that received a score of *Substantially Met* and the weighted (multiplied by 0.50) number that received a score of *Partially Met*, then dividing this total by the total number of applicable elements.

Strengths

Oakland County CMH Authority received an overall compliance score of 100 percent across all standards. In the 2008–2009 review, the PIHP had achieved 100 percent compliance on the following standards: QAPIP Plan and Structure, Performance Measurement and Improvement, Practice Guidelines, Staff Qualifications and Training, Utilization Management, Customer Services, Enrollee Grievance Process, Subcontracts and Delegation, Provider Network, Credentialing, Access and Availability, Coordination of Care, and Appeals. Therefore, no follow-up review was required for these standards. **Oakland County CMH Authority** successfully addressed the recommendation for improvement on the Enrollee Rights and Protections standard.

Recommendations

The 2009–2010 follow-up review did not result in any recommendations for improvement as **Oakland County CMH Authority** achieved 100 percent compliance on all standards.

Summary Assessment Related to Quality, Timeliness, and Access

Oakland County CMH Authority demonstrated exceptional performance across the three domains of **quality**, **timeliness**, and **access**. The 2008–2009 compliance review resulted in full compliance on 11 of the 12 standards in the **quality** domain, all 5 standards in the **timeliness** domain, and all 5 standards in the **access** domain. The standard included in the 2009–2010 follow-up review addressed the **quality** domain. **Oakland County CMH Authority** successfully addressed the prior recommendation on the Enrollee Rights and Protections standard. After the 2009–2010 follow-up review, **Oakland County CMH Authority** achieved 100 percent compliance on all standards across the three domains.

Saginaw County CMH Authority

Overall Compliance Monitoring Results

Table 3-16 presents the results from the initial review in 2008–2009 and the follow-up review in 2009–2010, showing the number of elements for each of the standards that received a score of *Met*, *Substantially Met*, *Partially Met*, *Not Met*, or *NA*. The table also shows total compliance scores after the follow-up review for each of the standards and across all standards. The 2009–2010 External Quality Review Compliance Monitoring Report for **Saginaw County CMH Authority** contains a more detailed description of the results.

Table 3-16—Summary of Compliance Scores
Prior Year (2008–2009) and Current Year (2009–2010)

Standard		Total Applicable Elements	Prior Year	Current Year					2009–2010 Total Compliance Score
			M	*M*	*SM*	*PM*	*NM*	*NA*	
I	QAPIP Plan and Structure	18	15	2	0	1	0	0	97%
II	Performance Measurement and Improvement	21	21	No follow-up review required					100%
III	Practice Guidelines	14	14	No follow-up review required					100%
IV	Staff Qualifications and Training	6	6	No follow-up review required					100%
V	Utilization Management	19	18	1	0	0	0	0	100%
VI	Customer Services	11	11	No follow-up review required					100%
VII	Enrollee Grievance Process	13	8	3	0	2	0	0	92%
VIII	Enrollee Rights and Protections	31	29	0	1	1	0	0	98%
IX	Subcontracts and Delegation	7	7	No follow-up review required					100%
X	Provider Network	12	12	No follow-up review required					100%
XI	Credentialing	25	25	No follow-up review required					100%
XII	Access and Availability	17	12	0	0	0	5	0	71%
XIII	Coordination of Care	3	3	No follow-up review required					100%
XIV	Appeals	15	13	2	0	0	0	0	100%
	Overall	212	194	8	1	4	5	0	97%

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

Total # of Applicable Elements: The total number of elements within each standard minus any elements that received a score of *NA*.

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* in the prior review plus the number of elements that received a score of *Met* in the current review to the weighted (multiplied by 0.75) number of elements that received a score of *Substantially Met* and the weighted (multiplied by 0.50) number that received a score of *Partially Met*, then dividing this total by the total number of applicable elements.

Strengths

Saginaw County CMH Authority received an overall compliance score of 97 percent across all standards. In the 2008–2009 review, the PIHP had achieved 100 percent compliance on the following standards: Performance Measurement and Improvement, Practice Guidelines, Staff Qualifications and Training, Customer Services, Subcontracts and Delegation, Provider Network, Credentialing, and Coordination of Care. Therefore, no follow-up review was required for these standards. **Saginaw County CMH Authority** successfully addressed all recommendations for improvement on the Utilization Management and Appeals standards.

Recommendations

Recommendations for improving **Saginaw County CMH Authority**'s performance addressed the QAPIP Plan and Structure, Enrollee Grievance Process, Enrollee Rights and Protections, and Access and Availability standards. The PIHP should implement corrective actions to ensure that its policy and practices are consistent with the technical requirement for the Behavior Treatment Review Committee and that all beneficiaries receive the required information about their rights and protections. **Saginaw County CMH Authority** should continue efforts to ensure that its grievance process complies with all contractual requirements and to meet the minimum performance standard for access to ongoing services and follow-up care after discharge from a psychiatric inpatient or detox unit.

Summary Assessment Related to Quality, Timeliness, and Access

Saginaw County CMH Authority demonstrated mixed performance across the three domains of **quality**, **timeliness**, and **access**. The 2008–2009 compliance review resulted in full compliance on 8 of the 12 standards in the **quality** domain, 1 of the 5 standards in the **timeliness** domain, and 3 of the 5 standards in the **access** domain. Standards included in the 2009–2010 follow-up review addressed all three domains. The PIHP's strongest performance was in the **access** domain, where **Saginaw County CMH Authority** successfully addressed all prior recommendations on the Utilization Management standard. In the **quality** domain, the PIHP achieved 100 percent compliance after the follow-up review on the Appeals standard. Most continued recommendations addressed the **timeliness** domain, where the PIHP achieved full compliance on two additional standards. After the 2009–2010 follow-up review, **Saginaw County CMH Authority**'s improved performance resulted in 100 percent compliance on 9 of the 12 standards in the **quality** domain, 3 of the 5 standards in the **timeliness** domain, and 4 of the 5 standards in the **access** domain.

Southwest Affiliation

Overall Compliance Monitoring Results

Table 3-17 presents the results from the initial review in 2008–2009 and the follow-up review in 2009–2010, showing the number of elements for each of the standards that received a score of *Met*, *Substantially Met*, *Partially Met*, *Not Met*, or *NA*. The table also shows total compliance scores after the follow-up review for each of the standards and across all standards. The 2009–2010 External Quality Review Compliance Monitoring Report for **Southwest Affiliation** contains a more detailed description of the results.

Table 3-17—Summary of Compliance Scores
Prior Year (2008–2009) and Current Year (2009–2010)

Standard		Total Applicable Elements	Prior Year	Current Year					2009–2010 Total Compliance Score
			M	*M*	*SM*	*PM*	*NM*	*NA*	
I	QAPIP Plan and Structure	18	17	1	0	0	0	0	100%
II	Performance Measurement and Improvement	21	21	No follow-up review required					100%
III	Practice Guidelines	14	14	No follow-up review required					100%
IV	Staff Qualifications and Training	6	6	No follow-up review required					100%
V	Utilization Management	19	19	No follow-up review required					100%
VI	Customer Services	11	11	No follow-up review required					100%
VII	Enrollee Grievance Process	13	12	1	0	0	0	0	100%
VIII	Enrollee Rights and Protections	31	31	No follow-up review required					100%
IX	Subcontracts and Delegation	7	7	No follow-up review required					100%
X	Provider Network	12	12	No follow-up review required					100%
XI	Credentialing	24	24	No follow-up review required					100%
XII	Access and Availability	17	15	1	0	1	0	0	97%
XIII	Coordination of Care	3	3	No follow-up review required					100%
XIV	Appeals	15	13	2	0	0	0	0	100%
	Overall	211	205	5	0	1	0	0	100%

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

Total # of Applicable Elements: The total number of elements within each standard minus any elements that received a score of *NA*.

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* in the prior review plus the number of elements that received a score of *Met* in the current review to the weighted (multiplied by 0.75) number of elements that received a score of *Substantially Met* and the weighted (multiplied by 0.50) number that received a score of *Partially Met*, then dividing this total by the total number of applicable elements.

Strengths

Southwest Affiliation received an overall compliance score of 100 percent across all standards. In the 2008–2009 review, the PIHP had achieved 100 percent compliance on the following standards: Performance Measurement and Improvement, Practice Guidelines, Staff Qualifications and Training, Utilization Management, Customer Services, Enrollee Rights and Protections, Subcontracts and Delegation, Provider Network, Credentialing, and Coordination of Care. Therefore, no follow-up review was required for these standards. **Southwest Affiliation** successfully addressed all recommendations for improvement in the QAPIP Plan and Structure, Enrollee Grievance Process, and Appeals standards.

Recommendations

The recommendation for improving **Southwest Affiliation**'s performance addressed the Access and Availability standard. The PIHP should continue efforts to meet the minimum performance standard for access to ongoing services for developmentally disabled adults.

Summary Assessment Related to Quality, Timeliness, and Access

Southwest Affiliation demonstrated excellent performance across the three domains of **quality**, **timeliness**, and **access**. The 2008–2009 compliance review resulted in full compliance on 9 of the 12 standards in the **quality** domain, 2 of the 5 standards in the **timeliness** domain, and 4 of the 5 standards in the **access** domain. Standards included in the 2009–2010 follow-up review addressed all three domains. The PIHP's strongest performance was in the **quality** domain, where **Southwest Affiliation** successfully addressed all prior recommendations on the QAPIP Plan and Structure, Enrollee Grievance Process, and Appeals standards. The continued recommendation from the 2009–2010 compliance review related to the Access and Availability standard, which addressed the domains of **timeliness** and **access**. After the 2009–2010 follow-up review, **Southwest Affiliation**'s improved performance resulted in 100 percent compliance on all 12 standards in the **quality** domain, 4 of the 5 standards in the **timeliness** domain, and 4 of the 5 standards in the **access** domain.

Thumb Alliance PIHP

Overall Compliance Monitoring Results

Table 3-18 presents the results from the initial review in 2008–2009 and the follow-up review in 2009–2010, showing the number of elements for each of the standards that received a score of *Met*, *Substantially Met*, *Partially Met*, *Not Met*, or *NA*. The table also shows total compliance scores after the follow-up review for each of the standards and across all standards. The 2009–2010 External Quality Review Compliance Monitoring Report for **Thumb Alliance PIHP** contains a more detailed description of the results.

Table 3-18—Summary of Compliance Scores
Prior Year (2008–2009) and Current Year (2009–2010)

Standard		Total Applicable Elements	Prior Year	Current Year					2009–2010 Total Compliance Score
			M	*M*	*SM*	*PM*	*NM*	*NA*	
I	QAPIP Plan and Structure	18	18	No follow-up review required					100%
II	Performance Measurement and Improvement	21	20	1	0	0	0	0	100%
III	Practice Guidelines	14	14	No follow-up review required					100%
IV	Staff Qualifications and Training	6	6	No follow-up review required					100%
V	Utilization Management	19	19	No follow-up review required					100%
VI	Customer Services	11	11	No follow-up review required					100%
VII	Enrollee Grievance Process	13	12	1	0	0	0	0	100%
VIII	Enrollee Rights and Protections	31	31	No follow-up review required					100%
IX	Subcontracts and Delegation	7	7	No follow-up review required					100%
X	Provider Network	12	12	No follow-up review required					100%
XI	Credentialing	24	24	No follow-up review required					100%
XII	Access and Availability	17	16	1	0	0	0	0	100%
XIII	Coordination of Care	3	3	No follow-up review required					100%
XIV	Appeals	15	14	0	0	1	0	0	97%
	Overall	211	207	3	0	1	0	0	100%

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

Total # of Applicable Elements: The total number of elements within each standard minus any elements that received a score of *NA*.

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* in the prior review plus the number of elements that received a score of *Met* in the current review to the weighted (multiplied by 0.75) number of elements that received a score of *Substantially Met* and the weighted (multiplied by 0.50) number that received a score of *Partially Met*, then dividing this total by the total number of applicable elements.

Strengths

Thumb Alliance PIHP received an overall compliance score of 100 percent across all standards. In the 2008–2009 review, the PIHP had achieved 100 percent compliance on the following standards: QAPIP Plan and Structure, Practice Guidelines, Staff Qualifications and Training, Utilization Management, Customer Services, Enrollee Rights and Protections, Subcontracts and Delegation, Provider Network, Credentialing, and Coordination of Care. Therefore, no follow-up review was required for these standards. **Thumb Alliance PIHP** successfully addressed all recommendations for improvement in the Performance Measurement and Improvement, Enrollee Grievance Process, and Access and Availability standards.

Recommendations

The recommendation for improving **Thumb Alliance PIHP**'s performance addressed the Appeals standard. The PIHP should ensure that notices of disposition for beneficiary appeals include all required information.

Summary Assessment Related to Quality, Timeliness, and Access

Thumb Alliance PIHP demonstrated excellent performance across the three domains of **quality**, **timeliness**, and **access.** The 2008–2009 compliance review resulted in full compliance on 9 of the 12 standards in the **quality** domain, 1 of the 5 standards in the **timeliness** domain, and 4 of the 5 standards in the **access** domain. Standards included in the 2009–2010 follow-up review addressed all three domains. The PIHP's strongest performance was in the **access** domain, where **Thumb Alliance PIHP** successfully addressed the prior recommendation on the Access and Availability standard to achieve full compliance on all standards in this domain. In the **quality** and **timeliness** domains, the PIHP implemented corrective actions on the Performance Measurement and Improvement and Enrollee Grievance Process standards to achieve 100 percent compliance, but received a continued recommendation related to the Appeals standard. After the 2009–2010 follow-up review, **Thumb Alliance PIHP**'s improved performance resulted in 100 percent compliance on all standards in the **access** domain, 11 of the 12 standards in the **quality** domain, and 4 of the 5 standards in the **timeliness** domain.

Venture Behavioral Health

Overall Compliance Monitoring Results

Table 3-19 presents the results from the initial review in 2008–2009 and the follow-up review in 2009–2010, showing the number of elements for each of the standards that received a score of *Met*, *Substantially Met*, *Partially Met*, *Not Met*, or *NA*. The table also shows total compliance scores after the follow-up review for each of the standards and across all standards. The 2009–2010 External Quality Review Compliance Monitoring Report for **Venture Behavioral Health** contains a more detailed description of the results.

Table 3-19—Summary of Compliance Scores Prior Year (2008–2009) and Current Year (2009–2010)

Standard		Total Applicable Elements	Prior Year	Current Year					2009–2010 Total Compliance Score
			M	*M*	*SM*	*PM*	*NM*	*NA*	
I	QAPIP Plan and Structure	18	17	1	0	0	0	0	100%
II	Performance Measurement and Improvement	21	20	0	1	0	0	0	99%
III	Practice Guidelines	10	10	No follow-up review required					100%
IV	Staff Qualifications and Training	6	6	No follow-up review required					100%
V	Utilization Management	19	18	0	1	0	0	0	99%
VI	Customer Services	11	11	No follow-up review required					100%
VII	Enrollee Grievance Process	13	13	No follow-up review required					100%
VIII	Enrollee Rights and Protections	31	31	No follow-up review required					100%
IX	Subcontracts and Delegation	7	7	No follow-up review required					100%
X	Provider Network	12	12	No follow-up review required					100%
XI	Credentialing	24	24	No follow-up review required					100%
XII	Access and Availability	17	15	2	0	0	0	0	100%
XIII	Coordination of Care	3	3	No follow-up review required					100%
XIV	Appeals	15	13	2	0	0	0	0	100%
	Overall	207	200	5	2	0	0	0	100%

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

Total # of Applicable Elements: The total number of elements within each standard minus any elements that received a score of *NA*.

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* in the prior review plus the number of elements that received a score of *Met* in the current review to the weighted (multiplied by 0.75) number of elements that received a score of *Substantially Met* and the weighted (multiplied by 0.50) number that received a score of *Partially Met*, then dividing this total by the total number of applicable elements.

Strengths

Venture Behavioral Health received an overall compliance score of 100 percent across all standards. In the 2008–2009 review, the PIHP had achieved 100 percent compliance on the following standards: Practice Guidelines, Staff Qualifications and Training, Customer Services, Enrollee Grievance Process, Enrollee Rights and Protections, Subcontracts and Delegation, Provider Network, Credentialing, and Coordination of Care. Therefore, no follow-up review was required for these standards. **Venture Behavioral Health** successfully addressed all recommendations for improvement on the QAPIP Plan and Structure, Access and Availability, and Appeals standards.

Recommendations

Recommendations for improving **Venture Behavioral Health**'s performance related to the Performance Measurement and Improvement and Utilization Management standards. The PIHP should continue efforts to implement enhanced monitoring activities to ensure compliance with the requirements related to the review of sentinel events and utilization management procedures.

Summary Assessment Related to Quality, Timeliness, and Access

Venture Behavioral Health demonstrated strong performance across the three domains of **quality**, **timeliness**, and **access**. The 2008–2009 compliance review resulted in full compliance on 9 of the 12 standards in the **quality** domain, 1 of the 5 standards in the **timeliness** domain, and 3 of the 5 standards in the **access** domain. Standards included in the 2009–2010 follow-up review addressed all three domains. The PIHP's strongest performance was in the **quality** domain, where **Venture Behavioral Health** successfully addressed all prior recommendations on the QAPIP Plan and Structure and Appeals standards. In the **timeliness** domain, the PIHP implemented corrective actions to achieve full compliance on two additional standards. In the **access** domain, **Venture Behavioral Health** achieved full compliance on the Access and Availability standard. After the 2009–2010 follow-up review, **Venture Behavioral Health**'s improved performance resulted in 100 percent compliance on 11 of the 12 standards in the **quality** domain, 3 of the 5 standards in the **timeliness** domain, and 4 of the 5 standards in the **access** domain.

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 2009–2010 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.

The validation review periods for the indicators were as follows: first quarter of SFY 2010 for Indicators 1 through 5, 8, and 12; SFY 2009 for Indicators 10, 11, and 13; and the last six months of SFY 2009 for Indicator 14.

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, the 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 3-20 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2010 Validation of Performance Measures Report for **Access Alliance of Michigan** includes additional details of the validation results.

Table 3-20—2009–2010 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:	98.68%	*Fully Compliant*
		Adults:	98.99%	
2.	Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	99.79%		*Fully Compliant*
3.	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional.	98.50%		*Fully Compliant*
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children:	93.10%	*Fully Compliant*
		Adults:	98.57%	
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).	8.34%		*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).	95.87%		*Fully Compliant*
10.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of adults dually diagnosed with mental illness/developmental disability served by the PIHPs who are employed competitively.	MI Adults:	12.10%	*Fully Compliant*
		DD Adults:	12.52%	
		MI/DD Adults:	14.13%	
11.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of adults dually diagnosed with mental illness/developmental disability served by the PIHPs who earned minimum wage or more from any employment activities.	MI Adults:	78.01%	*Fully Compliant*
		DD Adults:	39.58%	
		MI/DD Adults:	40.59%	
12.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children:	6.67%	*Fully Compliant*
		Adults:	11.90%	
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

Access Alliance of Michigan demonstrated strengths in the areas of its eligibility and claims/encounter data systems and oversight of its affiliates related to the encounter, QI, and performance indicator data. **Access Alliance of Michigan**'s use of a common data system ensured uniformity and data integrity. The PIHP worked collaboratively with its affiliates on the performance indicator reporting process. **Access Alliance of Michigan** formally monitored data completeness and required internal corrective action plans for affiliates falling below the threshold of 95 percent for completeness of QI data or any of the MDCH performance indicators. The PIHP shared the best practices of affiliates who consistently performed at a high level. The PIHP's performance indicator committee reviewed data quarterly.

Recommendations

Access Alliance of Michigan should consider implementing a requirement for affiliates to review performance indicator data monthly to keep cleanup to a minimum. The PIHP should continue close oversight of performance indicator and QI data to ensure compliance with the requirement for 95 percent data completeness. The PIHP should consider expanding documentation of the performance indicator calculation process. **Access Alliance of Michigan** was below the threshold of 95 percent completeness for the minimum wage data field; therefore, the PIHP was required to submit a corrective action plan to MDCH.

Summary Assessment Related to Quality, Timeliness, and Access

Access Alliance of Michigan's performance indicators related to **quality** were *Fully Compliant* with MDCH specifications. The PIHP met four of the five contractually required performance standards related to the **quality** of services provided by the PIHP. For the remaining indicators in the **quality** domain, **Access Alliance of Michigan** demonstrated above-average results. The PIHP's HSW rate exceeded the statewide rate. The rates for MI, DD, and MI/DD adults who were employed competitively or earned minimum wage were above the statewide rates. Performance indicators related to **timeliness** of and **access** to services were *Fully Compliant* with MDCH specifications. The PIHP met 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 exceeded the statewide rate. **Access Alliance of Michigan** demonstrated excellent 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.

CMH Affiliation of Mid-Michigan

Findings

Table 3-21 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2010 Validation of Performance Measures Report for **CMH Affiliation of Mid-Michigan** includes additional details of the validation results.

Table 3-21—2009–2010 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%	*Fully Compliant*
		Adults:	99.65%	
2.	Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	99.79%		*Fully Compliant*
3.	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional.	97.03%		*Fully Compliant*
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children:	84.62%	*Fully Compliant*
		Adults:	91.67%	
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).	97.37%		*Fully Compliant*
10.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of adults dually diagnosed with mental illness/developmental disability served by the PIHPs who are employed competitively.	MI Adults:	10.05%	*Fully Compliant*
		DD Adults:	13.36%	
		MI/DD Adults:	12.95%	
11.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of adults dually diagnosed with mental illness/developmental disability served by the PIHPs who earned minimum wage or more from any employment activities.	MI Adults:	82.55%	*Fully Compliant*
		DD Adults:	49.51%	
		MI/DD Adults:	52.76%	
12.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children:	5.88%	*Fully Compliant*
		Adults:	13.85%	
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 continued to demonstrate its commitment to the performance indicator reporting process. The PIHP continued its close oversight of data and maintained the requirement for corrective actions for findings at the affiliate level during annual on-site audits. The PIHP staff's active participation on various statewide work groups reflected **CMH Affiliation of Mid-Michigan**'s commitment to quality data and the goal of comparable, consistent data across the State.

Recommendations

CMH Affiliation of Mid-Michigan should continue its close oversight of all data from affiliates and coordinating agencies. The PIHP should consider modifying the Medicaid claims verification process to ensure complete encounter submission and continue efforts to ensure data quality and completeness.

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 three of the five contractually required performance standards related to the **quality** of services provided by the PIHP. For the remaining indicators in the **quality** domain, **CMH Affiliation of Mid-Michigan** achieved mostly above-average results. The PIHP's HSW rate exceeded the statewide rate. The rate for DD adults who were employed competitively was higher than the statewide rate, while the rates for MI and MI/DD adults who were employed competitively fell below the statewide average. The rates of MI, DD, and MI/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 the contractually required performance standards for five of the seven performance measures related to **timeliness** of and **access** to services provided by the PIHP. The PIHP's penetration rate exceeded the statewide rate. **CMH Affiliation of Mid-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 for Central Michigan

Findings

Table 3-22 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2010 Validation of Performance Measures Report for **CMH for Central Michigan** includes additional details of the validation results.

Table 3-22—2009–2010 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:	97.87%	*Fully Compliant*
		Adults:	98.46%	
2.	Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	98.24%		*Fully Compliant*
3.	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional.	98.65%		*Fully Compliant*
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children:	100%	*Fully Compliant*
		Adults:	95.00%	
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).	8.37%		*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).	97.30%		*Fully Compliant*
10.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of adults dually diagnosed with mental illness/developmental disability served by the PIHPs who are employed competitively.	MI Adults:	11.71%	*Substantially Compliant*
		DD Adults:	14.84%	
		MI/DD Adults:	10.00%	
11.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of adults dually diagnosed with mental illness/developmental disability served by the PIHPs who earned minimum wage or more from any employment activities.	MI Adults:	87.17%	*Substantially Compliant*
		DD Adults:	28.95%	
		MI/DD Adults:	37.78%	
12.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children:	10.00%	*Fully Compliant*
		Adults:	5.00%	
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 received nearly all encounter data electronically, which enhanced data accuracy and completeness. The PIHP used productivity reports and other methods to ensure that providers submit encounter data. **CMH for Central Michigan** incorporated methods to improve its minimum wage indicator data and demonstrated improvement since the corrective action was implemented. The PIHP continued to provide close oversight related to the affiliates' QI data to ensure ongoing compliance with the standard for 95 percent completeness.

Recommendations

CMH for Central Michigan should develop step-by-step, detailed documentation for preparation and submission of the encounter file to MDCH. The PIHP should consider implementing a performance indicator-specific audit that includes validating reasons for exceptions or confirming accurate reason selection. As a further measure of its oversight, the PIHP should request internal quality audit reports from the coordinating agency (CA). Although the PIHP implemented methods to ensure the completeness of the required QI data elements, two of the data elements (employment status and minimum wage) were well below MDCH's 95 percent completeness threshold. The PIHP should identify the cause of the incomplete capture and reporting of these data elements and must submit a corrective action plan to MDCH.

Summary Assessment Related to Quality, Timeliness, and Access

CMH for Central Michigan's performance indicators related to **quality** were *Fully Compliant* with MDCH specifications, except for Indicators 10 and 11, which continued to receive a designation of *Substantially Compliant*. Completeness of minimum wage data continued to be below the required 95 percent threshold, resulting in an understated rate for these measures. The PIHP met all contractually required performance standards related to the **quality** of services provided by the PIHP. For the remaining indicators in the **quality** domain, **CMH for Central Michigan** demonstrated mostly above average results. The PIHP's HSW rate exceeded the statewide rate. The rates for MI and DD adults who were employed competitively or earned minimum wage were higher than the statewide rates. The rate for MI/DD adults who were employed competitively fell below the statewide rate, while the rate for MI/DD adults who earned minimum wage was above the statewide rate. Performance indicators related to **timeliness** of and **access** to services were *Fully Compliant* with MDCH specifications. **CMH for Central Michigan** met 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 exceeded the statewide rate. **CMH for Central Michigan** demonstrated exceptional performance across all three domains of **quality**, **timeliness**, and **access** and continued to meet the minimum performance standard for all nine indicators.

CMH Partnership of Southeastern Michigan

Findings

Table 3-23 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2010 Validation of Performance Measures Report for **CMH Partnership of Southeastern Michigan** includes additional details of the validation results.

Table 3-23—2009–2010 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%	*Fully Compliant*
		Adults:	100%	
2.	Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	98.44%		*Fully Compliant*
3.	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional.	98.17%		*Fully Compliant*
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children:	100%	*Fully Compliant*
		Adults:	96.81%	
4b.	Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	92.47%		*Fully Compliant*
5.	Percentage of Medicaid recipients having received PIHP-managed services (penetration rate).	5.75%		*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).	87.30%		*Fully Compliant*
10.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of adults dually diagnosed with mental illness/developmental disability served by the PIHPs who are employed competitively.	MI Adults:	11.08%	*Substantially Compliant*
		DD Adults:	16.16%	
		MI/DD Adults:	17.65%	
11.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of adults dually diagnosed with mental illness/developmental disability served by the PIHPs who earned minimum wage or more from any employment activities.	MI Adults:	87.35%	*Substantially Compliant*
		DD Adults:	73.09%	
		MI/DD Adults:	81.25%	
12.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children:	8.33%	*Fully Compliant*
		Adults:	9.01%	
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 ensured accuracy and completeness of the data through a high degree of automation of many processes. The PIHP closely monitored affiliate data (QI, encounter, and performance indicator data), ensuring that necessary oversight was in place at the PIHP level. Continuing organizational collaboration was evident at the PIHP with the merging of the performance indicator and information management departments, as well as in enhanced organizational efforts related to data analysis and quality improvement. The PIHP independently explored opportunities for improvement identified through its many monitoring processes.

Recommendations

CMH Partnership of Southeastern Michigan should document the transition to Encompass in detail. The PIHP should also continue close monitoring of data to ensure that data are complete and accurate. **CMH Partnership of Southeastern Michigan** should work with MDCH to investigate the source of incomplete Medicaid IDs. A review of QI data for the first quarter of 2010 indicated that completeness for the minimum wage field was below MDCH's threshold of 95 percent. The PIHP must submit a corrective action plan addressing this finding.

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 except for Indicators 10 and 11, which received a designation of *Substantially Compliant*. Completeness of minimum wage data was below the required 95 percent threshold, resulting in an understated rate for these measures. The PIHP met four of the five contractually required performance standards related to the **quality** of services provided by the PIHP. For the remaining indicators in the **quality** domain, **CMH Partnership of Southeastern Michigan** demonstrated mostly above-average results. The PIHP's HSW rate was lower than the statewide rate. The rates for MI, DD, and MI/DD adults who were employed competitively or 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 Partnership of Southeastern Michigan** met 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 exceeded the statewide rate. **CMH Partnership of Southeastern Michigan** 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.

Detroit-Wayne County CMH Agency

Findings

Table 3-24 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2010 Validation of Performance Measures Report for **Detroit-Wayne County CMH Agency** includes additional details of the validation results.

Table 3-24—2009–2010 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:	100%	*Fully Compliant*
		Adults:	96.54%	
2.	Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	92.65%		*Fully Compliant*
3.	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional.	88.62%		*Fully Compliant*
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children:	98.87%	*Fully Compliant*
		Adults:	95.58%	
4b.	Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	96.11%		*Fully Compliant*
5.	Percentage of Medicaid recipients having received PIHP-managed services (penetration rate).	4.70%		*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).	86.79%		*Fully Compliant*
10.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of adults dually diagnosed with mental illness/developmental disability served by the PIHPs who are employed competitively.	MI Adults:	15.28%	*Substantially Compliant*
		DD Adults:	2.80%	
		MI/DD Adults:	7.89%	
11.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of adults dually diagnosed with mental illness/developmental disability served by the PIHPs who earned minimum wage or more from any employment activities.	MI Adults:	55.34%	*Substantially Compliant*
		DD Adults:	6.37%	
		MI/DD Adults:	15.79%	
12.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children:	7.32%	*Fully Compliant*
		Adults:	7.69%	
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 continued existing processes and implemented additional efforts to improve completeness of the QI data. The PIHP demonstrated good collaboration throughout the organization related to performance improvement and data collection. Performance indicator reports and trend analysis reports helped to create buy-in and ownership of data at the managed care provider network (MCPN) level. The PIHP continued to require corrective actions for underperforming MCPNs. **Detroit-Wayne County CMH Agency**'s process for tracking sentinel events and recipient rights was excellent. The PIHP's Internal Death database allowed different departments to track and monitor deaths and their causes and facilitated investigations into cases and events, enhancing the quality and completeness of these types of data.

Recommendations

Detroit-Wayne County CMH Agency should continue efforts to improve QI data completeness through close and frequent monitoring of these data. The PIHP should continue to work toward identifying all barriers and issues related to incomplete data and document the implementation of new quality initiatives. **Detroit-Wayne County CMH Agency** should continue to explore a performance-based contract with the MCPNs to ensure compliance with standards for QI data completeness. As the implementation of the Peter Chang Enterprises (PCE) system continues throughout the next year, the PIHP should document this transition and all changes to data processes, work flow, and reporting mechanisms. A review of final rates found that the PIHP had deficiencies in QI data completeness for MDCH-required data elements and must submit a corrective action plan.

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 continued to receive a designation of *Substantially Compliant*. Completeness of minimum wage data continued to be below the required 95 percent threshold, resulting in an understated rate for these measures. The PIHP met all contractually required performance standards related to the **quality** of services provided by the PIHP. For the remaining indicators in the **quality** domain, **Detroit-Wayne County CMH Agency** demonstrated the mostly below-average results. The PIHP's HSW rate fell below the statewide rate. While the rate for MI adults who were employed competitively exceeded the statewide rate, the rates for DD and MI/DD adults who were employed competitively and the rates for MI, DD, and MI/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 the contractually required performance standards for five of the seven performance measures related to **timeliness** of and **access** to services provided by the PIHP. The PIHP's penetration rate was lower than the statewide rate. **Detroit-Wayne County CMH Agency** demonstrated strong and 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.

Genesee County CMH

Findings

Table 3-25 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2010 Validation of Performance Measures Report for **Genesee County CMH** includes additional details of the validation results.

Table 3-25—2009–2010 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:	98.73%	*Fully Compliant*
		Adults:	98.95%	
2.	Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	97.39%		*Fully Compliant*
3.	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional.	99.20%		*Fully Compliant*
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children:	95.56%	*Fully Compliant*
		Adults:	96.12%	
4b.	Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	96.88%		*Fully Compliant*
5.	Percentage of Medicaid recipients having received PIHP-managed services (penetration rate).	4.89%		*Substantially 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).	25.71%		*Substantially Compliant*
10.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of adults dually diagnosed with mental illness/developmental disability served by the PIHPs who are employed competitively.	MI Adults:	4.59%	*Substantially Compliant*
		DD Adults:	5.52%	
		MI/DD Adults:	10.17%	
11.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of adults dually diagnosed with mental illness/developmental disability served by the PIHPs who earned minimum wage or more from any employment activities.	MI Adults:	70.32%	*Substantially Compliant*
		DD Adults:	21.39%	
		MI/DD Adults:	50.00%	
12.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children:	7.69%	*Fully Compliant*
		Adults:	15.24%	
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 provided excellent documentation of the transition to the new data system. The transition included training and monitoring of the data. The PIHP followed recommendations made last year related to the system transition, demonstrating careful planning and testing prior to going live. The PIHP's Data Certification Committee continued to perform thorough oversight of data prior to submission to MDCH, which was a best practice.

Recommendations

Genesee County CMH identified a significant number of unsigned service activity logs and encounters at the end of the first quarter of SFY 2010. The PIHP should work aggressively with its providers to resolve this issue to ensure that the penetration rate will be valid and not adversely impacted by large numbers of missing data. The PIHP should consider peer-to-peer review of clinical documentation to ensure that professional standards for documentation of services are consistent and reasonable. The PIHP should identify one or more individuals within its organization to monitor dashboard reports to ensure ongoing monitoring of performance in key areas of operation. A review of rates for the first quarter of SFY 2010 found deficiencies for the minimum wage QI data element, as well as a sharp drop in HSW and penetration rates. The PIHP should work with MDCH to determine the cause of the drop in rates and take appropriate action based on those findings.

Summary Assessment Related to Quality, Timeliness, and Access

Genesee County CMH's performance indicators related to **quality** were *Fully Compliant* with MDCH specifications except for Indicators 8, 10 and 11, which received a designation of *Substantially Compliant*. Completeness of Medicaid IDs and minimum wage data was below the required 95 percent threshold, resulting in an understated rate for these measures. The PIHP met four of the five contractually required performance standards related to the **quality** of services provided by the PIHP. For the remaining indicators in the **quality** domain, **Genesee County CMH** demonstrated mostly below-average results. The PIHP's HSW rate fell below the statewide rate. The rates for MI, DD, and MI/DD adults who were employed competitively and the rate for MI and DD adults who earned minimum wage were lower than the statewide rates, while the rate for MI/DD adults who earned minimum wage exceeded the statewide rate. Performance indicators related to **timeliness** of and **access** to services were *Fully Compliant* with MDCH specifications except for Indicator 5. **Genesee County CMH** met 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 fell below the statewide rate. **Genesee County CMH** demonstrated strong performance across all three domains of **quality**, **timeliness**, and **access** and met the minimum performance standard for eight of the nine indicators.

Lakeshore Behavioral Health Alliance

Findings

Table 3-26 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2010 Validation of Performance Measures Report for **Lakeshore Behavioral Health Alliance** includes additional details of the validation results.

Table 3-26—2009–2010 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:	100%	*Fully Compliant*
		Adults:	99.19%	
2.	Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	99.33%		*Fully Compliant*
3.	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional.	97.33%		*Fully Compliant*
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children:	100%	*Fully Compliant*
		Adults:	100%	
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).	5.25%		*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).	94.47%		*Fully Compliant*
10.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of adults dually diagnosed with mental illness/developmental disability served by the PIHPs who are employed competitively.	MI Adults:	7.28%	*Substantially Compliant*
		DD Adults:	14.34%	
		MI/DD Adults:	13.85%	
11.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of adults dually diagnosed with mental illness/developmental disability served by the PIHPs who earned minimum wage or more from any employment activities.	MI Adults:	76.64%	*Substantially Compliant*
		DD Adults:	35.63%	
		MI/DD Adults:	30.88%	
12.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children:	10.53%	*Fully Compliant*
		Adults:	10.00%	
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

Lakeshore Behavioral Health Alliance continued its efforts to further automate the performance indicator reporting process. PIHP oversight of its affiliates increased, and communication was effective and productive. **Lakeshore Behavioral Health Alliance** completed monthly reports to ensure complete and accurate QI data and prompt attention to any necessary corrections. The PIHP provided close oversight of its affiliates through work groups that met regularly and discussed any issues related to encounter, QI, or performance indicator data.

Recommendations

Lakeshore Behavioral Health Alliance should review an affiliate's processes for assessing the accuracy of data entry and continue close monitoring of required QI data elements. The PIHP should consider alternative methods to ensure compliance with QI data collection activities. A review of final rates for the first quarter of SFY 2010 determined that QI data completeness for the minimum wage and disability designation data elements was below the 95 percent completeness threshold. The PIHP must submit a corrective action plan addressing these findings.

Summary Assessment Related to Quality, Timeliness, and Access

Lakeshore Behavioral Health Alliance'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*. Completeness of minimum wage data was below the required 95 percent threshold, resulting in an understated rate for these measures. The PIHP met all contractually required performance standards related to the **quality** of services provided by the PIHP. For the remaining indicators in the **quality** domain, **Lakeshore Behavioral Health Alliance** achieved mostly above-average results. The PIHP's HSW rate exceeded the statewide rate. The rates for DD and MI/DD adults who were employed competitively and MI and DD adults who earned minimum wage were higher than the statewide rates. The rates for MI adults who were employed competitively and MI/DD adults who earned minimum wage fell below the statewide rate. Performance indicators related to **timeliness** of and **access** to services were *Fully Compliant* with MDCH specifications. **Lakeshore Behavioral Health Alliance** met 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 fell below the statewide rate. **Lakeshore Behavioral Health Alliance** demonstrated exceptional performance across all three domains of **quality**, **timeliness**, and **access** and continued to meet the minimum performance standard for all nine indicators.

LifeWays

Findings

Table 3-27 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2010 Validation of Performance Measures Report for **LifeWays** includes additional details of the validation results.

Table 3-27—2009–2010 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%	*Fully Compliant*
		Adults:	99.27%	
2.	Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	93.97%		*Fully Compliant*
3.	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional.	100%		*Fully Compliant*
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children:	100%	*Fully Compliant*
		Adults:	100%	
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).	NA		*Not Valid*
10.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of adults dually diagnosed with mental illness/developmental disability served by the PIHPs who are employed competitively.	MI Adults:	8.75%	*Substantially Compliant*
		DD Adults:	10.84%	
		MI/DD Adults:	5.49%	
11.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of adults dually diagnosed with mental illness/developmental disability served by the PIHPs who earned minimum wage or more from any employment activities.	MI Adults:	76.81%	*Substantially Compliant*
		DD Adults:	76.47%	
		MI/DD Adults:	80.95%	
12.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children:	11.76%	*Fully Compliant*
		Adults:	11.54%	
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 continued to demonstrate a commitment to accurate performance measure reporting. **LifeWays** had commendable documentation of all PIHP processes. The documentation included step-by-step, detailed instructions on how to perform each process from creating and submitting the 837 files to downloading eligibility data and generating the performance measures. **LifeWays** dedicated time to improving QI data completeness.

Recommendations

LifeWays should continue its efforts to reach 100 percent completeness for National Provider Identifier (NPI) numbers. The PIHP should continue with the requirement that all providers submit an NPI number for claims to be paid. **LifeWays** should also continue its efforts to meet minimum data completeness standards for the QI data elements. **LifeWays** is required to submit a corrective action plan addressing missing QI data, which affected validation findings for several performance indicators.

Summary Assessment Related to Quality, Timeliness, and Access

LifeWays' performance indicators related to **quality** were *Fully Compliant* with MDCH specifications except for Indicators 10 and 11, which received a designation of *Substantially Compliant*. Completeness of minimum wage data was below the required 95 percent threshold, resulting in an understated rate for these measures. Indicator 8 was rated *Not Valid* due to missing QI data elements for the reporting period. The PIHP met all contractually required performance standards related to the **quality** of services provided by the PIHP. For the remaining indicators in the **quality** domain, **LifeWays** achieved mixed results. The rates for MI, DD, and MI/DD adults who were employed competitively were lower than the statewide rates. The rates for MI, DD, and MI/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 5, which was rated *Not Valid*. **LifeWays** met the contractually required performance standards for six of the seven performance measures related to **timeliness** of and **access** to services provided by the PIHP. **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 3-28 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2010 Validation of Performance Measures Report for **Macomb County CMH Services** includes additional details of the validation results.

Table 3-28—2009–2010 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:	99.29%	*Fully Compliant*
		Adults:	99.78%	
2.	Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	98.76%		*Fully Compliant*
3.	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional.	99.73%		*Fully Compliant*
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children:	95.83%	*Fully Compliant*
		Adults:	97.44%	
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).	5.01%		*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).	97.99%		*Fully Compliant*
10.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of adults dually diagnosed with mental illness/developmental disability served by the PIHPs who are employed competitively.	MI Adults:	9.83%	*Fully Compliant*
		DD Adults:	8.61%	
		MI/DD Adults:	7.72%	
11.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of adults dually diagnosed with mental illness/developmental disability served by the PIHPs who earned minimum wage or more from any employment activities.	MI Adults:	58.03%	*Fully Compliant*
		DD Adults:	20.56%	
		MI/DD Adults:	16.67%	
12.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children:	19.70%	*Fully Compliant*
		Adults:	24.31%	
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 provided close monitoring of provider performance and required corrective action plans at the provider level if performance dropped below 95 percent. **Macomb County CMH Services** continued to demonstrate an effective working relationship with PCE Systems to support the PIHP's FOCUS system. **Macomb County CMH Services** employed a Department of Human Services (DHS) staff person internally at the PIHP to assist with processing Medicaid eligibility and resolving eligibility issues.

Recommendations

Macomb County CMH Services should continue to monitor QI data completeness and accuracy to ensure that quality indicators meet the State's data completeness standards. Because the completeness of the minimum wage QI data element fell below the 95 percent standard for the first quarter of 2010, the PIHP was required to submit a corrective action plan.

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 three of the five contractually required performance standards related to the **quality** of services provided by the PIHP. For the remaining indicators in the **quality** domain, **Macomb County CMH Services** achieved mostly below-average results. The PIHP's HSW rate exceeded the statewide rate. The rates for MI, DD, and MI/DD adults who were employed competitively or earned minimum wage were 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 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 was lower than 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 seven of the nine indicators.

network180

Findings

Table 3-29 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2010 Validation of Performance Measures Report for **network180** includes additional details of the validation results.

Table 3-29—2009–2010 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:	100%	*Fully Compliant*
		Adults:	98.82%	
2.	Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	99.89%		*Fully Compliant*
3.	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional.	93.61%		*Fully Compliant*
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children:	97.30%	*Fully Compliant*
		Adults:	95.74%	
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).	5.89%		*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).	97.63%		*Fully Compliant*
10.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of adults dually diagnosed with mental illness/developmental disability served by the PIHPs who are employed competitively.	MI Adults:	7.26%	*Substantially Compliant*
		DD Adults:	14.68%	
		MI/DD Adults:	19.01%	
11.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of adults dually diagnosed with mental illness/developmental disability served by the PIHPs who earned minimum wage or more from any employment activities.	MI Adults:	73.49%	*Substantially Compliant*
		DD Adults:	21.62%	
		MI/DD Adults:	18.72%	
12.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children:	12.50%	*Fully Compliant*
		Adults:	16.88%	
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

network180 identified the source of gaps in QI minimum wage data completeness. The PIHP's development of new reports facilitated tracking QI data completeness. **network180**'s staff demonstrated a proactive approach to improving the encounter data and performance indicator process. Providers received access to an online essential service education application, which helped to ensure that clinicians met their continuing education unit requirements. To improve data completeness, the PIHP implemented reverse incentives for case rate payments, which involved holding back payment for failure to submit required data.

Recommendations

network180 should prepare formal documentation of instructions on how to make revisions to the recipient rights database. In addition, the PIHP should incorporate formal evaluation of data entry accuracy for paper claims. The PIHP should continue its efforts to automate the encounter file submission process and continue to explore giving providers a means for capturing exclusion data in a consolidated fashion. The PIHP should continue efforts to get all providers on the fee-for-service model. Based on QI data completeness findings for the first quarter of SFY 2010, the minimum wage QI data element was below MDCH's 95 percent completeness threshold. The PIHP must submit a corrective action plan addressing this finding.

Summary Assessment Related to Quality, Timeliness, and Access

network180'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*. Completeness of minimum wage data was below the required 95 percent threshold, resulting in an understated rate for these measures. The PIHP met four of the five contractually required performance standards related to the **quality** of services provided by the PIHP. For the remaining indicators in the **quality** domain, **network180** demonstrated mixed results. The PIHP's HSW rate exceeded the statewide rate. The rates for DD and MI/DD adults who were employed competitively and the rate for MI adults who earned minimum wage were higher than the statewide rates, while the rate for MI adults who were employed competitively and the rates for DD and MI/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 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 exceeded the statewide rate. **network180** demonstrated strong performance and met the minimum performance standard for a total of seven of the nine indicators.

NorthCare

Findings

Table 3-30 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2010 Validation of Performance Measures Report for **NorthCare** includes additional details of the validation results.

Table 3-30—2009–2010 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%	*Fully Compliant*
		Adults:	98.48%	
2.	Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	98.46%		*Fully Compliant*
3.	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional.	97.24%		*Fully Compliant*
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children:	95.45%	*Fully Compliant*
		Adults:	97.50%	
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).	6.52%		*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).	95.93%		*Fully Compliant*
10.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of adults dually diagnosed with mental illness/developmental disability served by the PIHPs who are employed competitively.	MI Adults:	14.05%	*Substantially Compliant*
		DD Adults:	13.80%	
		MI/DD Adults:	17.58%	
11.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of adults dually diagnosed with mental illness/developmental disability served by the PIHPs who earned minimum wage or more from any employment activities.	MI Adults:	73.14%	*Substantially Compliant*
		DD Adults:	46.15%	
		MI/DD Adults:	40.63%	
12.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children:	19.23%	*Fully Compliant*
		Adults:	18.00%	
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 successfully transitioned to the PIHP-wide electronic medical record system (ELMER) without data loss and monitored encounter volume carefully to ensure that there was no loss of data. The movement to a uniform system will enhance reporting capabilities. In addition, the PIHP will require that each of its affiliates use the same audit tool for internal Medicaid verification audits, which will allow for more comparability of the audit results. **NorthCare** demonstrated effective communication with its affiliates, addressing any potential data quality issues quickly and efficiently.

Recommendations

NorthCare should require several affiliates to submit information related to the transition to ELMER in a Microsoft Word document and remind all affiliates to incorporate this information for next year's mini-ISCAT submission. The PIHP should continue to work with the CA and CareNet regarding the submission of encounter data. **NorthCare** should continue to monitor performance indicator rates, as well as encounter and QI data completeness. Based on QI data completeness findings for the first quarter of SFY 2010, the PIHP must submit a corrective action addressing the deficiency of the minimum wage data element.

Summary Assessment Related to Quality, Timeliness, and Access

NorthCare'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*. Completeness of minimum wage data was below the required 95 percent threshold, resulting in an understated rate for these measures. The PIHP met three of the five contractually required performance standards related to the **quality** of services provided by the PIHP. For the remaining indicators in the **quality** domain, **NorthCare** demonstrated above-average results. The PIHP's HSW rate exceeded the statewide rate. The rates for MI, DD, and MI/DD adults who were employed competitively or earned minimum wage were above the statewide rates. Performance indicators related to **timeliness** of and **access** to services were *Fully Compliant* with MDCH specifications. **NorthCare** met 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 exceeded the statewide rate. **NorthCare** demonstrated excellent performance across all three domains of **quality**, **timeliness**, and **access** and met the minimum performance standard for seven of the nine indicators.

Northern Affiliation

Findings

Table 3-31 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2010 Validation of Performance Measures Report for **Northern Affiliation** includes additional details of the validation results.

Table 3-31—2009–2010 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%	*Fully Compliant*
		Adults:	100%	
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.	100%		*Fully Compliant*
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children:	100%	*Fully Compliant*
		Adults:	100%	
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).	6.23%		*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).	93.61%		*Fully Compliant*
10.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of adults dually diagnosed with mental illness/developmental disability served by the PIHPs who are employed competitively.	MI Adults:	9.99%	*Fully Compliant*
		DD Adults:	20.03%	
		MI/DD Adults:	21.27%	
11.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of adults dually diagnosed with mental illness/developmental disability served by the PIHPs who earned minimum wage or more from any employment activities.	MI Adults:	70.22%	*Fully Compliant*
		DD Adults:	45.76%	
		MI/DD Adults:	55.95%	
12.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children:	4.17%	*Fully Compliant*
		Adults:	14.52%	
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

Northern Affiliation implemented processes to ensure the integrity of its data. The PIHP and its affiliates produced and reviewed numerous reports, including the Monthly Management and Reasons and Exceptions reports. The PIHP expanded its audit process significantly by taking advantage of staff already performing audits in the field. **Northern Affiliation** continually reviewed and ensured the integrity of performance indicator definitions and interpretations. The PIHP investigated exceptions and outliers. There were effective processes in place to ensure cross-training of affiliate staff members, including training on key responsibilities and critical elements. The PIHP had a strong relationship between its QI and information systems teams that further enhanced the reliability of the reported data.

Recommendations

Northern Affiliation should track and document the process of upgrading its cache system to ensure that no data are lost. Because the PIHP's completeness for the minimum wage QI data element fell below the threshold of 95 percent complete, the PIHP must submit a corrective action plan to MDCH.

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 all contractually required performance standards related to the **quality** of services provided by the PIHP. For the remaining indicators in the **quality** domain, **Northern Affiliation** achieved mostly above-average results. The PIHP's HSW rate exceeded the statewide rate. The rates for DD and MI/DD adults who were employed competitively or earned minimum wage were higher than the statewide rates, while the rates for MI adults who were employed competitively or earned minimum wage fell below the statewide rates. Performance indicators related to **timeliness** of and **access** to services were *Fully Compliant* with MDCH specifications. **Northern Affiliation** met 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 exceeded the statewide rate. **Northern Affiliation** demonstrated exceptional performance across all three domains of **quality**, **timeliness**, and **access** and continued to meet the minimum performance standard for all nine indicators.

Northwest CMH Affiliation

Findings

Table 3-32presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2010 Validation of Performance Measures Report for **Northwest CMH Affiliation** includes additional details of the validation results.

Table 3-32—2009–2010 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:	96.30%	*Fully Compliant*
		Adults:	96.97%	
2.	Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	99.74%		*Fully Compliant*
3.	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional.	97.89%		*Fully Compliant*
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children:	100%	*Fully Compliant*
		Adults:	100%	
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).	7.51%		*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).	92.47%		*Fully Compliant*
10.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of adults dually diagnosed with mental illness/developmental disability served by the PIHPs who are employed competitively.	MI Adults:	11.65%	*Fully Compliant*
		DD Adults:	18.09%	
		MI/DD Adults:	13.44%	
11.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of adults dually diagnosed with mental illness/developmental disability served by the PIHPs who earned minimum wage or more from any employment activities.	MI Adults:	96.62%	*Fully Compliant*
		DD Adults:	82.84%	
		MI/DD Adults:	94.26%	
12.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children:	11.54%	*Fully Compliant*
		Adults:	3.28%	
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 implemented a reconciliation process to audit the services provided at the community mental health service providers (CMHSPs). The PIHP generated a random sample and performed a validation of medical records for verification of documentation of services provided, timeliness of documentation, and quality of services provided and documented. In addition, the PIHP implemented a new Recap report in June 2009 that showed a four-year running summary of the history of encounter data totals. The PIHP shared the report—a best practice for tracking and trending encounter data completeness—with the CMHSPs.

Recommendations

Northwest CMH Affiliation should continue efforts to work with MDCH to ensure that the data at the State reflect the PIHP's data and that enrollment data are accurate and complete. The PIHP should continue monitoring encounter data completeness using the encounter report. **Northwest CMH Affiliation** was required to submit a corrective action plan addressing the below-threshold completeness of the minimum wage data element in the QI data file.

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 all contractually required performance standards related to the **quality** of services provided by the PIHP. For the remaining indicators in the **quality** domain, **Northwest CMH Affiliation** achieved above-average results. The PIHP's HSW rate exceeded the statewide rate. The rates for MI, DD, and MI/DD adults who were employed competitively or 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 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 exceeded the statewide rate. **Northwest CMH Affiliation** demonstrated exceptional performance across all three domains of **quality**, **timeliness**, and **access** and continued to meet the minimum performance standard for all nine indicators.

Oakland County CMH Authority

Findings

Table 3-33 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2010 Validation of Performance Measures Report for **Oakland County CMH Authority** includes additional details of the validation results.

Table 3-33—2009–2010 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:	95.91%	*Fully Compliant*
		Adults:	96.71%	
2.	Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	98.15%		*Fully Compliant*
3.	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional.	98.18%		*Fully Compliant*
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children:	96.49%	*Fully Compliant*
		Adults:	96.74%	
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).	7.43%		*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).	98.85%		*Fully Compliant*
10.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of adults dually diagnosed with mental illness/developmental disability served by the PIHPs who are employed competitively.	MI Adults:	8.27%	*Fully Compliant*
		DD Adults:	18.69%	
		MI/DD Adults:	19.44%	
11.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of adults dually diagnosed with mental illness/developmental disability served by the PIHPs who earned minimum wage or more from any employment activities.	MI Adults:	65.30%	*Fully Compliant*
		DD Adults:	27.11%	
		MI/DD Adults:	19.74%	
12.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children:	23.91%	*Fully Compliant*
		Adults:	11.54%	
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 was very proactive in the number of reports generated across various areas of the organization to monitor processes and to make improvements based on findings. These reports included data completeness results for providers in the form of grades. Other reports were run to track, trend, and monitor services provided to consumers. These reports (the info-mart), in addition to work groups that met to discuss findings, continued to be a best practice among the PIHPs in Michigan.

Recommendations

Oakland County CMH Authority should maintain complete documentation of the process and any issues that occur during the implementation of the PIHP-wide electronic medical record and new, centralized transactional system. The PIHP should work closely with its contracted vendor to ensure a smooth transition.

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 four of the five contractually required performance standards related to the **quality** of services provided by the PIHP. For the remaining indicators in the **quality** domain, **Oakland County CMH Authority** achieved mixed results. The PIHP's HSW rate exceeded the statewide rate. The rates for DD and MI/DD adults who were employed competitively were higher than the statewide rates, while the rate for MI adults who were employed competitively fell below the statewide rate. The rates for MI, DD, and MI/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. **Oakland County CMH Authority** met 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 exceeded the statewide rate. **Oakland County CMH Authority** demonstrated excellent performance across all three domains of **quality**, **timeliness**, and **access** and met the minimum performance standard for eight of the nine indicators.

Saginaw County CMH Authority

Findings

Table 3-34 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2010 Validation of Performance Measures Report for **Saginaw County CMH Authority** includes additional details of the validation results.

Table 3-34—2009–2010 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%	*Fully Compliant*
		Adults:	100%	
2.	Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	99.54%		*Fully Compliant*
3.	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional.	91.30%		*Fully Compliant*
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children:	100%	*Fully Compliant*
		Adults:	91.67%	
4b.	Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	40.00%		*Fully Compliant*
5.	Percentage of Medicaid recipients having received PIHP-managed services (penetration rate).	5.14%		*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).	95.87%		*Fully Compliant*
10.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of adults dually diagnosed with mental illness/developmental disability served by the PIHPs who are employed competitively.	MI Adults:	6.38%	*Substantially Compliant*
		DD Adults:	13.98%	
		MI/DD Adults:	8.70%	
11.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of adults dually diagnosed with mental illness/developmental disability served by the PIHPs who earned minimum wage or more from any employment activities.	MI Adults:	80.43%	*Substantially Compliant*
		DD Adults:	19.35%	
		MI/DD Adults:	33.33%	
12.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children:	10.53%	*Fully Compliant*
		Adults:	18.60%	
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's corrective action to improve QI data for the disability designation was successful in increasing completeness. The PIHP successfully implemented changes in the claims and billing systems with little disruption in data flow. **Saginaw County CMH Authority**'s board-operated billing integrity self-audit document and QI report were further evidence of the PIHP's commitment to data completeness and accuracy. The "auth lab" initiative was a practical approach to staff education, training, and reinforcement of system functionality.

Recommendations

Saginaw County CMH Authority should continue close oversight of performance indicator and encounter data. The PIHP should consider adding a review of omissions as a component of the medical record validation activities by the PIHP to assess data completeness. Due to the minimum wage QI data element for the first quarter of SFY 2010 falling below the 95 percent threshold for data completeness established by MDCH, the PIHP must submit a corrective action plan addressing this finding.

Summary Assessment Related to Quality, Timeliness, and Access

Saginaw County CMH Authority'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*. Completeness of minimum wage data was below the required 95 percent threshold, resulting in an understated rate for these measures. The PIHP met two of the five contractually required performance standards related to the **quality** of services provided by the PIHP. For the remaining indicators in the **quality** domain, **Saginaw County CMH Authority** demonstrated mixed results. The PIHP's HSW rate exceeded the statewide rate. The rates for MI and MI/DD adults who were employed competitively and the rates for DD and MI/DD adults who earned minimum wage were lower than the statewide rates, while the rates for DD adults who were employed competitively and MI adults who earned minimum wage exceeded the statewide rates. Performance indicators related to **timeliness** of and **access** to services were *Fully Compliant* with MDCH specifications. **Saginaw County CMH Authority** met 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 was lower than the statewide rate. **Saginaw County CMH Authority** demonstrated strong performance on several measures across the domains of **quality**, **timeliness**, and **access** and met the minimum performance standard for a total of five of the nine indicators.

Southwest Affiliation

Findings

Table 3-35 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2010 Validation of Performance Measures Report for **Southwest Affiliation** includes additional details of the validation results.

Table 3-35—2009–2010 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:	100%	*Fully Compliant*
		Adults:	98.21%	
2.	Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	96.77%		*Fully Compliant*
3.	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional.	98.36%		*Fully Compliant*
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children:	100%	*Fully Compliant*
		Adults:	97.73%	
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).	NA		*Not Valid*
10.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of adults dually diagnosed with mental illness/developmental disability served by the PIHPs who are employed competitively.	MI Adults:	9.17%	*Substantially Compliant*
		DD Adults:	14.73%	
		MI/DD Adults:	16.32%	
11.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of adults dually diagnosed with mental illness/developmental disability served by the PIHPs who earned minimum wage or more from any employment activities.	MI Adults:	84.57%	*Substantially Compliant*
		DD Adults:	72.92%	
		MI/DD Adults:	86.36%	
12.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children:	9.68%	*Fully Compliant*
		Adults:	16.36%	
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 demonstrated a collaborative approach to accurate performance measure reporting and an excellent working relationship between the affiliates and the PIHP. The longevity of staff at both the affiliates and the PIHP led to the consistency and accuracy of performance measure reporting. **Southwest Affiliation**'s process of providing HTML error reports in response to the 837 data submission was a best practice. Similar to previous years, the submitted documentation was thorough and facilitated an efficient on-site review. **Southwest Affiliation** demonstrated a dedication to accurate performance measure reporting. The PIHP demonstrated a proactive approach to the transition to the Avatar transactional system by participating in the Avatar User's Group.

Recommendations

Southwest Affiliation should continue its efforts and practices to ensure the accuracy and completeness of all QI and performance indicator data. As one of the affiliates transitions to an electronic health record, the PIHP should ensure that the affiliate documents the process and monitors the transition to ensure that no data are lost and that there are no delays in data reporting. **Southwest Affiliation** should continue efforts toward automation of the performance measures, as resources allow. The PIHP must submit a corrective action plan addressing findings related to incomplete minimum wage and Medicaid ID QI data elements identified upon review of rates from the first quarter of SFY 2010. In addition, data reflected a drop in the penetration and HSW rates. The PIHP stated that an information systems transition by an affiliate may have caused these rates to drop. The PIHP should confirm this finding and take appropriate action to ensure that affiliates submit complete encounter and QI data. The PIHP should also follow up with MDCH to ensure that the PIHP is in compliance with timelines for complete data submission.

Summary Assessment Related to Quality, Timeliness, and Access

Southwest Affiliation'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*. Completeness of minimum wage data was below the required 95 percent threshold, resulting in an understated rate for these measures. Indicator 8 was rated *Not Valid* due to concerns about QI data elements for the reporting period. The PIHP met four of the five contractually required performance standards related to the **quality** of services provided by the PIHP. For the remaining indicators in the **quality** domain, **Southwest Affiliation** achieved mostly above-average results. The rates for DD and MI/DD adults who were employed competitively and the rates for MI, DD, and MI/DD adults who earned minimum wage were higher than the statewide rates, while the rate for MI adults who were employed competitively fell below the statewide rate. Performance indicators related to **timeliness** of and **access** to services were *Fully Compliant* with MDCH specifications except for Indicator 5, which was rated *Not Valid*. **Southwest Affiliation** met the contractually required performance standards for all performance measures related to **timeliness** of and **access** to services provided by the PIHP. **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 3-36 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2010 Validation of Performance Measures Report for **Thumb Alliance PIHP** includes additional details of the validation results.

Table 3-36—2009–2010 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%	*Fully Compliant*
		Adults:	99.35%	
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.	99.47%		*Fully Compliant*
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children:	100%	*Fully Compliant*
		Adults:	98.31%	
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).	6.91%		*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).	97.65%		*Fully Compliant*
10.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of adults dually diagnosed with mental illness/developmental disability served by the PIHPs who are employed competitively.	MI Adults:	9.75%	*Substantially Compliant*
		DD Adults:	5.44%	
		MI/DD Adults:	5.15%	
11.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of adults dually diagnosed with mental illness/developmental disability served by the PIHPs who earned minimum wage or more from any employment activities.	MI Adults:	49.29%	*Substantially Compliant*
		DD Adults:	19.02%	
		MI/DD Adults:	17.11%	
12.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children:	4.35%	*Fully Compliant*
		Adults:	18.67%	
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 be dedicated to the performance measure process. The information systems and quality team moved its practices to a customer service-based relationship with its providers. **Thumb Alliance PIHP**'s Consumer Data Issues reports and the How To Guide continued to be best practices. Thumb distributed the OASIS newsletter, which communicated updates and information to all providers and interested parties. Documentation submitted contained a detailed explanation of the process of generating the performance measures. The Fiscal Year 2008 Review of Data Accuracy and Completeness report reflected the work and progress throughout the year.

Recommendations

Thumb Alliance PIHP should proceed with the planned implementation of the scheduler application to enhance data cohesiveness and accuracy and continue with increased oversight of CA data. The PIHP should continue exploring new methodologies to assess real-time completeness of QI data. **Thumb Alliance PIHP** should continue efforts to increase inpatient providers' use of the data system instead of paper claims. The PIHP should continue its efforts to hire a DHS staff person to work internally at the PIHP to assist with eligibility issues. Due to changes to the State's eligibility system and transactional system, the PIHP has had a backlog in processing Medicaid applications. Due to the minimum wage QI data element for the first quarter of SFY 2010 falling below the 95 percent threshold for data completeness established by MDCH, the PIHP must submit a corrective action plan addressing this finding.

Summary Assessment Related to Quality, Timeliness, and Access

Thumb Alliance PIHP'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*. Completeness of minimum wage data was below the required 95 percent threshold, resulting in an understated rate for these measures. The PIHP met four of the five contractually required performance standards related to the **quality** of services provided by the PIHP. For the remaining indicators in the **quality** domain, **Thumb Alliance PIHP** demonstrated mostly below-average results. The PIHP's HSW rate exceeded the statewide rate. The rates for MI, DD, and MI/DD adults who were employed competitively or 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 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 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 3-37 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2010 Validation of Performance Measures Report for **Venture Behavioral Health** includes additional details of the validation results.

Table 3-37—2009–2010 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: 98.08% Adults: 97.51%	*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.	98.70%	*Fully Compliant*
3.	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional.	97.25%	*Fully Compliant*
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children: 100% Adults: 98.48%	*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).	5.72%	*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).	94.74%	*Fully Compliant*
10.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of adults dually diagnosed with mental illness/developmental disability served by the PIHPs who are employed competitively.	MI Adults: 10.79% DD Adults: 13.77% MI/DD Adults: 14.48%	*Substantially Compliant*
11.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of adults dually diagnosed with mental illness/developmental disability served by the PIHPs who earned minimum wage or more from any employment activities.	MI Adults: 59.09% DD Adults: 29.49% MI/DD Adults: 40.00%	*Substantially Compliant*
12.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children: 14.29% Adults: 2.30%	*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 began implementation of ProviderAccess, an electronic encounter submission tool. The PIHP expected to complete the implementation of this application across all affiliates by September 1, 2010. The PIHP had good oversight of performance measure reporting. The PIHP monitored performance measures monthly through reports and queries against the Regional Data Warehouse. The PIHP and affiliates held monthly meetings to review performance indicator and encounter data.

Recommendations

Venture Behavioral Health should continue efforts to receive claims electronically or through the Web-based claims entry application. The PIHP should continue to monitor the completeness of encounter data received from the affiliates through trend reporting and other analyses. The PIHP must submit a corrective action plan addressing incomplete QI data elements discovered in its first quarter of SFY 2010 QI file submission.

Summary Assessment Related to Quality, Timeliness, and Access

Venture Behavioral Health'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*. Completeness of minimum wage data was far below the required 95 percent threshold, resulting in an understated rate for these measures. The PIHP met all contractually required performance standards related to the **quality** of services provided by the PIHP. For the remaining indicators in the **quality** domain, **Venture Behavioral Health** achieved mostly above-average results. The PIHP's HSW rate exceeded the statewide rate. The rates for MI, DD, and MI/DD adults who were employed competitively and the rates for DD adults and MI/DD adults who earned minimum wage were higher than the statewide rates, while the rate for MI adults who earned minimum wage was lower than the statewide rate. Performance indicators related to **timeliness** of and **access** to services were *Fully Compliant* with MDCH specifications. **Venture Behavioral Health** met 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 fell below the statewide rate. **Venture Behavioral Health** demonstrated excellent 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 2009–2010 validation, the PIHPs continued with the mandatory study topic: improving the penetration rates for children. The validation of PIPs addresses the validity and reliability of the PIHP's processes for conducting valid PIPs. Therefore, for the purposes of the EQR technical report, HSAG assigned all PIPs to the **quality** domain.

Access Alliance of Michigan

Findings

Table 3-38 and Table 3-39 show **Access Alliance of Michigan**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2009–2010 PIP Validation Tool for **Access Alliance of Michigan**. Validation of Steps 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. Based on the validation of this PIP, HSAG's assessment determined confidence in the results.

Table 3-38—PIP Validation Scores *for* Access Alliance of Michigan

Review Step		All Evaluation Elements (Including Critical Elements)					Critical Elements				
		Total	*M*	*PM*	*NM*	*NA*	Total	*M*	*PM*	*NM*	*NA*
I.	Review the Selected Study Topic(s)	6	5	0	0	1	1	1	0	0	0
II.	Review the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III.	Review the Selected Study Indicator(s)	7	4	0	0	3	3	3	0	0	0
IV.	Review the Identified Study Population	3	3	0	0	0	2	2	0	0	0
V.	Review Sampling Methods	6	0	0	0	6	1	0	0	0	1
VI.	Review Data Collection Procedures	11	5	0	0	6	1	0	0	0	1
VII.	Assess Improvement Strategies	4	3	0	0	1	1	1	0	0	0
VIII.	Review Data Analysis and Study Results	9	6	2	0	1	2	1	0	0	1
IX.	Assess for Real Improvement	4	3	1	0	0	No Critical Elements				
X.	Assess for Sustained Improvement	1	Not Assessed				No Critical Elements				
Totals for All Steps		**53**	**31**	**3**	**0**	**18**	**13**	**10**	**0**	**0**	**3**

Table 3-39—PIP Validation Status *for* Access Alliance of Michigan

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

Strengths

Access Alliance of Michigan demonstrated strength in its study design and study implementation by receiving *Met* scores for all applicable evaluation elements in Steps I through VII. The study topic was selected following the collection and analysis of data and included all eligible populations. The study questions were answerable and stated the problem to be studied in simple terms. The study indicators were well defined, objective, and measurable. The study population was accurately and completely defined. The plan provided all of the necessary documentation regarding the data collection process, completed causal/barrier analysis, and developed interventions based on the causes/barriers. The interventions included system changes likely to induce permanent change.

Recommendations

HSAG identified opportunities for improvement in Step VIII—Review Data Analysis and Study Results and Step IX—Assess for Real Improvement. **Access Alliance of Michigan** did not provide all of the results accurately and did not discuss the follow-up activities identified as a result of the overall success of the study. Future submissions should include the *z* test results and *p* values in the Activity IX results table. For this year's submission, although all of the study indicators showed improvement, not all of the study indicators demonstrated statistically significant improvement.

Summary Assessment Related to Quality, Timeliness, and Access

Access Alliance of Michigan implemented several interventions to improve services to children with SED, DD, or both SED and DD. Interventions included increasing program capacity, hiring additional staff, conducting educational presentations, and implementing training. Study results reflected that the PIHP exceeded its goals for improvement from Baseline to Remeasurement 1 for all three study indicators and achieved statistically significant increases in the percentages of children with DD and children with both SED and DD who received services. 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 3-40 and Table 3-41 show **CMH Affiliation of Mid-Michigan**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2009–2010 PIP Validation Tool for **CMH Affiliation of Mid-Michigan**. Validation of Steps I through IX resulted in a validation status of *Partially Met*, with an overall score of 76 percent and a score of 90 percent for critical elements. Based on the validation of this PIP, HSAG's assessment determined low confidence in the PIP results.

Table 3-40—PIP Validation Scores *for* CMH Affiliation of Mid-Michigan

Review Step		All Evaluation Elements (Including Critical Elements)					Critical Elements				
		Total	*M*	*PM*	*NM*	*NA*	Total	*M*	*PM*	*NM*	*NA*
I.	Review the Selected Study Topic(s)	6	5	0	0	1	1	1	0	0	0
II.	Review the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III.	Review the Selected Study Indicator(s)	7	4	0	0	3	3	3	0	0	0
IV.	Review the Identified Study Population	3	3	0	0	0	2	2	0	0	0
V.	Review Sampling Methods	6	0	0	0	6	1	0	0	0	1
VI.	Review Data Collection Procedures	11	5	0	0	6	1	0	0	0	1
VII.	Assess Improvement Strategies	4	2	1	0	1	1	1	0	0	0
VIII.	Review Data Analysis and Study Results	9	2	4	2	1	2	0	1	0	1
IX.	Assess for Real Improvement	4	3	1	0	0	No Critical Elements				
X.	Assess for Sustained Improvement	1	Not Assessed				No Critical Elements				
Totals for All Activities		**53**	**26**	**6**	**2**	**18**	**13**	**9**	**1**	**0**	**3**

Table 3-41—PIP Validation Status *for* CMH Affiliation of Mid-Michigan

Percentage Score of Evaluation Elements *Met*	**76%**
Percentage Score of Critical Elements *Met*	**90%**
Validation Status	***Partially Met***

Strengths

CMH Affiliation of Mid-Michigan's PIP documented a solid study design. The study topic was selected following the collection and analysis of data and included all eligible populations. The study questions were answerable and stated the problem to be studied in simple terms. The study indicators were well defined, objective, and measurable. The study population was accurately and completely defined. The plan provided all of the necessary documentation regarding the data collection process, completed causal/barrier analysis, and developed interventions based on the causes/barriers. The interventions included system changes likely to induce permanent change.

Recommendations

HSAG identified opportunities for improvement in Step VIII—Review Data Analysis and Study Results and Step IX—Assess for Real Improvement. **CMH Affiliation of Mid-Michigan** did not provide a complete data analysis plan or a complete interpretation of the study results. Additionally, some of the results were not presented accurately, and it was not clear if the plan completed statistical testing between Baseline and Remeasurement 1. Two of the study indicators showed a statistically significant increase; however, one study indicator showed an increase that was not statistically significant.

Summary Assessment Related to Quality, Timeliness, and Access

CMH Affiliation of Mid-Michigan implemented several interventions to improve services to children with SED, DD, or both SED and DD. Interventions included staff training; collaboration with schools, juvenile justice, and law enforcement; coordination with the Michigan Department of Human Services (DHS); initiatives for preschool and daycare; additional staff; and implementation of support groups for parents. Study results reflected that the PIHP exceeded its goals for improvement from Baseline to Remeasurement 1 for all three study indicators and achieved statistically significant increases in the percentages of children with SED and children with DD who received services. As **CMH Affiliation of Mid-Michigan** progresses in the study, assessment of the impact of the PIP on the **quality** of care and services will continue.

CMH for Central Michigan

Findings

Table 3-42 and Table 3-43 show **CMH for Central Michigan**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2009–2010 PIP Validation Tool for **CMH for Central Michigan**. Validation of Steps I through IX resulted in a validation status of *Met*, with an overall score of 85 percent and a score of 100 percent for critical elements. Based on the validation of this PIP, HSAG's assessment determined confidence in the results.

Table 3-42—PIP Validation Scores *for* CMH for Central Michigan

Review Step		All Evaluation Elements (Including Critical Elements)					Critical Elements				
		Total	*M*	*PM*	*NM*	*NA*	Total	*M*	*PM*	*NM*	*NA*
I.	Review the Selected Study Topic(s)	6	5	0	0	1	1	1	0	0	0
II.	Review the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III.	Review the Selected Study Indicator(s)	7	4	0	0	3	3	3	0	0	0
IV.	Review the Identified Study Population	3	3	0	0	0	2	2	0	0	0
V.	Review Sampling Methods	6	0	0	0	6	1	0	0	0	1
VI.	Review Data Collection Procedures	11	5	0	0	6	1	0	0	0	1
VII.	Assess Improvement Strategies	4	3	0	0	1	1	1	0	0	0
VIII.	Review Data Analysis and Study Results	9	6	2	0	1	2	1	0	0	1
IX.	Assess for Real Improvement	4	1	3	0	0	No Critical Elements				
X.	Assess for Sustained Improvement	1	Not Assessed								
Totals for All Activities		**53**	**29**	**5**	**0**	**18**	**13**	**10**	**0**	**0**	**3**

Table 3-43—PIP Validation Status *for* CMH for Central Michigan

Percentage Score of Evaluation Elements *Met*	**85%**
Percentage Score of Critical Elements *Met*	**100%**
Validation Status	***Met***

Strengths

CMH for Central Michigan demonstrated strength in its study design and study implementation by receiving *Met* scores for all applicable evaluation elements in Steps I through VII. The study topic was selected following the collection and analysis of data and included all eligible populations. The study questions were answerable and stated the problem to be studied in simple terms. The study indicators were well defined, objective, and measurable. The study population was accurately and completely defined. The plan provided all of the necessary documentation regarding the data collection process, completed causal/barrier analysis, and developed interventions based on the causes/barriers. The interventions included system changes likely to induce permanent change.

Recommendations

HSAG identified opportunities for improvement in Step VIII—Review Data Analysis and Study Results and Step IX—Assess for Real Improvement. **CMH for Central Michigan** did not provide all of the results accurately. For this year's submission, not all of the study indicators showed improvement. Two of the study indicators showed statistically significant increases; however, one study indicator did not show improvement.

Summary Assessment Related to Quality, Timeliness, and Access

CMH for Central Michigan implemented several interventions to improve services to children with SED, DD, or both SED and DD. Interventions included conducting outreach events to raise awareness of children's services, hiring additional staff, monthly meetings with DHS staff, implementing campaigns, establishing coalitions, conducting training sessions, providing education, and giving various presentations. Study results reflected that the PIHP met its goals for improvement from Baseline to Remeasurement 1 for two of the three study indicators and achieved statistically significant increases in the percentages of children with SED and children with both SED and DD who received services. As **CMH for Central Michigan** progresses in the study, assessment of the impact of the PIP on the **quality** of care and services will continue.

CMH Partnership of Southeastern Michigan

Findings

Table 3-44 and Table 3-45 show **CMH Partnership of Southeastern Michigan**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2009–2010 PIP Validation Tool for **CMH Partnership of Southeastern Michigan**. Validation of Activities I through IX resulted in a validation status of *Met*, with an overall score of 97 percent and a score of 100 percent for critical elements. Based on the validation of this PIP, HSAG's assessment determined high confidence in the results.

Table 3-44—PIP Validation Scores *for* CMH Partnership of Southeastern Michigan

Review Step		All Evaluation Elements (Including Critical Elements)					Critical Elements				
		Total	*M*	*PM*	*NM*	*NA*	Total	*M*	*PM*	*NM*	*NA*
I.	Review the Selected Study Topic(s)	6	5	0	0	1	1	1	0	0	0
II.	Review the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III.	Review the Selected Study Indicator(s)	7	4	0	0	3	3	3	0	0	0
IV.	Review the Identified Study Population	3	3	0	0	0	2	2	0	0	0
V.	Review Sampling Methods	6	0	0	0	6	1	0	0	0	1
VI.	Review Data Collection Procedures	11	5	0	0	6	1	0	0	0	1
VII.	Assess Improvement Strategies	4	3	0	0	1	1	1	0	0	0
VIII.	Review Data Analysis and Study Results	9	8	0	0	1	2	1	0	0	1
IX.	Assess for Real Improvement	4	3	1	0	0	No Critical Elements				
X.	Assess for Sustained Improvement	1	Not Assessed				No Critical Elements				
Totals for All Activities		**53**	**33**	**1**	**0**	**18**	**13**	**10**	**0**	**0**	**3**

Table 3-45—PIP Validation Status *for* CMH Partnership of Southeastern Michigan

Percentage Score of Evaluation Elements *Met*	**97%**
Percentage Score of Critical Elements *Met*	**100%**
Validation Status	***Met***

Strengths

CMH Partnership of Southeastern Michigan demonstrated strength in its study design, study implementation, and quality outcomes by receiving *Met* scores for all applicable evaluation elements in Steps I through VIII. The study topic was selected following the collection and analysis of data and included all eligible populations. The study questions were answerable and stated the problem to be studied in simple terms. The study indicators were well defined, objective, and measurable. The study population was accurately and completely defined. The plan provided all of the necessary documentation regarding the data collection process, completed causal/barrier analysis, and developed interventions based on the causes/barriers. The interventions included system changes likely to induce permanent change. The PIP completed data analysis according to the data analysis plan.

Recommendations

HSAG identified opportunities for improvement in Step VIII—Review Data Analysis and Study Results and Step IX—Assess for Real Improvement. **CMH Partnership of Southeastern Michigan** should provide direct comparisons between the Baseline and Remeasurement 1 results and ensure that all of the *p* values are reported accurately. Two of the study indicators showed statistically significant increases; however, one study indicator showed an increase that was not statistically significant.

Summary Assessment Related to Quality, Timeliness, and Access

CMH Partnership of Southeastern Michigan implemented several interventions to improve services to children with SED, DD, or both SED and DD. Interventions included communicating the project background with staff, collaborating with information technology (IT) staff, increasing staff, conducting quarterly meetings, implementing various children's programs, using screening tools, establishing referral procedures, and collaborating with various groups. Study results reflected that the PIHP exceeded its goals for improvement from Baseline to Remeasurement 1 for two of the three study indicators and achieved statistically significant increases in the percentages of children with SED and children with both SED and DD who received services. As **CMH Partnership of Southeastern Michigan** progresses in the study, assessment of the impact of the PIP on the **quality** of care and services will continue.

Detroit-Wayne County CMH Agency

Findings

Table 3-46 and Table 3-47 show **Detroit-Wayne County CMH Agency**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2009–2010 PIP Validation Tool for **Detroit-Wayne County CMH Agency**. Validation of Steps 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. Based on the validation of this PIP, HSAG's assessment determined low confidence in the results.

Table 3-46—PIP Validation Scores *for* Detroit-Wayne County CMH Agency

Review Step		All Evaluation Elements (Including Critical Elements)					Critical Elements				
		Total	*M*	*PM*	*NM*	*NA*	Total	*M*	*PM*	*NM*	*NA*
I.	Review the Selected Study Topic(s)	6	5	0	0	1	1	1	0	0	0
II.	Review the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III.	Review the Selected Study Indicator(s)	7	4	0	0	3	3	3	0	0	0
IV.	Review the Identified Study Population	3	3	0	0	0	2	2	0	0	0
V.	Review Sampling Methods	6	0	0	0	6	1	0	0	0	1
VI.	Review Data Collection Procedures	11	5	0	0	6	1	0	0	0	1
VII.	Assess Improvement Strategies	4	2	1	0	1	1	1	0	0	0
VIII.	Review Data Analysis and Study Results	9	6	2	0	1	2	0	1	0	1
IX.	Assess for Real Improvement	4	4	0	0	0	No Critical Elements				
X.	Assess for Sustained Improvement	1	Not Assessed				No Critical Elements				
Totals for All Activities		**53**	**31**	**3**	**0**	**18**	**13**	**9**	**1**	**0**	**3**

Table 3-47—PIP Validation Status *for* Detroit-Wayne County CMH Agency

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

Strengths

Detroit-Wayne County CMH Agency's PIP demonstrated strength in its study design and study implementation by receiving *Met* scores for all applicable evaluation elements in Steps I through VI. The PIP documented a solid study design. The study topic was selected following the collection and analysis of data and included all eligible populations. The study questions were answerable and stated the problem to be studied in simple terms. The study indicators were well defined, objective, and measurable. The study population was accurately and completely defined. The plan provided all of the necessary documentation regarding the data collection process. For this year's submission, all of the study indicators demonstrated statistically significant improvement.

Recommendations

HSAG identified opportunities for improvement in Step III—Review the Selected Study Indicators, Step VII—Assess Improvement Strategies, and Step VIII—Review Data Analysis and Study Results. **Detroit-Wayne County CMH Agency** should provide a goal for each measurement period, and the goal should be reported consistently throughout the PIP documentation. Future submissions should address the standardization and monitoring of the interventions. The plan should ensure that a complete data analysis plan is documented and that all of the results are provided accurately.

Summary Assessment Related to Quality, Timeliness, and Access

Detroit-Wayne County CMH Agency implemented several interventions to improve services to children with SED, DD, or both SED and DD. Interventions included different outreach activities, such as formal presentations, health fairs, focus group sessions, open houses, information displays, distribution of written materials, public service announcements, and other community events. Study results reflected that the PIHP exceeded its goals for improvement from Baseline to Remeasurement 1 for one of the three study indicators and achieved statistically significant increases in the percentages of children with SED and children with DD who received services. As **Detroit-Wayne County CMH Agency** progresses in the study, the assessment of the impact of the PIP on the **quality** of care and services will continue.

Genesee County CMH

Findings

Table 3-48 and Table 3-49 show **Genesee County CMH**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2009–2010 PIP Validation Tool for **Genesee County CMH**. Validation of Steps I through IX resulted in a validation status of *Met*, with an overall score of 82 percent and a score of 100 percent for critical elements. Based on the validation of this PIP, HSAG's assessment determined confidence in the results.

Table 3-48—PIP Validation Scores *for* Genesee County CMH

Review Step		All Evaluation Elements (Including Critical Elements)					Critical Elements				
		Total	*M*	*PM*	*NM*	*NA*	Total	*M*	*PM*	*NM*	*NA*
I.	Review the Selected Study Topic(s)	6	5	0	0	1	1	1	0	0	0
II.	Review the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III.	Review the Selected Study Indicator(s)	7	4	0	0	3	3	3	0	0	0
IV.	Review the Identified Study Population	3	3	0	0	0	2	2	0	0	0
V.	Review Sampling Methods	6	0	0	0	6	1	0	0	0	1
VI.	Review Data Collection Procedures	11	5	0	0	6	1	0	0	0	1
VII.	Assess Improvement Strategies	4	3	0	0	1	1	1	0	0	0
VIII.	Review Data Analysis and Study Results	9	5	3	0	1	2	1	0	0	1
IX.	Assess for Real Improvement	4	1	3	0	0	No Critical Elements				
X.	Assess for Sustained Improvement	1	Not Assessed				No Critical Elements				
Totals for All Activities		**53**	**28**	**6**	**0**	**18**	**13**	**10**	**0**	**0**	**3**

Table 3-49—PIP Validation Status *for* Genesee County CMH

Percentage Score of Evaluation Elements *Met*	**82%**
Percentage Score of Critical Elements *Met*	**100%**
Validation Status	***Met***

Strengths

Genesee County CMH's PIP demonstrated strength in its study design and study implementation by receiving *Met* scores for all applicable evaluation elements in Steps I through VII. The PIP documented a solid study design. The study topic was selected following the collection and analysis of data and included all eligible populations. The study questions were answerable and stated the problem to be studied in simple terms. The study indicators were well defined, objective, and measurable. The study population was accurately and completely defined. The plan provided all of the necessary documentation regarding the data collection process, completed causal/barrier analysis, and developed interventions based on the causes/barriers. The interventions included system changes likely to induce permanent change.

Recommendations

HSAG identified opportunities for improvement in Step III—Review the Selected Study Indicators, Step VIII—Review Data Analysis and Study Results, and Step IX—Assess for Real Improvement. Future submissions should document goals for each study indicator for every measurement period. **Genesee County CMH** should provide a complete interpretation of the study results, ensure that all of the results are presented accurately, and include follow-up activities in the interpretation of the extent to which the PIP was successful. For this year's submission, not all of the study indicators demonstrated improvement. Two of the study indicators showed a statistically significant increase; however, one study indicator showed a statistically significant decline.

Summary Assessment Related to Quality, Timeliness, and Access

Genesee County CMH implemented several interventions to improve services to children with SED, DD, or both SED and DD. Interventions included increasing staff, implementing screenings both off-site and on-site, improving referral source coding, developing collaborative agreements, researching reasons and patterns for no-shows, conducting training for community members, implementing telephone screenings, and creating committees for monitoring the interventions. Study results reflected that the PIHP exceeded its goals for improvement from Baseline to Remeasurement 1 for two of the three study indicators and achieved statistically significant increases in the percentages of children with SED and children with DD who received services. As **Genesee County CMH** progresses in the study, the assessment of the impact of the PIP on the **quality** of care and services will continue.

Lakeshore Behavioral Health Alliance

Findings

Table 3-50 and Table 3-51 show **Lakeshore Behavioral Health Alliance**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2009–2010 PIP Validation Tool for **Lakeshore Behavioral Health Alliance**. Validation of Steps I through IX resulted in a validation status of *Partially Met*, with an overall score of 76 percent and a score of 100 percent for critical elements. Based on the validation of this PIP, HSAG's assessment determined low confidence in the results.

Table 3-50—PIP Validation Scores *for* Lakeshore Behavioral Health Alliance

Review Step		All Evaluation Elements (Including Critical Elements)					Critical Elements				
		Total	*M*	*PM*	*NM*	*NA*	Total	*M*	*PM*	*NM*	*NA*
I.	Review the Selected Study Topic(s)	6	5	0	0	1	1	1	0	0	0
II.	Review the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III.	Review the Selected Study Indicator(s)	7	4	0	0	3	3	3	0	0	0
IV.	Review the Identified Study Population	3	3	0	0	0	2	2	0	0	0
V.	Review Sampling Methods	6	0	0	0	6	1	0	0	0	1
VI.	Review Data Collection Procedures	11	5	0	0	6	1	0	0	0	1
VII.	Assess Improvement Strategies	4	3	0	0	1	1	1	0	0	0
VIII.	Review Data Analysis and Study Results	9	3	4	1	1	2	1	0	0	1
IX.	Assess for Real Improvement	4	1	3	0	0	No Critical Elements				
X.	Assess for Sustained Improvement	1	Not Assessed				No Critical Elements				
Totals for All Activities		**53**	**26**	**7**	**1**	**18**	**13**	**10**	**0**	**0**	**3**

Table 3-51—PIP Validation Status *for* Lakeshore Behavioral Health Alliance

Percentage Score of Evaluation Elements *Met*	**76%**
Percentage Score of Critical Elements *Met*	**100%**
Validation Status	***Partially Met***

Strengths

Lakeshore Behavioral Health Alliance demonstrated strength in its study design and study implementation by receiving *Met* scores for all applicable evaluation elements in Steps I through VII. The study topic was selected following the collection and analysis of data and included all eligible populations. The study questions were answerable and stated the problem to be studied in simple terms. The study indicators were well defined, objective, and measurable. The study population was accurately and completely defined. The plan provided all of the necessary documentation regarding the data collection process, completed causal/barrier analysis, and developed interventions based on the causes/barriers. The interventions included system changes likely to induce permanent change.

Recommendations

HSAG identified opportunities for improvement in Step VIII—Review Data Analysis and Study Results and Step IX—Assess for Real Improvement. **Lakeshore Behavioral Health Alliance** did not provide all of the results accurately and the plan did not discuss the overall success of the PIP. Future submissions should include a comparison to the targets, a complete interpretation of the results, and a discussion of factors that could affect the ability to compare measurements. For this year's submission, not all of the study indicators demonstrated improvement. Two study indicators demonstrated statistically significant improvement; however, one study indicator showed a decline.

Summary Assessment Related to Quality, Timeliness, and Access

Lakeshore Behavioral Health Alliance implemented several interventions to improve services to children with SED, DD, or both SED and DD. Interventions included establishing partnerships with various groups, initiating pilot projects and collaboration, training staff, increasing staff capacity, conducting stakeholder meetings and staff presentations, and coordinating between various groups. Study results reflected that the PIHP exceeded its goals for improvement from Baseline to Remeasurement 1 for two of the three study indicators and achieved statistically significant increases in the percentages of children with SED and children with DD who received services. As the PIHP progresses in the study, the assessment of the impact of the PIP on the **quality** of care and services will continue.

LifeWays

Findings

Table 3-52 and Table 3-53 show **LifeWays**' scores based on HSAG's PIP evaluation. For additional details, refer to the 2009–2010 PIP Validation Tool for **LifeWays**. Validation of Steps I through IX resulted in a validation status of *Met*, with an overall score of 82 percent and a score of 100 percent for critical elements. Based on the validation of this PIP, HSAG's assessment determined confidence in the results.

Table 3-52—PIP Validation Scores *for* LifeWays

Review Step		All Evaluation Elements (Including Critical Elements)					Critical Elements				
		Total	*M*	*PM*	*NM*	*NA*	Total	*M*	*PM*	*NM*	*NA*
I.	Review the Selected Study Topic(s)	6	5	0	0	1	1	1	0	0	0
II.	Review the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III.	Review the Selected Study Indicator(s)	7	4	0	0	3	3	3	0	0	0
IV.	Review the Identified Study Population	3	3	0	0	0	2	2	0	0	0
V.	Review Sampling Methods	6	0	0	0	6	1	0	0	0	1
VI.	Review Data Collection Procedures	11	5	0	0	6	1	0	0	0	1
VII.	Assess Improvement Strategies	4	3	0	0	1	1	1	0	0	0
VIII.	Review Data Analysis and Study Results	9	5	2	1	1	2	1	0	0	1
IX.	Assess for Real Improvement	4	1	3	0	0	No Critical Elements				
X.	Assess for Sustained Improvement	1	Not Assessed				No Critical Elements				
Totals for All Activities		**53**	**28**	**5**	**1**	**18**	**13**	**10**	**0**	**0**	**3**

Table 3-53—PIP Validation Status *for* LifeWays

Percentage Score of Evaluation Elements *Met*	**82%**
Percentage Score of Critical Elements *Met*	**100%**
Validation Status	***Met***

Strengths

LifeWays demonstrated strength in its study design and study implementation by receiving *Met* scores for all applicable evaluation elements in Steps I through VII. The study topic was selected following the collection and analysis of data and included all eligible populations. The study questions were answerable and stated the problem to be studied in simple terms. The study indicators were well defined, objective, and measurable. The study population was accurately and completely defined. The plan provided all of the necessary documentation regarding the data collection process, completed causal/barrier analysis, and developed interventions based on the causes/barriers. The interventions included system changes likely to induce permanent change.

Recommendations

HSAG identified opportunities for improvement in Step VIII—Review Data Analysis and Study Results and Step IX—Assess for Real Improvement. Future submissions should ensure that the correct statistical test is used and that all of the results are reported accurately. **LifeWays** should identify factors that could affect the ability to compare measurements. For this year's submission, not all of the study indicators showed improvement. Two of the study indicators demonstrated a statistically significant increase; however, one study indicator showed a statistically significant decline.

Summary Assessment Related to Quality, Timeliness, and Access

LifeWays implemented several interventions to improve services to children with SED, DD, or both SED and DD. Interventions included training across the network, evaluating existing models of care, implementing new evidence-based programs, adding staff, training staff, and expanding services. Study results reflected that the PIHP exceeded its goals for improvement from Baseline to Remeasurement 1 for two of the three study indicators and achieved statistically significant increases in the percentages of children with SED and children with both SED and DD who received services. As **LifeWays** progresses in the study, the assessment of the impact of the PIP on the **quality** of care and services will continue.

Macomb County CMH Services

Findings

Table 3-54 and Table 3-55 show **Macomb County CMH Services**' scores based on HSAG's PIP evaluation. For additional details, refer to the 2009–2010 PIP Validation Tool for **Macomb County CMH Services**. Validation of Steps I through IX resulted in a validation status of *Met*, with an overall score of 85 percent and a score of 100 percent for critical elements. Based on the validation of this PIP, HSAG's assessment determined confidence in the results.

Table 3-54—PIP Validation Scores *for* Macomb County CMH Services

Review Step		All Evaluation Elements (Including Critical Elements)					Critical Elements				
		Total	*M*	*PM*	*NM*	*NA*	Total	*M*	*PM*	*NM*	*NA*
I.	Review the Selected Study Topic(s)	6	5	0	0	1	1	1	0	0	0
II.	Review the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III.	Review the Selected Study Indicator(s)	7	4	0	0	3	3	3	0	0	0
IV.	Review the Identified Study Population	3	3	0	0	0	2	2	0	0	0
V.	Review Sampling Methods	6	0	0	0	6	1	0	0	0	1
VI.	Review Data Collection Procedures	11	5	0	0	6	1	0	0	0	1
VII.	Assess Improvement Strategies	4	2	1	0	1	1	1	0	0	0
VIII.	Review Data Analysis and Study Results	9	5	3	0	1	2	1	0	0	1
IX.	Assess for Real Improvement	4	3	1	0	0	No Critical Elements				
X.	Assess for Sustained Improvement	1	Not Assessed				No Critical Elements				
Totals for All Activities		**53**	**29**	**5**	**0**	**18**	**13**	**10**	**0**	**0**	**3**

Table 3-55—PIP Validation Status *for* Macomb County CMH Services

Percentage Score of Evaluation Elements *Met*	**85%**
Percentage Score of Critical Elements *Met*	**100%**
Validation Status	***Met***

Strengths

Macomb County CMH Services' PIP demonstrated strength in its study design and study implementation by receiving *Met* scores for all applicable evaluation elements in Steps I through VI. The PIP documented a solid study design. The study questions were answerable and stated the problem to be studied in simple terms. The study indicators were well defined, objective, and measurable. The study population was accurately and completely defined. The PIHP provided all of the necessary documentation regarding the data collection process.

Recommendations

HSAG identified opportunities for improvement in Step VII—Assess Improvement Strategies, Step VIII—Review Data Analysis and Study Results, and Step IX—Assess for Real Improvement. **Macomb County CMH Services** did not discuss the standardization of interventions. Future submissions should include a complete interpretation of the findings, and the plan should ensure that all of the results are reported accurately. For this year's submission, two of the study indicators showed statistically significant improvement; however, one study indicator showed an improvement that was not statistically significant.

Summary Assessment Related to Quality, Timeliness, and Access

Macomb County CMH Services implemented several interventions to improve services to children with SED, DD, or both SED and DD. Interventions included creating a subcommittee to review methods to improve access, participating in other subcommittees, and initiating a pilot care coordination project. Study results reflected that the PIHP exceeded its goals for improvement from Baseline to Remeasurement 1 for all three study indicators and achieved statistically significant increases in the percentages of children with SED and children with DD who received services. As **Macomb County CMH Services** progresses in the study, the assessment of the impact of the PIP on the **quality** of care and services will continue.

network180

Findings

Table 3-56 and Table 3-57 show **network180**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2009–2010 PIP Validation Tool for **network180**. Validation of Steps 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. Based on the validation of this PIP, HSAG's assessment determined confidence in the results.

Table 3-56—PIP Validation Scores *for* network180

Review Step		All Evaluation Elements (Including Critical Elements)					Critical Elements				
		Total	*M*	*PM*	*NM*	*NA*	Total	*M*	*PM*	*NM*	*NA*
I.	Review the Selected Study Topic(s)	6	5	0	0	1	1	1	0	0	0
II.	Review the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III.	Review the Selected Study Indicator(s)	7	4	0	0	3	3	3	0	0	0
IV.	Review the Identified Study Population	3	3	0	0	0	2	2	0	0	0
V.	Review Sampling Methods	6	0	0	0	6	1	0	0	0	1
VI.	Review Data Collection Procedures	11	5	0	0	6	1	0	0	0	1
VII.	Assess Improvement Strategies	4	2	1	0	1	1	1	0	0	0
VIII.	Review Data Analysis and Study Results	9	6	1	1	1	2	1	0	0	1
IX.	Assess for Real Improvement	4	4	0	0	0	No Critical Elements				
X.	Assess for Sustained Improvement	1	Not Assessed				No Critical Elements				
Totals for All Activities		**53**	**31**	**2**	**1**	**18**	**13**	**10**	**0**	**0**	**3**

Table 3-57—PIP Validation Status *for* network180

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

Strengths

network 180's PIP demonstrated strength in its study design and study implementation by receiving *Met* scores for all applicable evaluation elements in Steps I through VI. The study topic was selected following the collection and analysis of data and included all eligible populations. The study questions were answerable and stated the problem to be studied in simple terms. The study indicators were well defined, objective, and measurable. The study population was accurately and completely defined. The PIHP provided all of the necessary documentation regarding the data collection process. For this year's submission, all of the study indicators demonstrated statistically significant improvement.

Recommendations

HSAG identified opportunities for improvement in Step I—Review the Selected Study Topic, Step III—Review the Selected Study Indicators, Step VI—Review Data Collection Procedures, Step VII—Assess Improvement Strategies, and Step VIII—Review Data Analysis and Study Results. Future submissions should ensure that the results align throughout the PIP. **network180** should document goals for the subsequent measurement period based on the results of the current measurement period and discuss the standardization and monitoring of the interventions. The PIHP should ensure that the data analysis plan and interpretation of the findings are complete.

Summary Assessment Related to Quality, Timeliness, and Access

network180 implemented several interventions to improve services to children with SED, DD, or both SED and DD. Interventions included providing on-site services, implementing case management programs, expanding providers, implementing a multisystemic therapy program, and integrating mental health and substance use disorder services. Study results reflected that the PIHP exceeded its goals for improvement from Baseline to Remeasurement 1 for all three study indicators and achieved statistically significant increases in the percentages of children with SED, children with DD, and children with both SED and DD who received services. As **network180** progresses in the study, the assessment of the impact of the PIP on the **quality** of care and services will continue.

NorthCare

Findings

Table 3-58 and Table 3-59 show **NorthCare**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2009–2010 PIP Validation Tool for **NorthCare**. Validation of Steps I through IX resulted in a validation status of *Partially Met*, with an overall score of 82 percent and a score of 90 percent for critical elements. Based on the validation of this PIP, HSAG's assessment determined low confidence in the results.

Table 3-58—PIP Validation Scores *for* NorthCare

Review Step		All Evaluation Elements (Including Critical Elements)					Critical Elements				
		Total	*M*	*PM*	*NM*	*NA*	Total	*M*	*PM*	*NM*	*NA*
I.	Review the Selected Study Topic(s)	6	5	0	0	1	1	1	0	0	0
II.	Review the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III.	Review the Selected Study Indicator(s)	7	4	0	0	3	3	3	0	0	0
IV.	Review the Identified Study Population	3	3	0	0	0	2	2	0	0	0
V.	Review Sampling Methods	6	0	0	0	6	1	0	0	0	1
VI.	Review Data Collection Procedures	11	5	0	0	6	1	0	0	0	1
VII.	Assess Improvement Strategies	4	2	1	0	1	1	0	1	0	0
VIII.	Review Data Analysis and Study Results	9	6	2	0	1	2	1	0	0	1
IX.	Assess for Real Improvement	4	1	3	0	0	No Critical Elements				
X.	Assess for Sustained Improvement	1	Not Assessed				No Critical Elements				
Totals for All Activities		**53**	**28**	**6**	**0**	**18**	**13**	**9**	**1**	**0**	**3**

Table 3-59—PIP Validation Status *for* NorthCare

Percentage Score of Evaluation Elements *Met*	**82%**
Percentage Score of Critical Elements *Met*	**90%**
Validation Status	***Partially Met***

Strengths

NorthCare demonstrated strength in its study design and study implementation by receiving *Met* scores for all applicable evaluation elements in Steps I through VI. The PIP documented a solid study design. The study topic was selected following the collection and analysis of data and included all eligible populations. The study questions were answerable and stated the problem to be studied in simple terms. The study indicators were well defined, objective, and measurable. The study population was accurately and completely defined. The PIHP provided all of the necessary documentation regarding the data collection process.

Recommendations

HSAG identified opportunities for improvement in Step VII—Assess Improvement Strategies, Step VIII—Review Data Analysis and Study Results, and Step IX—Assess for Real Improvement. **NorthCare** had not yet completed a causal/barrier analysis at the time of the submission. Future submissions should document that the results for each study indicator will be compared to the targets that were negotiated with MDCH. Additionally, the PIHP should document an interpretation of the results for each measurement period and ensure that the results are provided accurately. For this year's submission, one study indicator showed a statistically significant increase; however, two study indicators showed decreases.

Summary Assessment Related to Quality, Timeliness, and Access

NorthCare implemented several interventions to improve services to children with SED, DD, or both SED and DD. Interventions included developing and implementing a centralized access system and lowering the functional assessment standard to qualify a higher number of Medicaid-eligible children for services. Study results reflected that the PIHP met or exceeded its goals for improvement from Baseline to Remeasurement 1 for two of the three study indicators and achieved a statistically significant increase in the percentage of children with both SED and DD who received services. As **NorthCare** progresses in the study, the assessment of the impact of the PIP on the **quality** of care and services will continue.

Northern Affiliation

Findings

Table 3-60 and Table 3-61 show **Northern Affiliation**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2009–2010 PIP Validation Tool for **Northern Affiliation**. Validation of Steps I through IX resulted in a validation status of *Partially Met*, with an overall score of 76 percent and a score of 90 percent for critical elements. Based on the validation of this PIP, HSAG's assessment determined low confidence in the results.

Table 3-60—PIP Validation Scores *for* Northern Affiliation

Review Step		All Evaluation Elements (Including Critical Elements)					Critical Elements				
		Total	*M*	*PM*	*NM*	*NA*	Total	*M*	*PM*	*NM*	*NA*
I.	Review the Selected Study Topic(s)	6	5	0	0	1	1	1	0	0	0
II.	Review the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III.	Review the Selected Study Indicator(s)	7	4	0	0	3	3	3	0	0	0
IV.	Review the Identified Study Population	3	3	0	0	0	2	2	0	0	0
V.	Review Sampling Methods	6	0	0	0	6	1	0	0	0	1
VI.	Review Data Collection Procedures	11	5	0	0	6	1	0	0	0	1
VII.	Assess Improvement Strategies	4	0	3	0	1	1	0	1	0	0
VIII.	Review Data Analysis and Study Results	9	6	2	0	1	2	1	0	0	1
IX.	Assess for Real Improvement	4	1	3	0	0	No Critical Elements				
X.	Assess for Sustained Improvement	1	Not Assessed				No Critical Elements				
Totals for All Activities		**53**	**26**	**8**	**0**	**18**	**13**	**9**	**1**	**0**	**3**

Table 3-61—PIP Validation Status *for* Northern Affiliation

Percentage Score of Evaluation Elements *Met*	**76%**
Percentage Score of Critical Elements *Met*	**90%**
Validation Status	***Partially Met***

Strengths

Northern Affiliation's PIP demonstrated strength in its study design and study implementation by receiving *Met* scores for all applicable evaluation elements in Steps I through VI. The PIP documented a solid study design. The study topic was selected following the collection and analysis of data and included all eligible populations. The study questions were answerable and stated the problem to be studied in simple terms. The study indicators were well defined, objective, and measurable. The study population was accurately and completely defined. The PIHP provided all of the necessary documentation regarding the data collection process.

Recommendations

HSAG identified opportunities for improvement in Step VII—Assess Improvement Strategies, Step VIII—Review Data Analysis and Study Results, and Step IX—Assess for Real Improvement. **Northern Affiliation** did not complete a causal/barrier analysis after the baseline period. The PIHP should complete a causal/barrier analysis and link interventions to the identified causes and barriers. Some of the results were not presented accurately, and for this year's submission, not all of the study indicators demonstrated improvement. Two of the study indicators showed a statistically significant improvement; however, one study indicator showed a statistically significant decline.

Summary Assessment Related to Quality, Timeliness, and Access

Northern Affiliation implemented several interventions to improve services to children with SED, DD, or both SED and DD. The PIHP reported implementing several service expansions that would take place as a result of data analysis. Study results reflected that the PIHP exceeded its goals for improvement from Baseline to Remeasurement 1 for two of the three study indicators and achieved statistically significant increases in the percentages of children with DD and children with both SED and DD who received services. As **Northern Affiliation** progresses in the study, the assessment of the impact of the PIP on the **quality** of care and services will continue.

Northwest CMH Affiliation

Findings

Table 3-62 and Table 3-63 show **Northwest CMH Affiliation**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2009–2010 PIP Validation Tool for **Northwest CMH Affiliation**. Validation of Steps I through IX resulted in a validation status of *Partially Met*, with an overall score of 76 percent and a score of 90 percent for critical elements. Based on the validation of this PIP, HSAG's assessment determined low confidence in the results.

Table 3-62—PIP Validation Scores *for* Northwest CMH Affiliation

Review Step		All Evaluation Elements (Including Critical Elements)					Critical Elements				
		Total	*M*	*PM*	*NM*	*NA*	Total	*M*	*PM*	*NM*	*NA*
I.	Review the Selected Study Topic(s)	6	5	0	0	1	1	1	0	0	0
II.	Review the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III.	Review the Selected Study Indicator(s)	7	4	0	0	3	3	3	0	0	0
IV.	Review the Identified Study Population	3	3	0	0	0	2	2	0	0	0
V.	Review Sampling Methods	6	0	0	0	6	1	0	0	0	1
VI.	Review Data Collection Procedures	11	5	0	0	6	1	0	0	0	1
VII.	Assess Improvement Strategies	4	2	1	0	1	1	1	0	0	0
VIII.	Review Data Analysis and Study Results	9	2	4	2	1	2	0	1	0	1
IX.	Assess for Real Improvement	4	3	1	0	0	No Critical Elements				
X.	Assess for Sustained Improvement	1	Not Assessed				No Critical Elements				
Totals for All Activities		**53**	**26**	**6**	**2**	**18**	**13**	**9**	**1**	**0**	**3**

Table 3-63—PIP Validation Status *for* Northwest CMH Affiliation

Percentage Score of Evaluation Elements *Met*	**76%**
Percentage Score of Critical Elements *Met*	**90%**
Validation Status	***Partially Met***

Strengths

Northwest CMH Affiliation's PIP demonstrated strength in its study design and study implementation by receiving *Met* scores for all applicable evaluation elements in Steps I through VI. The PIP documented a solid study design. The study topic was selected following the collection and analysis of data and included all eligible populations. The study questions were answerable and stated the problem to be studied in simple terms. The study indicators were well defined, objective, and measurable. The study population was accurately and completely defined. The PIHP provided all of the necessary documentation regarding the data collection process, completed causal/barrier analysis, and developed interventions based on the causes/barriers. The interventions included system changes likely to induce permanent change.

Recommendations

HSAG identified opportunities for improvement in Step III—Review the Selected Study Indicators, Step—VII Assess Improvement Strategies, Step VIII—Review Data Analysis and Study Results, and Step IX—Assess for Real Improvement. Future submissions should ensure that the goals are documented correctly for each study indicator for every measurement period. The PIP submission should include a discussion of the standardization of the interventions. The PIHP should provide a complete data analysis plan and interpretation of the study results and ensure that all of the results are presented accurately. **Northwest CMH Affiliation** should identify factors that could affect the ability to compare measurements and include an interpretation of the extent to which the study was successful. For this year's submission, two study indicators demonstrated statistically significant increases; however, one study indicator showed an increase that was not statistically significant.

Summary Assessment Related to Quality, Timeliness, and Access

Northwest CMH Affiliation implemented several interventions to improve services to children with SED, DD, or both SED and DD. Interventions included ongoing monitoring of the study indicators, expanding two programs for parents and children, increasing staff, coordinating between offices, and improving practices. Study results reflected that the PIHP exceeded its goals for improvement from Baseline to Remeasurement 1 for two of the three study indicators and achieved statistically significant increases in the percentages of children with SED and children with both SED and DD who received services. As **Northwest CMH Affiliation** progresses in the study, the assessment of the impact of the PIP on the **quality** of care and services will continue.

Oakland County CMH Authority

Findings

Table 3-64 and Table 3-65 show **Oakland County CMH Authority**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2009–2010 PIP Validation Tool for **Oakland County CMH Authority**. Validation of Steps I through IX resulted in a validation status of *Met*, with an overall score of 85 percent and a score of 100 percent for critical elements. Based on the validation of this PIP, HSAG's assessment determined confidence in the results.

Table 3-64—PIP Validation Scores *for* Oakland County CMH Authority

Review Step		All Evaluation Elements (Including Critical Elements)					Critical Elements				
		Total	*M*	*PM*	*NM*	*NA*	Total	*M*	*PM*	*NM*	*NA*
I.	Review the Selected Study Topic(s)	6	5	0	0	1	1	1	0	0	0
II.	Review the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III.	Review the Selected Study Indicator(s)	7	4	0	0	3	3	3	0	0	0
IV.	Review the Identified Study Population	3	3	0	0	0	2	2	0	0	0
V.	Review Sampling Methods	6	0	0	0	6	1	0	0	0	1
VI.	Review Data Collection Procedures	11	5	0	0	6	1	0	0	0	1
VII.	Assess Improvement Strategies	4	3	0	0	1	1	1	0	0	0
VIII.	Review Data Analysis and Study Results	9	6	2	0	1	2	1	0	0	1
IX.	Assess for Real Improvement	4	1	2	1	0	No Critical Elements				
X.	Assess for Sustained Improvement	1	Not Assessed				No Critical Elements				
Totals for All Activities		**53**	**29**	**4**	**1**	**18**	**13**	**10**	**0**	**0**	**3**

Table 3-65—PIP Validation Status *for* Oakland County CMH Authority

Percentage Score of Evaluation Elements *Met*	**85%**
Percentage Score of Critical Elements *Met*	**100%**
Validation Status	***Met***

Strengths

Oakland County CMH Authority demonstrated strength in its study design and study implementation by receiving *Met* scores for all applicable evaluation elements in Steps I through VII. The study topic was selected following the collection and analysis of data and included all eligible populations. The study questions were answerable and stated the problem to be studied in simple terms. The study indicators were well defined, objective, and measurable. The study population was accurately and completely defined. The PIHP provided all of the necessary documentation regarding the data collection process, completed causal/barrier analysis, and developed interventions based on the causes/barriers. The interventions included system changes likely to induce permanent change.

Recommendations

HSAG identified opportunities for improvement in Step VIII—Review Data Analysis and Study Results and Step IX—Assess for Real Improvement. **Oakland County CMH Authority** did not provide all of the results accurately. For this year's submission, not all of the study indicators showed an improvement and none of the study indicators demonstrated statistically significant improvement.

Summary Assessment Related to Quality, Timeliness, and Access

Oakland County CMH Authority implemented several interventions to improve services to children with SED, DD, or both SED and DD. Interventions included implementing child care enhancement projects, collaborating with the Oakland County Department of Health Services and child placement agencies, managing the children's SED waiver in the county, reorganizing the service delivery system, and increasing the number of providers. Study results reflected that the PIHP exceeded its goals for improvement from Baseline to Remeasurement 1 for one of the three study indicators but did not achieve statistically significant increases in the percentages of children who received services. As **Oakland County CMH Authority** progresses in the study, the assessment of the impact of the PIP on the **quality** of care and services will continue.

Saginaw County CMH Authority

Findings

Table 3-66 and Table 3-67 show **Saginaw County CMH Authority**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2009–2010 PIP Validation Tool for **Saginaw County CMH Authority**. Validation of Steps I through IX resulted in a validation status of *Partially Met*, with an overall score of 82 percent and a score of 90 percent for critical elements. Based on the validation of this PIP, HSAG's assessment determined low confidence in the results.

Table 3-66—PIP Validation Scores *for* Saginaw County CMH Authority

Review Step		All Evaluation Elements (Including Critical Elements)					Critical Elements				
		Total	*M*	*PM*	*NM*	*NA*	Total	*M*	*PM*	*NM*	*NA*
I.	Review the Selected Study Topic(s)	6	4	1	0	1	1	1	0	0	0
II.	Review the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III.	Review the Selected Study Indicator(s)	7	4	0	0	3	3	3	0	0	0
IV.	Review the Identified Study Population	3	3	0	0	0	2	2	0	0	0
V.	Review Sampling Methods	6	0	0	0	6	1	0	0	0	1
VI.	Review Data Collection Procedures	11	5	0	0	6	1	0	0	0	1
VII.	Assess Improvement Strategies	4	2	1	0	1	1	1	0	0	0
VIII.	Review Data Analysis and Study Results	9	4	3	1	1	2	0	1	0	1
IX.	Assess for Real Improvement	4	4	0	0	0	No Critical Elements				
X.	Assess for Sustained Improvement	1	Not Assessed				No Critical Elements				
Totals for All Activities		**53**	**28**	**5**	**1**	**18**	**13**	**9**	**1**	**0**	**3**

Table 3-67—PIP Validation Status *for* Saginaw County CMH Authority

Percentage Score of Evaluation Elements *Met*	**82%**
Percentage Score of Critical Elements *Met*	**90%**
Validation Status	***Partially Met***

Strengths

Saginaw County CMH Authority demonstrated strength in its study design and study implementation by receiving *Met* scores for all applicable evaluation elements in Steps II through VI. The study topic included all eligible populations. The study questions were answerable and stated the problem to be studied in simple terms. The study indicators were well defined, objective, and measurable. The study population was accurately and completely defined. The PIHP provided all of the necessary documentation regarding the data collection process, completed causal/barrier analysis, and developed interventions based on the causes/barriers. The interventions included system changes likely to induce permanent change. For this year's submission, all of the study indicators demonstrated statistically significant improvement.

Recommendations

HSAG identified opportunities for improvement in Step I—Review the Selected Study Topic, Step III—Review the Selected Study Indicators, Step VII—Assess Improvement Strategies, and Step VIII—Review Data Analysis and Study Results. **Saginaw County CMH Authority** did not provide plan-specific data in Activity I to support the selection of the study topic. Future submissions should also include the actual percentage goal for each study indicator for every measurement period, and the PIHP should discuss the standardization and monitoring of the interventions. **Saginaw County CMH Authority** should ensure that the data analysis plan and interpretation of the findings are complete. The PIHP should provide all of the results accurately and document factors that could affect the ability to compare measurements.

Summary Assessment Related to Quality, Timeliness, and Access

Saginaw County CMH Authority implemented several interventions to improve services to children with SED, DD, or both SED and DD. Interventions included establishing a Juvenile Justice Mental Health program, implementing a System of Care Block Grant, training children's agencies on access and referrals, redirecting capacity and efforts, changing children's eligibility criteria, extending mental health screening tools, and adding new capacity for case management. Study results reflected that the PIHP exceeded its goals for improvement from Baseline to Remeasurement 1 for all three study indicators and achieved statistically significant increases in the percentages of children with SED, children with DD, and children with both SED and DD who received services. As **Saginaw County CMH Authority** progresses in the study, the assessment of the impact of the PIP on the **quality** of care and services will continue.

Southwest Affiliation

Findings

Table 3-68 and Table 3-69 show **Southwest Affiliation**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2009–2010 PIP Validation Tool for **Southwest Affiliation**. Validation of Steps I through IX resulted in a validation status of *Partially Met*, with an overall score of 79 percent and a score of 90 percent for critical elements. Based on the validation of this PIP, HSAG's assessment determined low confidence in the results.

Table 3-68—PIP Validation Scores *for* Southwest Affiliation

Review Step		All Evaluation Elements (Including Critical Elements)					Critical Elements				
		Total	*M*	*PM*	*NM*	*NA*	Total	*M*	*PM*	*NM*	*NA*
I.	Review the Selected Study Topic(s)	6	5	0	0	1	1	1	0	0	0
II.	Review the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III.	Review the Selected Study Indicator(s)	7	4	0	0	3	3	3	0	0	0
IV.	Review the Identified Study Population	3	3	0	0	0	2	2	0	0	0
V.	Review Sampling Methods	6	0	0	0	6	1	0	0	0	1
VI.	Review Data Collection Procedures	11	5	0	0	6	1	0	0	0	1
VII.	Assess Improvement Strategies	4	3	0	0	1	1	1	0	0	0
VIII.	Review Data Analysis and Study Results	9	4	4	0	1	2	0	1	0	1
IX.	Assess for Real Improvement	4	1	3	0	0	No Critical Elements				
X.	Assess for Sustained Improvement	1	Not Assessed				No Critical Elements				
Totals for All Activities		**53**	**27**	**7**	**0**	**18**	**13**	**9**	**1**	**0**	**3**

Table 3-69—PIP Validation Status *for* Southwest Affiliation

Percentage Score of Evaluation Elements *Met*	**79%**
Percentage Score of Critical Elements *Met*	**90%**
Validation Status	***Partially Met***

Strengths

Southwest Affiliation demonstrated strength in its study design and study implementation by receiving *Met* scores for all applicable evaluation elements in Steps I through VII. The study topic was selected following the collection and analysis of data and included all eligible populations. The study questions were answerable and stated the problem to be studied in simple terms. The study indicators were well defined, objective, and measurable. The study population was accurately and completely defined. The PIHP provided all of the necessary documentation regarding the data collection process, completed causal/barrier analysis, and developed interventions based on the causes/barriers. The interventions included system changes likely to induce permanent change.

Recommendations

HSAG identified opportunities for improvement in Step III—Review the Selected Study Indicators, Step VIII—Review Data Analysis and Study Results, and Step IX—Assess for Real Improvement. **Southwest Affiliation** should ensure that in future submissions the goals and results are reported accurately and that the data analysis plan and interpretation of the findings are complete. For this year's submission, not all of the study indicators demonstrated improvement. One study indicator showed a statistically significant increase; however, two study indicators showed a decline.

Summary Assessment Related to Quality, Timeliness, and Access

Southwest Affiliation implemented several interventions to improve services to children with SED, DD, or both SED and DD. Interventions included implementing screening for early intervention and an early childhood intervention program, streamlining referral processes, improving coordination with the local public school system, training staff, formalizing the coordination process between the county and juvenile court system, implementing data collection processes, increasing collaboration efforts, and improving service system coordination. Study results reflected that the PIHP exceeded its goals for improvement from Baseline to Remeasurement 1 for one of the three study indicators and achieved a statistically significant increase in the percentage of children with SED who received services. As **Southwest Affiliation** progresses in the study, the assessment of the impact of the PIP on the **quality** of care and services will continue.

Thumb Alliance PIHP

Findings

Table 3-70 and Table 3-71 show **Thumb Alliance PIHP**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2009–2010 PIP Validation Tool for **Thumb Alliance PIHP**. Validation of Steps I through IX resulted in a validation status of *Met*, with an overall score of 97 percent and a score of 100 percent for critical elements. Based on the validation of this PIP, HSAG's assessment determined high confidence in the results.

Table 3-70—PIP Validation Scores *for* Thumb Alliance PIHP

Review Step		All Evaluation Elements (Including Critical Elements)					Critical Elements				
		Total	*M*	*PM*	*NM*	*NA*	Total	*M*	*PM*	*NM*	*NA*
I.	Review the Selected Study Topic(s)	6	5	0	0	1	1	1	0	0	0
II.	Review the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III.	Review the Selected Study Indicator(s)	7	4	0	0	3	3	3	0	0	0
IV.	Review the Identified Study Population	3	3	0	0	0	2	2	0	0	0
V.	Review Sampling Methods	6	0	0	0	6	1	0	0	0	1
VI.	Review Data Collection Procedures	11	5	0	0	6	1	0	0	0	1
VII.	Assess Improvement Strategies	4	3	0	0	1	1	1	0	0	0
VIII.	Review Data Analysis and Study Results	9	7	1	0	1	2	1	0	0	1
IX.	Assess for Real Improvement	4	4	0	0	0	No Critical Elements				
X.	Assess for Sustained Improvement	1	Not Assessed				No Critical Elements				
Totals for All Activities		**53**	**33**	**1**	**0**	**18**	**13**	**10**	**0**	**0**	**3**

Table 3-71—PIP Validation Status *for* Thumb Alliance PIHP

Percentage Score of Evaluation Elements *Met*	**97%**
Percentage Score of Critical Elements *Met*	**100%**
Validation Status	***Met***

Strengths

Thumb Alliance PIHP demonstrated strength in its study design and study implementation by receiving *Met* scores for all applicable evaluation elements in Steps I through VII. The study topic was selected following the collection and analysis of data and included all eligible populations. The study questions were answerable and stated the problem to be studied in simple terms. The study indicators were well defined, objective, and measurable. The study population was accurately and completely defined. The PIHP provided all of the necessary documentation regarding the data collection process, completed causal/barrier analysis, and developed interventions based on the causes/barriers. The interventions included system changes likely to induce permanent change. For this year's submission, all of the study indicators demonstrated statistically significant improvement.

Recommendations

HSAG identified opportunities for improvement in Step I—Review the Selected Study Topic, Step III—Review the Selected Study Indicators, and Step VIII—Review Data Analysis and Study Results. Future submissions should report the Baseline rates provided by MDCH. **Thumb Alliance PIHP** should complete statistical testing between the Baseline rates provided by MDCH and the Remeasurement 1 results.

Summary Assessment Related to Quality, Timeliness, and Access

Thumb Alliance PIHP implemented several interventions to improve services to children with SED, DD, or both SED and DD. Interventions included initiating marketing efforts to inform the community of services, increasing school-based referrals, continuing formal collaborative agreements with the court systems, applying for planning grants, training staff, increasing collaboration with the Parent Advisory Council and the juvenile justice program, establishing a referral process, and pursuing a dual initiative for children with developmental disabilities. Study results reflected that the PIHP exceeded its goals for improvement from Baseline to Remeasurement 1 for all three study indicators and achieved statistically significant increases in the percentages of children with SED, children with DD, and children with both SED and DD who received services. As **Thumb Alliance PIHP** progresses in the study, the assessment of the impact of the PIP on the **quality** of care and services will continue.

Venture Behavioral Health

Findings

Table 3-72 and Table 3-73 show **Venture Behavioral Health**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2009–2010 PIP Validation Tool for **Venture Behavioral Health**. Validation of Steps 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. Based on the validation of this PIP, HSAG's assessment determined confidence in the results.

Table 3-72—PIP Validation Scores *for* Venture Behavioral Health

		All Evaluation Elements (Including Critical Elements)					Critical Elements				
Review Step		Total	*M*	*PM*	*NM*	*NA*	Total	*M*	*PM*	*NM*	*NA*
I.	Review the Selected Study Topic(s)	6	5	0	0	1	1	1	0	0	0
II.	Review the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III.	Review the Selected Study Indicator(s)	7	4	0	0	3	3	3	0	0	0
IV.	Review the Identified Study Population	3	3	0	0	0	2	2	0	0	0
V.	Review Sampling Methods	6	0	0	0	6	1	0	0	0	1
VI.	Review Data Collection Procedures	11	5	0	0	6	1	0	0	0	1
VII.	Assess Improvement Strategies	4	2	1	0	1	1	1	0	0	0
VIII.	Review Data Analysis and Study Results	9	7	0	1	1	2	1	0	0	1
IX.	Assess for Real Improvement	4	3	1	0	0	No Critical Elements				
X.	Assess for Sustained Improvement	1	Not Assessed				No Critical Elements				
Totals for All Activities		**53**	**31**	**2**	**1**	**18**	**13**	**10**	**0**	**0**	**3**

Table 3-73—PIP Validation Status *for* Venture Behavioral Health

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

Strengths

Venture Behavioral Health's PIP demonstrated strength in its study design and study implementation by receiving *Met* scores for all applicable evaluation elements in Steps I through VI. The PIP documented a solid study design. The study topic was selected following the collection and analysis of data and included all eligible populations. The study questions were answerable and stated the problem to be studied in simple terms. The study indicators were well defined, objective, and measurable. The study population was accurately and completely defined. The PIHP provided all of the necessary documentation regarding the data collection process, completed causal/barrier analysis, and developed interventions based on the causes/barriers. The interventions included system changes likely to induce permanent change.

Recommendations

HSAG identified opportunities for improvement in Step III—Review the Selected Study Indicators, Step VI—Review Data Collection Procedures, Step VII—Assess Improvement Strategies, Step VIII—Review Data Analysis and Study Results, and Step IX—Assess for Real Improvement. **Venture Behavioral Health** should discuss the standardization and monitoring of the interventions and factors that could affect the ability to compare measurements. The PIHP should ensure that all of the results are provided accurately. For this year's submission, two study indicators demonstrated statistically significant improvement; however, one study indicator showed an increase that was not statistically significant.

Summary Assessment Related to Quality, Timeliness, and Access

Venture Behavioral Health implemented several interventions to improve services to children with SED, DD, or both SED and DD. Interventions included conducting ongoing community outreach, improving staffing and operations to increase children's access to care, developing promotional materials and activities, improving information systems, and ongoing monitoring of children served. Study results reflected that the PIHP exceeded its goals for improvement from Baseline to Remeasurement 1 for all three study indicators and achieved statistically significant increases in the percentages of children with DD and children with both SED and DD who received services. As **Venture Behavioral Health** progresses in the study, the assessment of the impact of the PIP on the **quality** of care and services will continue.

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 all the three EQR activities: compliance monitoring, validation of performance measures, and validation of performance improvement projects.

The 2009–2010 compliance monitoring reviews evaluated the PIHPs' progress in implementing corrective actions identified in the 2008–2009 review of 14 compliance standards. The PIHP-specific parts of Section 3 contain a more detailed description of the PIHPs' performance in these areas.

The current-year validation of performance measures assessed the PIHPs' processes related to the reporting of performance indicator data and oversight of subcontractors' performance indicator reporting activities for the same set of indicators validated in 2008–2009. The PIHP-specific parts of Section 3 present a detailed description of the 2009–2010 validation results.

The 2009–2010 validation cycle assessed the PIHP's follow-up on recommendations from the 2008–2009 validation of performance improvement projects on improving the penetration rates for children.

Access Alliance of Michigan

Compliance Monitoring

Table 4-1 shows the results for **Access Alliance of Michigan** from the 2008–2009 compliance monitoring review and the 2009–2010 assessment of the PIHP's follow-up on HSAG's recommendations.

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	
I	QAPIP Plan and Structure	✓		
II	Performance Measurement	✓		
III	Practice Guidelines	✓		
IV	Staff Qualifications	✓		
V	Utilization Management		✓	
VI	Customer Services	✓		
VII	Enrollee Grievance Process		✓	
VIII	Enrollee Rights		✓	
IX	Subcontracts and Delegation	✓		
X	Provider Network	✓		
XI	Credentialing	✓		
XII	Access and Availability		✓	
XIII	Coordination of Care	✓		
XIV	Appeals	✓		

The 2008–2009 compliance monitoring review resulted in recommendations for improvement for the following standards: Utilization Management, Enrollee Grievance Process, Enrollee Rights, and Access and Availability. The PIHP addressed recommendations through corrective action plans and implemented improvements. As determined in the 2009–2010 review, **Access Alliance of Michigan** successfully addressed all prior recommendations and achieved full compliance on all standards.

Validation of Performance Measures

Access Alliance of Michigan addressed the recommendation for improvement from the 2008–2009 validation of performance measures. During the 2009–2010 on-site visit, **Access Alliance of Michigan** demonstrated that the PIHP implemented the recommendation to develop formal policies for claims data entry and audit processing.

Validation of Performance Improvement Projects

Table 4-2 displays activities/elements scored *Partially Met* or *Not Met* for **Access Alliance of Michigan** during the 2008–2009 validation of PIPs and results of the assessment of these elements from the 2009–2010 EQR.

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

Activity/ Element	2008–2009 Score	2009–2010 Score	2009–2010 Comment
VIII.1	*Partially Met*	*Met*	The PIHP conducted data analysis according to the data analysis plan. The data analysis plan included the type of data analysis the PIHP would conduct, how the PIHP would calculate the rate, how the PIHP would compare the rate to the goal, and the statistical test that the data analysis plan would use.
VIII.4	*Not Met*	*Met*	The PIP documentation included an interpretation of the findings for each study indicator.

Access Alliance of Michigan addressed the recommendations for improvement from the 2008–2009 PIP validation.

CMH Affiliation of Mid-Michigan

Compliance Monitoring

Table 4-3 shows the results for **CMH Affiliation of Mid-Michigan** from the 2008–2009 compliance monitoring review and the 2009–2010 assessment of the PIHP's follow-up on HSAG's recommendations.

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	
I	QAPIP Plan and Structure		✓	
II	Performance Measurement		✓	
III	Practice Guidelines		✓	
IV	Staff Qualifications		✓	
V	Utilization Management	✓		
VI	Customer Services		✓	
VII	Enrollee Grievance Process		✓	
VIII	Enrollee Rights	✓		
IX	Subcontracts and Delegation	✓		
X	Provider Network		✓	
XI	Credentialing	✓		
XII	Access and Availability	✓		
XIII	Coordination of Care	✓		
XIV	Appeals		✓	

The 2008–2009 compliance monitoring review resulted in recommendations for improvement for the following standards: QAPIP Plan and Structure, Performance Measurement, Practice Guidelines, Staff Qualifications, Customer Services, Enrollee Grievance Process, Provider Network, and Appeals. The PIHP addressed recommendations through corrective action plans and implemented improvements. As determined in the 2009–2010 review, **CMH Affiliation of Mid-Michigan** successfully addressed all prior recommendations and achieved full compliance on all standards.

Validation of Performance Measures

CMH Affiliation of Mid-Michigan addressed the recommendations for improvement from the 2008–2009 validation of performance measures. The PIHP implemented a requirement for each affiliate or agency to submit a corrective action plan to address identified issues. **CMH Affiliation of Mid-Michigan** specified in its policies and procedures timelines for the submission of corrected encounter data by its affiliates. The PIHP corrected programming related to the calculation of timeliness measures.

Validation of Performance Improvement Projects

Table 4-4 displays activities/elements scored *Partially Met* or *Not Met* for **CMH Affiliation of Mid-Michigan** during the 2008–2009 validation of PIPs and results of the assessment of these elements from the 2009–2010 EQR.

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

Activity/ Element	2008–2009 Score	2009–2010 Score	2009–2010 Comment
I.2	*Partially Met*	*Met*	Selection of the PIP topic followed the collection and analysis of plan-specific data.
I.4	*Not Met*	*Met*	The PIP included all eligible populations that met the study criteria.
I.5	*Not Met*	*Met*	The PIP did not exclude members with special health care needs.
I.6	*Not Met*	*Met*	The PIP has the potential to affect health, functional status, or satisfaction.
III.1	*Not Met*	*Met*	The study indicators were objective, clear, and unambiguously defined. The PIP provided correct codes, when applicable, for the numerators. The documentation provided a description of the study indicators as well as the definitions for the numerators or denominators.
III.3	*Partially Met*	*Met*	The study indicators aligned with the study questions. The results of the study indicators would answer the study question.
III.4	*Partially Met*	*Met*	The study indicators measured change in health, functional status, satisfaction, or valid process alternatives.
IV.1	*Partially Met*	*Met*	The PIP accurately and completely defined the study population, providing correct codes, when applicable, for the denominators.
IV.3	*Partially Met*	*Met*	The eligible population captured all members to whom the study question applied.
VI.10	*Partially Met*	*Met*	The PIP used administrative data collection. The documentation included the development of the steps in the production of the study indicators.

Table 4-4—Follow-Up on Prior Recommendations *for* CMH Affiliation of Mid-Michigan			
Activity/ Element	**2008–2009 Score**	**2009–2010 Score**	**2009–2010 Comment**
VI.11	*Not Met*	*Met*	The estimated degree of administrative data completeness was between 80 percent and 100 percent. The documentation explained how the PIHP determined administrative data completeness.
VII.1	*Partially Met*	*Met*	The plan completed a causal/barrier analysis and used improvement strategies related to the causes/barriers identified through data analysis and a quality improvement process.
VIII.1	*Partially Met*	*Partially Met*	The data analysis plan did not document that the results from each measurement period will be compared to their respective goals.
VIII.3	*Not Met*	*Met*	The documentation identified and discussed factors that threatened the internal or external validity of the findings and included the impact and resolution of these factors.
VIII.4	*Not Met*	*Partially Met*	The PIP did not include an interpretation of the findings for all of the Baseline and Remeasurement 1 study indicator results. Additionally, the plan reported that the increases for Study Indicators 1 and 2 were not significant; however, the increases were significant at the 0.05 level.
VIII.5	*Not Met*	*Partially Met*	Some of the results were not presented accurately.

CMH Affiliation of Mid-Michigan addressed most recommendations for improvement from the 2008–2009 PIP validation.

CMH for Central Michigan

Compliance Monitoring

Table 4-5 shows the results for **CMH for Central Michigan** from the 2008–2009 compliance monitoring review and the 2009–2010 assessment of the PIHP's follow-up on HSAG's recommendations.

Table 4-5—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	
I	QAPIP Plan and Structure	✓		
II	Performance Measurement	✓		
III	Practice Guidelines	✓		
IV	Staff Qualifications	✓		
V	Utilization Management	✓		
VI	Customer Services		✓	
VII	Enrollee Grievance Process		✓	
VIII	Enrollee Rights	✓		
IX	Subcontracts and Delegation	✓		
X	Provider Network	✓		
XI	Credentialing	✓		
XII	Access and Availability	✓		
XIII	Coordination of Care	✓		
XIV	Appeals		✓	

The 2008–2009 compliance monitoring review resulted in recommendations for improvement for the following standards: Customer Services, Enrollee Grievance Process, and Appeals. The PIHP addressed recommendations through corrective action plans and implemented improvements. As determined in the 2009–2010 review, **CMH for Central Michigan** successfully addressed all prior recommendations and achieved full compliance on all standards.

Validation of Performance Measures

CMH for Central Michigan addressed the recommendations for improvement from the 2008–2009 validation of performance measures. The PIHP implemented systematic changes that helped to improve the completeness of QI data and was considering additional ways to monitor and increase the oversight of QI data.

Validation of Performance Improvement Projects

Table 4-6 displays activities/elements scored *Partially Met* or *Not Met* for **CMH for Central Michigan** during the 2008–2009 validation of PIPs and results of the assessment of these elements from the 2009–2010 EQR.

Table 4-6—Follow-Up on Prior Recommendations *for* CMH for Central Michigan

Activity/ Element	2008–2009 Score	2009–2010 Score	2009–2010 Comment
VIII.4	*Partially Met*	*Met*	The PIP documentation included an interpretation of the findings for each study indicator.

CMH for Central Michigan addressed the recommendation for improvement from the 2008–2009 PIP validation.

CMH Partnership of Southeastern Michigan

Compliance Monitoring

Table 4-7 shows the results for **CMH Partnership of Southeastern Michigan** from the 2008–2009 compliance monitoring review and the 2009–2010 assessment of the PIHP's follow-up on HSAG's recommendations.

Table 4-7—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	
I	QAPIP Plan and Structure			✓
II	Performance Measurement	✓		
III	Practice Guidelines	✓		
IV	Staff Qualifications	✓		
V	Utilization Management	✓		
VI	Customer Services	✓		
VII	Enrollee Grievance Process		✓	
VIII	Enrollee Rights	✓		
IX	Subcontracts and Delegation	✓		
X	Provider Network	✓		
XI	Credentialing	✓		
XII	Access and Availability	✓		
XIII	Coordination of Care	✓		
XIV	Appeals			✓

The 2008–2009 compliance monitoring review resulted in recommendations for improvement for the following standards: QAPIP Plan and Structure, Enrollee Grievance Process, and Appeals. The PIHP addressed recommendations through corrective action plans and implemented improvements. As determined in the 2009–2010 review, **CMH Partnership of Southeastern Michigan** successfully addressed the prior recommendations for the Enrollee Grievance Process standard but received one continued recommendation each for the QAPIP Plan and Structure and Appeals standards, addressing requirements related to the Behavior Treatment Review Committee and the content of the notice of disposition for appeals. The PIHP achieved full compliance on 12 of the 14 standards.

Validation of Performance Measures

CMH Partnership of Southeastern Michigan addressed the recommendations for improvement from the 2008–2009 validation of performance measures. The PIHP explored other methods to improve reporting of exceptions at the affiliate level. The planned upgrade to the PIHP's data system will address this concern with its expanded capabilities. **CMH Partnership of Southeastern Michigan** continued its close monitoring of providers to ensure that they submit complete and accurate encounter data. The PIHP continued efforts to develop additional reporting capabilities for its incident reporting module.

Validation of Performance Improvement Projects

HSAG identified no opportunities for improvement for **CMH Partnership of Southeastern Michigan** during the 2008–2009 PIP validation.

Detroit-Wayne County CMH Agency

Compliance Monitoring

Table 4-8 shows the results for **Detroit-Wayne County CMH Agency** from the 2008–2009 compliance monitoring review and the 2009–2010 assessment of the PIHP's follow-up on HSAG's recommendations.

Table 4-8—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	
I	QAPIP Plan and Structure			✓
II	Performance Measurement	✓		
III	Practice Guidelines	✓		
IV	Staff Qualifications	✓		
V	Utilization Management		✓	
VI	Customer Services		✓	
VII	Enrollee Grievance Process			✓
VIII	Enrollee Rights	✓		
IX	Subcontracts and Delegation	✓		
X	Provider Network	✓		
XI	Credentialing	✓		
XII	Access and Availability			✓
XIII	Coordination of Care	✓		
XIV	Appeals			✓

The 2008–2009 compliance monitoring review resulted in recommendations for improvement for the following standards: QAPIP Plan and Structure, Utilization Management, Customer Services, Enrollee Grievance Process, Access and Availability, and Appeals. The PIHP addressed recommendations through corrective action plans and implemented improvements. As determined in the 2009–2010 review, **Detroit-Wayne County CMH Agency** successfully addressed all recommendations for the Utilization Management and Customer Services standards. The PIHP received a continued recommendation on the QAPIP Plan and Structure standard related to the review of data from the Behavior Treatment Review Committee. The PIHP addressed four of the six recommendations for grievances, with continued recommendations related to requirements for timeliness of the resolution and the notice of disposition. For the Access and Availability standard, the PIHP achieved compliance with most access standards addressed in the follow-up review but did not meet all minimum performance standards for face-to-face assessments or access to ongoing services. The PIHP also addressed three of the four recommendations for appeals, with a continued recommendation related to requirements for timeliness of the resolution. After the 2009–2010 follow-up review, **Detroit-Wayne County CMH Agency** achieved full compliance on 10 of the 14 standards.

Validation of Performance Measures

Detroit-Wayne County CMH Agency addressed the recommendations for improvement from the 2008–2009 validation of performance measures. The PIHP implemented improvements to address the low completion rate for QI data indicator fields for employment status and minimum wage. **Detroit-Wayne County CMH Agency** progressed in the implementation of its new data system and completed the first phase of the transition. The PIHP documented the completed steps of the transition process.

Validation of Performance Improvement Projects

Table 4-9 displays activities/elements scored *Partially Met* or *Not Met* for **Detroit-Wayne County CMH Agency** during the 2008–2009 validation of PIPs and results of the assessment of these elements from the 2009–2010 EQR.

Table 4-9—Follow-Up on Prior Recommendations *for* Detroit-Wayne County CMH Agency

Activity/ Element	2008–2009 Score	2009–2010 Score	2009–2010 Comment
I.2	*Partially Met*	*Met*	Selection of the PIP topic followed the collection and analysis of plan-specific data.
I.4	*Not Met*	*Met*	The PIP included all eligible populations that met the study criteria.
1.5	*Not Met*	*Met*	The PIP did not exclude members with special health care needs.
IV.1	*Partially Met*	*Met*	The PIP accurately and completely defined the study population, providing correct codes, when applicable, for the denominator.
IV.2	*Not Met*	*Met*	The PIP documentation defined the requirements for length of enrollment for the eligible population.
IV.3	*Partially Met*	*Met*	The eligible population captured all members to whom the study question applied.
VI.1	*Partially Met*	*Met*	The documentation included the identification of data elements for collection.
VIII.1	*Partially Met*	*Partially Met*	The data analysis plan did not document how the rates were calculated or that the rates were compared to the goals.
VIII.4	*Not Met*	*Met*	The PIP documentation included an interpretation of the findings for each study indicator.
VIII.5	*Partially Met*	*Partially Met*	The denominator for each study indicator for every measurement period should be the number provided by MDCH.

Detroit-Wayne County CMH Agency addressed most recommendations for improvement from the 2008–2009 PIP validation.

Genesee County CMH

Compliance Monitoring

Table 4-10 shows the results for **Genesee County CMH** from the 2008–2009 compliance monitoring review and the 2009–2010 assessment of the PIHP's follow-up on HSAG's recommendations.

Table 4-10—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	
I	QAPIP Plan and Structure	✓		
II	Performance Measurement	✓		
III	Practice Guidelines	✓		
IV	Staff Qualifications	✓		
V	Utilization Management	✓		
VI	Customer Services	✓		
VII	Enrollee Grievance Process		✓	
VIII	Enrollee Rights	✓		
IX	Subcontracts and Delegation	✓		
X	Provider Network	✓		
XI	Credentialing	✓		
XII	Access and Availability		✓	
XIII	Coordination of Care	✓		
XIV	Appeals	✓		

The 2008–2009 compliance monitoring review resulted in recommendations for improvement for the Enrollee Grievance Process and Access and Availability standards. The PIHP addressed recommendations through corrective action plans and implemented improvements. As determined in the 2009–2010 review, **Genesee County CMH** successfully addressed all prior recommendations and achieved full compliance on all standards.

Validation of Performance Measures

Genesee County CMH addressed the recommendations for improvement from the 2008–2009 validation of performance measures. The PIHP provided excellent documentation of the transition to the new data system and conducted testing prior to the conversion. The PIHP did not act on other recommendations because the new system's capabilities made the recommended actions unnecessary. The new system's built-in edits prohibit invalid code entry on the front end. Due to a decrease in paper claims received by the PIHP, additional audit processes for manually entered claims were no longer necessary. The new system included a module for scheduling appointments, which addressed the need for a validation process to ensure accurate documentation and completion of appointments.

Validation of Performance Improvement Projects

Table 4-11 displays activities/elements scored *Partially Met* or *Not Met* for **Genesee County CMH** during the 2008–2009 validation of PIPs and results of the assessment of these elements from the 2009–2010 EQR.

Table 4-11—Follow-Up on Prior Recommendations *for* Genesee County CMH

Activity/ Element	2008–2009 Score	2009–2010 Score	2009–2010 Comment
I.4	*Not Met*	*Met*	The PIP included all eligible populations that met the study criteria.
I.5	*Not Met*	*Met*	The PIP did not exclude members with special health care needs.
I.6	*Not Met*	*Met*	The PIP has the potential to affect health, functional status, or satisfaction.
IV.2	*Partially Met*	*Met*	The PIP documentation defined the requirements for length of enrollment for the eligible population.
VI.3	*Not Met*	*NA*	The PIP used only administrative data collection.
VI.10	*Not Met*	*Met*	The PIP used administrative data collection. The documentation included the development of the steps in the production of the study indicators.

Genesee County CMH addressed the recommendations for improvement from the 2008–2009 PIP validation.

Lakeshore Behavioral Health Alliance

Compliance Monitoring

Table 4-12 shows the results for **Lakeshore Behavioral Health Alliance** from the 2008–2009 compliance monitoring review and the 2009–2010 assessment of the PIHP's follow-up on HSAG's recommendations.

Table 4-12—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	
I	QAPIP Plan and Structure			✓
II	Performance Measurement			✓
III	Practice Guidelines	✓		
IV	Staff Qualifications	✓		
V	Utilization Management			✓
VI	Customer Services		✓	
VII	Enrollee Grievance Process			✓
VIII	Enrollee Rights			✓
IX	Subcontracts and Delegation	✓		
X	Provider Network	✓		
XI	Credentialing	✓		
XII	Access and Availability		✓	
XIII	Coordination of Care	✓		
XIV	Appeals			✓

The 2008–2009 compliance monitoring review resulted in recommendations for improvement for the following standards: QAPIP Plan and Structure, Performance Measurement, Utilization Management, Customer Services, Enrollee Grievance Process, Enrollee Rights, Access and Availability, and Appeals. The PIHP addressed recommendations through corrective action plans and implemented improvements. As determined in the 2009–2010 review, **Lakeshore Behavioral Health Alliance** successfully addressed all recommendations for the Customer Services and Access and Availability standards. On the QAPIP standard, the PIHP addressed five of the six recommendations, with one continued recommendation related to the approval of the QI Plan. The PIHP addressed two of the three recommendations on the Performance Measurement standard, with one continued recommendation related to reporting results of customer satisfaction surveys. On the Utilization Management standard, **Lakeshore Behavioral Health Alliance** addressed 10 of the 15 recommendations, with continued recommendations related to denial procedures and PIHP oversight of the delegated utilization management function. The PIHP addressed two of the three recommendations on the Enrollee Grievance Process standard, with one continued recommendation

related to the PIHP's grievance policy. On the Enrollee Rights and Appeals standards, the PIHP did not achieve compliance with the requirements addressed in the follow-up review and received continued recommendations related to providing beneficiaries with information about their rights and protections and the PIHP's appeals policy. After the 2009–2010 follow-up review, **Lakeshore Behavioral Health Alliance** achieved full compliance on 8 of the 14 standards.

Validation of Performance Measures

Lakeshore Behavioral Health Alliance addressed the recommendations for improvement from the 2008–2009 validation of performance measures. The PIHP continued to work with one of its affiliates to automate the performance indicator calculation process. **Lakeshore Behavioral Health Alliance** implemented a thorough review and validation of the data, and at the time of the site visit, the PIHP's completeness of QI data elements met or exceeded State thresholds.

Validation of Performance Improvement Projects

Table 4-13 displays activities/elements scored *Partially Met* or *Not Met* for **Lakeshore Behavioral Health Alliance** during the 2008–2009 validation of PIPs and results of the assessment of these elements from the 2009–2010 EQR.

Table 4-13—Follow-Up on Prior Recommendations *for* Lakeshore Behavioral Health Alliance

Activity/ Element	2008–2009 Score	2009–2010 Score	2009–2010 Comment
I.2	*Partially Met*	*Met*	Selection of the PIP topic followed the collection and analysis of plan-specific data.
I.4	*Not Met*	*Met*	The PIP included all eligible populations that met the study criteria.
I.5	*Not Met*	*Met*	The PIP did not exclude members with special health care needs.
I.6	*Not Met*	*Met*	The PIP has the potential to affect health, functional status, or satisfaction.
VI.3	*Not Met*	*NA*	The PIP used only administrative data collection.
VI.10	*Not Met*	*Met*	The PIP used administrative data collection, and the documentation included the development of the steps in the production of the study indicators.
VII.1	*Not Met*	*Met*	The plan completed a causal/barrier analysis and used improvement strategies related to the causes/barriers identified through data analysis and a quality improvement process.
VII.2	*Not Met*	*Met*	The documentation included system interventions that were likely to have a long-term effect.

Table 4-13—Follow-Up on Prior Recommendations *for* Lakeshore Behavioral Health Alliance			
Activity/ Element	**2008–2009 Score**	**2009–2010 Score**	**2009–2010 Comment**
VIII.1	*Partially Met*	*Met*	The PIHP conducted data analysis according to the data analysis plan. The data analysis plan included the type of data analysis the PIHP would conduct, how the PIHP would calculate the rate, how the PIHP would compare the rate to the goal, and the statistical test that the data analysis plan would use.
VIII.3	*Not Met*	*Met*	The documentation identified and discussed factors that threatened the internal or external validity of the findings and included the impact and resolution of these factors.
VIII.5	*Partially Met*	*Partially Met*	HSAG calculated a different *p* value for Study Indicator 3 and different Chi-square values for all three of the study indicators.

Lakeshore Behavioral Health Alliance addressed all except one of the recommendations for improvement from the 2008–2009 PIP validation.

LifeWays

Compliance Monitoring

Table 4-14 shows the results for **LifeWays** from the 2008–2009 compliance monitoring review and the 2009–2010 assessment of the PIHP's follow-up on HSAG's recommendations.

Table 4-14—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	
I	QAPIP Plan and Structure	✓		
II	Performance Measurement	✓		
III	Practice Guidelines	✓		
IV	Staff Qualifications	✓		
V	Utilization Management	✓		
VI	Customer Services	✓		
VII	Enrollee Grievance Process			✓
VIII	Enrollee Rights		✓	
IX	Subcontracts and Delegation	✓		
X	Provider Network	✓		
XI	Credentialing	✓		
XII	Access and Availability	✓		
XIII	Coordination of Care	✓		
XIV	Appeals			✓

The 2008–2009 compliance monitoring review resulted in recommendations for improvement for the following standards: Enrollee Grievance Process, Enrollee Rights, and Appeals. The PIHP addressed recommendations through corrective action plans and implemented improvements. As determined in the 2009–2010 review, **LifeWays** successfully addressed the prior recommendation on the Enrollee Rights standard. On the Enrollee Grievance Process standard, the PIHP addressed two of the three prior recommendations, with one continued recommendation related to acknowledgment of receipt of a grievance. **LifeWays** successfully addressed two of the three prior recommendations on the Appeals standard, with one continued recommendation related to information about beneficiaries' right to a State fair hearing. After the 2009–2010 follow-up review, **LifeWays** achieved full compliance on 12 of the 14 standards.

Validation of Performance Measures

LifeWays addressed the recommendations for improvement from the 2008–2009 validation of performance measures. The PIHP implemented processes to improve the completeness of QI data by instituting edits in the QI data collection screens that require staff to enter data in all fields. **LifeWays** performed weekly monitoring of Medicaid ID data completeness.

Validation of Performance Improvement Projects

Table 4-15 displays activities/elements scored *Partially Met* or *Not Met* for **LifeWays** during the 2008–2009 validation of PIPs and results of the assessment of these elements from the 2009–2010 EQR.

Table 4-15—Follow-Up on Prior Recommendations *for* LifeWays

Activity/ Element	2008–2009 Score	2009–2010 Score	2009–2010 Comment
I.2	*Partially Met*	*Met*	Selection of the PIP topic followed the collection and analysis of plan-specific data.
I.6	*Not Met*	*Met*	The PIP has the potential to affect health, functional status, or satisfaction.
VI.1	*Partially Met*	*Met*	The documentation included the identification of data elements for collection.
VI.11	*Partially Met*	*Met*	The estimated degree of administrative data completeness was between 80 percent and 100 percent. The documentation explained how the PIHP determined administrative data completeness.
VII.1	*Partially Met*	*Met*	The plan completed a causal/barrier analysis and used improvement strategies related to the causes/barriers identified through data analysis and a quality improvement process.
VIII.1	*Not Met*	*Met*	The PIHP conducted data analysis according to the data analysis plan. The data analysis plan included the type of data analysis the PIHP would conduct, how the PIHP would calculate the rate, how the PIHP would compare the rate to the goal, and the statistical test that the data analysis plan would use.
VIII.3	*Not Met*	*Met*	The documentation identified and discussed factors that threatened the internal or external validity of the findings and included the impact and resolution of these factors.
VIII.4	*Not Met*	*Met*	The PIP documentation included an interpretation of the findings for each study indicator.

LifeWays addressed all recommendations for improvement from the 2008–2009 PIP validation.

Macomb County CMH Services

Compliance Monitoring

Table 4-16 shows the results for **Macomb County CMH Services** from the 2008–2009 compliance monitoring review and the 2009–2010 assessment of the PIHP's follow-up on HSAG's recommendations.

Table 4-16—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	
I	QAPIP Plan and Structure	✓		
II	Performance Measurement	✓		
III	Practice Guidelines	✓		
IV	Staff Qualifications	✓		
V	Utilization Management	✓		
VI	Customer Services			✓
VII	Enrollee Grievance Process		✓	
VIII	Enrollee Rights	✓		
IX	Subcontracts and Delegation	✓		
X	Provider Network	✓		
XI	Credentialing	✓		
XII	Access and Availability		✓	
XIII	Coordination of Care	✓		
XIV	Appeals			✓

The 2008–2009 compliance monitoring review resulted in recommendations for improvement for the following standards: Customer Services, Enrollee Grievance Process, Access and Availability, and Appeals. The PIHP addressed recommendations through corrective action plans and implemented improvements. As determined in the 2009–2010 review, **Macomb County CMH Services** successfully addressed all recommendations for the Enrollee Grievance Process and Access and Availability standards. The PIHP also addressed one of the three recommendations for the Customer Services standard, with continued recommendations for the member handbook. On the Appeals standard, the PIHP did not successfully address the prior recommendation about information about beneficiaries' right to a State fair hearing. After the 2009–2010 follow-up review, **Macomb County CMH Services** achieved full compliance on 12 of the 14 standards.

Validation of Performance Measures

Macomb County CMH Services addressed the recommendations for improvement from the 2008–2009 validation of performance measures. The PIHP continued efforts to automate the process of assessing QI data completeness. **Macomb County CMH Services** integrated the CA data into the FOCUS system as business practices allowed. The PIHP worked with its data system vendor to develop automated processes for systematic identification of valid performance indicator exceptions to facilitate the automation of summary performance indicator reports.

Validation of Performance Improvement Projects

Table 4-17 displays activities/elements scored *Partially Met* or *Not Met* for **Macomb County CMH Services** during the 2008–2009 validation of PIPs and results of the assessment of these elements from the 2009–2010 EQR.

Table 4-17—Follow-Up on Prior Recommendations *for* Macomb County CMH Services

Activity/ Element	2008–2009 Score	2009–2010 Score	2009–2010 Comment
I.5	*Not Met*	*Met*	The PIP did not exclude members with special health care needs.
I.6	*Not Met*	*Met*	The PIP has the potential to affect health, functional status, or satisfaction.
VIII.1	*Partially Met*	*Met*	The PIHP conducted data analysis according to the data analysis plan. The data analysis plan included the type of data analysis the PIHP would conduct, how the PIHP would calculate the rate, how the PIHP would compare the rate to the goal, and the statistical test that the data analysis plan would use.
VIII.3	*Not Met*	*Met*	The documentation identified and discussed factors that threatened the internal or external validity of the findings and included the impact and resolution of these factors.
VIII.4	*Not Met*	*Partially Met*	Although the PIHP provided an interpretation of the findings for the change from Baseline to Remeasurement 1 that included the statistical testing results and a comparison to the goals, the PIHP should also include a narrative discussion of the results for each measurement period.

Macomb County CMH Services addressed all except one of the recommendations for improvement from the 2008–2009 PIP validation.

network180

Compliance Monitoring

Table 4-18 shows the results for **network180** from the 2008–2009 compliance monitoring review and the 2009–2010 assessment of the PIHP's follow-up on HSAG's recommendations.

Table 4-18—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	
I	QAPIP Plan and Structure	✓		
II	Performance Measurement	✓		
III	Practice Guidelines	✓		
IV	Staff Qualifications	✓		
V	Utilization Management	✓		
VI	Customer Services	✓		
VII	Enrollee Grievance Process			✓
VIII	Enrollee Rights	✓		
IX	Subcontracts and Delegation	✓		
X	Provider Network	✓		
XI	Credentialing			✓
XII	Access and Availability			✓
XIII	Coordination of Care	✓		
XIV	Appeals			✓

The 2008–2009 compliance monitoring review resulted in recommendations for improvement for the following standards: Enrollee Grievance Process, Credentialing, Access and Availability, and Appeals. The PIHP addressed recommendations through corrective action plans and implemented improvements. As determined in the 2009–2010 review, **network180** successfully addressed two of the recommendations for the Enrollee Grievance Process standard, with continued recommendations related to its grievance process policy and monitoring of the delegated grievance function. The PIHP achieved compliance with one of the two follow-up elements on the Credentialing standard and received a continued recommendation related to its credentialing policy. **network180** met the minimum performance threshold for one of three access standards addressed in the follow-up review, with continued recommendations for access to ongoing services. On the Appeals standard, the PIHP did not successfully address the recommendation related to handling beneficiary appeals. After the 2009–2010 follow-up review, **network180** achieved full compliance on 10 of the 14 standards.

Validation of Performance Measures

network180 addressed the recommendations for improvement from the 2008–2009 validation of performance measures. The PIHP continued efforts to improve the completeness of QI data by adding several new features to the data system that facilitate documentation of exceptions, including a "no-show" option. **network180** continued efforts to automate the encounter data submission process and made significant progress toward having a fee-for-service model. The PIHP continued enforcing financial penalties for failure to submit encounter data for case rate providers.

Validation of Performance Improvement Projects

Table 4-19 displays activities/elements scored *Partially Met* or *Not Met* for **network180** during the 2008–2009 validation of PIPs and results of the assessment of these elements from the 2009–2010 EQR.

Table 4-19—Follow-Up on Prior Recommendations *for* network180

Activity/ Element	2008–2009 Score	2009–2010 Score	2009–2010 Comment
I.2	*Partially Met*	*Met*	Selection of the PIP topic followed the collection and analysis of plan-specific data.
I.4	*Not Met*	*Met*	The PIP included all eligible populations that met the study criteria.
I.5	*Not Met*	*Met*	The PIP did not exclude members with special health care needs.
I.6	*Not Met*	*Met*	The PIP has the potential to affect health, functional status, or satisfaction.
IV.1	*Partially Met*	*Met*	The PIP accurately and completely defined the study population, providing correct codes, when applicable, for the denominators.
IV.3	*Partially Met*	*Met*	The eligible population captured all members to whom the study question applied.
VI.1	*Not Met*	*Met*	The documentation included the identification of data elements for collection.
VI.3	*Not Met*	*NA*	The PIP used only administrative data collection.
VI.10	*Not Met*	*Met*	The PIP used administrative data collection, and the documentation included the development of the steps in the production of the study indicators.
VIII.1	*Partially Met*	*Met*	The PIHP conducted data analysis according to the data analysis plan. The data analysis plan included the type of data analysis the PIHP would conduct, how the PIHP would calculate the rate, how the PIHP would compare the rate to the goal, and the statistical test that the data analysis plan would use.
VIII.5	*Partially Met*	*Met*	The PIP presented results in a clear, accurate, and easy-to-understand format.

network180 addressed all recommendations for improvement from the 2008–2009 PIP validation.

NorthCare

Compliance Monitoring

Table 4-20 shows the results for **NorthCare** from the 2008–2009 compliance monitoring review and the 2009–2010 assessment of the PIHP's follow-up on HSAG's recommendations.

Table 4-20—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	
I	QAPIP Plan and Structure	✓		
II	Performance Measurement		✓	
III	Practice Guidelines		✓	
IV	Staff Qualifications	✓		
V	Utilization Management	✓		
VI	Customer Services	✓		
VII	Enrollee Grievance Process			✓
VIII	Enrollee Rights		✓	
IX	Subcontracts and Delegation	✓		
X	Provider Network	✓		
XI	Credentialing	✓		
XII	Access and Availability		✓	
XIII	Coordination of Care	✓		
XIV	Appeals			✓

The 2008–2009 compliance monitoring review resulted in a recommendation for improvement for the following standards: Performance Measurement, Practice Guidelines, Enrollee Grievance Process, Enrollee Rights, Access and Availability, and Appeals. The PIHP addressed recommendations through corrective action plans and implemented improvements. As determined in the 2009–2010 review, **NorthCare** successfully addressed all recommendations for the Performance Measurement, Practice Guidelines, Enrollee Rights, and Access and Availability standards. On the Enrollee Grievance Process standard, the PIHP addressed one of the two prior recommendations, with one continued recommendation related to the notice of disposition. The PIHP addressed one of the three recommendations for the Appeals standard and received continued recommendations related to the content of the notice of disposition. After the 2009–2010 follow-up review, **NorthCare** achieved full compliance on 12 of the 14 standards.

Validation of Performance Measures

NorthCare addressed the recommendation for improvement from the 2008–2009 validation of performance measures. The PIHP completed the transition of the remaining affiliates to the new electronic medical record system and resolved the concern related to these affiliates' high volume of paper claims and manual data entry. The PIHP and the CA continued efforts to resolve remaining issues related to reporting processes for encounter data.

Validation of Performance Improvement Projects

Table 4-21 displays activities/elements scored *Partially Met* or *Not Met* for **NorthCare** during the 2008–2009 validation of PIPs and results of the assessment of these elements from the 2009–2010 EQR.

Table 4-21—Follow-Up on Prior Recommendations *for* NorthCare

Activity/ Element	2008–2009 Score	2009–2010 Score	2009–2010 Comment
I.4	*Not Met*	*Met*	The PIP included all eligible populations that met the study criteria.
I.5	*Not Met*	*Met*	The PIP did not exclude members with special health care needs.
I.6	*Not Met*	*Met*	The PIP has the potential to affect health, functional status, or satisfaction.
IV.1	*Partially Met*	*Met*	The PIP accurately and completely defined the study population, providing correct codes, when applicable, for the denominators.
IV.3	*Partially Met*	*Met*	The eligible population captured all members to whom the study question applied.
VI.1	*Partially Met*	*Met*	The documentation included the identification of data elements for collection.
VIII.1	*Partially Met*	*Met*	The PIHP conducted data analysis according to the data analysis plan. The data analysis plan included the type of data analysis the PIHP would conduct, how the PIHP would calculate the rate, how the PIHP would compare the rate to the goal, and the statistical test that the data analysis plan would use.
VIII.4	*Partially Met*	*Partially Met*	The PIHP provided an interpretation of the change from Baseline to Remeasurement 1; however, it did not provide an interpretation of the results for each measurement period.

NorthCare addressed all except one of the recommendations for improvement from the 2008–2009 PIP validation.

Northern Affiliation

Compliance Monitoring

Table 4-22 shows the results for **Northern Affiliation** from the 2008–2009 compliance monitoring review and the 2009–2010 assessment of the PIHP's follow-up on HSAG's recommendations.

Table 4-22—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	
I	QAPIP Plan and Structure	✓		
II	Performance Measurement	✓		
III	Practice Guidelines	✓		
IV	Staff Qualifications	✓		
V	Utilization Management		✓	
VI	Customer Services	✓		
VII	Enrollee Grievance Process		✓	
VIII	Enrollee Rights	✓		
IX	Subcontracts and Delegation	✓		
X	Provider Network	✓		
XI	Credentialing	✓		
XII	Access and Availability			✓
XIII	Coordination of Care	✓		
XIV	Appeals		✓	

The 2008–2009 compliance monitoring review resulted in recommendations for improvement for the following standards: Utilization Management, Enrollee Grievance Process, Access and Availability, and Appeals. The PIHP addressed recommendations through corrective action plans and implemented improvements. As determined in the 2009–2010 review, **Northern Affiliation** successfully addressed the recommendations for the Utilization Management, Enrollee Grievance Process, and Appeals standards, but received a continued recommendation on the Access and Availability standard related to access to ongoing services for adults with a developmental disability. After the 2009–2010 follow-up review, **Northern Affiliation** achieved full compliance on 13 of the 14 standards.

Validation of Performance Measures

Northern Affiliation addressed the recommendations for improvement from the 2008–2009 validation of performance measures. The PIHP implemented a formal process to audit the manual entry of paper claims and reviewed the coding rules document to determine if any updates were necessary. The PIHP refined the reports instituted last year and generated additional reports to monitor service delivery by the affiliates and the PIHP.

Validation of Performance Improvement Projects

Table 4-23 displays activities/elements scored *Partially Met* or *Not Met* for **Northern Affiliation** during the 2008–2009 validation of PIPs and results of the assessment of these elements from the 2009–2010 EQR.

Table 4-23—Follow-Up on Prior Recommendations *for* Northern Affiliation

Activity/ Element	2008–2009 Score	2009–2010 Score	2009–2010 Comment
I.2	*Partially Met*	*Met*	Selection of the PIP topic followed the collection and analysis of plan-specific data.
I.4	*Not Met*	*Met*	The PIP included all eligible populations that met the study criteria.
I.5	*Not Met*	*Met*	The PIP did not exclude members with special health care needs.
I.6	*Not Met*	*Met*	The PIP has the potential to affect health, functional status, or satisfaction.
VI.3	*Partially Met*	*NA*	The PIP used only administrative data collection.
VIII.1	*Partially Met*	*Met*	The PIHP conducted data analysis according to the data analysis plan. The data analysis plan included the type of data analysis the PIHP would conduct, how the PIHP would calculate the rate, how the PIHP would compare the rate to the goal, and the statistical test that the data analysis plan would use.
VIII.4	*Not Met*	*Met*	The PIP documentation included an interpretation of the findings for each study indicator.

Northern Affiliation addressed all recommendations for improvement from the 2008–2009 PIP validation.

Northwest CMH Affiliation

Compliance Monitoring

Table 4-24 shows the results for **Northwest CMH Affiliation** from the 2008–2009 compliance monitoring review and the 2009–2010 assessment of the PIHP's follow-up on HSAG's recommendations.

Table 4-24—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	
I	QAPIP Plan and Structure		✓	
II	Performance Measurement	✓		
III	Practice Guidelines	✓		
IV	Staff Qualifications		✓	
V	Utilization Management			✓
VI	Customer Services		✓	
VII	Enrollee Grievance Process			✓
VIII	Enrollee Rights	✓		
IX	Subcontracts and Delegation	✓		
X	Provider Network	✓		
XI	Credentialing	✓		
XII	Access and Availability		✓	
XIII	Coordination of Care	✓		
XIV	Appeals		✓	

The 2008–2009 compliance monitoring review resulted in recommendations for improvement for the following standards: QAPIP Plan and Structure, Staff Qualifications, Utilization Management, Customer Services, Enrollee Grievance Process, Access and Availability, and Appeals. The PIHP addressed recommendations through corrective action plans and implemented improvements. As determined in the 2009–2010 review, **Northwest CMH Affiliation** successfully addressed the recommendations for the QAPIP Plan and Structure, Staff Qualifications, Customer Services, Access and Availability, and Appeals standards. On the Utilization Management standard, the PIHP addressed two of the three recommendations, with one continued recommendation related to notification of denial decisions. **Northwest CMH Affiliation** did not address the prior recommendation for the Enrollee Grievance Process standard and received a continued recommendation related to the notice of disposition. After the 2009–2010 follow-up review, **Northwest CMH Affiliation** achieved full compliance on 12 of the 14 standards.

Validation of Performance Measures

Northwest CMH Affiliation addressed the recommendations for improvement from the 2008–2009 validation of performance measures. Both of the PIHP's affiliates implemented automated processes for pieces of the performance indicator calculations. The PIHP cross-trained additional staff members, ensuring that staff absences would not affect production of the performance indicators. To address the recommendation for more formal reporting and evaluation of data completeness, the PIHP implemented the Recap report in June 2009, which displays a running four-year history of encounter data reporting.

Validation of Performance Improvement Projects

Table 4-25 displays activities/elements scored *Partially Met* or *Not Met* for **Northwest CMH Affiliation** during the 2008–2009 validation of PIPs and results of the assessment of these elements from the 2009–2010 EQR.

Table 4-25—Follow-Up on Prior Recommendations *for* Northwest CMH Affiliation

Activity/ Element	2008–2009 Score	2009–2010 Score	2009–2010 Comment
I.2	*Partially Met*	*Met*	Selection of the PIP topic followed the collection and analysis of plan-specific data.
I.6	*Not Met*	*Met*	The PIP has the potential to affect health, functional status, or satisfaction.
VII.1	*Not Met*	*Met*	The plan completed causal/barrier analysis and used improvement strategies related to the causes/barriers identified through data analysis and a quality improvement process.
VII.2	*Not Met*	*Met*	The documentation included system interventions that were likely to have a long-term effect.
VIII.1	*Not Met*	*Partially Met*	The PIP did not include a complete data analysis plan.
VIII.3	*Not Met*	*Met*	The documentation identified and discussed factors that threatened the internal or external validity of the findings and included the impact and resolution of these factors.
VIII.4	*Not Met*	*Partially Met*	The PIP did not include an interpretation of the results in comparison to the goals.
VIII.5	*Partially Met*	*Partially Met*	The Baseline results for Study Indicators 1 and 2 should be the rates provided by MDCH. HSAG was unable to replicate the Chi-square and *p* values using a standard Chi-square test.

Northwest CMH Affiliation demonstrated progress in addressing the recommendations for improvement from the 2008–2009 PIP validation.

Oakland County CMH Authority

Compliance Monitoring

Table 4-26 shows the results for **Oakland County CMH Authority** from the 2008–2009 compliance monitoring review and the 2009–2010 assessment of the PIHP's follow-up on HSAG's recommendations.

Table 4-26—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	
I	QAPIP Plan and Structure	✓		
II	Performance Measurement	✓		
III	Practice Guidelines	✓		
IV	Staff Qualifications	✓		
V	Utilization Management	✓		
VI	Customer Services	✓		
VII	Enrollee Grievance Process	✓		
VIII	Enrollee Rights		✓	
IX	Subcontracts and Delegation	✓		
X	Provider Network	✓		
XI	Credentialing	✓		
XII	Access and Availability	✓		
XIII	Coordination of Care	✓		
XIV	Appeals	✓		

The 2008–2009 compliance monitoring review resulted in a recommendation for improvement for the Enrollee Rights standard. As determined in the 2009–2010 review, **Oakland County CMH Authority** successfully addressed the prior recommendation and achieved full compliance on all standards.

Validation of Performance Measures

Oakland County CMH Authority addressed the recommendations for improvement from the 2008–2009 validation of performance measures. The PIHP continued to make progress on centralization of its system and completion of the EMR project. At the time of the site visit, **Oakland County CMH Authority** was in the planning process to automate processes related to generation of the performance measures.

Validation of Performance Improvement Projects

Table 4-27 displays activities/elements scored *Partially Met* or *Not Met* for **Oakland County CMH Authority** during the 2008–2009 validation of PIPs and results of the assessment of these elements from the 2009–2010 EQR.

Table 4-27—Follow-Up on Prior Recommendations *for* Oakland County CMH Authority

Activity/ Element	2008–2009 Score	2009–2010 Score	2009–2010 Comment
III.1	*Partially Met*	*Met*	The study indicators were objective, clear, and unambiguously defined. The PIHP provided correct codes, when applicable, for the numerators. The documentation provided a description of the study indicators as well as the definitions for the numerators or denominators.
III.3	*Partially Met*	*Met*	The study indicators aligned with the study question, and the results of the study indicators would answer the study question.
III.4	*Partially Met*	*Met*	The study indicators measured change in health, functional status, satisfaction, or valid process alternatives.
VIII.1	*Partially Met*	*Met*	The PIHP conducted data analysis according to the data analysis plan. The data analysis plan included the type of data analysis the PIHP would conduct, how the PIHP would calculate the rate, how the PIHP would compare the rate to the goal, and the statistical test that the data analysis plan would use.
VIII.3	*Partially Met*	*Met*	The documentation identified that no factors threatened the internal or external validity of the findings.

Oakland County CMH Authority addressed all recommendations for improvement from the 2008–2009 PIP validation.

Saginaw County CMH Authority

Compliance Monitoring

Table 4-28 shows the results for **Saginaw County CMH Authority** from the 2008–2009 compliance monitoring review and the 2009–2010 assessment of the PIHP's follow-up on HSAG's recommendations.

Table 4-28—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	
I	QAPIP Plan and Structure			✓
II	Performance Measurement	✓		
III	Practice Guidelines	✓		
IV	Staff Qualifications	✓		
V	Utilization Management		✓	
VI	Customer Services	✓		
VII	Enrollee Grievance Process			✓
VIII	Enrollee Rights			✓
IX	Subcontracts and Delegation	✓		
X	Provider Network	✓		
XI	Credentialing	✓		
XII	Access and Availability			✓
XIII	Coordination of Care	✓		
XIV	Appeals		✓	

The 2008–2009 compliance monitoring review resulted in recommendations for improvement for the following standards: QAPIP Plan and Structure, Utilization Management, Enrollee Grievance Process, Enrollee Rights, Access and Availability, and Appeals. The PIHP addressed recommendations through corrective action plans and implemented improvements. As determined in the 2009–2010 review, **Saginaw County CMH Authority** successfully addressed the recommendations for the Utilization Management and Appeals standards. On the QAPIP Plan and Structure standard, the PIHP successfully addressed two of the three recommendations, with one continued recommendation related to the Behavior Treatment Review Committee. On the Enrollee Grievance Process standard, the **Saginaw County CMH Authority** successfully addressed three of the five recommendations and received continued recommendations related to the requirements for timely resolution of grievances and providing beneficiaries with information about the grievance process. The PIHP did not address the recommendations on the Enrollee Rights standard and received continued recommendations related to providing beneficiaries with information about their rights and protections. On the Access and Availability standard, the PIHP did not meet the

minimum performance threshold for any of the access standards addressed in the follow-up review and received continued recommendations related to access to ongoing services and follow-up care after discharge from a psychiatric inpatient or detox unit. After the 2009–2010 follow-up review, **Saginaw County CMH Authority** achieved full compliance on 10 of the 14 standards.

Validation of Performance Measures

Saginaw County CMH Authority addressed the recommendations for improvement from the 2008–2009 validation of performance measures. The PIHP updated the Encompass system (now known as Sentri) to meet its current business practices and proceeded with the integrity environment initiative. **Saginaw County CMH Authority** implemented transaction checks, comparing authorizations to provider services, as an automated method to check for completeness of direct provider data. The PIHP developed new reports for QI data, which will assist the PIHP in monitoring the level of completeness for required data elements.

Validation of Performance Improvement Projects

Table 4-29 displays activities/elements scored *Partially Met* or *Not Met* for **Saginaw County CMH Authority** during the 2008–2009 validation of PIPs and results of the assessment of these elements from the 2009–2010 EQR.

Table 4-29—Follow-Up on Prior Recommendations *for* Saginaw County CMH Authority

Activity/ Element	2008–2009 Score	2009–2010 Score	2009–2010 Comment
I.2	*Partially Met*	*Partially Met*	The PIHP did not provide plan-specific data in Activity I to support the selection of the study topic.
I.4	*Not Met*	*Met*	The PIP included all eligible populations that met the study criteria.
I.5	*Not Met*	*Met*	The PIP did not exclude members with special health care needs.
I.6	*Not Met*	*Met*	The PIP has the potential to affect health, functional status, or satisfaction.
III.2	*Not Met*	*NA*	The PIP documentation reflected that MDCH selected the study indicators.
IV.1	*Partially Met*	*Met*	The PIHP accurately and completely defined the study population, providing correct codes, when applicable, for the denominator(s).
IV.3	*Partially Met*	*Met*	The eligible population captured all members to whom the study question applied.
VI.1	*Partially Met*	*Met*	The documentation included the identification of data elements for collection.
VI.4	*Partially Met*	*Met*	The documentation provided a timeline with dates that delineate data collection in both the baseline and remeasurement periods.

Table 4-29—Follow-Up on Prior Recommendations *for* Saginaw County CMH Authority			
Activity/ Element	**2008–2009 Score**	**2009–2010 Score**	**2009–2010 Comment**
VII.1	*Not Met*	*Met*	The PIHP completed a causal/barrier analysis and used improvement strategies related to the causes/barriers identified through data analysis and a quality improvement process.
VIII.1	*Not Met*	*Partially Met*	The data analysis plan did not include how the rates were calculated or a comparison to the goals.
VIII.3	*Not Met*	*Met*	The documentation identified and discussed factors that threatened the internal or external validity of the findings and included the impact and resolution of these factors.
VIII.4	*Not Met*	*Partially Met*	The PIP did not provide an interpretation of the results for each measurement period.
VIII.5	*Not Met*	*Partially Met*	The PIP submission did not include the baseline result for Study Indicator 1 provided by MDCH. The goal for Study Indicator 1 was not consistent throughout the document.

Saginaw County CMH Authority addressed most recommendations for improvement from the 2008–2009 PIP validation.

Southwest Affiliation

Compliance Monitoring

Table 4-30 shows the results for **Southwest Affiliation** from the 2008–2009 compliance monitoring review and the 2009–2010 assessment of the PIHP's follow-up on HSAG's recommendations.

Table 4-30—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	
I	QAPIP Plan and Structure		✓	
II	Performance Measurement	✓		
III	Practice Guidelines	✓		
IV	Staff Qualifications	✓		
V	Utilization Management	✓		
VI	Customer Services	✓		
VII	Enrollee Grievance Process		✓	
VIII	Enrollee Rights	✓		
IX	Subcontracts and Delegation	✓		
X	Provider Network	✓		
XI	Credentialing	✓		
XII	Access and Availability			✓
XIII	Coordination of Care	✓		
XIV	Appeals		✓	

The 2008–2009 compliance monitoring review resulted in recommendations for improvement for the following standards: QAPIP Plan and Structure, Enrollee Grievance Process, Access and Availability, and Appeals. The PIHP addressed recommendations through corrective action plans and implemented improvements. As determined in the 2009–2010 review, **Southwest Affiliation** successfully addressed all prior recommendations except one. On the Access and Availability standard, the PIHP received one continued recommendation related to access to ongoing services for adults with a developmental disability. After the 2009–2010 follow-up review, **Southwest Affiliation** achieved full compliance on 13 of the 14 standards.

Validation of Performance Measures

Southwest Affiliation addressed the recommendations for improvement from the 2008–2009 validation of performance measures. The PIHP's affiliates were proactive in identifying areas of concern based on poor performance on some of the performance indicators, performing a root-cause analysis, and implementing processes to resolve the identified issues. The affiliates implemented edits within their data systems to prompt providers to include required performance indicator data elements. Based on the prior year's recommendation related to review of numerator-compliant cases and exceptions, the PIHP believed that it had already incorporated this step into its overall review of the performance indicators. The PIHP documented activities related to the transition to its new data system, Avatar.

Validation of Performance Improvement Projects

Table 4-31 displays activities/elements scored *Partially Met* or *Not Met* for **Southwest Affiliation** during the 2008–2009 validation of PIPs and results of the assessment of these elements from the 2009–2010 EQR.

Table 4-31—Follow-Up on Prior Recommendations *for* Southwest Affiliation

Activity/ Element	2008–2009 Score	2009–2010 Score	2009–2010 Comment
I.2	*Partially Met*	*Met*	Selection of the PIP topic followed the collection and analysis of plan-specific data.
VI.3	*Not Met*	*NA*	The PIP used only administrative data collection.
VI.10	*Not Met*	*Met*	The PIP used administrative data collection, and the documentation included the development of the steps in the production of the study indicators.
VIII.3	*Not Met*	*Met*	The documentation identified and discussed factors that threatened the internal and external validity of the findings and included the impact and resolution of these factors.

Southwest Affiliation addressed all recommendations for improvement from the 2008–2009 PIP validation.

Thumb Alliance PIHP

Compliance Monitoring

Table 4-32 shows the results for **Thumb Alliance PIHP** from the 2008–2009 compliance monitoring review and the 2009–2010 assessment of the PIHP's follow-up on HSAG's recommendations.

Table 4-32—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	
I	QAPIP Plan and Structure	✓		
II	Performance Measurement		✓	
III	Practice Guidelines	✓		
IV	Staff Qualifications	✓		
V	Utilization Management	✓		
VI	Customer Services	✓		
VII	Enrollee Grievance Process		✓	
VIII	Enrollee Rights	✓		
IX	Subcontracts and Delegation	✓		
X	Provider Network	✓		
XI	Credentialing	✓		
XII	Access and Availability		✓	
XIII	Coordination of Care	✓		
XIV	Appeals			✓

The 2008–2009 compliance monitoring review resulted in recommendations for improvement for the following standards: Performance Measurement, Enrollee Grievance Process, Access and Availability, and Appeals. The PIHP addressed recommendations through corrective action plans and implemented improvements. As determined in the 2009–2010 review, **Thumb Alliance PIHP** successfully addressed all prior recommendations except one. On the Appeals standard, the PIHP received one continued recommendation related to the content of the notice of disposition. After the 2009–2010 follow-up review, **Thumb Alliance PIHP** achieved full compliance on 13 of the 14 standards.

Validation of Performance Measures

Thumb Alliance PIHP addressed the recommendations for improvement from the 2008–2009 validation of performance measures. The PIHP fully integrated the CA data into the PIHP's OASIS data system and continued efforts to improve the completeness of the QI data.

Validation of Performance Improvement Projects

Table 4-33 displays activities/elements scored *Partially Met* or *Not Met* for **Thumb Alliance PIHP** during the 2008–2009 validation of PIPs and results of the assessment of these elements from the 2009–2010 EQR.

Table 4-33—Follow-Up on Prior Recommendations *for* Thumb Alliance PIHP

Activity/ Element	2008–2009 Score	2009–2010 Score	2009–2010 Comment
VI.10	*Partially Met*	*Met*	The PIHP used administrative data collection. The documentation included the development of the steps in the production of the study indicators.
VIII.1	*Partially Met*	*Met*	The PIHP conducted data analysis according to the data analysis plan. The data analysis plan included the type of data analysis the PIHP would conduct, how the PIHP would calculate the rate, how the PIHP would compare the rate to the goal, and the statistical test that the data analysis plan would use.
VIII.4	*Not Met*	*Met*	The PIP documentation included an interpretation of the findings for each study indicator.
VIII.5	*Not Met*	*Partially Met*	The PIHP provided rates and completed Chi-square testing. The PIP documentation did not include the Baseline data from MDCH.

Thumb Alliance PIHP addressed all except one of the recommendations for improvement from the 2008–2009 PIP validation.

Venture Behavioral Health

Compliance Monitoring

Table 4-34 shows the results for **Venture Behavioral Health** from the 2008–2009 compliance monitoring review and the 2009–2010 assessment of the PIHP's follow-up on HSAG's recommendations.

Table 4-34—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	
I	QAPIP Plan and Structure		✓	
II	Performance Measurement			✓
III	Practice Guidelines	✓		
IV	Staff Qualifications	✓		
V	Utilization Management			✓
VI	Customer Services	✓		
VII	Enrollee Grievance Process	✓		
VIII	Enrollee Rights	✓		
IX	Subcontracts and Delegation	✓		
X	Provider Network	✓		
XI	Credentialing	✓		
XII	Access and Availability		✓	
XIII	Coordination of Care	✓		
XIV	Appeals		✓	

The 2008–2009 compliance monitoring review resulted in recommendations for improvement for the following standards: QAPIP Plan and Structure, Performance Measurement, Utilization Management, Access and Availability, and Appeals. The PIHP addressed recommendations through corrective action plans and implemented improvements. As determined in the 2009–2010 review, **Venture Behavioral Health** successfully addressed all prior recommendations for the QAPIP Plan and Structure, Access and Availability, and Appeals standards. On the Performance Measurement and Utilization Management standards, the PIHP received continued recommendations related to the review of sentinel events and monitoring of the delegated utilization management function. After the 2009–2010 follow-up review, **Venture Behavioral Health** achieved full compliance on 12 of the 14 standards.

Validation of Performance Measures

Venture Behavioral Health addressed the recommendations for improvement from the 2008–2009 validation of performance measures. The PIHP began implementation of an electronic encounter submission tool to reduce the delay in data processing. The compliance department instituted a claims audit process for auditing claims data that included a review of codes and services provided. **Venture Behavioral Health** updated the SmartCare tool to explicitly define when a member is considered "clinically available" to be screened. The PIHP provided training on the measure definitions at least annually. **Venture Behavioral Health** continued to explore options for comparative reporting of data completeness across affiliates and providers.

Validation of Performance Improvement Projects

Table 4-35 displays activities/elements scored *Partially Met* or *Not Met* for **Venture Behavioral Health** during the 2008–2009 validation of PIPs and results of the assessment of these elements from the 2009–2010 EQR.

Table 4-35—Follow-Up on Prior Recommendations *for* Venture Behavioral Health

Activity/ Element	2008–2009 Score	2009–2010 Score	2009–2010 Comment
VIII.3	*Not Met*	*Met*	The documentation identified and discussed factors that threatened the internal or external validity of the findings and included the impact and resolution of these factors.
VIII.4	*Partially Met*	*Met*	The PIP documentation included an interpretation of the findings for each study indicator.

Venture Behavioral Health addressed the recommendations for improvement from the 2008–2009 PIP validation.

Appendix A. Summary Tables of External Quality Review Activity Results

Introduction

This section of the report presents results for the prior and current years for all 14 compliance monitoring standards reviewed this year, as well as two-year comparison tables for statewide and PIHP scores for the validation of performance measures and the validation of PIPs.

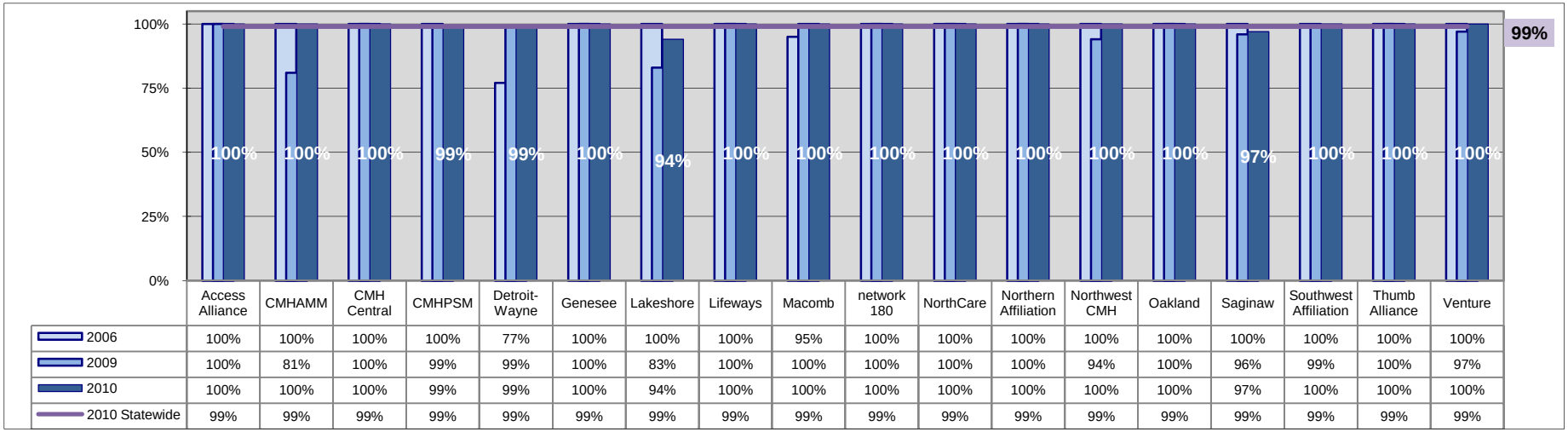
Results for Compliance Monitoring

The following tables and graphs present the results from the 2009–2010 compliance monitoring reviews compared to the results of previous reviews to provide an overview of the PIHP and statewide performance trends on all 14 compliance monitoring standards. The 2009–2010 follow-up review assessed PIHP compliance for only those elements that received a score of less than *Met* in the 2008–2009 review.

Compliance Monitoring Standards

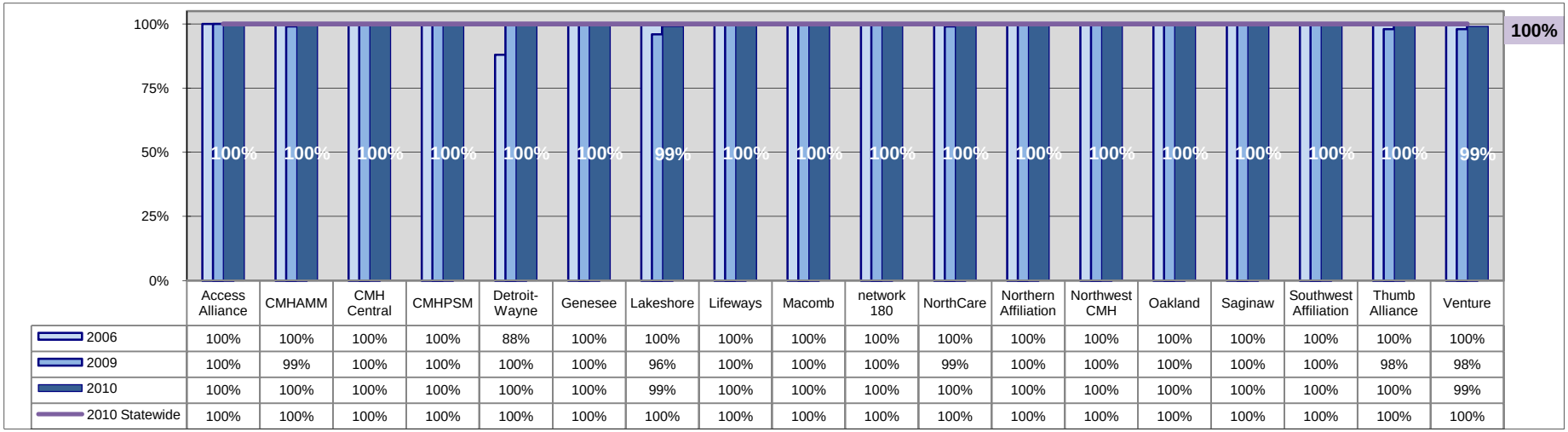
Figure A-1 through Figure A-14 present compliance scores for each of the 18 PIHPs for the following three review periods: the current year 2009–2010 scores after the follow-up review, the 2008–2009 full review scores, and the previous scores after follow-up review (2005–2006 for Standards I through VIII and 2007–2008 for Standards IX through XIV. The graphs also show the 2010 statewide score for each of the 14 compliance monitoring standards.

Figure A-1—Standard I: QAPIP



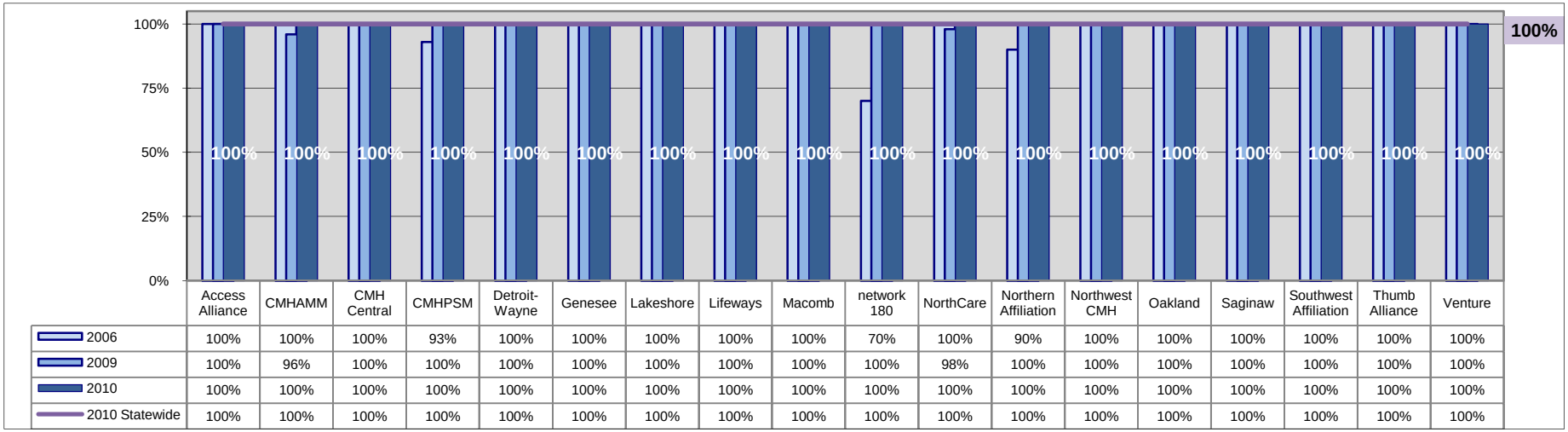
	Access Alliance	CMHAMM	CMH Central	CMHPSM	Detroit-Wayne	Genesee	Lakeshore	Lifeways	Macomb	network 180	NorthCare	Northern Affiliation	Northwest CMH	Oakland	Saginaw	Southwest Affiliation	Thumb Alliance	Venture
2006	100%	100%	100%	100%	77%	100%	100%	100%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%
2009	100%	81%	100%	99%	99%	100%	83%	100%	100%	100%	100%	100%	94%	100%	96%	99%	100%	97%
2010	100%	100%	100%	99%	99%	100%	94%	100%	100%	100%	100%	100%	100%	100%	97%	100%	100%	100%
2010 Statewide	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%

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



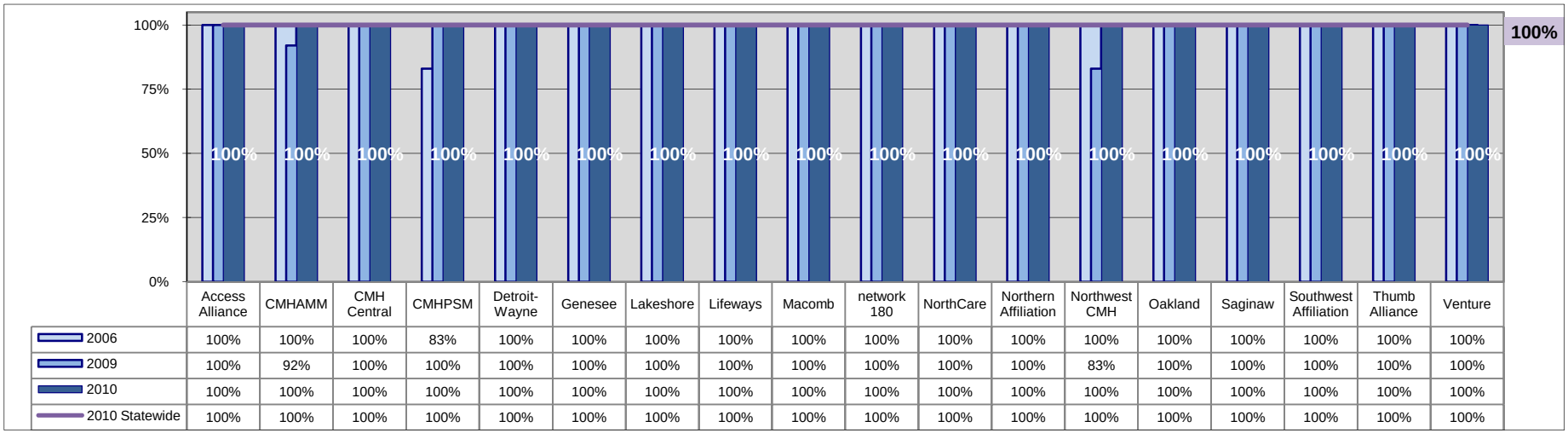
	Access Alliance	CMHAMM	CMH Central	CMHPSM	Detroit-Wayne	Genesee	Lakeshore	Lifeways	Macomb	network 180	NorthCare	Northern Affiliation	Northwest CMH	Oakland	Saginaw	Southwest Affiliation	Thumb Alliance	Venture
2006	100%	100%	100%	100%	88%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
2009	100%	99%	100%	100%	100%	100%	96%	100%	100%	100%	99%	100%	100%	100%	100%	100%	98%	98%
2010	100%	100%	100%	100%	100%	100%	99%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	99%
2010 Statewide	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Figure A-3—Standard III: Practice Guidelines



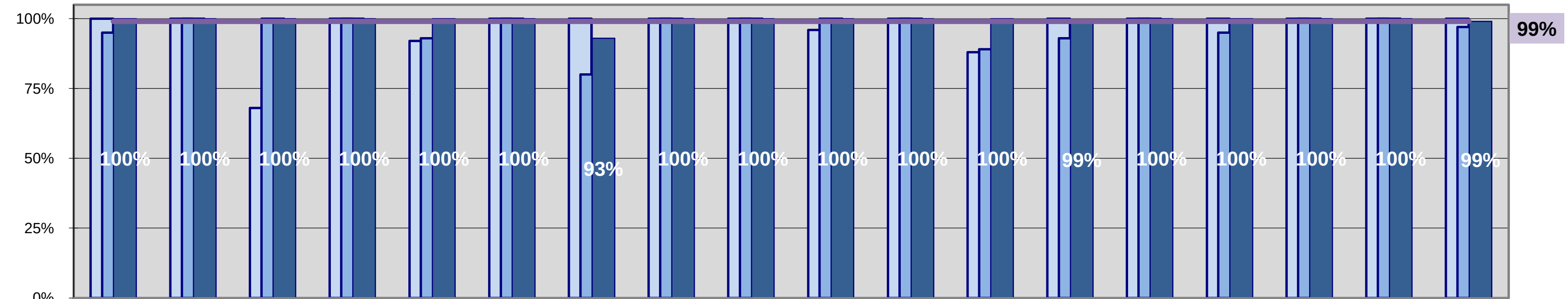
	Access Alliance	CMHAMM	CMH Central	CMHPSM	Detroit-Wayne	Genesee	Lakeshore	Lifeways	Macomb	network 180	NorthCare	Northern Affiliation	Northwest CMH	Oakland	Saginaw	Southwest Affiliation	Thumb Alliance	Venture
2006	100%	100%	100%	93%	100%	100%	100%	100%	100%	70%	100%	90%	100%	100%	100%	100%	100%	100%
2009	100%	96%	100%	100%	100%	100%	100%	100%	100%	100%	98%	100%	100%	100%	100%	100%	100%	100%
2010	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
2010 Statewide	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

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



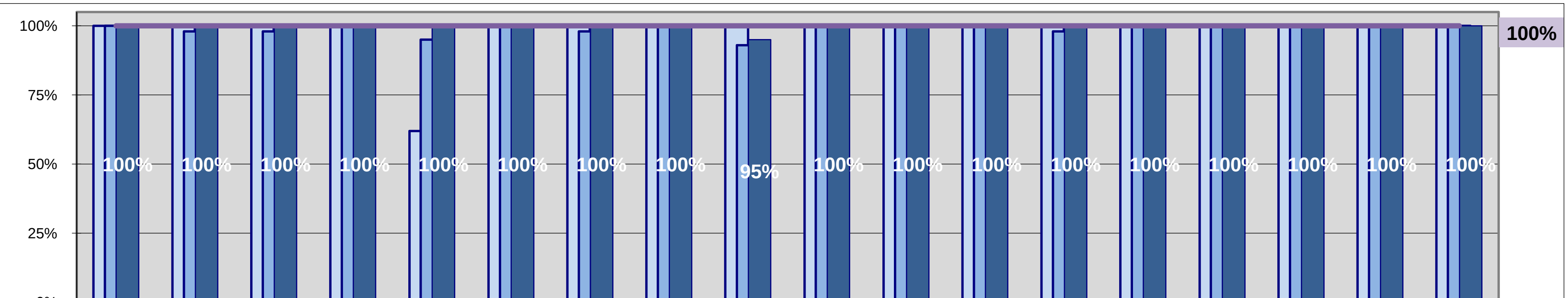
	Access Alliance	CMHAMM	CMH Central	CMHPSM	Detroit-Wayne	Genesee	Lakeshore	Lifeways	Macomb	network 180	NorthCare	Northern Affiliation	Northwest CMH	Oakland	Saginaw	Southwest Affiliation	Thumb Alliance	Venture
2006	100%	100%	100%	83%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
2009	100%	92%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	83%	100%	100%	100%	100%	100%
2010	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
2010 Statewide	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Figure A-5—Standard V: Utilization Management



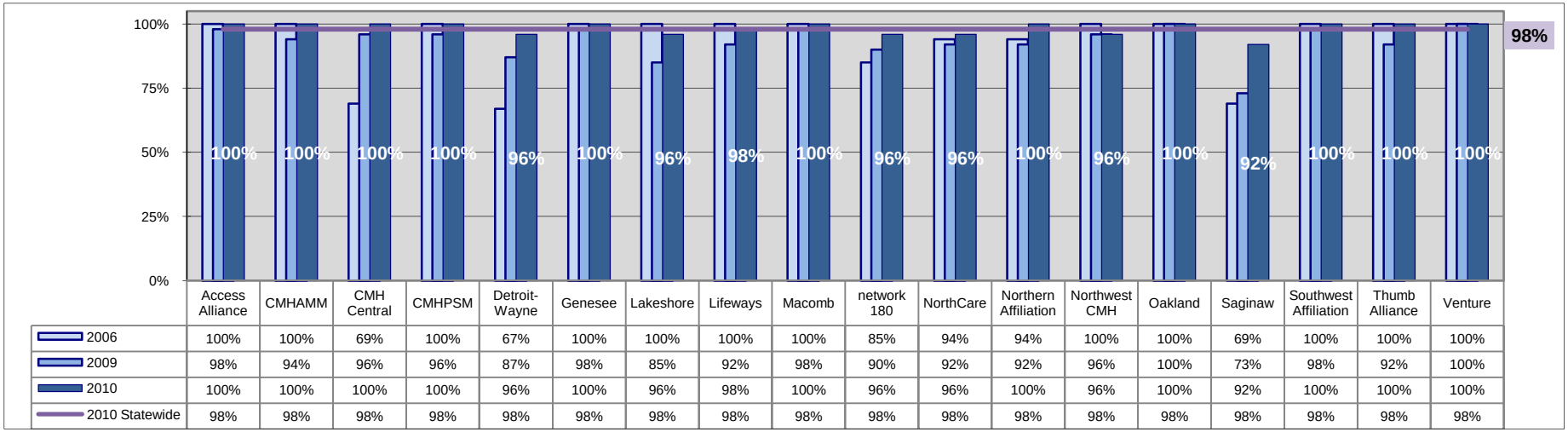
	Access Alliance	CMHAMM	CMH Central	CMHPSM	Detroit-Wayne	Genesee	Lakeshore	Lifeways	Macomb	network 180	NorthCare	Northern Affiliation	Northwest CMH	Oakland	Saginaw	Southwest Affiliation	Thumb Alliance	Venture
2006	100%	100%	68%	100%	92%	100%	100%	100%	100%	96%	100%	88%	100%	100%	100%	100%	100%	100%
2009	95%	100%	100%	100%	93%	100%	80%	100%	100%	100%	100%	89%	93%	100%	95%	100%	100%	97%
2010	100%	100%	100%	100%	100%	100%	93%	100%	100%	100%	100%	100%	99%	100%	100%	100%	100%	99%
2010 Statewide	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%

Figure A-6—Standard VI: Customer Services



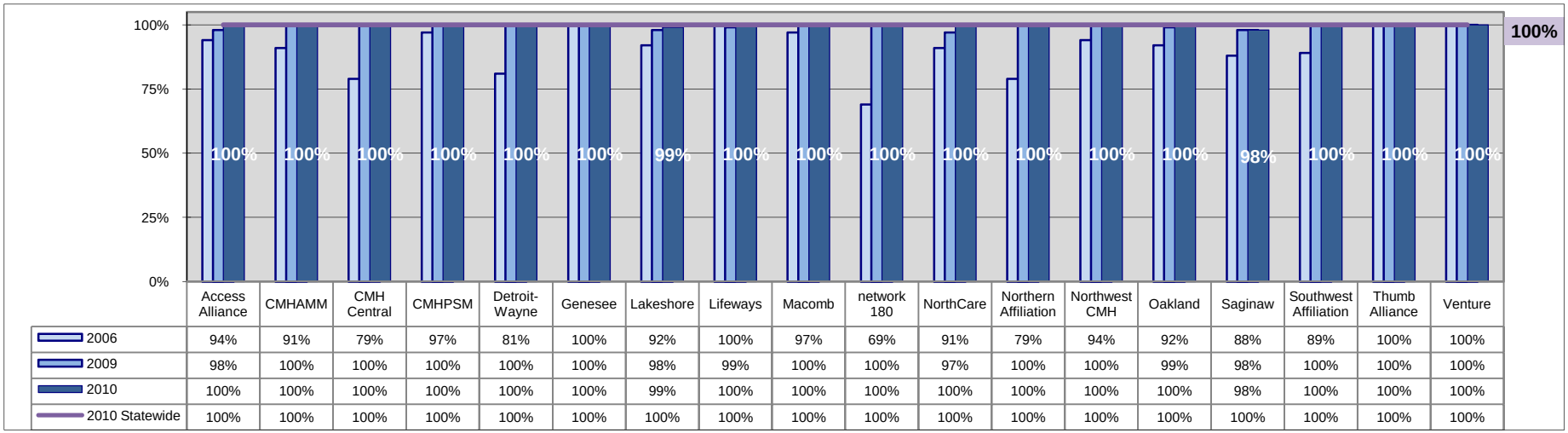
	Access Alliance	CMHAMM	CMH Central	CMHPSM	Detroit-Wayne	Genesee	Lakeshore	Lifeways	Macomb	network 180	NorthCare	Northern Affiliation	Northwest CMH	Oakland	Saginaw	Southwest Affiliation	Thumb Alliance	Venture
2006	100%	100%	100%	100%	62%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
2009	100%	98%	98%	100%	95%	100%	98%	100%	93%	100%	100%	100%	98%	100%	100%	100%	100%	100%
2010	100%	100%	100%	100%	100%	100%	100%	100%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%
2010 Statewide	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Figure A-7—Standard VII: Enrollee Grievance Process



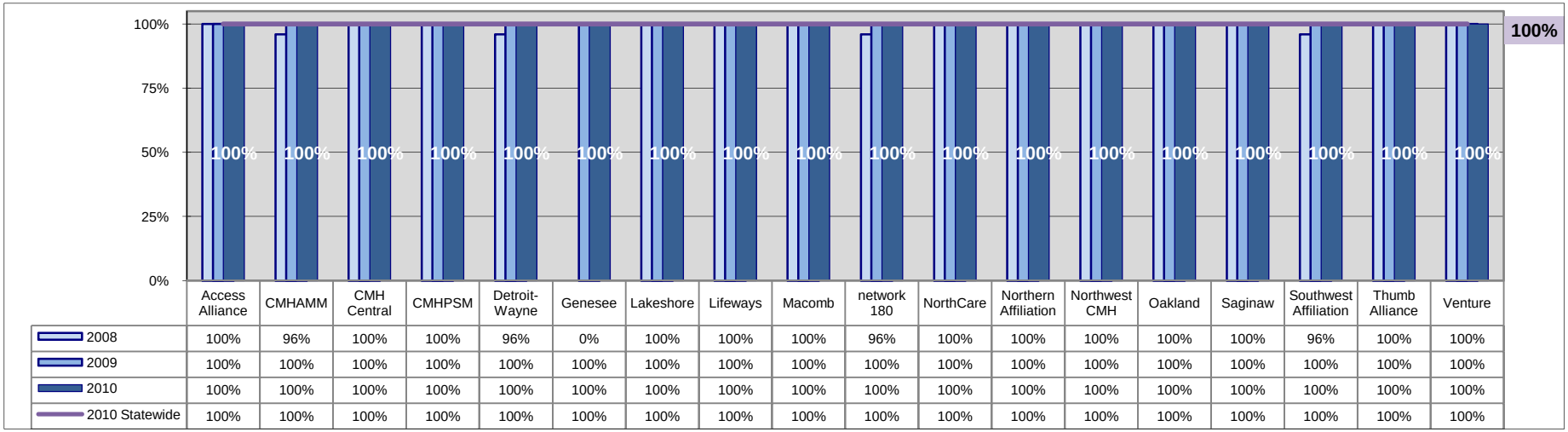
	Access Alliance	CMHAMM	CMH Central	CMHPSM	Detroit-Wayne	Genesee	Lakeshore	Lifeways	Macomb	network 180	NorthCare	Northern Affiliation	Northwest CMH	Oakland	Saginaw	Southwest Affiliation	Thumb Alliance	Venture
2006	100%	100%	69%	100%	67%	100%	100%	100%	100%	85%	94%	94%	100%	100%	69%	100%	100%	100%
2009	98%	94%	96%	96%	87%	98%	85%	92%	98%	90%	92%	92%	96%	100%	73%	98%	92%	100%
2010	100%	100%	100%	100%	96%	100%	96%	98%	100%	96%	96%	100%	96%	100%	92%	100%	100%	100%
2010 Statewide	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%

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



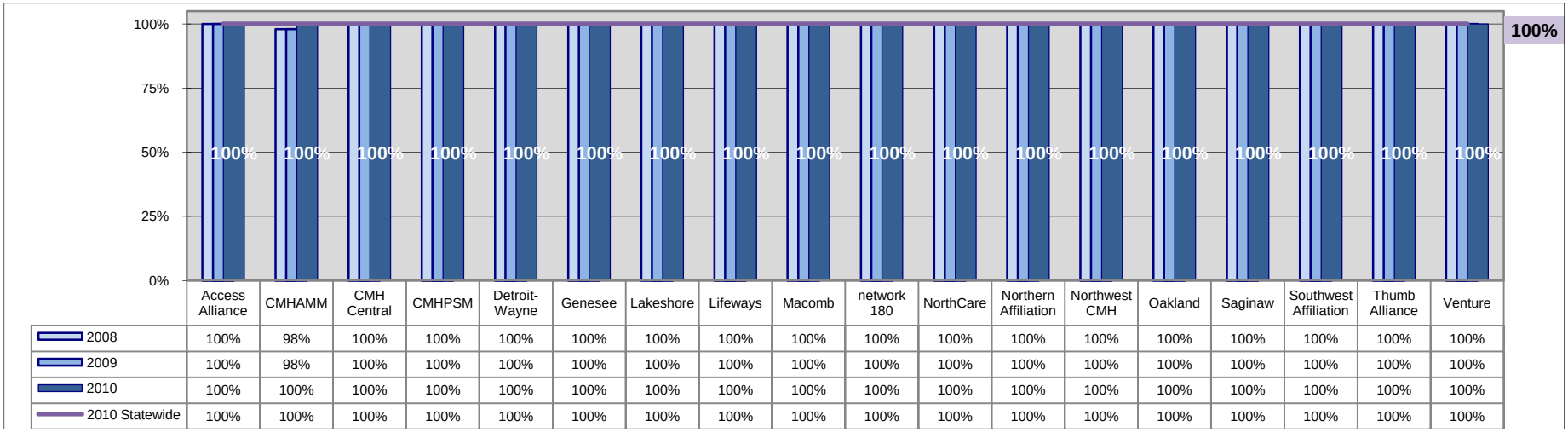
	Access Alliance	CMHAMM	CMH Central	CMHPSM	Detroit-Wayne	Genesee	Lakeshore	Lifeways	Macomb	network 180	NorthCare	Northern Affiliation	Northwest CMH	Oakland	Saginaw	Southwest Affiliation	Thumb Alliance	Venture
2006	94%	91%	79%	97%	81%	100%	92%	100%	97%	69%	91%	79%	94%	92%	88%	89%	100%	100%
2009	98%	100%	100%	100%	100%	100%	98%	99%	100%	100%	97%	100%	100%	99%	98%	100%	100%	100%
2010	100%	100%	100%	100%	100%	100%	99%	100%	100%	100%	100%	100%	100%	100%	98%	100%	100%	100%
2010 Statewide	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Figure A-9—Standard IX: Subcontracts and Delegation



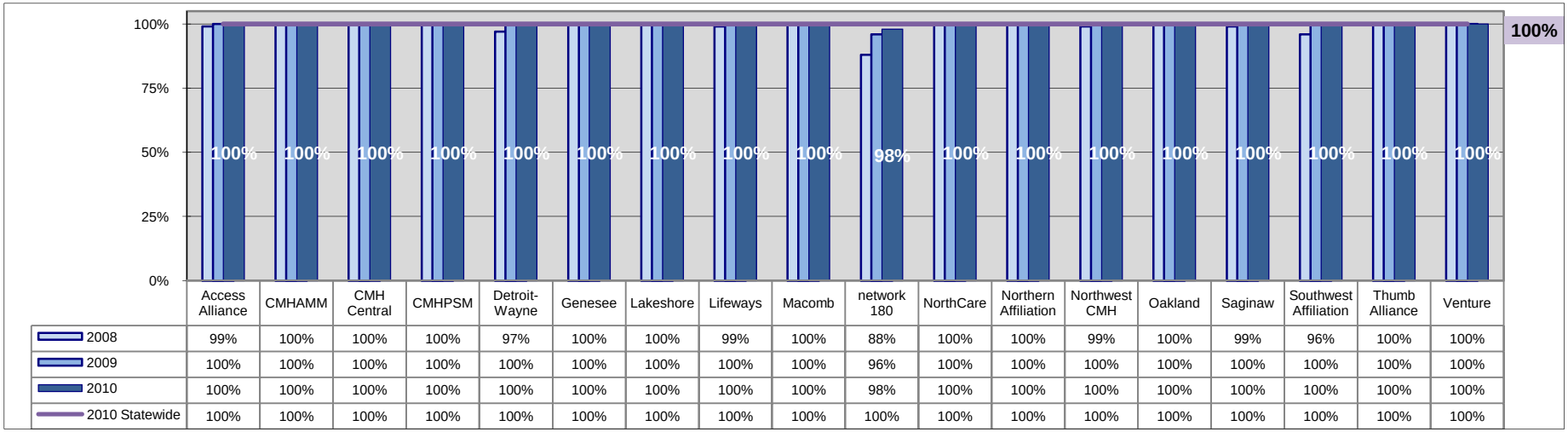
	Access Alliance	CMHAMM	CMH Central	CMHPSM	Detroit-Wayne	Genesee	Lakeshore	Lifeways	Macomb	network 180	NorthCare	Northern Affiliation	Northwest CMH	Oakland	Saginaw	Southwest Affiliation	Thumb Alliance	Venture
2008	100%	96%	100%	100%	96%	0%	100%	100%	100%	96%	100%	100%	100%	100%	100%	96%	100%	100%
2009	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
2010	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
2010 Statewide	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Figure A-10—Standard X: Provider Network



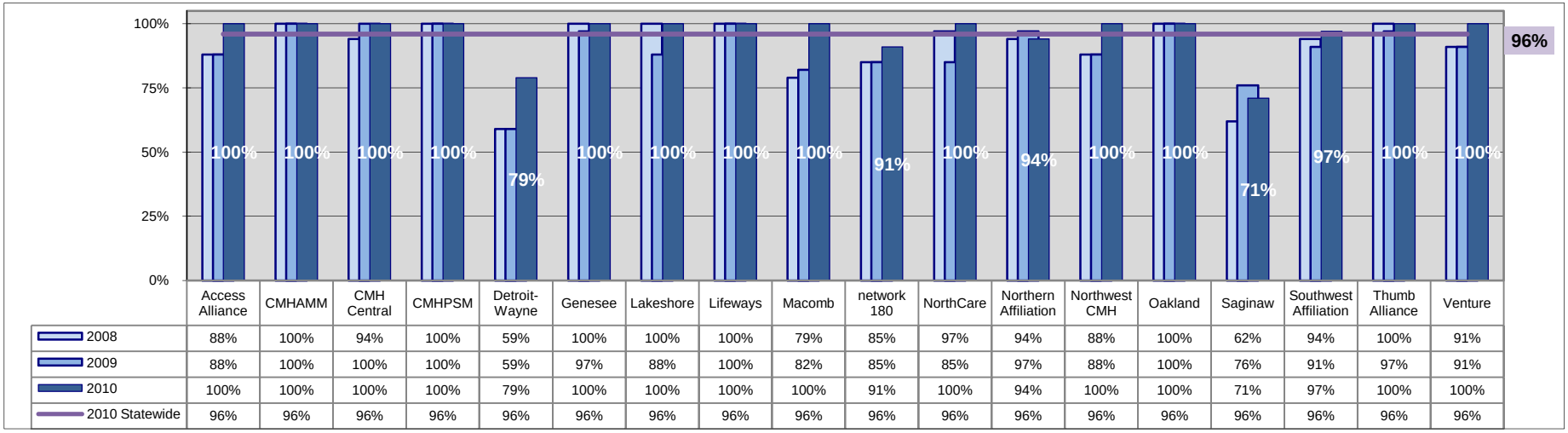
	Access Alliance	CMHAMM	CMH Central	CMHPSM	Detroit-Wayne	Genesee	Lakeshore	Lifeways	Macomb	network 180	NorthCare	Northern Affiliation	Northwest CMH	Oakland	Saginaw	Southwest Affiliation	Thumb Alliance	Venture
2008	100%	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
2009	100%	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
2010	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
2010 Statewide	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Figure A-11—Standard XI: Credentialing



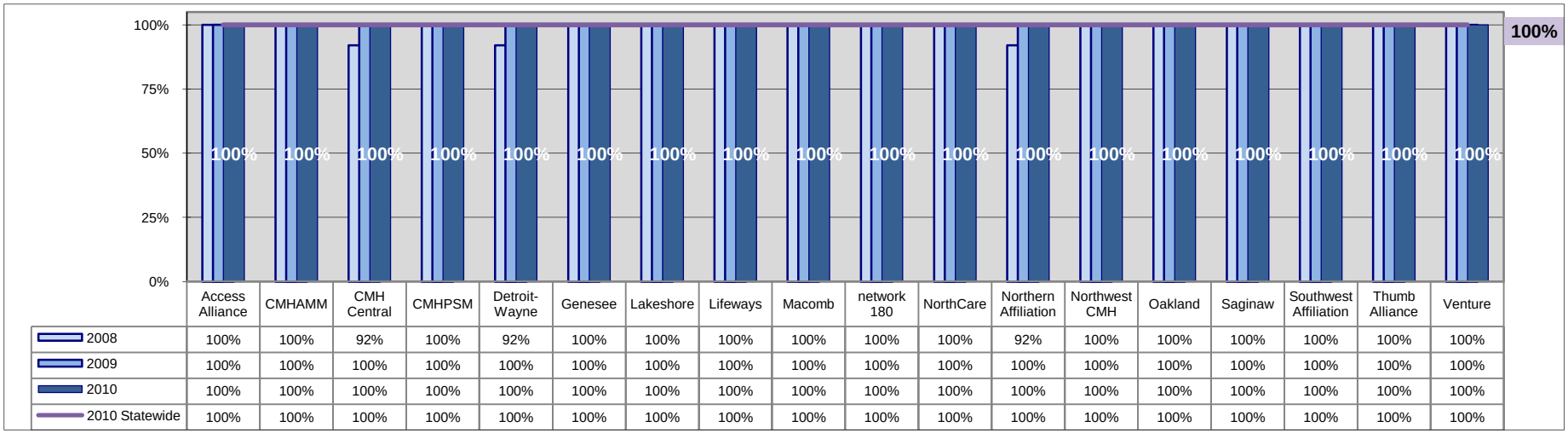
	Access Alliance	CMHAMM	CMH Central	CMHPSM	Detroit-Wayne	Genesee	Lakeshore	Lifeways	Macomb	network 180	NorthCare	Northern Affiliation	Northwest CMH	Oakland	Saginaw	Southwest Affiliation	Thumb Alliance	Venture
2008	99%	100%	100%	100%	97%	100%	100%	99%	100%	88%	100%	100%	99%	100%	99%	96%	100%	100%
2009	100%	100%	100%	100%	100%	100%	100%	100%	100%	96%	100%	100%	100%	100%	100%	100%	100%	100%
2010	100%	100%	100%	100%	100%	100%	100%	100%	100%	98%	100%	100%	100%	100%	100%	100%	100%	100%
2010 Statewide	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Figure A-12—Standard XII: Access and Availability



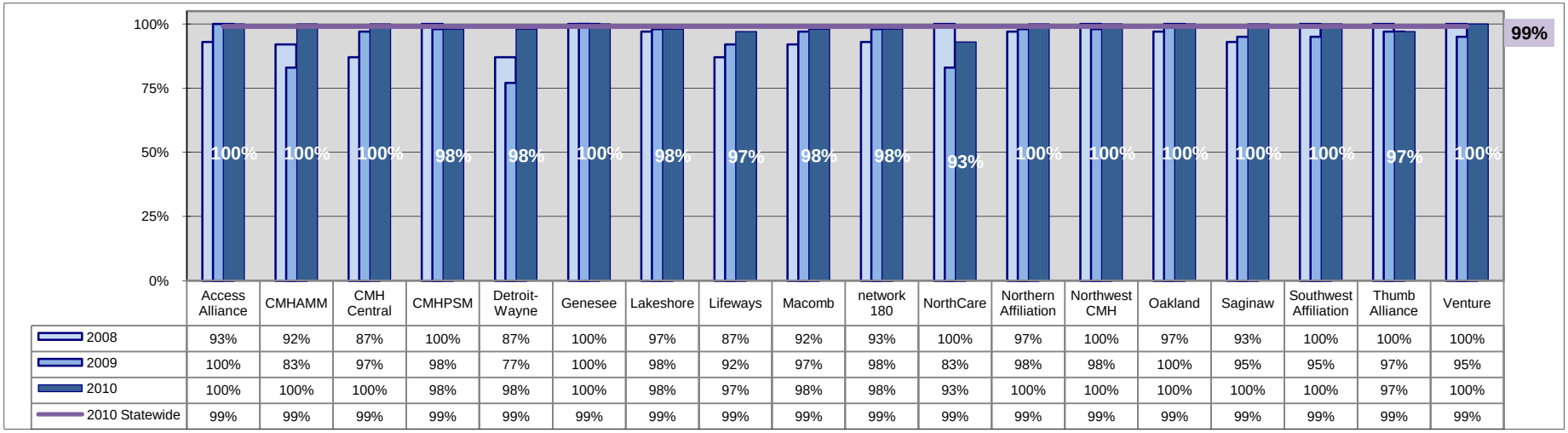
	Access Alliance	CMHAMM	CMH Central	CMHPSM	Detroit-Wayne	Genesee	Lakeshore	Lifeways	Macomb	network 180	NorthCare	Northern Affiliation	Northwest CMH	Oakland	Saginaw	Southwest Affiliation	Thumb Alliance	Venture
2008	88%	100%	94%	100%	59%	100%	100%	100%	79%	85%	97%	94%	88%	100%	62%	94%	100%	91%
2009	88%	100%	100%	100%	59%	97%	88%	100%	82%	85%	85%	97%	88%	100%	76%	91%	97%	91%
2010	100%	100%	100%	100%	79%	100%	100%	100%	100%	91%	100%	94%	100%	100%	71%	97%	100%	100%
2010 Statewide	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%

Figure A-13—Standard XIII: Coordination of Care



	Access Alliance	CMHAMM	CMH Central	CMHPSM	Detroit-Wayne	Genesee	Lakeshore	Lifeways	Macomb	network 180	NorthCare	Northern Affiliation	Northwest CMH	Oakland	Saginaw	Southwest Affiliation	Thumb Alliance	Venture
2008	100%	100%	92%	100%	92%	100%	100%	100%	100%	100%	100%	92%	100%	100%	100%	100%	100%	100%
2009	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
2010	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
2010 Statewide	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Figure A-14—Standard XIV: Appeals



	Access Alliance	CMHAMM	CMH Central	CMHPSM	Detroit-Wayne	Genesee	Lakeshore	Lifeways	Macomb	network 180	NorthCare	Northern Affiliation	Northwest CMH	Oakland	Saginaw	Southwest Affiliation	Thumb Alliance	Venture
2008	93%	92%	87%	100%	87%	100%	97%	87%	92%	93%	100%	97%	100%	97%	93%	100%	100%	100%
2009	100%	83%	97%	98%	77%	100%	98%	92%	97%	98%	83%	98%	98%	100%	95%	95%	97%	95%
2010	100%	100%	100%	98%	98%	100%	98%	97%	98%	98%	93%	100%	100%	100%	100%	100%	97%	100%
2010 Statewide	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%

PIHP Compliance

Table A-1 presents the compliance scores for all 18 PIHPs on the 14 compliance monitoring standards. Prior-year scores represent the percentage of compliance after the 2008–2009 full review of each standard. Current-year scores reflect performance after the 2009–2010 follow-up review, representing the combined compliance monitoring review scores over the two review periods.

Table A-1—Summary of PIHP Compliance Scores (Percentage of Compliance) for Prior-Year (P) and Current-Year (C) Reviews

PIHP	Review Year	I. QAPIP Plan and Structure	II. Performance Measurement and Improvement	III. Practice Guidelines	IV. Staff Qualifications and Training	V. Utilization Management	VI. Customer Services	VII. Enrollee Grievance Process	VIII. Enrollee Rights	IX. Subcontracts and Delegation	X. Provider Network	XI. Credentialing	XII. Access and Availability	XIII. Coordination of Care	XIV. Appeals
Access Alliance	P	100	100	100	100	95	100	98	98	100	100	100	88	100	100
	C					100		100	100				100		
CMHAMM	P	81	99	96	92	100	98	94	100	100	98	100	100	100	83
	C	100	100	100	100		100	100			100				100
CMH Central	P	100	100	100	100	100	98	96	100	100	100	100	100	100	97
	C						100	100							100
CMHPSM	P	99	100	100	100	100	100	96	100	100	100	100	100	100	98
	C	99						100							98
Detroit-Wayne	P	99	100	100	100	93	95	87	100	100	100	100	59	100	77
	C	99				100	100	96					79		98
Genesee	P	100	100	100	100	100	100	98	100	100	100	100	97	100	100
	C							100					100		
Lakeshore	P	83	96	100	100	80	98	85	98	100	100	100	88	100	98
	C	94	99			93	100	96	99				100		98
LifeWays	P	100	100	100	100	100	100	92	99	100	100	100	100	100	92
	C							98	100						97
Macomb	P	100	100	100	100	100	93	98	100	100	100	100	82	100	97
	C						95	100					100		98
network180	P	100	100	100	100	100	100	90	100	100	100	96	85	100	98
	C							96				98	91		98
NorthCare	P	100	99	98	100	100	100	92	97	100	100	100	85	100	83
	C		100	100				96	100				100		93
Northern Affiliation	P	100	100	100	100	89	100	92	100	100	100	100	97	100	98
	C					100		100					94		100

Table A-1—Summary of PIHP Compliance Scores (Percentage of Compliance) for Prior-Year (P) and Current-Year (C) Reviews

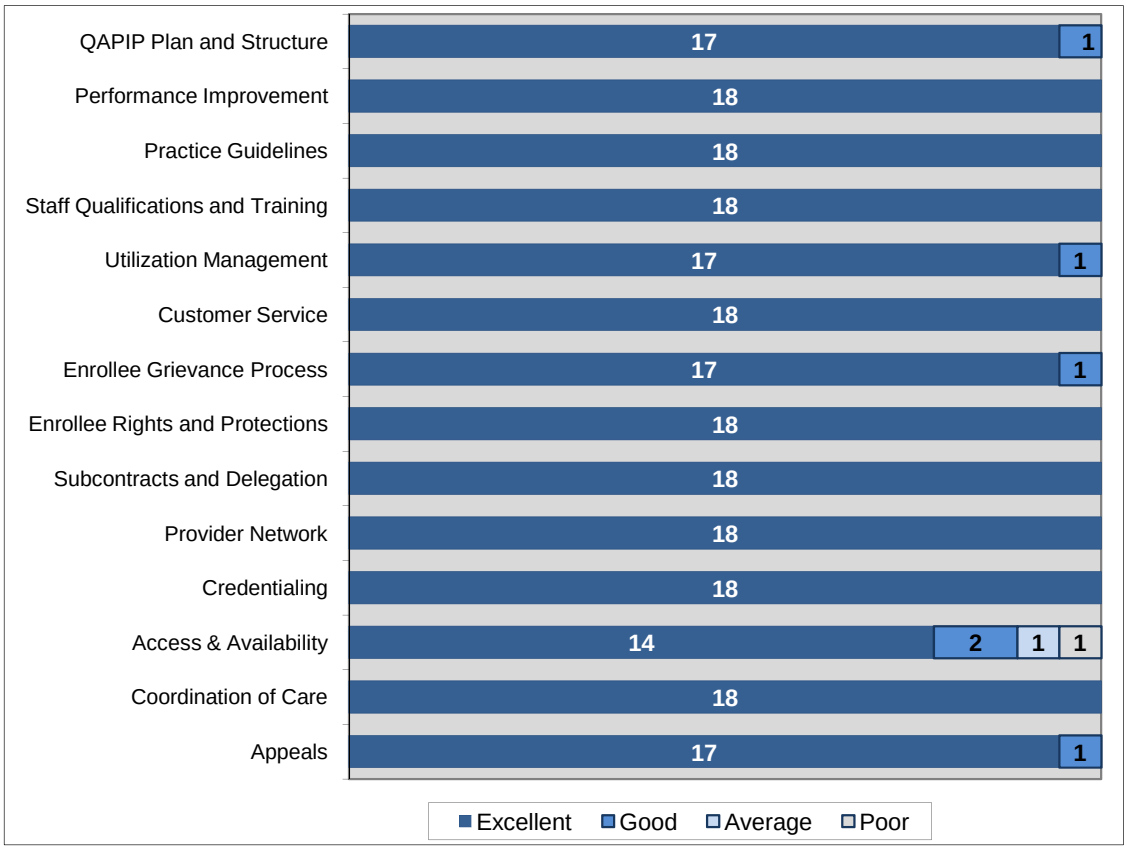
PIHP	Review Year	I. QAPIP Plan and Structure	II. Performance Measurement and Improvement	III. Practice Guidelines	IV. Staff Qualifications and Training	V. Utilization Management	VI. Customer Services	VII. Enrollee Grievance Process	VIII. Enrollee Rights	IX. Subcontracts and Delegation	X. Provider Network	XI. Credentialing	XII. Access and Availability	XIII. Coordination of Care	XIV. Appeals
Northwest CMH	P	94	100	100	83	93	98	96	100	100	100	100	88	100	98
	C	100			100	99	100	96					100		100
Oakland	P	100	100	100	100	100	100	100	99	100	100	100	100	100	100
	C								100						
Saginaw	P	96	100	100	100	95	100	73	98	100	100	100	76	100	95
	C	97				100		92	98				71		100
Southwest Affiliation	P	99	100	100	100	100	100	98	100	100	100	100	91	100	95
	C	100						100					97		100
Thumb Alliance	P	100	98	100	100	100	100	92	100	100	100	100	97	100	97
	C		100					100					100		97
Venture	P	97	98	100	100	97	100	100	100	100	100	100	91	100	95
	C	100	99			99							100		100
Statewide Score	P	**97**	**99**	**100**	**99**	**97**	**99**	**93**	**99**	**100**	**100**	**100**	**90**	**100**	**95**
	C	**99**	**100**	**100**	**100**	**99**	**100**	**98**	**100**	**100**	**100**	**100**	**96**	**100**	**99**

PIHP Compliance Scores

Compliance monitoring scores had the following ratings: scores ranging from 95 percent to 100 percent were *Excellent*, scores from 85 percent to 94 percent were *Good*, scores from 75 percent to 84 percent were *Average*, and scores of 74 percent and lower were *Poor*.

Figure A-15 presents the number of PIHPs receiving *Excellent/Good/Average/Poor* compliance scores after the 2009–2010 follow-up review for each of the 14 standards.

Figure A-15—Number of PIHPs Receiving *Excellent/Good/Average/Poor* Compliance Scores



Results for Validation of Performance Measures

Table A-2 shows the overall statewide PIHP compliance with the MDCH code book specifications for performance indicators validated by HSAG in 2008–2009 and 2009–2010.

Table A-2—Degree of Compliance for Performance Measures

Indicator		Percentage of PIHPs					
		Fully Compliant		*Substantially Compliant*		*Not Valid*	
		2008 – 2009	2009 – 2010	2008 – 2009	2009 – 2010	2008 – 2009	2009 – 2010
1.	Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	100%	100%	0%	0%	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).	100%	83%	0%	6%	0%	11%
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%	83%	0%	6%	0%	11%
10.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of adults dually diagnosed with mental illness/developmental disability served by the PIHPs who are employed competitively.	83%	33%	17%	67%	0%	0%
11.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of adults dually diagnosed with mental illness/developmental disability served by the PIHPs who earned minimum wage or more from any employment activities.	83%	33%	17%	67%	0%	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.	100%	100%	0%	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%

Table A-3 presents a two-year comparison of the statewide results for the validated performance indicators. For Indicators 10 and 11, 2009–2010 was the first year that MDCH reported data for adults with a dual diagnosis of mental illness and developmental disability. Therefore, data for 2008–2009 was designated as NA.

Table A-3—Statewide Performance Measure Rates

Indicator			Reported Rate	
			2008–2009	2009–2010
1.	Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Adults	99%	99%
		Children	98%	98%
2.	Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.		96%	98%
3.	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional.		96%	96%
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Adults	97%	98%
		Children	96%	96%
4b.	Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.		96%	96%
5.	Percentage of Medicaid recipients having received PIHP-managed services (penetration rate).		7%	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).		83%	90%
10.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of adults dually diagnosed with mental illness/developmental disability served by the PIHPs who are employed competitively.	Adults with DD	10%	11%
		Adults with MI	11%	11%
		Adults With MI/DD	NA	13%
11.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of adults dually diagnosed with mental illness/developmental disability served by the PIHPs who earned minimum wage or more from any employment activities.	Adults with DD	79%	72%
		Adults with MI	29%	29%
		Adults With MI/DD	NA	34%
12.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Adults	8%	11%
		Children	12%	11%

Table A-4 presents a two-year comparison of the PIHP-specific results for the validated performance indicators.

Table A-4—PIHP Performance Measure Results—Percentage Scores
Comparison of Prior-Year (2008–2009) and Current-Year (2009–2010) Rates

		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	
PIHP	Year	Children	Adults			Psychiatric — Children	Psychiatric — Adults	Detox			Adults With MI	Adults With DD	Adults With MI/DD	Adults With MI	Adults With DD	Adults with MI/DD	Children	Adults
Access Alliance	P	98.65	98.72	98.25	98.90	96.55	98.18	94.12	8.20	96.86	12.34	14.23	NA	82.96	40.23	NA	6.25	10.45
	C	98.68	98.99	99.79	98.50	93.10	98.57	100	8.34	95.87	12.10	12.52	14.13	78.01	39.58	40.59	6.67	11.90
CMHAMM	P	100	97.36	98.65	98.08	93.75	92.00	100	6.27	97.35	12.31	13.45	NA	85.00	48.46	NA	0.00	10.53
	C	100	99.65	99.79	97.03	84.62	91.67	100	5.82	97.37	10.05	13.36	12.95	82.55	49.51	52.76	5.88	13.85
CMH Central	P	100	98.13	99.46	98.17	100	100	100	8.97	96.38	12.92	14.34	NA	93.28	28.85	NA	0.00	9.09
	C	97.87	98.46	98.24	98.65	100	95.00	100	8.37	97.30	11.71	14.84	10.00	87.17	28.95	37.78	10.00	5.00
CMHPSM	P	100	100	98.59	100	100	100	97.37	5.86	83.47	12.15	17.54	NA	81.82	68.85	NA	28.95	8.75
	C	100	100	98.44	98.17	100	96.81	92.47	5.75	87.30	11.08	16.16	17.65	87.35	73.09	81.25	8.33	9.01
Detroit-Wayne	P	99.30	92.90	81.64	89.96	96.97	92.15	100	6.12	13.74	8.99	2.29	NA	90.54	6.92	NA	2.43	13.37
	C	100	96.54	92.65	88.62	98.87	95.58	96.11	4.70	86.79	15.28	2.80	7.89	55.34	6.37	15.79	7.32	7.69
Genesee	P	98.98	99.68	98.92	97.19	100	98.44	100	6.84	91.53	5.71	4.82	NA	78.60	20.28	NA	11.11	9.01
	C	98.73	98.95	97.39	99.20	95.56	96.12	96.88	4.89	25.71	4.59	5.52	10.17	70.32	21.39	50.00	7.69	15.24
Lakeshore	P	97.44	100	98.39	96.56	100	100	100	5.07	96.52	9.59	14.90	NA	71.90	37.42	NA	0.00	6.45
	C	100	99.19	99.33	97.33	100	100	100	5.25	94.47	7.28	14.34	13.85	76.64	35.63	30.88	10.53	10.00
LifeWays	P	100	100	97.80	98.80	100	100	100	5.46	93.70	11.34	13.33	NA	81.75	75.00	NA	15.00	15.87
	C	100	99.27	93.97	100	100	100	100	*NV*	*NV*	8.75	10.84	5.49	76.81	76.47	80.95	11.76	11.54
Macomb	P	100	98.68	99.55	99.26	100	97.64	98.04	7.11	98.59	11.31	10.48	NA	56.12	25.89	NA	10.94	14.65
	C	99.29	99.78	98.76	99.73	95.83	97.44	100	5.01	97.99	9.83	8.61	7.72	58.03	20.56	16.67	19.70	24.31
network180	P	97.62	96.83	98.52	84.57	100	97.41	100	5.65	92.40	10.64	17.82	NA	72.65	50.00	NA	0.00	8.59
	C	100	98.82	99.89	93.61	97.30	95.74	100	5.89	97.63	7.26	14.68	19.01	73.49	21.62	18.72	12.50	16.88

Table A-4—PIHP Performance Measure Results—Percentage Scores
Comparison of Prior-Year (2008–2009) and Current-Year (2009–2010) Rates

PIHP	Year	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 MI	Adults With DD	Adults With MI/DD	Adults With MI	Adults With DD	Adults with MI/DD	Children	Adults
NorthCare	P	100	100	97.49	98.07	100	96.43	100	8.04	98.90	14.72	11.85	NA	74.42	43.06	NA	8.70	11.90
	C	100	98.48	98.46	97.24	95.45	97.50	100	6.52	95.93	14.05	13.80	17.58	73.14	46.15	40.63	19.23	18.00
Northern Affiliation	P	100	97.81	98.37	98.27	100	97.92	100	7.26	96.57	11.93	21.91	NA	77.00	53.70	NA	6.90	14.08
	C	100	100	100	100	100	100	100	6.23	93.61	9.99	20.03	21.27	70.22	45.76	55.95	4.17	14.52
Northwest CMH	P	97.44	99.18	99.17	98.47	100	97.67	100	8.15	95.00	13.58	17.07	NA	92.25	88.96	NA	5.00	8.62
	C	96.30	96.97	99.74	97.89	100	100	100	7.51	92.47	11.65	18.09	13.44	96.62	82.84	94.26	11.54	3.28
Oakland	P	99.07	98.51	99.76	98.44	97.78	96.15	100	8.16	98.84	9.31	20.46	NA	67.83	26.43	NA	13.51	13.75
	C	95.91	96.71	98.15	98.18	96.49	96.74	100	7.43	98.85	8.27	18.69	19.44	65.30	27.11	19.74	23.91	11.54
Saginaw	P	100	100	98.36	93.38	61.54	93.18	54.17	4.98	96.58	9.01	13.04	NA	49.23	19.63	NA	12.50	22.45
	C	100	100	99.54	91.30	100	91.67	40.00	5.14	95.87	6.38	13.98	8.70	80.43	19.35	33.33	10.53	18.60
Southwest Affiliation	P	100	100	94.54	99.15	92.31	96.67	90.91	6.72	94.23	9.62	15.15	NA	85.77	60.94	NA	0.00	5.56
	C	100	98.21	96.77	98.36	100	97.73	100	*NV*	*NV*	9.17	14.73	16.32	84.57	72.92	86.36	9.68	16.36
Thumb Alliance	P	100	100	99.47	99.14	100	97.33	100	8.09	98.31	10.79	5.55	NA	53.26	14.15	NA	15.00	18.37
	C	100	99.35	100	99.47	100	98.31	100	6.91	97.65	9.75	5.44	5.15	49.29	19.02	17.11	4.35	18.67
Venture	P	95.65	99.38	99.10	96.72	100	100	100	6.56	94.14	13.24	13.63	NA	64.85	36.57	NA	18.18	4.48
	C	98.08	97.51	98.70	97.25	100	98.48	100	5.72	94.74	10.79	13.77	14.48	59.09	29.49	40.00	14.29	2.30

Notes: For Indicators 10 and 11, 2009–2010 was the first year that MDCH reported data for adults with a dual diagnosis of mental illness and developmental disability. Therefore, data for 2008–2009 was designated as NA. *NV* = Rate Not Valid

Results for Validation of Performance Improvement Projects

Table A-5 presents a two-year comparison of the PIHPs' PIP validation status.

Table A-5—Comparison of PIHPs' PIP Validation Status		
Validation Status	Number of PIPs	
	2008–2009	2009–2010
Met	4	10
Partially Met	4	8
Not Met	10	0

Table A-6 presents a two-year comparison of statewide PIP validation results, showing how many of the PIPs reviewed for each activity received *Met* scores for all evaluation or critical elements.

Table A-6—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	
		2008–2009	2009–2010	2008–2009	2009–2010
I.	Review the Selected Study Topic(s)	6/18	17/18	8/18	18/18
II.	Review the Study Question(s)	18/18	18/18	18/18	18/18
III.	Review the Selected Study Indicator(s)	15/18	18/18	16/18	18/18
IV.	Review the Identified Study Population	11/18	18/18	12/18	18/18
V.	Review Sampling Methods	18/18*	18/18	18/18*	18/18
VI.	Review Data Collection Procedures	7/18	18/18	18/18*	18/18
VII.	Assess Improvement Strategies	11/16	9/18	11/16	16/18
VIII.	Review Data Analysis and Study Results	2/18	1/18	5/18	13/18
IX.	Assess for Real Improvement	0/0	4/18	*NA*	*NA*
X.	Assess for Sustained Improvement	0/0	0/0	*NA*	*NA*

* HSAG scored all elements *NA* for all PIPs.

Table A-7 presents a two-year comparison of PIP scores for each PIHP.

Table A-7—Comparison of PIHP PIP Validation Scores						
PIHP	% of All Evaluation Elements *Met*		% of All Critical Elements *Met*		Validation Status	
	2008–2009	2009–2010	2008–2009	2009–2010	2008–2009	2009–2010
Access Alliance	92%	91%	90%	100%	*Partially Met*	*Met*
CMHAMM	38%	76%	30%	90%	*Not Met*	*Partially Met*
CMH Central	96%	85%	100%	100%	*Met*	*Met*
CMHPSM	100%	97%	100%	100%	*Met*	*Met*
Detroit-Wayne	62%	91%	70%	90%	*Partially Met*	*Partially Met*
Genesee	75%	82%	89%	100%	*Not Met*	*Met*
Lakeshore	58%	76%	70%	100%	*Not Met*	*Partially Met*
LifeWays	62%	82%	50%	100%	*Not Met*	*Met*
Macomb	79%	85%	78%	100%	*Not Met*	*Met*
network180	58%	91%	60%	100%	*Not Met*	*Met*
NorthCare	69%	82%	60%	90%	*Not Met*	*Partially Met*
Northern Affiliation	73%	76%	80%	90%	*Not Met*	*Partially Met*
Northwest CMH	69%	76%	70%	90%	*Not Met*	*Partially Met*
Oakland	81%	85%	70%	100%	*Partially Met*	*Met*
Saginaw	48%	82%	50%	90%	*Not Met*	*Partially Met*
Southwest Affiliation	85%	79%	100%	90%	*Met*	*Partially Met*
Thumb Alliance	85%	97%	90%	100%	*Partially Met*	*Met*
Venture	92%	91%	100%	100%	*Met*	*Met*

Appendix B. Compliance Monitoring Tool

The compliance monitoring tool appendix follows this cover page.

HSAG customized the 2009–2010 compliance monitoring tool for each PIHP based on the prior-year corrective action plan template that included only those elements that scored less than *Met* in the 2008–2009 review. For each PIHP, the tool included the 2008–2009 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 14 standards addressed in the 2009–2010 follow-up compliance review.

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

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
1. Quality Monitoring (QM) Goals and Objectives 42 CFR 438.240 Attachment P 6.7.1.1 PIHP Contract 6.1		
a. There is a written quality assessment performance improvement program (QAPIP) description.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
b. The QAPIP description specifies an adequate organizational structure that allows for clear and appropriate administration and evaluation of the QAPIP.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

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

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
2. Role of Beneficiaries The written QAPIP description includes a description of the role for beneficiaries. Attachment P 6.7.1.1		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

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

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

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
4. Accountability to the Governing Body Attachment P 6.7.1.1		
a. The QAPIP is accountable to the Governing Body.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Responsibilities of the Governing Body for monitoring, evaluating, and making improvements to care include the following:		
b. There is documentation that the Governing Body has approved the overall QAPIP Plan.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
c. There is documentation that the Governing Body has approved an annual QI Plan.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
d. The Governing Body routinely receives written reports from the QAPIP.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Standard I—Quality Assessment and Performance Improvement Program Plan and Structure		
e. The written reports from the QAPIP describe performance improvement projects undertaken.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
f. The written reports from the QAPIP describe actions taken.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
g. The written reports from the QAPIP describe the results of those actions.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
h. The Governing Body formally reviews on a periodic basis (but no less than annually) a written report on the operation of the QAPIP.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

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

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
5. Designated Senior Official There is a designated senior official responsible for the QAPIP implementation. Attachment P 6.7.1.1		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
6. Active Participation Attachment P 6.7.1.1		
a. There is active participation of <u>providers</u> in the QAPIP.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
b. There is active participation of <u>consumers</u> in the QAPIP.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

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

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
7. Verification of Services The written description of the PIHP's QAPIP addresses how it will verify whether services reimbursed by Medicaid were actually furnished to beneficiaries by affiliates (as applicable), providers, and subcontractors. Attachment P 6.7.1.1		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
8. Data from the Behavior Treatment Committee The QAPIP quarterly reviews analyses of data from the behavior treatment review committee where intrusive or restrictive techniques have been approved for use with beneficiaries and where physical management has been used in an emergency situation. Data shall include numbers of interventions and length of time the interventions were used per person. Attachment P 6.7.1.1		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Findings

Results—Standard I						
Met	=		X	1.0	=	
Substantially Met	=		X	.75	=	
Partially Met	=		X	.50	=	
Not Met	=		X	.00	=	
Not Applicable	=					
Total Applicable	=		Total Score		=	
Total Score ÷ Total Applicable					=	

Standard II—Performance Measurement and Improvement

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
1. Performance Measures The PIHP utilizes standardized performance measures established by the department, which, at a minimum, address: 42 CFR 438.240(c) Attachment P 6.7.1.1		
a. Access		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
b. Efficiency		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
c. Outcome		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Standard II—Performance Measurement and Improvement

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
2. Minimum Performance Levels Attachment P 6.7.1.1		
a. The PIHP utilizes its QAPIP to ensure that it achieves minimum performance levels on performance indicators as established by the department.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
b. The PIHP analyzes the causes of negative statistical outliers when they occur.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
3. Performance Improvement Projects The PIHP's QAPIP includes at least two affiliation-wide performance improvement projects (PIPs) during the waiver renewal period. 42 CFR 438.240(d) Attachment P 6.7.1.1		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Standard II—Performance Measurement and Improvement

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
4. Review of Sentinel Events Attachment P 6.7.1.1		
a. The QAPIP describes the process for the review of sentinel events.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
b. The QAPIP describes the process for follow-up of sentinel events.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
5. Appropriate Credentials PIHP has a process to ensure that persons involved in the review of sentinel events must have the appropriate credentials to review the scope of care. Attachment P 6.7.1.1		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Standard II—Performance Measurement and Improvement

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
6. Assessments of Beneficiary Experiences with Services Attachment P 6.7.1.1		
a. The QAPIP includes periodic qualitative assessments of beneficiaries' experiences with its services.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
b. The QAPIP includes periodic quantitative assessments of beneficiaries' experiences with its services.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
c. Assessments represent persons served and services and supports offered.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
d. The assessments address issues of the quality of care.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
e. The assessments address issues of the availability of care.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Standard II—Performance Measurement and Improvement		
Requirement	**Evidence/Documentation as Submitted by the PIHP**	**Score**
f. The assessments address issues of the accessibility of care.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
g. As a result of the assessments, the organization takes specific action on individual cases as appropriate.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
h. As a result of the assessments, the organization identifies and investigates sources of dissatisfaction.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
i. As a result of the assessments, the organization outlines systematic action steps to follow- up on the findings.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
j. As a result of the assessments, the organization informs practitioners, providers, beneficiaries, and the Governing Body of assessment results.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Standard II—Performance Measurement and Improvement

k. The organization evaluates the effects of the above activities.		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
7. Consumer Inclusion The organization ensures the incorporation of consumers receiving long-term supports or services (persons receiving case management or supports coordination) into the review and analysis of the information obtained from quantitative and qualitative methods. Attachment P 6.7.1.1		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Findings

Results—Standard II						
Met	=		X	1.0	=	
Substantially Met	=		X	.75	=	
Partially Met	=		X	.50	=	
Not Met	=		X	.00	=	
Not Applicable	=					
Total Applicable	=		Total Score		=	
Total Score ÷ Total Applicable					=	

Standard III—Practice Guidelines

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
1. Relevant Practice Guidelines The QAPIP describes the process for the use of practice guidelines, including the following: Attachment P 6.7.1.1 42 CFR 438.236		
a. Adoption process		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
b. Development process		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
c. Implementation		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
d. Continuous monitoring		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Standard III—Practice Guidelines

e. Evaluation		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
2. Practice Guideline Development If practice guidelines are adopted, the PIHP meets the following requirements: 42 CFR 438.236(b)		
a. Practice guidelines are based on valid and reliable clinical evidence or consensus of health care professionals.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
b. Practice guidelines consider the needs of beneficiaries.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
c. Practice guidelines are adopted in consultation with contracting health care professionals.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Standard III—Practice Guidelines

d. Practice guidelines are reviewed and updated periodically, as appropriate.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
3. Practice Guideline Dissemination 42 CFR 438.236(c)		
a. Practice guidelines are disseminated to all affected providers.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
b. Practice guidelines are disseminated, upon request, to beneficiaries and potential beneficiaries.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Findings

Standard III—Practice Guidelines

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
4. Application of Practice Guidelines 42 CFR 438.236(d)		
a. Decisions for utilization management are consistent with the guidelines.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
b. Decisions for beneficiary education are consistent with the guidelines.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
c. Decisions for coverage of services are consistent with the guidelines.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Results—Standard III						
Met	=		X	1.0	=	
Substantially Met	=		X	.75	=	
Partially Met	=		X	.50	=	
Not Met	=		X	.00	=	
Not Applicable	=					
Total Applicable	=		Total Score		=	
Total Score ÷ Total Applicable					=	

Standard IV—Staff Qualifications and Training

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
1. Employed and Contracted Staff Qualifications Attachment P 6.7.1.1 PIHP Contract 6.4.3		
a. The QAPIP contains written procedures to determine whether physicians are qualified to perform their services.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
b. The QAPIP contains written procedures to determine whether other licensed health care professionals are qualified to perform their services.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
c. The QAPIP contains written procedures to ensure non-licensed providers of care or support are qualified to perform their jobs.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Standard IV—Staff Qualifications and Training

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
2. Staff Training The PIHP's QAPI program for staff training includes: Attachment P 6.7.1.1		
a. Training for new personnel with regard to their responsibilities, program policy, and operating procedures		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
b. Methods for identifying staff training needs		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
c. In-service training, continuing education, and staff development activities.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Results—Standard IV						
Met	=		X	1.0	=	
Substantially Met	=		X	.75	=	
Partially Met	=		X	.50	=	
Not Met	=		X	.00	=	
Not Applicable	=					
Total Applicable	=		Total Score		=	
Total Score ÷ Total Applicable					=	

Standard V—Utilization Management

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
1. Written Program Description 42 CFR 438.210(a)(4) Attachment P 6.7.1.1		
a. The PIHP has a written utilization program description that includes procedures to evaluate medical necessity.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
b. The PIHP has a written utilization program description that includes the criteria used in making decisions.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
c. The PIHP has a written utilization program description that includes the process used to review and approve the provision of medical services.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Standard V—Utilization Management

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
2. Scope 42 CFR 438.240(b)(3) Attachment P 6.7.1.1		
a. The program has mechanisms to identify and correct under-utilization.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
b. The program has mechanisms to identify and correct over-utilization.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
3. Procedures Prospective (preauthorization), concurrent, and retrospective procedures are established and include: 42 CFR 438.210(b) Attachment P 6.7.1.1		
a. Review decisions are supervised by qualified medical professionals.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Standard V—Utilization Management		
b. Decisions to deny or reduce services are made by health care professionals who have the appropriate clinical expertise to treat the conditions.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
c. Efforts are made to obtain all necessary information including pertinent clinical information and consult with treating physician as appropriate.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
d. The reasons for decisions are clearly documented.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
e. The reasons for decisions are available to the beneficiary.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
f. There are well-publicized and readily available appeals mechanisms for providers.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
g. There are well-publicized and readily available appeals mechanisms for beneficiaries.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Standard V—Utilization Management		
h. Notification of the denial is sent to the beneficiary.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
i. Notification of the denial is sent to the provider.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
j. Notification of a denial includes a description of how to file an appeal.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
k. UM Decisions are made in a timely manner as required by the exigencies of the situation.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
l. Decisions on appeals are made in a timely manner as required by the exigencies of the situation.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
m. There are mechanisms to evaluate the effects of the program using data on beneficiary satisfaction, provider satisfaction, or other appropriate measures.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Standard V—Utilization Management		
n. If the organization delegates responsibility for utilization management, it has mechanisms to ensure that these standards are met by the delegate.		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings		

Results—Standard V						
Met	=		X	1.0	=	
Substantially Met	=		X	.75	=	
Partially Met	=		X	.50	=	
Not Met	=		X	.00	=	
Not Applicable	=					
Total Applicable	=		Total Score		=	
Total Score ÷ Total Applicable					=	

Standard VI—Customer Services

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
1. Designated Unit The PIHP has a designated unit called "Customer Services", with a minimum of one full-time equivalent (FTE) performing the customer services function, within the customer services unit or elsewhere within the PIHP. Attachment P.6.3.1.1		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
2. Phone Access Attachment P.6.3.1.1		
a. Toll-Free Telephone Line The PIHP has a designated toll-free customer services telephone line and access to a TTY number. The telephone numbers are displayed in agency brochures and public information material.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
b. Live Voice The PIHP ensures that the customer services telephone line is answered by a live voice during business hours. The PIHP uses methods other than telephone menus to triage high volumes of calls and ensures that that there is a response to each call within one business day.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Standard VI—Customer Services

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
3. Hours of Operation The PIHP publishes the hours of customer services unit operation and the process for accessing information from customer services outside those hours. Attachment P.6.3.1.1		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
4. Customer Handbook The customer handbook includes: ◆ All state-required topics as specified in the contract attachment. ◆ The date of the publication and revision(s). ◆ Names, addresses, phone numbers, TTYs, e-mails, and web addresses for affiliate CMHSPs, substance abuse coordinating agency, or network providers. ◆ Information about how to contact the Medicaid Health Plans or Medicaid fee-for-service programs in the PIHP service area (actual phone numbers and addresses may be omitted and held at the customer services office due to frequent turnover of plans and providers). Attachment P.6.3.1.1		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Standard VI—Customer Services

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
5. Provider Listing Attachment P.6.3.1.1		
a. Current Provider Listing The customer services unit maintains a current listing of all providers, both organizations and practitioners, with whom the PIHP contracts, the services they provide, languages they speak, and any specialty for which they are known. The list includes independent PCP facilitators and identification of providers that are not accepting new patients.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
b. Distribution Beneficiaries receive the provider listing initially and are informed of its availability annually.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
6. Access to Information The customer services unit has access to information about the PIHP, including CMHSP affiliate annual report; current organizational chart; CMHSP board member list, meeting schedule, and minutes, that are available to be provided in a timely manner to the beneficiary upon request. Attachment P.6.3.1.1		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Standard VI—Customer Services

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
7. Assistance with Grievances and Appeals Upon request, the customer services unit assists beneficiaries with the grievance, appeals, and local dispute resolution processes and coordinates, as appropriate, with the Fair Hearing Officer and the local Office of Recipient Rights. Attachment P.6.3.1.1		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
8. Training Customer services staff receives training to welcome people to the public mental health system and to possess current working knowledge, or know where in the organization detailed information can be obtained, in at least the following areas: Attachment P.6.3.1.1		
a. Working Knowledge About: ◆ The populations served (serious mental illness, serious emotional disturbance, developmental disability, and substance abuse disorder) and eligibility criteria for various benefit plans (e.g., Medicaid, Adult Benefit Waiver, MIChild) ◆ Service array (including substance abuse treatment services), medical necessity requirements, and eligibility for and referral to specialty services ◆ Grievance and appeals, fair hearings, local dispute resolution processes, and recipient rights ◆ Information about and referral for Medicaid-covered services within the PIHP as well as outside to Medicaid health plans, fee-for-service practitioners, and the Department of Human Services		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Standard VI—Customer Services

b. Knowledge Where to Obtain Information About: ◆ Person-centered planning ◆ Self-determination ◆ Recovery and resiliency ◆ Peer specialists ◆ Limited English proficiency and cultural competency ◆ The organization of the public mental health system ◆ Balanced Budget Act relative to the customer services functions and beneficiary rights and protections ◆ Community resources (e.g., advocacy organizations, housing options, schools, public health agencies) ◆ Public Health Code (for substance abuse treatment recipients if not delegated to the substance abuse coordinating agency)		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Findings

Results—Standard VI						
Met	=		X	1.0	=	
Substantially Met	=		X	.75	=	
Partially Met	=		X	.50	=	
Not Met	=		X	.00	=	
Not Applicable	=					
Total Applicable	=		**Total Score**		=	
Total Score ÷ Total Applicable					=	

Standard VII—Enrollee Grievance Process

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
1. General Requirement The PIHP has a grievance process in place for enrollees. 42 CFR 438.402		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
2. Information to Enrollees The PIHP provides enrollees with information about the grievances, procedures, and timeframes that include: ◆ The right to file grievances; ◆ The requirements and timeframes for filing a grievance; ◆ The availability of assistance in the filing process; and ◆ The toll-free numbers that the enrollee can use to file a grievance by phone. 42 CFR 438.10(g)(1) PIHP Contract 6.3.3		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Standard VII—Enrollee Grievance Process

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
3. Information to Subcontractors and Providers The PIHP provides information about the grievance system to all providers and subcontractors at the time they enter into a contract. The information includes: ◆ The right to file grievances; ◆ The requirement and timeframes for filing a grievance; ◆ The availability of assistance in the filing process; and ◆ The toll-free numbers that the enrollee can use to file a grievance by phone. 42 CFR 438.414 42 CFR 438.10(g)(1)		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
4. Method for Filing Grievance procedures allow the enrollee to file a grievance either orally or in writing. 42 CFR 438.402(b)(3)(1)		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Findings

Standard VII—Enrollee Grievance Process

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
5. Providing Assistance In handling grievances, the PIHP gives enrollees reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. 42 CFR 438.406(a)(7)		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
6. Process for Handling Grievances Customer Services or the Recipient Rights Office performs the following functions: 42 CFR 438.406(a)(3)(i) and (ii) 42 CFR 438.408(a) 42 CFR 438.408(d)(1) Attachment P.6.3.2.1		
a. Logs the receipt of the verbal or written grievance for reporting to the PIHP QI Program.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
b. Determines whether the grievance is more appropriately an enrollee rights complaint, and if so, refers the grievance, with the beneficiary's permission, to the Office of Recipient Rights.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Standard VII—Enrollee Grievance Process		
c. Acknowledges to the beneficiary the receipt of the grievance.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
d. Submits the written grievance to appropriate staff, including a PIHP administrator with the authority to require corrective action and none of whom shall have been involved in the initial determination.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
e. For grievances regarding denial of expedited resolution of an appeal and for a grievance that involves clinical issues, the grievance is reviewed by health care professionals who have the appropriate clinical expertise in treating the enrollee's condition or disease.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
f. Facilitates resolution of the grievance as expeditiously as the enrollee's health condition requires, but no later than 60 calendar days of receipt of the grievance.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Standard VII—Enrollee Grievance Process

g. Provides a written disposition within 60 calendar days of the PIHP's receipt of the grievance to the customer, guardian, or parent of a minor child. The content of the notice of disposition includes: ◆ The results of the grievance process; ◆ The date the grievance process was conducted; ◆ The beneficiary's right to request a fair hearing if the notice is more than 60 calendar days from the date of the request for a grievance; and ◆ How to access the fair hearing process.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
7. Recordkeeping The PIHP maintains records of grievances. 42 CFR 438.416 PIHP Contract 6.3.2		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Findings

Results—Standard VII						
Met	=		X	1.0	=	
Substantially Met	=		X	.75	=	
Partially Met	=		X	.50	=	
Not Met	=		X	.00	=	
Not Applicable	=					
Total Applicable	=		Total Score		=	
Total Score ÷ Total Applicable					=	

Standard VIII—Enrollee Rights and Protections

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
1. Written Policies 42 CFR 438.100 (a)(1) 42 CFR 438.100(a)(2)		
a. The PIHP has written policies regarding enrollee rights.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
b. The PIHP has processes to ensure that its staff and affiliated providers take those rights into account when furnishing services to enrollees.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Standard VIII—Enrollee Rights and Protections

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
2. Information Requirements—Manner and Format A enrollee has the right to receive information in accordance with the following: 42 CFR 438.100(b)(2)		
a. The PIHP ensures that enrollees have the right to receive informational materials and instructional materials relating to them in a manner and format that may be easily understood. Informative materials intended to be distributed through written or other media to beneficiaries or the broader community that describe the availability of covered services and supports and how to access are written at the fourth-grade reading level when possible. (Note: In some instances, it is necessary to include information about medications, diagnoses, and conditions that does not meet the fourth-grade level criteria.) 42 CFR 438.10(b) PIHP Contract 6.3.3		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
b. The PIHP makes its written information available in the prevalent, non-English languages in its service area. 42 CFR 438.10(c)(3) PIHP Contract 6.3.3		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
c. The PIHP makes oral interpretation services available free of charge to its enrollees and potential enrollees for all non-English languages. 42 CFR 438.10(c) (4) PIHP Contract 6.3.3 LEP Policy Guidance (Executive Order 13166 of August 11, 2002) Federal Register Vol 65, August 16, 2002.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Standard VIII—Enrollee Rights and Protections		
d. The PIHP notifies its enrollees that oral interpretation is available for any language. 42 CFR 438.10(c)(5)(i and ii) PIHP Contract 6.3.3		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
e. The PIHP notifies its enrollees that written information is available in prevalent languages. 42 CFR 438.10(c)(5)(i and ii) PIHP Contract 6.3.3		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
f. The PIHP notifies its enrollees that written information is available about how to access those services. 42 CFR 438.10(c)(5)(i and ii) PIHP Contract 6.3.3		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
g. Written material must be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually impaired or have limited reading proficiency. 42 CFR 438.10(d)(1)(ii), PIHP Contract 6.3.3 Americans with Disabilities Act (ADA)		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
h. Enrollees and potential enrollees are informed that information is available in alternative formats. 42 CFR 438.10(d)(2) PIHP Contract 6.3.3		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
i. Enrollees and potential enrollees are informed about how to access those formats. 42 CFR 438.10(d)(2) PIHP Contract 6.3.3		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Enrollee Rights and Protections

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
3. General Information for All Enrollees Information is made available to PIHP enrollees within a reasonable time after PIHP enrollment, including: 42 CFR 438.10(f)(3)		
a. Any restrictions on the enrollee's freedom of choice among network providers. 42 CFR 438.10(f)(6)(ii) PIHP Contract 6.3.3		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Standard VIII—Enrollee Rights and Protections

b. Grievance, appeal, and fair hearing procedures and timeframes that include: ◆ The right to a state fair hearing; ◆ The method for obtaining a hearing; ◆ The rules that govern representation at the hearing; ◆ The right to file grievances and appeals; ◆ The requirements and timeframes for filing a grievance or appeal; ◆ The availability of assistance in the filing process; ◆ The toll-free numbers that the beneficiary can use to file a grievance or an appeal by phone; ◆ The fact that when requested by the beneficiary, benefits will continue if the beneficiary files an appeal or a request for State fair hearing within the timeframes specified and that the beneficiary may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the beneficiary; and ◆ Any appeal rights that the State chooses to make available to providers to challenge the failure to cover a service. 42 CFR 438.10(g)(1)(vi)(A) PIHP Contract 6.3.3		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
c. The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled. 42 CFR 438.10(f)(6)(v) PIHP Contract 6.3.3		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Standard VIII—Enrollee Rights and Protections		
d. Procedures for obtaining benefits, including authorization requirements. 42 CFR 438.10(f)(6)(vi) PIHP Contract 6.3.3		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
e. The extent to which, and how, enrollees may obtain benefits from out-of-network providers. 42 CFR 438.10(f)(6)(vii) PIHP Contract 6.3.3		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
f. The extent to which, and how, after-hours and emergency coverage is provided, including: ◆ What constitutes emergency medical condition, emergency services, and post-stabilization services; ◆ The fact that prior authorization is not required for emergency services; ◆ The process and procedures for obtaining emergency services, including use of the 911 telephone system or its local equivalent; ◆ The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered under the contract; and ◆ The fact that, subject to these provisions, the enrollee has the right to use any hospital or other setting for emergency care. 42 CFR 438.10(f)(6)(viii) PIHP Contract 6.3.3		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Standard VIII—Enrollee Rights and Protections

g. Policy on referrals for specialty care and for other benefits not furnished by the enrollee's primary care provider. 42 CFR 438.10(f)(6)(x)		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
h. Cost sharing, if any. 42 CFR 438.10(f)(6)(xi)		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
i. How and where to access any benefits that are available under the State plan but are not covered under the contract, including any cost sharing and how transportation is provided. 42 CFR 438.10 (e)(2)(ii)(E)		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
j. The PIHP provides adult enrollees with written information on advance directives policies, and include a description of applicable State law. The information reflects changes in State law as soon as possible, but not later than 90 days after the effective date of the change. 42 CFR 438.10(g)(2), 42 CFR 438.6(i) PIHP Contract 6.8.6		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
k. Additional information that is available upon request, including information on the structure and operation of the PIHP and physician incentive plans in use by the PIHP or network providers. 42 CFR 438.10(g)(3)(i) 42 CFR 438.6(h) PIHP Contract 6.3.3		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Findings

Standard VIII—Enrollee Rights and Protections

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
4. Written Notice of Significant Change The PIHP gives each enrollee written notice of any significant change, as defined by the State, in any of the general information (3 A-L), including change in its provider network (e.g., addition of new providers and planned termination of existing providers). 42 CFR 438.10(f)(4) PIHP Contract 6.3.3		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
5. Notice of Termination of Providers 42 CFR 438.10(f)(5) PIHP Contract 6.3.3		
a. The PIHP makes a good faith effort to give written notice of termination of a contracted provider to each enrollee who received his or her primary care from, or was seen on a regular basis by, the terminated provider.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
b. The PIHP makes a good faith effort to give written notice of termination of a contracted provider within 15 days after receipt or issuance of the termination notice.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Standard VIII—Enrollee Rights and Protections

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
6. Right to Request and Obtain Information 42 CFR 438.10(f)(2)		
a. The PIHP (or State) notifies all enrollees of their right to, at least once a year request and obtain information about enrollee rights and protections.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
b. This information includes the information described in 3 a-k on the previous pages.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
7. Right to Be Treated with Dignity and Respect PIHP enrollee rights policies and enrollee materials include the enrollee's right to be treated with respect and with due consideration for his or her dignity and privacy. 42 CFR 438.100(b)(1)(2)(ii)		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Standard VIII—Enrollee Rights and Protections

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
8. Right to Receive Information on Treatment Options PIHP enrollee rights policies and enrollee materials include the enrollee's right to receive information about available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand. 42 CFR 438.100(b)(2)(iii)		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
9. Provider-Enrollee Communication The PIHP does not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a enrollee who is his or her patient, for the following: ◆ The enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered; ◆ Any information the enrollee needs in order to decide among all relevant treatment options; ◆ The risks, benefits, and consequences of treatment or nontreatment; and ◆ The enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. 42 CFR 438.102(a)		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Standard VIII—Enrollee Rights and Protections

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
10. Services Not Covered on Moral/Religious Basis A PIHP not electing to provide, reimburse for, or provide coverage of, a counseling or referral service based on objections to the service on moral or religious grounds must furnish information about the services it does not cover as follows: ◆ To the State, with its application for a Medicaid contract, and whenever it adopts the policy during the term of the contract; ◆ To potential enrollees, before and during enrollment; and ◆ To enrollees, within 90 days after adopting the policy with respect to any particular service, with the overriding rule to furnish the information at least 30 days before the effective date of the policy. (The PIHP does not have to include how and where to obtain the services.) 42 CFR 438.102(a)(2)(b)(1)		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
11. Right to Participate The PIHP policies provide the enrollee the right to participate in decisions regarding his or her health care, including the right to refuse treatment. 42 CFR 438,100(b)(2)(iv)		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Findings

Standard VIII—Enrollee Rights and Protections

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
12. Free of Restraint/Seclusion The PIHP policies and enrollee materials provide enrollees the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. 42 CFR 438.100(b)(2)(v)		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Findings

Results—Standard VIII						
Met	=		X	1.0	=	
Substantially Met	=		X	.75	=	
Partially Met	=		X	.50	=	
Not Met	=		X	.00	=	
Not Applicable	=					
Total Applicable	=		**Total Score**		=	
Total Score ÷ Total Applicable					=	

Standard IX—Subcontracts and Delegation

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		

Results—Standard IX					
Met	=		X 1.0	=	
Substantially Met	=		X .75	=	
Partially Met	=		X .50	=	
Not Met	=		X .00	=	
Not Applicable	=				
Total Applicable	=		**Total Score**	=	
Total Score ÷ Total Applicable				=	

Standard X—Provider Network

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		

Results—Standard X						
Met	=		X	1.0	=	
Substantially Met	=		X	.75	=	
Partially Met	=		X	.50	=	
Not Met	=		X	.00	=	
Not Applicable	=					
Total Applicable	=		**Total Score**		=	
Total Score ÷ Total Applicable					=	

Standard XI—Credentialing

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**
Findings		

Standard XI—Credentialing

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 Attachment P.6.4.3.1		☐ **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

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—Credentialing for Individuals Employed by, or Contracted with, an Organizational Provider The PIHP must ensure that the contract between the PIHP and any organizational provider requires the organizational provider to credential and recredential their directly employed and subcontracted direct service providers in accordance with the PIHP's credentialing/recredentialing policies and procedures (which must conform to MDCH's credentialing process.		☐ **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

Results—Standard XI						
Met	=		X	1.0	=	
Substantially Met	=		X	.75	=	
Partially Met	=		X	.50	=	
Not Met	=		X	.00	=	
Not Applicable	=					
Total Applicable	=		**Total Score**		=	
Total Score ÷ Total Applicable					=	

Standard XII—Access And Availability

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		☐ **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

Results—Standard XII					
Met	=		X 1.0	=	
Substantially Met	=		X .75	=	
Partially Met	=		X .50	=	
Not Met	=		X .00	=	
Not Applicable	=				
Total Applicable	=		**Total Score**	=	
Total Score ÷ Total Applicable				=	

Standard XIII—Coordination of Care

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		

Results—Standard XIII						
Met	=		X	1.0	=	
Substantially Met	=		X	.75	=	
Partially Met	=		X	.50	=	
Not Met	=		X	.00	=	
Not Applicable	=					
Total Applicable	=		Total Score		=	
Total Score ÷ Total Applicable					=	

Standard XIV—Appeals

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
1. Appeals The PIHP has internal appeals procedures that address: 438.402 MDCH 6.4(B) Attachment P6.3.2.1		
a. The beneficiary's right to a State fair hearing.		☐ **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

Results—Standard XIV						
Met	=		X	1.0	=	
Substantially Met	=		X	.75	=	
Partially Met	=		X	.50	=	
Not Met	=		X	.00	=	
Not Applicable	=					
Total Applicable	=		Total Score		=	
Total Score ÷ Total Applicable					=	

Appendix C. Performance Measure Validation Tool

The performance measure validation tool 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 (the mini-ISCAT) was submitted by the PIHP subcontractors, as well.

Appendix C: Michigan Department of Community Health Information Systems Capabilities Assessment (ISCA) 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 2009 _____

July 2009 _____

August 2009 _____

September 2009 _____

October 2009 _____

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

I. GENERAL INFORMATION

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)?

III. DATA ACQUISITION CAPABILITIES

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)	_____

III. DATA ACQUISITION CAPABILITIES

Measure	Subcontractors
The percent of adults with mental illness, the percent of adults with developmental disabilities, and the percent of adults with dual diagnoses served by PIHPs who are in competitive employment. (This indicator is calculated by MDCH). The validation will focus on FY09 and the first quarter of FY10 for this indicator.	_____
The percent of adults with mental illness, the percent of adults with developmental disabilities, and the percent of adults with dual diagnoses 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 FY09 and the first quarter of FY10 for this indicator.	_____
The percent of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	_____
The 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 PIHPs.	_____
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, and persons with developmental disabilities not on the Habilitation Supports Waiver, persons on the Habilitation Supports Waiver, and persons with substance abuse disorder.	_____

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 follows this cover page.

Appendix D: Michigan 2009–2010 PIP Validation Tool: <PIP Topic> *for* <PIHP Full Name>

DEMOGRAPHIC INFORMATION

PIHP Name: **<Full PIHP Name>**

Study Leader Name: _____ Title: _____

Telephone Number: _____ E-mail Address: _____

Name of Project/Study: **<PIP Topic>**

Type of Study:

☐ Clinical ☐ Nonclinical

☐ Collaborative ☐ HEDIS

Type of Delivery System – check all that apply:

☐ PIHP ☐ Other: _____

Date of Study: _____ to _____

Number of Medicaid Beneficiaries Served by PIHP _____

Number of Medicaid Beneficiaries in Project/Study _____

Submission Date: _____

Section to be completed by HSAG

_____ Year 1 Validation _____ Initial Submission _____ Resubmission

_____ Year 2 Validation _____ Initial Submission _____ Resubmission

_____ Year 3 Validation _____ Initial Submission _____ Resubmission

_____ Baseline Assessment _____ Remeasurement 1

_____Remeasurement 2 _____ Remeasurement 3

Year 1 validated through Step _____

Year 2 validated through Step _____

Year 3 validated through Step _____

Appendix D: Michigan 2009–2010 PIP Validation Tool: <PIP Topic> *for* <PIHP Full Name>

EVALUATION ELEMENTS		SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation			
I.	**Review the Selected Study Topic(s): Topics selected for the study should reflect the Medicaid-enrollment population in terms of demographic characteristics, prevalence of disease, and the potential consequences (risks) of 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 for the affected population. The topic may be specified by the state Medicaid agency or based on input from Medicaid beneficiaries. The study topic:**		
—	1. Reflects high-volume or high-risk conditions	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
—	2. Is selected following collection and analysis of data. ***NA*** is not applicable to this element for scoring.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
—	3. Addresses a broad spectrum of care and services The score for this element will be ***Met* 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 ***Met* or *Not Met*.**	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	

HSAG HEALTH SERVICES ADVISORY GROUP

Appendix D: Michigan 2009–2010 PIP Validation Tool: <PIP Topic> *for* <PIHP Full Name>

EVALUATION ELEMENTS		SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation			
I.	**Review the Selected Study Topic(s): Topics selected for the study should reflect the Medicaid-enrollment population in terms of demographic characteristics, prevalence of disease, and the potential consequences (risks) of 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 for the affected population. The topic may be specified by the state Medicaid agency or based on input from Medicaid beneficiaries. The study topic:**		
C*	6. Has the potential to affect beneficiary health, functional status, or satisfaction. The score for this element will be ***Met* or *Not Met*.**	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	

Results for Step I

Total Evaluation Elements				
Total Evaluation Elements**	*Met*	*Partially Met*	*Not Met*	*NA*
6	0	0	0	0

Critical Elements				
Critical Elements***	*Met*	*Partially Met*	*Not Met*	*NA*
1	0	0	0	0

* "C" in this column denotes a *critical* evaluation element.

** This is the total number of *all* evaluation elements for this review step.

*** This is the total number of *critical* evaluation elements for this review step.

Appendix D: Michigan 2009–2010 PIP Validation Tool: <PIP Topic> *for* <PIHP Full Name>

EVALUATION ELEMENTS		SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation			
II.	**Review the Study Question(s): Stating the study question(s) helps maintain the focus of the PIP and sets the framework for data collection, analysis, and interpretation. The study question:**		
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*	

Results for Step II

Total Evaluation Elements				
Total Evaluation Elements	*Met*	*Partially Met*	*Not Met*	*NA*
2	0	0	0	0

Critical Elements				
Critical Elements	*Met*	*Partially Met*	*Not Met*	*NA*
2	0	0	0	0

Appendix D: Michigan 2009–2010 PIP Validation Tool: <PIP Topic> *for* <PIHP Full Name>

EVALUATION ELEMENTS		SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation			
III.	**Review the Selected 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 influenza vaccination 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. The study indicators:**		
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-reviewed 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 technical specifications, when appropriate. The scoring for this element will be ***Met* or *NA*.**	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	

Appendix D: Michigan 2009–2010 PIP Validation Tool: <PIP Topic> *for* <PIHP Full Name>

EVALUATION ELEMENTS		SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation			
III.	**Review the Selected 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 influenza vaccination 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. The study indicators:**		
—	7. Includes the basis on which indicator(s) was adopted, if internally developed.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	

Results for Step III

Total Evaluation Elements				
Total Evaluation Elements	*Met*	*Partially Met*	*Not Met*	*NA*
7	0	0	0	0

Critical Elements				
Critical Elements	*Met*	*Partially Met*	*Not Met*	*NA*
3	0	0	0	0

Appendix D: Michigan 2009–2010 PIP Validation Tool: <PIP Topic> *for* <PIHP Full Name>

EVALUATION ELEMENTS		SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation			
IV.	**Review the 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. The study population:**		
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 an beneficiary's enrollment in the MCO.	☐ *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*	

Results for Step IV

Total Evaluation Elements				
Total Evaluation Elements	*Met*	*Partially Met*	*Not Met*	*NA*
3	0	0	0	0

Critical Elements				
Critical Elements	*Met*	*Partially Met*	*Not Met*	*NA*
2	0	0	0	0

Appendix D: Michigan 2009–2010 PIP Validation Tool: <PIP Topic> *for* <PIHP Full Name>

EVALUATION ELEMENTS		SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation			
V.	**Review Sampling Methods: (This step is scored only if sampling is used.) If sampling is 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. Sampling methods:**		
—	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*	

Results for Step V

Total Evaluation Elements				
Total Evaluation Elements	*Met*	*Partially Met*	*Not Met*	*NA*
6	0	0	0	0

Critical Elements				
Critical Elements	*Met*	*Partially Met*	*Not Met*	*NA*
1	0	0	0	0

Appendix D: Michigan 2009–2010 PIP Validation Tool: <PIP Topic> *for* <PIHP Full Name>

EVALUATION ELEMENTS		SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation			
VI.	**Review Data Collection Procedures: 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. Data collection procedures include:**		
—	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*	
—	10. Administrative data collection algorithms/ flow charts that show activities in the production of indicators.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	

EVALUATION ELEMENTS		SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation			
VI.	**Review Data Collection Procedures: 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. Data collection procedures include:**		
—	11. An estimated degree of administrative data completeness. *Met* =80–100 percent *Partially Met* =50–79 percent *Not Met* =<50 percent or not provided	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	

Results for Step VI									
Total Evaluation Elements					Critical Elements				
Total Evaluation Elements	*Met*	*Partially Met*	*Not Met*	*NA*	Critical Elements	*Met*	*Partially Met*	*Not Met*	*NA*
11	0	0	0	0	1	0	0	0	0

Appendix D: Michigan 2009–2010 PIP Validation Tool: <PIP Topic> *for* <PIHP Full Name>

EVALUATION ELEMENTS		SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation			
VII.	**Assess Improvement Strategies: Real, sustained improvements in care result from a continuous cycle of measuring and analyzing performance, as well as developing and implementing systemwide improvements in care. Interventions are designed to change behavior at an institutional, practitioner, or beneficiary level. The improvement strategies are:**		
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 are not successful.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
__	4. Standardized and monitored if interventions are successful.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	

Results for Step VII

Total Evaluation Elements				
Total Evaluation Elements	*Met*	*Partially Met*	*Not Met*	*NA*
4	0	0	0	0

Critical Elements				
Critical Elements	*Met*	*Partially Met*	*Not Met*	*NA*
1	0	0	0	0

Appendix D: Michigan 2009–2010 PIP Validation Tool: <PIP Topic> *for* <PIHP Full Name>

EVALUATION ELEMENTS		SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation			
VIII.	**Review Data Analysis and the Interpretation of Study Results: Review the data analysis process for the selected clinical or nonclinical study indicators. Review appropriateness of, and adherence to, the statistical analysis techniques used. The data analysis and interpretation of the study results:**		
C	1. Are 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. Allow for the 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. Identify factors that threaten internal or external validity of findings. ***NA*** is not applicable to this element for scoring.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
—	4. Include an interpretation of findings. ***NA*** is not applicable to this element for scoring.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
—	5. Are presented in a way that provides accurate, clear, and easily understood information. ***NA*** is not applicable to this element for scoring.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
—	6. Identify the initial measurement and the remeasurement of study indicators.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
—	7. Identify statistical differences between the initial measurement and the remeasurement.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
—	8. Identify factors that affect the ability to compare the initial measurement with the remeasurement.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	

Appendix D: Michigan 2009–2010 PIP Validation Tool: <PIP Topic> *for* <PIHP Full Name>

EVALUATION ELEMENTS		SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation			
VIII.	**Review Data Analysis and the Interpretation of Study Results: Review the data analysis process for the selected clinical or nonclinical study indicators. Review appropriateness of, and adherence to, the statistical analysis techniques used. The data analysis and interpretation of the study results:**		
—	9. Include an interpretation of the extent to which the study was successful.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	

Results for Step VIII

Total Evaluation Elements				
Total Evaluation Elements	*Met*	*Partially Met*	*Not Met*	*NA*
9	0	0	0	0

Critical Elements				
Critical Elements	*Met*	*Partially Met*	*Not Met*	*NA*
2	0	0	0	0

Appendix D: Michigan 2009–2010 PIP Validation Tool: <PIP Topic> *for* <PIHP Full Name>

EVALUATION ELEMENTS		SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation			
IX.	**Assess for Real Improvement: Through repeated measurement of the quality indicators selected for the project, meaningful change in performance relative to the performance observed during baseline measurement must be demonstrated. Assess for any random, year-to-year variations, population changes, or sampling errors that may have occurred during the measurement process.**		
—	1. The remeasurement methodology is the same as the 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*	

Results for Step IX

Total Evaluation Elements				
Total Evaluation Elements	*Met*	*Partially Met*	*Not Met*	*NA*
4	0	0	0	0

Critical Elements				
Critical Elements	*Met*	*Partially Met*	*Not Met*	*NA*
0	0	0	0	0

Appendix D: Michigan 2009–2010 PIP Validation Tool: <PIP Topic> *for* <PIHP Full Name>

EVALUATION ELEMENTS		SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation			
X.	**Assess for Sustained Improvement: Assess for any demonstrated improvement through repeated measurements over comparable time periods. Assess for any random year-to-year variations, population changes, or sampling errors 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*	

Results for Step X

Total Evaluation Elements				
Total Evaluation Elements	*Met*	*Partially Met*	*Not Met*	*NA*
1	0	0	0	0

Critical Elements				
Critical Elements	*Met*	*Partially Met*	*Not Met*	*NA*
0	0	0	0	0

Appendix D: Michigan 2009–2010 PIP Validation Tool: <PIP Topic> *for* <PIHP Full Name>

Table 3–1—2009–2010 PIP Validation Summary Scores *for* <PIP Topic> *for* <PIHP Full Name>										
Review Steps	**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. Review the Selected Study Topic	6					1				
II. Review the Study Question(s)	2					2				
III. Review the Selected Study Indicators	7					3				
IV. Review the Identified Study Population	3					2				
V. Review Sampling Methods	6					1				
VI. Review Data Collection Procedures	11					1				
VII. Assess Improvement Strategies	4					1				
VIII. Review Data Analysis and Interpretation of Study Results	9					2				
IX. Assess for Real Improvement	4					No Critical Elements				
X. Assess for Sustained Improvement	1					No Critical Elements				
Totals for All Steps	**53**					**13**				

Table 3–2—2009–2010 PIP Validation Summary Overall Score *for* <PIP Topic> *for* <PIHP Full Name>	
Percentage Score of Evaluation Elements *Met**	%
Percentage Score of Critical Elements *Met* **	%
Validation Status* **	***<Met, Partially Met, or Not Met>***

* The percentage score for all evaluation elements *Met* is calculated by dividing the total *Met* by the sum of all evaluation elements *Met, Partially Met*, and *Not Met*.

** The percentage score for 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.

Appendix D: Michigan 2009–2010 PIP Validation Tool: <PIP Topic> *for* <PIHP Full Name>

EVALUATION OF THE OVERALL VALIDITY AND RELIABILITY OF PIP RESULTS
HSAG assessed the implications of the study's findings on the likely validity and reliability of the results based on the CMS Protocol for validating PIPs. HSAG also assessed whether the State should have confidence in the reported PIP findings.
***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**
Summary of Aggregate Validation Findings ☐ ***Met*** ☐ ***Partially Met*** ☐ ***Not Met***
Summary statement on the validation findings: Steps xx through xx were assessed for this PIP Validation Report. Based on the validation of this PIP, HSAG's assessment determined xx confidence in the results.

HSAG HEALTH SERVICES ADVISORY GROUP

Appendix D: 2009-2010 PIP Summary Form: Improving The Penetration Rates For Children *for* <PIHP FULL NAME>

DEMOGRAPHIC INFORMATION	
PIHP Name: **<PIHP Full Name>**	
Study Leader Name: _____	Title: _____
Telephone Number: _____	E-mail Address: _____
Name of Project/Study: Improving the Penetration Rates for Children with Serious Emotional Disturbance, Children with a Developmental Disability, and Children who have both a Serious Emotional Disturbance, and a Developmental Disability	
Type of Study: ☐ Clinical ☐ Nonclinical ☐ Collaborative ☐ HEDIS	**Section to be completed by HSAG** _____ Year 1 Validation _____ Initial Submission _____ Resubmission _____ Year 2 Validation _____ Initial Submission _____ Resubmission _____ Year 3 Validation _____ Initial Submission _____ Resubmission
Type of Delivery System: PIHP	_____ Baseline Assessment _____ Remeasurement 1 _____ Remeasurement 2 _____ Remeasurement 3
Date of Study: _____ to _____	
Number of Medicaid Beneficiaries Served by PIHP _____ Number of Medicaid Beneficiaries in Project/Study _____	Year 1 validated through Step _____ Year 2 validated through Step _____ Year 3 validated through Step _____
Submission Date: _____	

HSAG HEALTH SERVICES ADVISORY GROUP

Appendix D: 2009-2010 PIP Summary Form: Improving The Penetration Rates For Children *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 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; or local or national data related to Medicaid risk populations. The goal of the project should be to improve processes and outcomes of health care or services 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, or it may 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:

Appendix D: 2009-2010 PIP Summary Form: Improving The Penetration Rates For Children *for* <PIHP FULL NAME>

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: 2009-2010 PIP Summary Form: Improving The Penetration Rates For Children *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 12 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 the rationale for selection of the study indicator:**
Numerator: (no numeric value)	
Denominator: (no numeric value)	
Baseline Measurement Period	
Baseline Goal	
Remeasurement 1 Period	
Remeasurement 2 Period	
Benchmark	
Source of Benchmark	
Study Indicator 2	**Describe the rationale for selection of the study indicator:**
Numerator: (no numeric value)	
Denominator: (no numeric value)	
Baseline Measurement Period	

Appendix D: 2009-2010 PIP Summary Form: Improving The Penetration Rates For Children *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 12 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.	
Baseline Goal	
Remeasurement 1 Period	
Remeasurement 2 Period	
Benchmark	
Source of Benchmark	

Appendix D: 2009-2010 PIP Summary Form: Improving The Penetration Rates For Children *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 12 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 the rationale for selection of the study indicator:**
Numerator: (no numeric value)	
Denominator: (no numeric value)	
Baseline Measurement Period	
Baseline Goal	
Remeasurement 1 Period	
Remeasurement 2 Period	
Benchmark	
Source of Benchmark	

Use this area to provide additional information. Discuss the guidelines used and the basis for each study indicator.

Appendix D: 2009-2010 PIP Summary Form: Improving The Penetration Rates For Children *for* <PIHP FULL NAME>

D. Activity IV: Use a representative and generalizable study population. The selected topic should represent the entire eligible population of Medicare beneficiaries, with systemwide measurement and improvement efforts to which the study indicators apply. Once the population is identified, a decision must be made whether or not to review data for the entire population or a sample of that population. The length of beneficiaries' enrollment needs to be defined to meet the study population criteria.
Study population:

Appendix D: 2009-2010 PIP Summary Form: Improving The Penetration Rates For Children *for* <PIHP FULL NAME>

E. Activity V: Use sound sampling methods. If sampling is 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*)

Appendix D: 2009-2010 PIP Summary Form: Improving The Penetration Rates For Children *for* <PIHP FULL NAME>

F. Activity VIa: Use valid and reliable data collection procedures. Data collection must ensure that data collected on PIP 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 to 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 _____

Appendix D: 2009-2010 PIP Summary Form: Improving The Penetration Rates For Children *for* <PIHP FULL NAME>

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.

Estimated percentage degree of administrative data completeness: _____ percent.

Describe the process used to determine data completeness and accuracy:

Supporting documentation:

Appendix D: 2009-2010 PIP Summary Form: Improving The Penetration Rates For Children *for* <PIHP FULL NAME>

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

Appendix D: 2009-2010 PIP Summary Form: Improving The Penetration Rates For Children *for* <PIHP FULL NAME>

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
Describe the process used for the casual/barrier analyses that led to the development of the interventions:			

Appendix D: 2009-2010 PIP Summary Form: Improving The Penetration Rates For Children *for* <PIHP FULL NAME>

G. Activity VIIb: Implement intervention and improvement strategies. Real, sustained improvements in care result from a continuous cycle of measuring and analyzing performance, as well as, 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:

Appendix D: 2009-2010 PIP Summary Form: Improving The Penetration Rates For Children *for* <PIHP FULL NAME>

H. Activity VIIIa: Data analysis. Describe the data analysis process done in accordance with the data analysis plan and any ad hoc analyses (e.g., data mining) done on the selected clinical or nonclinical study indicators. Include the statistical analysis techniques used and *p* values.
Describe the data analysis process (include the data analysis plan): **Baseline Measurement:** **Baseline to Remeasurement 1:** **Remeasurement 1 to Remeasurement 2:** **Remeasurement 2 to Remeasurement 3:**

Appendix D: 2009-2010 PIP Summary Form: Improving The Penetration Rates For Children *for* <PIHP FULL NAME>

H. Activity VIIIb: Interpretation of study results. Describe the results of the statistical analysis, interpret the findings, and compare and discuss results/changes from measurement period to measurement period. Discuss the successfulness of the study and indicate follow-up activities. Identify any factors that could influence the measurement or validity of the findings.
Interpretation of study results (address factors that threaten the internal or external validity of the findings for each measurement period): **Baseline Measurement:** **Baseline to Remeasurement 1:** **Remeasurement 1 to Remeasurement 2:** **Remeasurement 2 to Remeasurement 3:**

Appendix D: 2009-2010 PIP Summary Form: Improving The Penetration Rates For Children *for* <PIHP FULL NAME>

I. Activity IX: Report improvement. Enter results for each study indicator, including benchmarks and statistical testing with complete *p* values, and statistical significance.

Quantifiable Measure 1: Enter title of study indicator

Time Period Measurement Covers	Baseline Project Indicator Measurement	Numerator	Denominator	Rate or Results	Industry Benchmark	Statistical Test Significance, and *p* value
	Baseline:					
	Remeasurement 1					
	Remeasurement 2					
	Remeasurement 3					
	Remeasurement 4					
	Remeasurement 5					

Describe any demonstration of meaningful change in performance observed from Baseline and each measurement period (e.g., Baseline to Remeasurement 1, Remeasurement 1 to Remeasurement 2, or Baseline to final remeasurement):

Quantifiable Measure 2: Enter title of study indicator

Time Period Measurement Covers	Baseline Project Indicator Measurement	Numerator	Denominator	Rate or Results	Industry Benchmark	Statistical Test Significance, and *p* value
	Baseline:					
	Remeasurement 1					
	Remeasurement 2					
	Remeasurement 3					
	Remeasurement 4					
	Remeasurement 5					

Appendix D: 2009-2010 PIP Summary Form: Improving The Penetration Rates For Children *for* <PIHP FULL NAME>

I. Activity IX: Report improvement. Enter results for each study indicator, including benchmarks and statistical testing with complete *p* values, and statistical significance.
Describe any demonstration of meaningful change in performance observed from Baseline and each measurement period (e.g., Baseline to Remeasurement 1, Remeasurement 1 to Remeasurement 2, or Baseline to final remeasurement):

Appendix D: 2009-2010 PIP Summary Form: Improving The Penetration Rates For Children *for* <PIHP FULL NAME>

I. Activity IX: Report improvement. Enter results for each study indicator, including benchmarks and statistical testing with complete *p* values, and statistical significance.

Quantifiable Measure 3: Enter title of study indicator

Time Period Measurement Covers	Baseline Project Indicator Measurement	Numerator	Denominator	Rate or Results	Industry Benchmark	Statistical Test Significance, and *p* value
	Baseline:					
	Remeasurement 1					
	Remeasurement 2					
	Remeasurement 3					
	Remeasurement 4					
	Remeasurement 5					

Describe any demonstration of meaningful change in performance observed from Baseline and each measurement period (e.g., Baseline to Remeasurement 1, Remeasurement 1 to Remeasurement 2, or Baseline to final remeasurement):

Appendix D: 2009-2010 PIP Summary Form: Improving The Penetration Rates For Children *for* <PIHP FULL NAME>

J. Activity X: Describe sustained improvement. Describe any demonstrated improvement through repeated measurements over comparable time periods. Discuss any random, year-to-year variations, population changes, sampling errors, or statistically significant declines that may have occurred during the remeasurement process.
Sustained improvement: