

*Michigan Department
of Community Health*



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**Behavioral Health and Developmental Disabilities
Administration**

**2011–2012 EXTERNAL QUALITY REVIEW
TECHNICAL REPORT**

for

Prepaid Inpatient Health Plans

December 2012



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Purpose of Report

The Balanced Budget Act of 1997 (BBA), Public Law 105-33, requires states to prepare an annual technical report that describes the manner in which data from activities conducted in accordance with 42 Code of Federal Regulations (CFR) 438.358 were aggregated and analyzed. The report must describe how conclusions were drawn as to the quality and timeliness of and access to care furnished by the states' managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs). The report of results must also contain an assessment of the strengths and weaknesses of the PIHPs 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 the following 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 2011–2012 compliance monitoring review was designed to determine the PIHPs’ compliance with their contract and with State and federal regulations through review of performance in eight compliance standards: Performance Measurement and Improvement, Practice Guidelines, Customer Services, Enrollee Rights and Protections, Subcontracts and Delegation, Provider Network, Credentialing, and Coordination of Care. HSAG will assess PIHP’s compliance with the remaining six standards (Quality Assessment and Performance Improvement Program Plan and Structure, Staff Qualifications and Training, Utilization Management, Enrollee Grievance Process, Access and Availability, and Appeals) in the next review cycle.
- ◆ **Validation of performance measures:** HSAG validated the performance measures identified by MDCH to evaluate the accuracy of the rates 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 the 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.

In addition to the three mandatory activities, HSAG conducted an optional activity as well. A summary of the 2010–2011 Coordination of Care/Medical Services Utilization Focused Study is located in Appendix E.

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 II.	Performance Measurement and Improvement	99%	89%	100%	
Standard III.	Practice Guidelines	100%	100%	100%	
Standard VI.	Customer Services	99%	90%	100%	
Standard VIII.	Enrollee Rights and Protections	99%	94%	100%	
Standard IX.	Subcontracts and Delegation	97%	81%	100%	
Standard X.	Provider Network	99%	96%	100%	
Standard XI.	Credentialing	99%	90%	100%	
Standard XIII.	Coordination of Care	98%	88%	100%	
Performance Measure Indicators					
Indicator 4a:	Follow-Up Care	Children	97%	58%	100%
		Adults	98%	88%	100%
Indicator 4b:	Follow-Up Care After Detox		99%	84%	100%
Indicator 6:	Habilitation Supports Waiver (HSW) Rate		89%	40%	99%
Indicator 8:	Competitive Employment	MI Adults	7%	4%	11%
		DD Adults	8%	3%	15%
		MI/DD Adults	8%	4%	17%
Indicator 9:	Earning Minimum Wage	MI Adults	71%	35%	95%
		DD Adults	29%	10%	92%
		MI/DD Adults	38%	12%	89%
Indicator 10†:	Readmission Rate	Children	10%	0%	18%
		Adults	12%	3%	20%
Indicator 13:	Adults with DD living in a private residence		19%	7%	30%
Indicator 14:	Adults with MI living in a private residence		41%	22%	67%
Performance Improvement Projects					
All evaluation elements <i>Met</i>		90%	73%	100%	
Critical elements <i>Met</i>		99%	90%	100%	
† Lower rates are better for this measure. 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. All eight standards included in the 2011–2012 review cycle addressed this domain. PIHP performance was strongest on the Practice Guidelines standard, with a statewide score of 100 percent. Performance on the remaining standards in the **quality** domain was also strong, with statewide scores ranging from 97 percent for the Subcontracts and Delegation standard

to 99 percent for the standards of Performance Measurement and Improvement, Customer Services, Enrollee Rights and Protections, Provider Network, and Credentialing. The statewide score for the Coordination of Care standard was 98 percent.

The PIPs reviewed in this validation cycle addressed the **quality** of services. The PIPs were designed to increase the likelihood of desired mental health outcomes by providing beneficiaries with a peer-delivered service or support. Therefore, for the purposes of the EQR technical report, HSAG assigned the PIPs to the **quality** domain. For this validation cycle of second-year submissions on the PIP topic of *Increasing the Proportion of Medicaid Eligible Adults With a Mental Illness Who Receive Peer-Delivered Services or Supports*, HSAG validated Activities I through IX. Most PIHPs received a validation status of *Met*, demonstrating compliance with the CMS PIP protocol requirements for these activities. The findings indicated that overall, the 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' validation results for performance measures related to **quality** of care and services reflected strong performance as well as improvement in the PIHP's compliance with MDCH specifications, resulting in a higher percentage of rates with a validation finding of *Fully Compliant*. Four of the eight indicators received validation ratings of *Fully Compliant* across all PIHPs: readmission rates, HSW rate, and both indicators for living in a private residence. While the PIHPs demonstrated an improved ability to report data on the employment status of their enrollees, with only two PIHPs receiving a validation status of *Substantially Compliant* for this indicator, complete quality improvement (QI) data for the minimum wage indicator remained a challenge. Seven PIHPs received validation ratings of *Substantially Compliant* for Indicator 9 due to low data completeness, resulting in understated rates. One PIHP received validation ratings of *Substantially Compliant* for the two indicators addressing follow-up care after discharge from a psychiatric inpatient or detox unit. Eleven PIHPs achieved validation findings of *Fully Compliant* for all indicators in the **quality** domain.

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—continued to exceed the minimum performance standard set by MDCH for all indicators in this domain. Statewide rates remained close to their prior-year levels, with changes in most cases of about one percentage point or less. Ten PIHPs met all performance standards in the **quality** domain. MDCH did not specify a minimum performance standard for the remaining indicators in this domain. Rates for competitive employment (Indicator 8) showed slight decreases for all three populations, while minimum wage earners (Indicator 9) had slight increases for DD and MI/DD adults and an almost 4 percent decrease for MI adults when compared to last year's results. The statewide HSW rate (Indicator 6) decreased by six percentage points. Indicators 13 and 14—Living in a Private Residence, were validated for the first time this year.

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 and Improvement		99%	89%	100%
Performance Measure Indicators				
Indicator 1: Preadmission Screening	Children	99%	88%	100%
	Adults	99%	94%	100%
Indicator 2: Face-to-Face Assessment	MI Children	98%	96%	100%
	MI Adults	98%	94%	100%
	DD Children	98%	67%	100%
	DD Adults	99%	94%	100%
	SA	97%	78%	100%
	Total	98%	89%	100%
Indicator 3: First Service	MI Children	96%	80%	100%
	MI Adults	98%	92%	100%
	DD Children	97%	83%	100%
	DD Adults	93%	57%	100%
	SA	98%	80%	100%
	Total	97%	90%	100%
Indicator 4a: Follow-Up Care	Children	97%	58%	100%
	Adults	98%	88%	100%
Indicator 4b: Follow-Up Care After Detox		99%	84%	100%

SA = Medicaid beneficiaries with substance use disorders

Statewide performance on the compliance monitoring standard in the **timeliness** domain was strong, with a statewide score of 99 percent for Performance Measurement and Improvement. Most PIHPs achieved full compliance on this standard.

Timeliness, as addressed by the validation of performance measures, reflected a statewide strength. Sixteen of the 18 PIHPs received validation scores of *Fully Compliant* for all indicators related to **timeliness** of care and services for this validation cycle; one PIHP received validation findings of *Substantially Compliant* for Indicator 2—Face-to-Face Assessment and Indicator 3—First Service, while another PIHP received validation findings of *Substantially Compliant* for Indicators 4a and 4b—Follow-Up Care. Sixteen of the 17 indicators related to **timeliness** of care and services achieved statewide averages that exceeded the minimum performance level as specified by MDCH; only the statewide rate for timeliness of first service for DD adults fell below the 95 percent threshold. The statewide rates for timely preadmission screenings for children and adults, timeliness

of face-to-face assessments or first service (total rates), and follow-up care for beneficiaries discharged from a psychiatric inpatient or detox unit showed little change from their prior-year levels. Excluding rates for subpopulations for Indicators 2 and 3, 11 PIHPs (an increase from nine PIHPs in the previous year) met all minimum performance standards in the **timeliness** domain. Four PIHPs met the minimum performance standards for all indicators, including all subpopulations.

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 VI.	Customer Services		99%	90%	100%
Standard X.	Provider Network		99%	96%	100%
Standard XIII.	Coordination of Care		98%	88%	100%
Performance Measure Indicators					
Indicator 1:	Preadmission Screening	Children	99%	88%	100%
		Adults	99%	94%	100%
Indicator 2:	Face-to-Face Assessment	MI Children	98%	96%	100%
		MI Adults	98%	94%	100%
		DD Children	98%	67%	100%
		DD Adults	99%	94%	100%
		SA	97%	78%	100%
		Total	98%	89%	100%
Indicator 3:	First Service	MI Children	96%	80%	100%
		MI Adults	98%	92%	100%
		DD Children	97%	83%	100%
		DD Adults	93%	57%	100%
		SA	98%	80%	100%
		Total	97%	90%	100%
Indicator 4a:	Follow-Up Care	Children	97%	58%	100%
		Adults	98%	88%	100%
Indicator 4b:	Follow-Up Care After Detox		99%	84%	100%
Indicator 5:	Penetration Rate		7%	4%	9%

Overall, PIHP performance on the compliance monitoring standards in the **access** domain continued to reflect another statewide strength. Statewide scores for the three standards in the **access** domain ranged from a low of 98 percent for the Coordination of Care standard to a high of 99 percent for the Customer Services and Provider Network standards. Most PIHPs achieved full compliance on the standards assessing **access** to care and services.

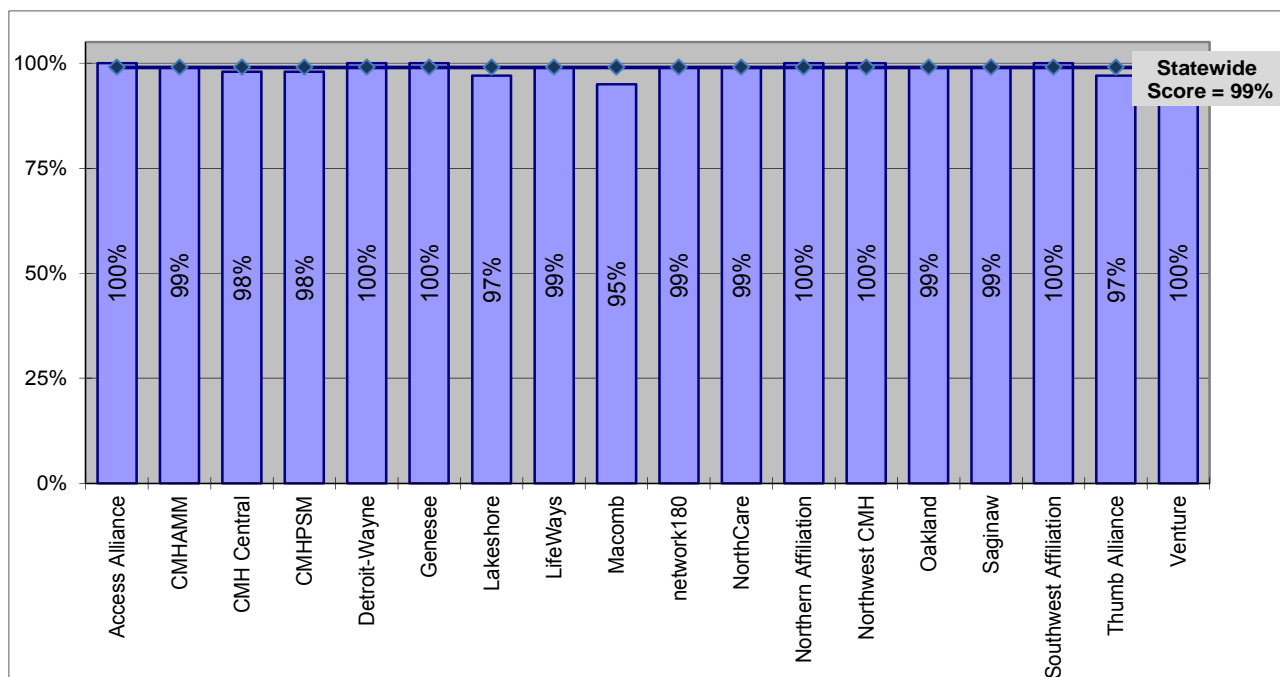
Access, as assessed by the validation of performance measures, indicated a statewide strength. Fifteen PIHPs received a validation score of *Fully Compliant* for all six indicators related to **access** to care and services. In addition to Indicators 2, 3, 4a, and 4b, which received a designation of *Substantially Compliant* for one PIHP each, Indicator 5—Penetration Rate was scored *Substantially Compliant* for one PIHP. Statewide rates continued to exceed the minimum performance standard for all but one of the indicators in this domain, 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. The statewide penetration rate showed a slight increase from the prior-year rate.

Findings for the Compliance Monitoring Reviews

The regulatory provisions addressed in the 2011–2012 compliance monitoring reviews included Performance Improvement (42 CFR 438.240); Practice Guidelines (42 CFR 438.236); Enrollee Rights and Information Requirements (42 CFR 438.100, 438.10, and 438.218); Subcontracts and Delegation (42 CFR 438.230); Provider Network (42 CFR 438.106, 438.12, 438.206, 438.207, and 438.214); Credentialing (42 CFR 438.12 and 438.214); Coordination of Care (42 CFR 438.208); and one standard from the MDCH contract that was not specific to BBA regulations—Customer Services.

The overall compliance rating across all standards for the 18 PIHPs was 99 percent, with individual PIHP scores ranging from 95 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 seven PIHPs receiving overall compliance scores of 100 percent.

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



While the PIHPs demonstrated high levels of compliance with federal and contractual requirements in all areas assessed, performance was strongest on the Practice Guidelines standard, with all 18 PIHPs demonstrating compliance with all requirements.

All 18 PIHPs performed at the *Excellent* level on the Provider Network standard, indicating that the PIHPs maintained a network of providers supported by written agreements that provided adequate access to covered services and had effective processes for the management of their provider networks. Standards with 17 of the 18 PIHPs achieving scores in the *Excellent* range included Performance Measurement and Improvement, Customer Services, Enrollee Rights and Protections, and Credentialing. The PIHPs used standardized performance measures to monitor access to services, efficiency, and outcomes of care. Practice guidelines were adopted, developed, implemented, and disseminated as required. The PIHPs' customer services units demonstrated compliance with contractual standards, facilitating access to services and assisting beneficiaries with the grievance and appeals processes. Overall, beneficiaries received information about their rights and protections and the PIHPs demonstrated adequate processes to ensure that beneficiaries' rights were protected. PIHPs' credentialing policies, procedures, and processes were generally consistent with the State policy.

While most PIHPs achieved full compliance in these areas, there were several recommendations related to the performance improvement process—primarily focusing on the process for review and follow-up on sentinel events, some requirements for providing beneficiaries with information about their rights and services, and parts of the PIHPs' policies and procedures for credentialing. Most of these recommendations applied to only one or two PIHPs.

Coordination of Care and Subcontracts and Delegation were also areas of strong performance, with most PIHPs receiving scores in the *Excellent* range. Overall, policies, procedures, and internal processes demonstrated that the PIHPs maintained adequate oversight of functions delegated to their subcontractors and that the PIHPs had and followed processes for coordinating care with other providers or organizations involved in the beneficiaries' care. For the 2011–2012 review cycle, each of these two standards included a new requirement. Most of the opportunities for improvement on these standards related to these two new elements, which addressed requirements for the PIHPs' review and follow-up on their subcontractors' provider network monitoring and mandated completion of written, functioning coordination agreements with all Medicaid health plans in the PIHP's service area.

Table 1-4 presents the PIHPs’ 2011–2012 compliance monitoring scores (percentage of compliance) on each of the eight standards reviewed as well as an overall compliance score across all eight standards.

PIHP	II. Performance Measurement and Improvement	III. Practice Guidelines	VI. Customer Services	VIII. Enrollee Rights and Protections	IX. Subcontracts and Delegation	X. Provider Network	XI. Credentialing	XIII. Coordination of Care	Overall
Access Alliance	100%	100%	100%	100%	100%	100%	100%	100%	100%
CMHAMM	100%	100%	100%	98%	100%	100%	100%	88%	99%
CMH Central	98%	100%	100%	97%	94%	100%	97%	100%	98%
CMHPSM	99%	100%	100%	100%	91%	100%	95%	100%	98%
Detroit-Wayne	100%	100%	100%	100%	94%	100%	100%	100%	100%
Genesee	100%	100%	100%	99%	NA	100%	100%	100%	100%
Lakeshore	95%	100%	90%	98%	97%	96%	100%	100%	97%
LifeWays	98%	100%	100%	100%	100%	100%	100%	88%	99%
Macomb	89%	100%	100%	100%	94%	96%	90%	100%	95%
network180	100%	100%	100%	99%	81%	100%	100%	100%	99%
NorthCare	100%	100%	100%	98%	100%	100%	99%	100%	99%
Northern Affiliation	100%	100%	100%	100%	100%	98%	100%	100%	100%
Northwest CMH	100%	100%	100%	99%	100%	98%	100%	100%	100%
Oakland	100%	100%	100%	97%	100%	100%	100%	100%	99%
Saginaw	99%	100%	100%	98%	100%	100%	96%	100%	99%
Southwest Affiliation	100%	100%	100%	100%	100%	100%	100%	100%	100%
Thumb Alliance	98%	100%	100%	94%	97%	96%	99%	94%	97%
Venture	100%	100%	100%	100%	100%	100%	99%	100%	100%
Statewide Score	99%	100%	99%	99%	97%	99%	99%	98%	99%

Shaded cells show PIHP performance below the statewide score. NA=Standard not applicable

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

Findings for the Validation of Performance Measures

CMS designed the validation of performance measures activity to ensure the accuracy of the 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 measures for each PIHP for compliance with technical requirements, specifications, and construction. HSAG scored the performance measures as *Fully Compliant* (the PIHP followed the specifications without any deviation), *Substantially Compliant* (some deviation was noted, but the reported rate was not significantly biased), or *Not Valid* (significant deviation from the specifications that resulted in a +/- bias of greater than 5 percent in the final reported rate).

The 18 PIHPs combined reported 216 individual indicators that were calculated in combination by the PIHPs and MDCH, as detailed in Section 2 of this report (Table 2-4). Table 1-5 below presents the validation results.

Table 1-5—Overall Performance Indicator Compliance With MDCH Specifications Across All PIHPs	
Validation Finding	Percent
<i>Fully Compliant (FC)</i>	94%
<i>Substantially Compliant (SC)</i>	6%
<i>Not Valid (NV)</i>	0%

Table 1-6 shows overall PIHP compliance with the MDCH codebook specifications for each of the 12 performance measures validated by HSAG.

Table 1-6—Performance Measure Results—Validation Status				
	Performance Measure Indicator	Percentage of PIHPs		
		FC	SC	NV
1.	Percentage of persons during the quarter receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	100%	0%	0%
2.	Percentage of new persons during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service.	94%	6%	0%
3.	Percentage of new persons during the quarter starting any needed ongoing service within 14 days of a nonemergent face-to-face assessment with a professional.	94%	6%	0%
4a.	Percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within seven days.	94%	6%	0%
4b.	Percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within seven days.	94%	6%	0%

Table 1-6—Performance Measure Results—Validation Status				
	Performance Measure Indicator	Percentage of PIHPs		
		FC	SC	NV
5.	Percentage of Medicaid recipients having received PIHP-managed services (penetration rate).	94%	6%	0%
6.	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 that is not supports coordination (HSW rate).	100%	0%	0%
8.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of dual MI/DD adults served by the PIHP who are in competitive employment.	89%	11%	0%
9.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of dual MI/DD adults served by the PIHP who earned at least minimum wage from any employment activities.	61%	39%	0%
10.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	100%	0%	0%
13.	Percentage of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	100%	0%	0%
14.	Percentage of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	100%	0%	0%

FC = Fully Compliant, SC = Substantially Compliant, NV = Not Valid

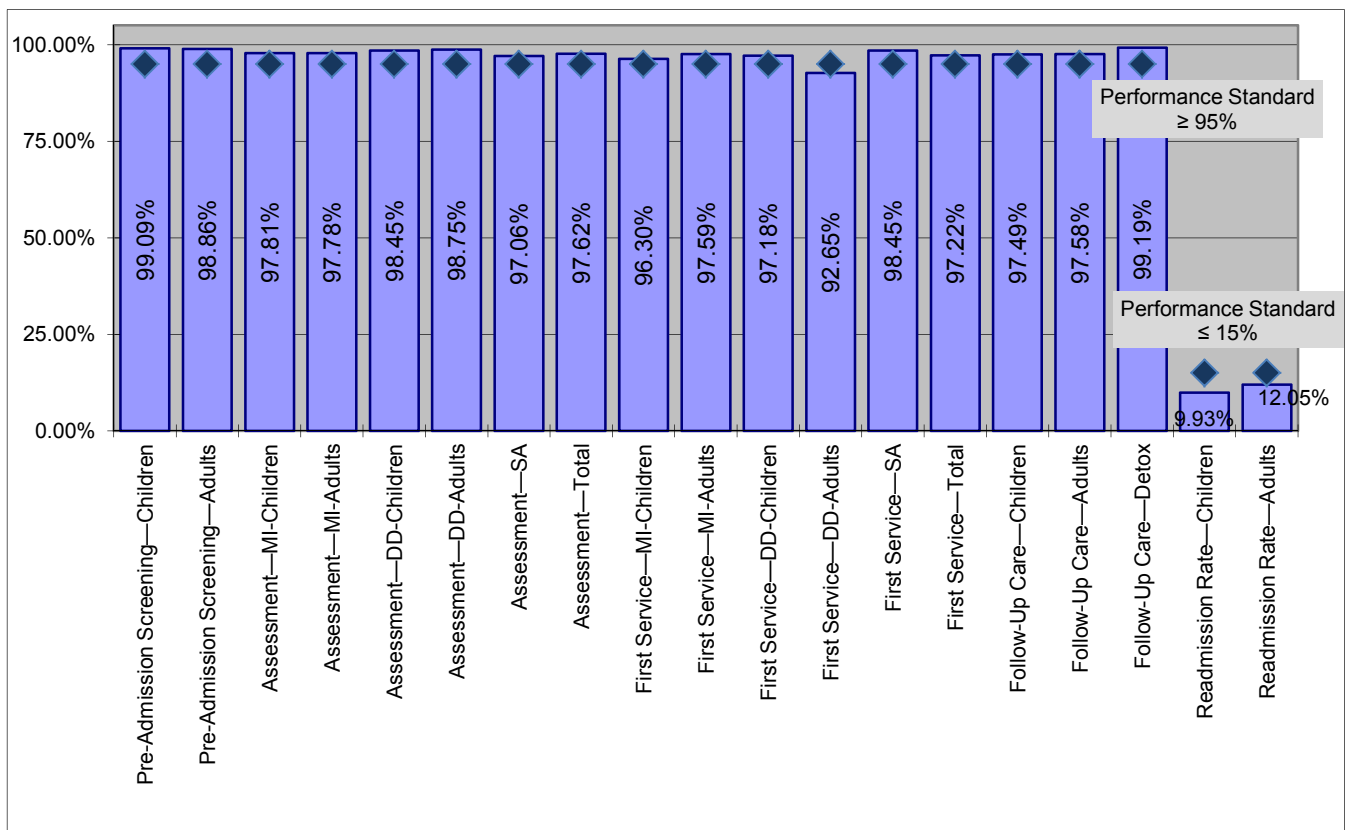
Five of the 12 measures were *Fully Compliant* for all PIHPs. Ten PIHPs received validation findings of *Fully Compliant* for all indicators. Seventeen of the 18 PIHPs received findings of *Fully Compliant* for Indicators 2, 3, 4a, 4b, and 5. Two PIHPs received a score of *Substantially Compliant* for Indicator 8, and seven PIHPs received a validation finding of *Substantially Compliant* for Indicator 9. These results reflect improvement over the prior-year results, as the percentage of *Fully Compliant* rates increased and none of the rates received a validation finding of *Not Valid* for the current validation cycle. The validation results reflected an improved ability of the PIHPs to collect and report complete QI data for beneficiaries’ employment status, and continued challenges to collect data on minimum wage earners. Low levels of data completeness continued to result in some understated rates. Overall, the PIHPs demonstrated compliance with technical requirements and specifications in their collection and reporting of performance indicators.

Accurate data integration, sound data control processes, and complete and detailed documentation of performance indicator calculations continued to be statewide strengths. Evaluation of the PIHPs’ systems for eligibility as well as claims and encounter data reflected that the PIHPs had adequate procedures in place for receiving and processing these data. Oversight of affiliate community mental health centers and coordinating agencies, when applicable, continued to be strong. The PIHPs continued to work closely with MDCH to ensure that any issues with the State’s data system, Community Health Automated Medicaid Processing Systems (CHAMPS), were resolved. Improvements implemented by the PIHPs to increase the quality and completeness of their QI data included the following: automating processes for performance indicator reporting, adding specialized reporting functions to the data system to review and monitor indicators and to identify

any anomalies in the data prior to submission to MDCH; edits in the PIHPs' electronic medical records to support complete and accurate data entry; and continued efforts to automate uniform processes for performance indicator reporting. PIHPs were encouraged to continue detailed documentation of any transition to new data systems, with particular attention to any factors that may impact data accuracy or completeness, and to further refine their systems to enhance tracking and monitoring of indicator performance and QI data completeness.

Statewide rates, as shown in Figure 1-2, 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). Statewide performance exceeded the MDCH-established minimum performance standards for all but one (Timeliness of First Service for DD Adults) of the 19 indicators with MDCH-specified minimum performance standards. MDCH did not specify a standard for Indicators 5, 6, 8, 9, 13, or 14.

Figure 1-2—Statewide Rates for Performance Measures



Continued strong performance resulted in statewide rates that exceeded the MDCH benchmark for all but one of the indicators. Indicator 1—Preadmission Screening for Adults and Children, Indicator 4b—Follow-Up Care After Detox, and Indicator 2d—Face-to-Face Assessment for DD adults showed the highest statewide rates. Indicator 2c—Face-to-Face Assessment for MI Children had the strongest performance, with all PIHPs exceeding the MDCH performance standard. Each of the remaining indicators with MDCH performance standards had at least one PIHP that did not reach the standard.

Table 1-7 and Table 1-8 display the 2011–2012 PIHP results for the validated performance indicators. Most indicators (Indicators 1 through 6 and 10) were reported and validated for the first quarter of State fiscal year (SFY) 2012. Indicators 8, 9, 13, and 14 were reported and validated for SFY 2011.

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 Percentage Scores: Access

PIHP	1. Timeliness/ Inpatient Screening		2. Timeliness/ First Request						3. Timeliness/ First Service						4. Continuity of Care		
	Children	Adults	MI—Children	MI—Adults	DD—Children	DD—Adults	Medicaid SA	Total	MI—Children	MI—Adults	DD—Children	DD—Adults	Medicaid SA	Total	Follow-Up Care—Children	Follow-Up Care—Adults	Follow-Up Care—Detox
Access Alliance	100	99.34	98.96	98.13	100	100	99.40	98.75	97.24	97.74	100	100	100	98.30	100	100	100
CMHAMM	97.37	95.04	99.16	99.51	100	100	97.67	99.00	95.93	96.27	100	85.71	100	96.94	100	100	100
CMH Central	100	100	98.03	98.87	100	100	100	98.77	91.18	97.20	0.00*	90.91	100	95.13	100	100	100
CMHPSM	100	100	100	100	100	100	96.20	99.12	97.75	91.67	100	100	98.75	96.91	96.97	96.30	84.00
Detroit-Wayne	100	98.22	96.26	95.41	98.59	96.83	100	96.80	98.05	97.18	94.12	91.67	100	97.80	98.63	97.56	100
Genesee	100	100	97.89	97.29	100	96.15	91.41	95.67	99.15	97.85	100	96.15	95.29	97.04	100	98.53	100
Lakeshore	100	100	97.54	100	100	100	90.09	95.12	98.81	97.78	100	76.92	98.10	97.51	100	100	100
LifeWays	88.24	99.02	97.62	94.03	100	100	77.63	89.05	79.55	92.31	83.33	57.14	100	90.22	58.33	88.89	100
Macomb	100	100	100	97.96	100	93.55	98.92	98.54	100	96.77	93.10	82.76	100	97.53	100	100	100
network180	96.33	98.25	96.55	97.06	94.74	100	97.20	96.90	91.23	96.90	100	83.33	80.17	90.31	95.56	87.61	100
NorthCare	100	99.33	100	98.81	100	100	100	99.68	97.10	94.03	100	100	100	97.83	88.24	97.62	100
Northern Affiliation	100	98.96	100	100	100	100	100	100	100	95.24	100	100	100	98.60	100	100	100
Northwest CMH	94.12	100	98.82	96.47	100	100	100	98.14	97.14	100	100	100	100	99.06	100	100	100
Oakland	94.19	93.63	98.00	97.30	100	100	100	98.69	99.51	100	100	100	100	99.89	100	99.41	100
Saginaw	100	100	97.78	100	66.67	100	100	97.88	84.62	100	85.71	90.00	98.91	95.24	100	100	100
Southwest Affiliation	96.00	99.29	97.85	99.41	100	100	94.79	97.92	98.62	97.44	100	100	99.00	98.38	89.74	96.94	95.45
Thumb Alliance	100	100	99.16	99.29	100	100	100	99.55	100	100	100	100	100	100	100	100	100
Venture	100	100	97.59	98.51	100	100	95.80	97.86	97.79	98.81	100	100	99.31	98.76	100	98.46	0.00*
Statewide Rate	99.09	98.86	97.81	97.78	98.45	98.75	97.06	97.62	96.30	97.59	97.18	92.65	98.45	97.22	97.49	97.58	99.19
MDCH Standard	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%

Notes: Shaded cells indicate performance not meeting the MDCH minimum performance standard. * There were no applicable cases and the rate was based on a denominator of 0.

Table 1-8—PIHP Performance Measure Percentage Scores: Penetration Rate, HSW Rate, and Outcomes

PIHP	5.	6.	8. Outcomes— Competitive Employment			9. Outcomes— Minimum Wage			10. Outcomes— Inpatient Recidivism		13/14. Outcomes— Private Residence	
	Penetration Rate	HSW Rate	Adults With MI	Adults With DD	Adults With MI/DD	Adults With MI	Adults With DD	Adults With MI/DD	Children	Adults	DD Adults	MI Adults
Access Alliance	9.08	94.13	10.67	9.22	12.41	79.72	36.29	38.84	5.71	10.58	21.04	66.89
CMHAMM	6.45	97.01	8.96	9.03	10.37	77.93	58.27	55.28	6.25	7.69	13.73	49.75
CMH Central	9.35	95.39	10.42	9.45	5.60	82.00	21.55	23.19	18.18	9.38	30.10	62.71
CMHPSM	6.08	44.89	8.22	9.82	9.90	89.62	72.31	88.64	5.26	7.78	24.27	35.89
Detroit-Wayne	7.16	96.77	4.26	2.89	3.90	58.72	12.87	31.37	11.78	12.61	22.86	21.56
Genesee	7.08	97.60	4.73	6.65	4.89	64.23	16.00	20.93	10.20	11.28	7.58	46.83
Lakeshore	3.60	98.74	8.04	9.32	8.42	77.33	28.92	28.13	0.00	5.71	10.96	60.31
LifeWays	7.17	92.69	4.69	8.70	4.61	80.39	91.67	66.67	15.38	16.67	12.63	39.91
Macomb	5.85	98.77	7.08	5.86	4.40	51.55	37.42	37.70	11.34	18.42	18.15	36.32
network180	6.63	99.40	8.68	8.25	10.17	75.87	21.02	25.21	4.08	20.30	11.61	51.46
NorthCare	7.51	97.75	10.19	5.95	5.86	73.27	31.23	41.11	17.39	20.45	17.83	58.11
Northern Affiliation	6.69	95.36	7.71	15.48	17.35	57.32	43.98	62.79	8.33	7.41	23.80	57.20
Northwest CMH	7.66	95.05	9.58	9.50	8.43	94.55	52.27	78.40	17.65	12.73	7.39	58.80
Oakland	7.78	98.94	8.10	12.70	8.92	61.76	34.68	23.39	8.00	10.80	17.66	34.18
Saginaw	5.59	97.48	6.01	11.65	6.78	84.31	21.43	30.77	11.11	3.03	9.87	34.85
Southwest Affiliation	7.15	40.26	9.09	11.45	9.56	82.89	42.57	58.18	10.87	6.19	19.47	59.31
Thumb Alliance	8.02	98.95	8.19	3.93	3.72	35.38	9.69	12.23	8.33	12.05	15.84	56.65
Venture	6.92	96.28	11.03	9.29	6.27	81.29	42.16	47.62	0.00	6.90	13.59	50.64
Statewide Rate	6.95	88.81	7.30	7.65	7.74	71.30	28.81	38.43	9.93	12.05	18.63	41.32
MDCH Standard	NA	NA	NA	NA	NA	NA	NA	NA	≤15%	≤15%	NA	NA

Notes: Shaded cells indicate performance not meeting the MDCH minimum performance standard.

Findings for the Validation of Performance Improvement Projects

For each PIHP, HSAG validated one PIP based on CMS’ protocol. For the current validation cycle, the PIHPs continued with the State-mandated study topic, *Increasing the Proportion of Medicaid Eligible Adults With a Mental Illness Who Receive Peer-Delivered Services or Supports*. Table 1-9 presents a summary of the PIPs’ validation status results. For this second-year submission, 83 percent (15 of 18) of the PIPs received a *Met* validation status.

Validation Status	Number of PIHPs
<i>Met</i>	15
<i>Partially Met</i>	2
<i>Not Met</i>	1

Table 1-10 presents a statewide summary of the PIHPs’ validation results for each of the CMS PIP protocol activities. HSAG validated Activities I through IX for all 18 PIPs. Since this was a second-year submission, none of the PIPs had progressed to Activity X—Assess for Sustained Improvement. All PIPs received a rating of *Not Applicable* for all elements in Activity V and for the critical element in Activity VI, as the PIHPs did not use sampling or manual data collection.

Review Activity		Number of PIPs Meeting All Evaluation Elements/ Number Reviewed	Number of PIPs Meeting All Critical Elements/ Number Reviewed
I.	Select the Study Topic(s)	17/18	18/18
II.	Define the Study Question(s)	18/18	18/18
III.	Select the Study Indicator(s)	18/18	18/18
IV.	Use a Representative and Generalizable Study Population	17/18	17/18
V.	Use Sound Sampling Techniques*	NA	NA
VI.	Reliably Collect Data	16/18	NA
VII.	Implement Intervention and Improvement Strategies	15/18	18/18
VIII.	Analyze Data and Interpret Study Results	7/18	18/18
IX.	Assess for Real Improvement	7/18	No Critical Elements
X.	Assess for Sustained Improvement	0/0	No Critical Elements

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

The PIHPs demonstrated high levels of compliance with CMS PIP protocol requirements for Activities I through VII. The PIPs on the state-mandated study topic included well-designed study questions and study indicators, as well as accurately defined study populations. The PIP submissions detailed the data collection processes and data analysis plans and presented the

intervention and improvement strategies designed to increase the proportion of Medicaid eligible adults with a mental illness receiving peer-delivered services and supports. In the second year of this PIP, the PIHPs progressed to reporting first remeasurement data and conducted data analysis and interpretation of results according to the data analysis plan outlined in the PIP. The PIHPs documented whether or not there were factors that threatened internal or external validity of the findings and that there were no changes to the study’s methodology. While most PIHPs included an interpretation of their findings, about one-third of the PIHPs received recommendations related to presenting accurate and easily understood results, identifying statistical differences between the initial and remeasurement findings, and discussing any factors that affect the ability to compare the results. While about two-thirds of the studies demonstrated that the interventions resulted in improvement in the outcomes of care, fewer than half of the PIHPs achieved statistically significant improvements in the study indicators. As the PIPs progress to Activity X, the next validation will assesses for real and sustained improvement in the study indicators.

Table 1-11 presents the results of the 2011–2012 PIP validation.

Table 1-11—PIP Validation Results by PIHP			
PIHP	% of All Elements Met	% of All Critical Elements Met	Validation Status
Access Alliance	82%	100%	<i>Met</i>
CMHAMM	91%	100%	<i>Met</i>
CMH Central	94%	100%	<i>Met</i>
CMHPSM	94%	100%	<i>Met</i>
Detroit-Wayne	100%	100%	<i>Met</i>
Genesee	91%	100%	<i>Met</i>
Lakeshore	100%	100%	<i>Met</i>
LifeWays	82%	100%	<i>Met</i>
Macomb	73%	100%	<i>Partially Met</i>
network180	91%	100%	<i>Met</i>
NorthCare	88%	100%	<i>Met</i>
Northern Affiliation	100%	100%	<i>Met</i>
Northwest CMH	91%	100%	<i>Met</i>
Oakland	91%	100%	<i>Met</i>
Saginaw	76%	100%	<i>Partially Met</i>
Southwest Affiliation	100%	100%	<i>Met</i>
Thumb Alliance	73%	90%	<i>Not Met</i>
Venture	97%	100%	<i>Met</i>

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 2011–2012 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 review reflected high levels of compliance across all eight standards included in the 2011–2012 review cycle. The findings indicated that overall, the PIHPs demonstrated compliance with the federal and State requirements in all areas assessed.

Results from the validation of performance measures reflected increased compliance with technical requirements and specifications in the collection and reporting of performance indicators, particularly for some QI data elements. The PIHPs' rates continued to meet or exceed the MDCH-specified thresholds, with fewer than 15 percent of the individual rates failing to meet the minimum performance standard, and all but one of the statewide rates exceeded the respective MDCH benchmark.

For the second validation cycle for the PIP on increasing the proportion of Medicaid eligible adults with a mental illness who receive peer-delivered services or supports, HSAG validated Activities I through IX. The PIHPs demonstrated high levels of compliance with the requirements of the CMS PIP protocol for Activities I through VII. The validation identified opportunities for improvement for most PIPs in Activity VIII—Analyze Data and Interpret Study Results and Activity IX—Assess for Real Improvement. The results of the 2011–2012 validation suggest that the PIHPs designed and implemented PIPs intended to improve care and service outcomes for Medicaid beneficiaries.

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

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 2011–2012 compliance monitoring reviews evaluated the PIHPs' compliance with federal and State regulations and with contractual requirements related to the following standards:

- ◆ Standard II. Performance Measurement and Improvement
- ◆ Standard III. Practice Guidelines
- ◆ Standard VI. Customer Services
- ◆ Standard VIII. Enrollee Rights and Protections
- ◆ Standard IX. Subcontracts and Delegation
- ◆ Standard X. Provider Network
- ◆ Standard XI. Credentialing
- ◆ Standard XIII. Coordination of Care

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.

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 each of the PIHP reviews in 2011–2012, 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 submitted by the PIHPs: the *Desk Audit Form* describing the PIHP's structure, processes, and operational practices related to the areas assessed; the comprehensive EQR compliance review tool—*Documentation Request and Evaluation Tool*—that was adapted from EQR protocols; and PIHP documents (policies, member materials, subcontracts, etc.) to demonstrate compliance with each requirement in the tool. The focus of the desk review was to identify compliance with the BBA and MDCH contractual rules and regulations.
- ◆ **Compliance Monitoring Reviews:** The 2011–2012 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. The on-site reviews included an entrance conference, document reviews using the HSAG compliance monitoring 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 degree of compliance for each of the standards and elements included in the review and a closing statement at the end of the call.
- ◆ **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 Quality Assessment and Performance Improvement Program (QAPI) plan, work plan, and annual evaluation.
- ◆ Management/monitoring reports.
- ◆ 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.

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	State Fiscal Year (SFY) 2011 to Date of Review
Information From Interviews Conducted	State Fiscal Year (SFY) 2011 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. Based on the evaluation of findings, reviewers noted compliance with each element. The compliance monitoring tool listed the score for each element evaluated.

HSAG evaluated each element addressed in the compliance monitoring review and applied one of the following scores:

- ◆ *Met (M)*
- ◆ *Substantially Met (SM)*
- ◆ *Partially Met (PM)*
- ◆ *Not Met (NM)*
- ◆ *Not Applicable (NA)*

HSAG determined the overall score for each of the eight standards by totaling the number of *Met* elements (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, 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
II.	Performance Measurement and Improvement	✓	✓	
III.	Practice Guidelines	✓		
VI.	Customer Services	✓		✓
VIII.	Enrollee Rights and Protections	✓		
IX.	Subcontracts and Delegation	✓		
X.	Provider Network	✓		✓
XI.	Credentialing	✓		
XIII.	Coordination of Care	✓		✓

Validation of Performance Measures

Objectives

As set forth in 42 CFR 438.358, the validation of performance measures was one of the mandatory EQR activities. The primary objectives of the performance measure validation activities 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 and selected by MDCH for validation. Each PIHP collected and reported six of these indicators quarterly, with the remaining six calculated by MDCH. The majority of the performance indicators were reported and validated for the first quarter of the Michigan SFY 2012, as shown in Table 2-4.

Technical Methods of Data Collection and Analysis

HSAG conducted the performance measure validation activities 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 worksheets derived from Attachment I of the CMS performance measure validation protocol.
 - HSAG prepared a documentation request, which included the Information Systems Capabilities Assessment Tool (ISCAT), Appendix Z of the CMS performance measure validation protocol, PMV activity timeline, list of performance indicators selected by MDCH for validation, and helpful tips for ISCAT completion. 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 with each PIHP. Information was collected using several methods, including interviews, systems demonstrations, 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 measure validation activities. The review purpose, 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 rates were calculated 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 the 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 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 conducted 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, 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 accuracy of the output files. Supporting documentation for the PIHP's data integration processes was reviewed and data control and security procedures were addressed during this session.
 - e. **Closing conference**—summarized preliminary findings based on ISCAT review and on-site visit findings. During the conference, the list of outstanding documentation was reviewed along with the remaining steps and timeline for completion of the performance measure validation 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.** 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 source code from each PIHP (if applicable) and MDCH (for the indicators calculated by MDCH). If the PIHP did not produce source code to generate the performance indicators, they submitted a description of the steps taken for measure calculation from the point the service was rendered through the final calculation process. HSAG reviewed the source code or process description to determine compliance with the performance indicator specifications provided by MDCH.
- ◆ **Previous Performance Measure Results Reports.** HSAG obtained these reports from MDCH 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 onsite systems demonstrations.

Table 2-3 displays the data sources HSAG obtained for the validation of performance measures activities 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 and mini-ISCAT(s), if applicable (From PIHPs)	SFY 2011
Source Code/Programming Language for Performance Measures (From PIHPs and MDCH) or Description of the Performance Measure Calculation Process (From PIHPs)	SFY 2011
Previous Performance Measure Results Reports (From MDCH)	SFY 2011
Performance Measure Results (From PIHPs and MDCH)	First Quarter of SFY 2012
Supporting Documentation (From PIHPs and MDCH)	SFY 2011
On-site Interviews and Systems Demonstrations (From PIHPs and MDCH)	During site visit

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.	The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours (by two sub-populations: children and adults).	PIHP	First Quarter SFY 2012
2.	The percentage of new persons during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service (by five sub-populations: MI-adults, MI-children, DD-adults, DD-children, and persons with Substance Use Disorders).	PIHP	First Quarter SFY 2012
3.	Percentage of new persons during the quarter starting any needed ongoing service within 14 days of a non-emergent face-to-face assessment with a professional (by five sub-populations: MI-adults, MI-children, DD-adults, DD-children, and persons with Substance Use Disorders).	PIHP	First Quarter SFY 2012
4a.	The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.	PIHP	First Quarter SFY 2012
4b.	The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.	PIHP	First Quarter SFY 2012
5.	The percentage of Medicaid recipients having received PIHP managed services (MI adults, MI children, DD adults, DD children, and SA).	MDCH	First Quarter SFY 2012
6.	The percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	MDCH	First Quarter SFY 2012
8.	The percentage of adults with mental illness, the percent of adults with developmental disabilities, and the percent of dual MI/DD adults served by the CMHSP who are in competitive employment.	MDCH	SFY 2011
9.	The percentage of adults with mental illness, the percent of adults with developmental disabilities, and the percent of dual MI/DD adults served by the CMHSP who earn minimum wage or more from employment activities.	MDCH	SFY 2011
10.	The percentage of MI and DD children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	PIHP	First Quarter SFY 2012
13.	The percentage of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	MDCH	SFY 2011
14.	The percentage of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	MDCH	SFY 2011

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 assigned 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 validation review findings, which included 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.

	Indicator	Quality	Timeliness	Access
1.	The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.		✓	✓
2.	The percentage of new persons during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service.		✓	✓
3.	Percentage of new persons during the quarter starting any needed ongoing service within 14 days of a non-emergent face-to-face assessment with a professional.		✓	✓
4a.	The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.	✓	✓	✓
4b.	The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.	✓	✓	✓
5.	The percentage of Medicaid recipients having received PIHP managed services.			✓
6.	The percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	✓		
8.	The percentage of adults with mental illness, the percent of adults with developmental disabilities, and the percent of dual MI/DD adults served by the CMHSP who are in competitive employment.	✓		

Table 2-5—Assignment of Performance Measures to Performance Domains				
	Indicator	Quality	Timeliness	Access
9.	The percentage of adults with mental illness, the percent of adults with developmental disabilities, and the percent of dual MI/DD adults served by the CMHSP who earn minimum wage or more from employment activities.	✓		
10.	The percentage of MI and DD children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	✓		
13.	The percentage of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	✓		
14.	The percentage of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	✓		

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 2011–2012 validation cycle, all PIHPs continued with the statewide PIP on increasing the proportion of Medicaid eligible adults with a mental illness who receive peer-delivered services or supports. HSAG provided technical assistance to the PIHPs as requested. The technical assistance sessions provided an opportunity for the PIHPs to ask questions and obtain assistance for conducting a successful PIP. For the 2011–2012 validation cycle, HSAG provided technical assistance to four PIHPs prior to the submission of the PIPs for validation, and to three PIHPs after the PIPs had been submitted.

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 evaluated each of the PIPs according to the CMS protocols. The CMS protocols identify 10 activities that should be validated for each PIP, although in some cases the PIP may not have progressed to the point where all of the activities can be validated.

These activities are:

- ◆ Activity I. Select the Study Topic(s)
- ◆ Activity II. Define the Study Question(s)
- ◆ Activity III. Select the Study Indicator(s)
- ◆ Activity IV. Use a Representative and Generalizable Study Population
- ◆ Activity V. Use Sound Sampling Techniques
- ◆ Activity VI. Reliably Collect Data
- ◆ Activity VII. Implement Intervention and Improvement Strategies
- ◆ Activity VIII. Analyze Data and Interpret Study Results
- ◆ Activity IX. Assess for Real Improvement
- ◆ Activity 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 activities reviewed and evaluated. Table 2-6 presents the source from which HSAG obtained the data and the time period to 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 2012

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 activity 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 Activity V, if the PIP did not use sampling techniques, HSAG would score the evaluation elements in Activity V as *Not Applicable*. HSAG used the *Not Assessed* scoring designation when the PIP had not progressed to the remaining activities 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 and to draw conclusions about the PIHP’s performance in the domains of quality, timeliness, and access to care and services. The *Increasing the Proportion of Medicaid Eligible Adults With a Mental Illness Who Receive Peer-Delivered Services or Supports* PIP addressed CMS’ requirements related to quality outcomes—specifically, quality of care and services. The goal of the PIP was to improve the quality of care and services by increasing the proportion of adult beneficiaries with a mental illness who received peer-delivered services or supports; therefore, HSAG assigned the PIPs to the quality domain as depicted in Table 2-7.

Table 2-7—Assignment of PIPs to Performance Domains			
Topic	Quality	Timeliness	Access
<i>Increasing the Proportion of Medicaid Eligible Adults With a Mental Illness Who Receive Peer-Delivered Services or Supports</i>	✓		

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 2011–2012 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 2011–2012 compliance monitoring reviews. These reviews evaluated the PIHPs’ compliance with federal and State regulations and contractual requirements related to the following eight standards: Performance Measurement and Improvement, Practice Guidelines, Customer Services, Enrollee Rights and Protections, Subcontracts and Delegation, Provider Network, Credentialing, and Coordination of Care.

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

Standard		Quality	Timeliness	Access
II.	Performance Measurement and Improvement	✓	✓	
III.	Practice Guidelines	✓		
VI.	Customer Services	✓		✓
VIII.	Enrollee Rights and Protections	✓		
IX.	Subcontracts and Delegation	✓		
X.	Provider Network	✓		✓
XI.	Credentialing	✓		
XIII.	Coordination of Care	✓		✓

Access Alliance of Michigan

Compliance Monitoring Results

Table 3-2 presents the results from the 2011–2012 compliance monitoring review, 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 a compliance score for each of the standards and an overall compliance score across all standards. The 2011–2012 External Quality Review Compliance Monitoring Report for **Access Alliance of Michigan** contains a more detailed description of the results.

Table 3-2—Summary of Scores for the Standards									
Standard	Total Elements	Total Applicable Elements	Number of Elements					Total Compliance Score	
			<i>M</i>	<i>SM</i>	<i>PM</i>	<i>NM</i>	<i>NA</i>		
II.	Performance Measurement and Improvement	21	21	21	0	0	0	0	100%
III.	Practice Guidelines	14	14	14	0	0	0	0	100%
VI.	Customer Services	10	10	10	0	0	0	0	100%
VIII.	Enrollee Rights and Protections	34	32	32	0	0	0	2	100%
IX.	Subcontracts and Delegation	8	8	8	0	0	0	0	100%
X.	Provider Network	12	12	12	0	0	0	0	100%
XI.	Credentialing	25	24	24	0	0	0	1	100%
XIII.	Coordination of Care	4	4	4	0	0	0	0	100%
	Overall	128	125	125	0	0	0	3	100%

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

Total Elements: The total number of elements in each standard.

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

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

Strengths

Access Alliance of Michigan received an overall compliance score of 100 percent across the eight standards reviewed. The PIHP achieved 100 percent compliance on all eight standards: *Performance Measurement and Improvement*, *Practice Guidelines*, *Customer Services*, *Enrollee Rights and Protections*, *Subcontracts and Delegation*, *Provider Network*, *Credentialing*, and *Coordination of Care*.

Recommendations

The 2011–2012 compliance review for **Access Alliance of Michigan** did not result in any recommendations for improvement as the PIHP demonstrated compliance with all requirements.

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 PIHP achieved full compliance on all standards across the three domains.

CMH Affiliation of Mid-Michigan

Compliance Monitoring Results

Table 3-3 presents the results from the 2011–2012 compliance monitoring review, 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 a compliance score for each of the standards and an overall compliance score across all standards. The 2011–2012 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 Scores for the Standards									
Standard		Total Elements	Total Applicable Elements	Number of Elements					Total Compliance Score
				<i>M</i>	<i>SM</i>	<i>PM</i>	<i>NM</i>	<i>NA</i>	
II.	Performance Measurement and Improvement	21	21	21	0	0	0	0	100%
III.	Practice Guidelines	14	14	14	0	0	0	0	100%
VI.	Customer Services	10	10	10	0	0	0	0	100%
VIII.	Enrollee Rights and Protections	34	32	31	0	1	0	2	98%
IX.	Subcontracts and Delegation	8	8	8	0	0	0	0	100%
X.	Provider Network	12	12	12	0	0	0	0	100%
XI.	Credentialing	25	24	24	0	0	0	1	100%
XIII.	Coordination of Care	4	4	3	0	1	0	0	88%
Overall		128	125	123	0	2	0	3	99%

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

Total Elements: The total number of elements in each standard.

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

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

Strengths

CMH Affiliation of Mid-Michigan received an overall compliance score of 99 percent across the eight standards reviewed. The PIHP achieved 100 percent compliance on six standards: *Performance Measurement and Improvement*, *Practice Guidelines*, *Customer Services*, *Subcontracts and Delegation*, *Provider Network*, and *Credentialing*. **CMH Affiliation of Mid-Michigan** also demonstrated strong performance on the standards of *Enrollee Rights and Protections* and *Coordination of Care*.

Recommendations

Recommendations for improving **CMH Affiliation of Mid-Michigan**'s performance addressed *Enrollee Rights and Protections* and *Coordination of Care*. The PIHP should ensure that—within reasonable time after enrollment—beneficiaries receive all required information about their rights and services. **CMH Affiliation of Mid-Michigan** should monitor and ensure that each affiliate maintains written, functioning coordination agreements with each Medicaid health plan serving in any part of an affiliate's service area.

Summary Assessment Related to Quality, Timeliness, and Access

CMH Affiliation of Mid-Michigan demonstrated strong performance across the three domains of **quality**, **timeliness**, and **access**. The PIHP achieved full compliance on six of the eight standards in the **quality** domain. Performance in the **access** domain was also strong, with full compliance on two of three standards. **CMH Affiliation of Mid-Michigan** achieved 100 percent compliance on the one standard addressing the **timeliness** domain.

CMH for Central Michigan

Compliance Monitoring Results

Table 3-4 presents the results from the 2011–2012 compliance monitoring review, 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 a compliance score for each of the standards and an overall compliance score across all standards. The 2011–2012 External Quality Review Compliance Monitoring Report for **CMH for Central Michigan** contains a more detailed description of the results.

Table 3-4—Summary of Scores for the Standards									
Standard		Total Elements	Total Applicable Elements	Number of Elements					Total Compliance Score
				<i>M</i>	<i>SM</i>	<i>PM</i>	<i>NM</i>	<i>NA</i>	
II.	Performance Measurement and Improvement	21	21	19	2	0	0	0	98%
III.	Practice Guidelines	14	14	14	0	0	0	0	100%
VI.	Customer Services	10	10	10	0	0	0	0	100%
VIII.	Enrollee Rights and Protections	34	32	30	0	2	0	2	97%
IX.	Subcontracts and Delegation	8	8	7	0	1	0	0	94%
X.	Provider Network	12	12	12	0	0	0	0	100%
XI.	Credentialing	25	25	23	1	1	0	0	97%
XIII.	Coordination of Care	4	4	4	0	0	0	0	100%
Overall		128	126	119	3	4	0	2	98%

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

Total Elements: The total number of elements in each standard.

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

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

Strengths

CMH for Central Michigan received an overall compliance score of 98 percent across the eight standards reviewed. The PIHP achieved 100 percent compliance on four standards: *Practice Guidelines*, *Customer Services*, *Provider Network*, and *Coordination of Care*. **CMH for Central Michigan** also demonstrated strong performance on the standards of *Performance Measurement and Improvement*, *Enrollee Rights and Protections*, *Subcontracts and Delegation*, and *Credentialing*.

Recommendations

Recommendations for improving **CMH for Central Michigan**'s performance addressed *Performance Measurement and Improvement, Enrollee Rights and Protections, Subcontracts and Delegation, and Credentialing*. The PIHP should implement the revised sentinel policy and ensure that all network providers are made aware of the policy changes. **CMH for Central Michigan** should ensure compliance with the requirements for timely, written notice of termination of a contracted provider to each affected enrollee and develop and implement a process for review of and follow-up on any provider network monitoring of its subcontractors. The PIHP should revise its credentialing and recredentialing policies, procedures, and processes to comply with the requirements related to provider discrimination and initial credentialing.

Summary Assessment Related to Quality, Timeliness, and Access

CMH for Central Michigan demonstrated mixed performance across the three domains of **quality**, **timeliness**, and **access**. The PIHP demonstrated its strongest performance in the **access** domain, achieving full compliance on all standards. Performance in the **quality** domain was not as strong, with full compliance on four of the eight standards in this domain. The PIHP received recommendations for improvement on the standard addressing the **timeliness** domain.

CMH Partnership of Southeastern Michigan

Compliance Monitoring Results

Table 3-5 presents the results from the 2011–2012 compliance monitoring review, 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 a compliance score for each of the standards and an overall compliance score across all standards. The 2011–2012 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 Scores for the Standards									
Standard		Total Elements	Total Applicable Elements	Number of Elements					Total Compliance Score
				<i>M</i>	<i>SM</i>	<i>PM</i>	<i>NM</i>	<i>NA</i>	
II.	Performance Measurement and Improvement	21	21	20	1	0	0	0	99%
III.	Practice Guidelines	14	14	14	0	0	0	0	100%
VI.	Customer Services	10	10	10	0	0	0	0	100%
VIII.	Enrollee Rights and Protections	34	34	34	0	0	0	0	100%
IX.	Subcontracts and Delegation	8	8	6	1	1	0	0	91%
X.	Provider Network	12	12	12	0	0	0	0	100%
XI.	Credentialing	25	25	21	3	1	0	0	95%
XIII.	Coordination of Care	4	4	4	0	0	0	0	100%
Overall		128	128	121	5	2	0	0	98%

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

Total Elements: The total number of elements in each standard.

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

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

Strengths

CMH Partnership of Southeastern Michigan received an overall compliance score of 98 percent across the eight standards reviewed. The PIHP achieved 100 percent compliance on five standards: *Practice Guidelines*, *Customer Services*, *Enrollee Rights and Protections*, *Provider Network*, and *Coordination of Care*. **CMH Partnership of Southeastern Michigan** also demonstrated strong performance on the standards of *Performance Measurement and Improvement*, *Subcontracts and Delegation*, and *Credentialing*.

Recommendations

Recommendations for improving **CMH Partnership of Southeastern Michigan**'s performance addressed *Performance Measurement and Improvement*, *Subcontracts and Delegation*, and *Credentialing*. The PIHP should revise its Sentinel Events and Report and Review of Recipient Death policies to incorporate all related contract requirements and consider cross-referencing the policies. **CMH Partnership of Southeastern Michigan** should ensure that its written agreements include provisions for revoking delegation if the subcontractor's performance is inadequate. The PIHP should finalize and implement the process for review and follow-up on provider network monitoring of all its subcontractors. **CMH Partnership of Southeastern Michigan** should revise its credentialing and recredentialing policies and processes to ensure network compliance with federal requirements that prohibit employment or contracts with providers excluded from participation under either Medicare or Medicaid. The revised policies should reflect the applicable changes in administrative staff responsibilities resulting from the PIHP's reorganization and ensure that contracts or subcontracts with organizational providers require them to credential and recredential their directly employed and subcontracted direct-service providers in accordance with the PIHP's policies and procedures.

Summary Assessment Related to Quality, Timeliness, and Access

CMH Partnership of Southeastern Michigan demonstrated strong performance across the three domains of **quality**, **timeliness**, and **access**. The PIHP demonstrated its strongest performance in the **access** domain, achieving full compliance on all standards. Performance in the **quality** domain was not as strong, with full compliance on five of the eight standards in this domain. The PIHP received a recommendation for improvement on the standard addressing the **timeliness** domain.

Detroit-Wayne County CMH Agency

Compliance Monitoring Results

Table 3-6 presents the results from the 2011–2012 compliance monitoring review, 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 a compliance score for each of the standards and an overall compliance score across all standards. The 2011–2012 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 Scores for the Standards									
Standard		Total Elements	Total Applicable Elements	Number of Elements					Total Compliance Score
				<i>M</i>	<i>SM</i>	<i>PM</i>	<i>NM</i>	<i>NA</i>	
II.	Performance Measurement and Improvement	21	21	21	0	0	0	0	100%
III.	Practice Guidelines	14	14	14	0	0	0	0	100%
VI.	Customer Services	10	10	10	0	0	0	0	100%
VIII.	Enrollee Rights and Protections	34	32	32	0	0	0	2	100%
IX.	Subcontracts and Delegation	8	8	7	0	1	0	0	94%
X.	Provider Network	12	12	12	0	0	0	0	100%
XI.	Credentialing	25	25	25	0	0	0	0	100%
XIII.	Coordination of Care	4	4	4	0	0	0	0	100%
Overall		128	126	125	0	1	0	2	100%

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

Total Elements: The total number of elements in each standard.

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

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

Strengths

Detroit-Wayne County CMH Agency received an overall compliance score of 100 percent across the eight standards reviewed. The PIHP achieved 100 percent compliance on seven standards: *Performance Measurement and Improvement*, *Practice Guidelines*, *Customer Services*, *Enrollee Rights and Protections*, *Provider Network*, *Credentialing*, and *Coordination of Care*. **Detroit-Wayne County CMH Agency** also demonstrated strong performance on the *Subcontracts and Delegation* standard.

Recommendations

The recommendation for improving **Detroit-Wayne County CMH Agency's** performance addressed *Subcontracts and Delegation*. The PIHP should ensure that its written agreements include provisions for revoking delegations if the subcontractor's performance is inadequate.

Summary Assessment Related to Quality, Timeliness, and Access

Detroit-Wayne County CMH Agency demonstrated excellent performance across the three domains of **quality**, **timeliness**, and **access**. The PIHP demonstrated its strongest performance in the **timeliness** and **access** domains, achieving full compliance on all standards. Performance in the **quality** domain was also strong, with full compliance on seven of the eight standards in this domain.

Genesee County CMH

Compliance Monitoring Results

Table 3-7 presents the results from the 2011–2012 compliance monitoring review, 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 a compliance score for each of the standards and an overall compliance score across all standards. The 2011–2012 External Quality Review Compliance Monitoring Report for **Genesee County CMH** contains a more detailed description of the results.

Table 3-7—Summary of Scores for the Standards									
Standard		Total Elements	Total Applicable Elements	Number of Elements					Total Compliance Score
				<i>M</i>	<i>SM</i>	<i>PM</i>	<i>NM</i>	<i>NA</i>	
II.	Performance Measurement and Improvement	21	21	21	0	0	0	0	100%
III.	Practice Guidelines	14	14	14	0	0	0	0	100%
VI.	Customer Services	10	10	10	0	0	0	0	100%
VIII.	Enrollee Rights and Protections	34	32	31	1	0	0	2	99%
IX.	Subcontracts and Delegation	8	0	0	0	0	0	8	N/A
X.	Provider Network	12	12	12	0	0	0	0	100%
XI.	Credentialing	25	23	23	0	0	0	2	100%
XIII.	Coordination of Care	4	4	4	0	0	0	0	100%
Overall		128	116	115	1	0	0	12	100%

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

Total Elements: The total number of elements in each standard.

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

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

Strengths

Genesee County CMH received an overall compliance score of 100 percent across the eight standards reviewed. The PIHP achieved 100 percent compliance on six standards: *Performance Measurement and Improvement*, *Practice Guidelines*, *Customer Services*, *Provider Network*, *Credentialing*, and *Coordination of Care*. The *Subcontracts and Delegation* standard was scored *Not Applicable* as the PIHP did not delegate any functions. **Genesee County CMH** also demonstrated strong performance on the *Enrollee Rights and Protections* standard.

Recommendations

The recommendation for improving **Genesee County CMH**'s performance addressed *Enrollee Rights and Protections*. The PIHP should revise its Provider Relations Contractor Termination Guideline to clearly state the requirement to make 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.

Summary Assessment Related to Quality, Timeliness, and Access

Genesee County CMH demonstrated excellent performance across the three domains of **quality**, **timeliness**, and **access**. The PIHP demonstrated its strongest performance in the **timeliness** and **access** domains, achieving full compliance on all standards. Performance in the **quality** domain was also strong, with full compliance on six of the seven applicable standards in this domain.

Lakeshore Behavioral Health Alliance

Compliance Monitoring Results

Table 3-8 presents the results from the 2011–2012 compliance monitoring review, 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 a compliance score for each of the standards and an overall compliance score across all standards. The 2011–2012 External Quality Review Compliance Monitoring Report for **Lakeshore Behavioral Health Alliance** contains a more detailed description of the results.

Table 3-8—Summary of Scores for the Standards									
Standard		Total Elements	Total Applicable Elements	Number of Elements					Total Compliance Score
				<i>M</i>	<i>SM</i>	<i>PM</i>	<i>NM</i>	<i>NA</i>	
II.	Performance Measurement and Improvement	21	21	19	0	2	0	0	95%
III.	Practice Guidelines	14	14	14	0	0	0	0	100%
VI.	Customer Services	10	10	7	2	1	0	0	90%
VIII.	Enrollee Rights and Protections	34	32	30	2	0	0	2	98%
IX.	Subcontracts and Delegation	8	8	7	1	0	0	0	97%
X.	Provider Network	12	12	10	2	0	0	0	96%
XI.	Credentialing	25	25	25	0	0	0	0	100%
XIII.	Coordination of Care	4	4	4	0	0	0	0	100%
Overall		128	126	116	7	3	0	2	97%

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

Total Elements: The total number of elements in each standard.

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

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

Strengths

Lakeshore Behavioral Health Alliance received an overall compliance score of 97 percent across the eight standards reviewed. The PIHP achieved 100 percent compliance on three standards: *Practice Guidelines*, *Credentialing*, and *Coordination of Care*. **Lakeshore Behavioral Health Alliance** also demonstrated strong performance on the standards of *Performance Measurement and Improvement*, *Customer Services*, *Enrollee Rights and Protections*, *Subcontracts and Delegation*, and *Provider Network*.

Recommendations

Recommendations for improving **Lakeshore Behavioral Health Alliance**'s performance addressed *Performance Measurement and Improvement, Customer Services, Enrollee Rights and Protections, Subcontracts and Delegation, and Provider Network*. The PIHP should update its sentinel events policy to incorporate the most current MDCH contract and QAPIP requirements and ensure that affiliate policies and processes are accurate and congruent. **Lakeshore Behavioral Health Alliance** should ensure that all calls to customer services are answered by a live voice, revise the handbook to include information about how to contact the Medicaid Health Plans in the PIHP's service area, and revise its customer services policy to accurately reflect the requirement for distribution of the provider listing as stated in the MDCH contract. The PIHP should continue its efforts to ensure that all enrollees are notified of their right to request and obtain information about enrollee rights and protections. **Lakeshore Behavioral Health Alliance** should formalize its process for review and follow up on subcontractors' provider network monitoring, continue its efforts to ensure that it provides adequate access to all services covered under the contract, and develop a comprehensive evaluation of its delivery network that includes documentation of the findings and conclusions.

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 PIHP achieved full compliance on three standards, which primarily addressed the **quality** domain. The 2011–2012 compliance review also resulted in recommendations for improvement in all three domains.

LifeWays

Compliance Monitoring Results

Table 3-9 presents the results from the 2011–2012 compliance monitoring review, 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 a compliance score for each of the standards and an overall compliance score across all standards. The 2011–2012 External Quality Review Compliance Monitoring Report for **LifeWays** contains a more detailed description of the results.

Table 3-9—Summary of Scores for the Standards									
Standard		Total Elements	Total Applicable Elements	Number of Elements					Total Compliance Score
				<i>M</i>	<i>SM</i>	<i>PM</i>	<i>NM</i>	<i>NA</i>	
II.	Performance Measurement and Improvement	21	21	19	2	0	0	0	98%
III.	Practice Guidelines	14	14	14	0	0	0	0	100%
VI.	Customer Services	10	10	10	0	0	0	0	100%
VIII.	Enrollee Rights and Protections	34	32	32	0	0	0	2	100%
IX.	Subcontracts and Delegation	8	8	8	0	0	0	0	100%
X.	Provider Network	12	12	12	0	0	0	0	100%
XI.	Credentialing	25	25	25	0	0	0	0	100%
XIII.	Coordination of Care	4	4	3	0	1	0	0	88%
Overall		128	126	123	2	1	0	2	99%

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

Total Elements: The total number of elements in each standard.

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

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

Strengths

LifeWays received an overall compliance score of 99 percent across the eight standards reviewed. The PIHP achieved 100 percent compliance on six standards: *Practice Guidelines*, *Customer Services*, *Enrollee Rights and Protections*, *Subcontracts and Delegation*, *Provider Network*, and *Credentialing*. **LifeWays** also demonstrated strong performance on the standards of *Performance Measurement and Improvement* and *Coordination of Care*.

Recommendations

Recommendations for improving **LifeWays**' performance addressed *Performance Measurement and Improvement* and *Coordination of Care*. The PIHP should ensure that its process specifies that persons involved in the review of sentinel events must have the appropriate credentials to review the scope of care. **LifeWays** should involve persons receiving case management or supports coordination services into the review and analysis of satisfaction results data. **LifeWays** should ensure that it maintains written, functioning coordination agreements with each Medicaid health plan serving in any part of its service area.

Summary Assessment Related to Quality, Timeliness, and Access

LifeWays demonstrated strong performance across the three domains of **quality**, **timeliness**, and **access**. The PIHP demonstrated its strongest performance in the **quality** domain, achieving full compliance on six of the eight standards. Performance in the **access** domain was also strong, with full compliance on two of the three standards in this domain. The PIHP received recommendations for improvement on the standard addressing the **timeliness** domain.

Macomb County CMH Services

Compliance Monitoring Results

Table 3-10 presents the results from the 2011–2012 compliance monitoring review, 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 a compliance score for each of the standards and an overall compliance score across all standards. The 2011–2012 External Quality Review Compliance Monitoring Report for **Macomb County CMH Services** contains a more detailed description of the results.

Table 3-10—Summary of Scores for the Standards									
Standard		Total Elements	Total Applicable Elements	Number of Elements					Total Compliance Score
				<i>M</i>	<i>SM</i>	<i>PM</i>	<i>NM</i>	<i>NA</i>	
II.	Performance Measurement and Improvement	21	21	16	1	4	0	0	89%
III.	Practice Guidelines	14	14	14	0	0	0	0	100%
VI.	Customer Services	10	10	10	0	0	0	0	100%
VIII.	Enrollee Rights and Protections	34	32	32	0	0	0	2	100%
IX.	Subcontracts and Delegation	8	8	7	0	1	0	0	94%
X.	Provider Network	12	12	11	0	1	0	0	96%
XI.	Credentialing	25	25	16	8	1	0	0	90%
XIII.	Coordination of Care	4	4	4	0	0	0	0	100%
Overall		128	126	110	9	7	0	2	95%

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

Total Elements: The total number of elements in each standard.

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

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

Strengths

Macomb County CMH Services received an overall compliance score of 95 percent across the eight standards reviewed. The PIHP achieved 100 percent compliance on four standards: *Practice Guidelines*, *Customer Services*, *Enrollee Rights and Protections*, and *Coordination of Care*. **Macomb County CMH Services** also demonstrated strong performance on the standards of *Performance Measurement and Improvement*, *Subcontracts and Delegation*, *Provider Network*, and *Credentialing*.

Recommendations

Recommendations for improving **Macomb County CMH Services'** performance addressed *Performance Measurement and Improvement, Subcontracts and Delegation, Provider Network, and Credentialing*. The PIHP should ensure that its sentinel event policy and process include the requirements and time frames as specified in the MDCH contract. **Macomb County CMH Services** should ensure that it addresses the findings of the qualitative and quantitative assessment of beneficiaries' experiences with its services as described in its QAPIP; that it documents how it informs practitioners, providers, beneficiaries, and the governing body of assessment results; and how it addresses individual and systemic findings. The PIHP should formalize its process for review and follow-up on any provider network monitoring of its subcontractors and ensure that written notices to providers that were declined participation in the PIHP's network include the reason for the decision. **Macomb County CMH Services** should revise its credentialing and recredentialing policies and processes to ensure compliance with federal requirements and conform to MDCH's credentialing and recredentialing process specifications.

Summary Assessment Related to Quality, Timeliness, and Access

Macomb County CMH Services demonstrated mixed performance across the three domains of **quality, timeliness, and access**. The PIHP achieved full compliance on two of the three standards in the **access** domain. Performance in the **quality** domain was also strong, with full compliance on four of the eight standards in this domain. The PIHP received several recommendations for improvement on the standard addressing the **timeliness** domain.

network180

Compliance Monitoring Results

Table 3-11 presents the results from the 2011–2012 compliance monitoring review, 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 a compliance score for each of the standards and an overall compliance score across all standards. The 2011–2012 External Quality Review Compliance Monitoring Report for **network180** contains a more detailed description of the results.

Table 3-11—Summary of Scores for the Standards									
Standard		Total Elements	Total Applicable Elements	Number of Elements					Total Compliance Score
				<i>M</i>	<i>SM</i>	<i>PM</i>	<i>NM</i>	<i>NA</i>	
II.	Performance Measurement and Improvement	21	21	21	0	0	0	0	100%
III.	Practice Guidelines	14	14	14	0	0	0	0	100%
VI.	Customer Services	10	10	10	0	0	0	0	100%
VIII.	Enrollee Rights and Protections	34	32	31	1	0	0	2	99%
IX.	Subcontracts and Delegation	8	8	4	2	2	0	0	81%
X.	Provider Network	12	12	12	0	0	0	0	100%
XI.	Credentialing	25	24	24	0	0	0	1	100%
XIII.	Coordination of Care	4	4	4	0	0	0	0	100%
Overall		128	125	120	3	2	0	3	99%

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

Total Elements: The total number of elements in each standard.

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

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

Strengths

network180 received an overall compliance score of 99 percent across the eight standards reviewed. The PIHP achieved 100 percent compliance on six standards: *Performance Measurement and Improvement*, *Practice Guidelines*, *Customer Services*, *Provider Network*, *Credentialing*, and *Coordination of Care*. **network180** also demonstrated strong performance on the standards of *Enrollee Rights and Protections* and *Subcontracts and Delegation*.

Recommendations

Recommendations for improving **network180**'s performance addressed *Enrollee Rights and Protections* and *Subcontracts and Delegation*. The PIHP should ensure that within reasonable time after enrollment, beneficiaries receive all required information about services and rights and protections. **network180** should ensure that its written agreements specify the activities and the report responsibilities delegated to the subcontractor, and review and revise its processes for monitoring subcontractors' performance related to delegated functions to ensure that the monitoring addresses each delegated function in sufficient detail to determine the adequacy of the subcontractors' performance. The PIHP should formalize its process for review and follow-up on any provider network monitoring of its subcontractors.

Summary Assessment Related to Quality, Timeliness, and Access

network180 demonstrated excellent performance across the three domains of **quality**, **timeliness**, and **access**. The PIHP demonstrated its strongest performance in the **timeliness** and **access** domains, achieving full compliance on all standards. Performance in the **quality** domain was also strong, with full compliance on six of the eight standards in this domain.

NorthCare

Compliance Monitoring Results

Table 3-12 presents the results from the 2011–2012 compliance monitoring review, 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 a compliance score for each of the standards and an overall compliance score across all standards. The 2011–2012 External Quality Review Compliance Monitoring Report for **NorthCare** contains a more detailed description of the results.

Table 3-12—Summary of Scores for the Standards									
Standard		Total Elements	Total Applicable Elements	Number of Elements					Total Compliance Score
				<i>M</i>	<i>SM</i>	<i>PM</i>	<i>NM</i>	<i>NA</i>	
II.	Performance Measurement and Improvement	21	21	21	0	0	0	0	100%
III.	Practice Guidelines	14	14	14	0	0	0	0	100%
VI.	Customer Services	10	10	10	0	0	0	0	100%
VIII.	Enrollee Rights and Protections	34	32	30	2	0	0	2	98%
IX.	Subcontracts and Delegation	8	8	8	0	0	0	0	100%
X.	Provider Network	12	12	12	0	0	0	0	100%
XI.	Credentialing	25	25	24	1	0	0	0	99%
XIII.	Coordination of Care	4	4	4	0	0	0	0	100%
Overall		128	126	123	3	0	0	2	99%

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

Total Elements: The total number of elements in each standard.

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

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

Strengths

NorthCare received an overall compliance score of 99 percent across the eight standards reviewed. The PIHP achieved 100 percent compliance on six standards: *Performance Measurement and Improvement*, *Practice Guidelines*, *Customer Services*, *Subcontracts and Delegation*, *Provider Network*, and *Coordination of Care*. **NorthCare** also demonstrated strong performance on the standards of *Enrollee Rights and Protections* and *Credentialing*.

Recommendations

Recommendations for improving **NorthCare**'s performance addressed *Enrollee Rights and Protections* and *Credentialing*. The PIHP should ensure that its member handbook includes all required information and strengthen its monitoring of affiliates' distribution of member materials, **NorthCare** should ensure that its procedures for reporting improper provider conduct are consistent with contractual requirements.

Summary Assessment Related to Quality, Timeliness, and Access

NorthCare demonstrated strong performance across the three domains of **quality, timeliness, and access**. The PIHP demonstrated its strongest performance in the **timeliness** and **access** domains, achieving full compliance on all standards. Performance in the **quality** domain was also strong, with full compliance on six of the eight standards in this domain.

Northern Affiliation

Compliance Monitoring Results

Table 3-13 presents the results from the 2011–2012 compliance monitoring review, 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 a compliance score for each of the standards and an overall compliance score across all standards. The 2011–2012 External Quality Review Compliance Monitoring Report for **Northern Affiliation** contains a more detailed description of the results.

Table 3-13—Summary of Scores for the Standards									
Standard		Total Elements	Total Applicable Elements	Number of Elements					Total Compliance Score
				<i>M</i>	<i>SM</i>	<i>PM</i>	<i>NM</i>	<i>NA</i>	
II.	Performance Measurement and Improvement	21	21	21	0	0	0	0	100%
III.	Practice Guidelines	14	14	14	0	0	0	0	100%
VI.	Customer Services	10	10	10	0	0	0	0	100%
VIII.	Enrollee Rights and Protections	34	32	32	0	0	0	2	100%
IX.	Subcontracts and Delegation	8	8	8	0	0	0	0	100%
X.	Provider Network	12	12	11	1	0	0	0	98%
XI.	Credentialing	25	24	24	0	0	0	1	100%
XIII.	Coordination of Care	4	4	4	0	0	0	0	100%
Overall		128	125	124	1	0	0	3	100%

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

Total Elements: The total number of elements in each standard.

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

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

Strengths

Northern Affiliation received an overall compliance score of 100 percent across the eight standards reviewed. The PIHP achieved 100 percent compliance on seven standards: *Performance Measurement and Improvement*, *Practice Guidelines*, *Customer Services*, *Enrollee Rights and Protections*, *Subcontracts and Delegation*, *Credentialing*, and *Coordination of Care*. **Northern Affiliation** also demonstrated strong performance on the *Provider Network* standard.

Recommendations

The recommendation for improving **Northern Affiliation's** performance addressed *Provider Network*. The PIHP should incorporate the requirement to give affected providers written notice of the reason for the decision to decline their participation in the network into its monitoring of the delegated network management function.

Summary Assessment Related to Quality, Timeliness, and Access

Northern Affiliation demonstrated strong performance across the three domains of **quality**, **timeliness**, and **access**. The PIHP achieved full compliance on seven of the eight standards in the **quality** domain. Performance in the **access** domain was also strong, with full compliance on two of three standards. The PIHP achieved 100 percent compliance on the one standard addressing the **timeliness** domain.

Northwest CMH Affiliation

Compliance Monitoring Results

Table 3-14 presents the results from the 2011–2012 compliance monitoring review, 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 a compliance score for each of the standards and an overall compliance score across all standards. The 2011–2012 External Quality Review Compliance Monitoring Report for **Northwest CMH Affiliation** contains a more detailed description of the results.

Table 3-14—Summary of Scores for the Standards									
Standard		Total Elements	Total Applicable Elements	Number of Elements					Total Compliance Score
				<i>M</i>	<i>SM</i>	<i>PM</i>	<i>NM</i>	<i>NA</i>	
II.	Performance Measurement and Improvement	21	21	21	0	0	0	0	100%
III.	Practice Guidelines	14	14	14	0	0	0	0	100%
VI.	Customer Services	10	10	10	0	0	0	0	100%
VIII.	Enrollee Rights and Protections	34	32	31	1	0	0	2	99%
IX.	Subcontracts and Delegation	8	8	8	0	0	0	0	100%
X.	Provider Network	12	12	11	1	0	0	0	98%
XI.	Credentialing	25	24	24	0	0	0	1	100%
XIII.	Coordination of Care	4	4	4	0	0	0	0	100%
Overall		128	125	123	2	0	0	3	100%

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

Total Elements: The total number of elements in each standard.

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

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

Strengths

Northwest CMH Affiliation received an overall compliance score of 100 percent across the eight standards reviewed. The PIHP achieved 100 percent compliance on six standards: *Performance Measurement and Improvement*, *Practice Guidelines*, *Customer Services*, *Subcontracts and Delegation*, *Credentialing*, and *Coordination of Care*. **Northwest CMH Affiliation** also demonstrated strong performance on the standards of *Enrollee Rights and Protections* and *Provider Network*.

Recommendations

Recommendations for improving **Northwest CMH Affiliation**'s performance addressed *Enrollee Rights and Protections* and *Provider Network*. The PIHP should clarify in the Guide to Services that the provider directory is available upon request at any time. **Northwest CMH Affiliation** should develop policies and procedures for providing in-network second opinions.

Summary Assessment Related to Quality, Timeliness, and Access

Northwest CMH Affiliation demonstrated strong performance across the three domains of **quality**, **timeliness**, and **access**. The PIHP achieved full compliance on six of the eight standards in the **quality** domain. Performance in the **access** domain was also strong, with full compliance on two of three standards. The PIHP achieved 100 percent compliance on the one standard addressing the **timeliness** domain.

Oakland County CMH Authority

Compliance Monitoring Results

Table 3-15 presents the results from the 2011–2012 compliance monitoring review, 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 a compliance score for each of the standards and an overall compliance score across all standards. The 2011–2012 External Quality Review Compliance Monitoring Report for **Oakland County CMH Authority** contains a more detailed description of the results.

Table 3-15—Summary of Scores for the Standards									
Standard		Total Elements	Total Applicable Elements	Number of Elements					Total Compliance Score
				<i>M</i>	<i>SM</i>	<i>PM</i>	<i>NM</i>	<i>NA</i>	
II.	Performance Measurement and Improvement	21	21	21	0	0	0	0	100%
III.	Practice Guidelines	14	14	14	0	0	0	0	100%
VI.	Customer Services	10	10	10	0	0	0	0	100%
VIII.	Enrollee Rights and Protections	34	32	30	0	2	0	2	97%
IX.	Subcontracts and Delegation	8	8	8	0	0	0	0	100%
X.	Provider Network	12	12	12	0	0	0	0	100%
XI.	Credentialing	25	24	24	0	0	0	1	100%
XIII.	Coordination of Care	4	4	4	0	0	0	0	100%
Overall		128	125	123	0	2	0	3	99%

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

Total Elements: The total number of elements in each standard.

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

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

Strengths

Oakland County CMH Authority received an overall compliance score of 99 percent across the eight standards reviewed. The PIHP achieved 100 percent compliance on seven standards: *Performance Measurement and Improvement*, *Practice Guidelines*, *Customer Services*, *Subcontracts and Delegation*, *Provider Network*, *Credentialing*, and *Coordination of Care*. **Oakland County CMH Authority** also demonstrated strong performance on the *Enrollee Rights and Protections* standard.

Recommendations

Recommendations for improving **Oakland County CMH Authority**'s performance addressed *Enrollee Rights and Protections*. The PIHP should ensure that it monitors subcontractors' compliance with the requirement to provide written notice of termination of a contracted provider to each enrollee who received his or her primary care from, or was seen regularly by, the terminated provider, within 15 days after receipt or issuance of the termination notice.

Summary Assessment Related to Quality, Timeliness, and Access

Oakland County CMH Authority demonstrated excellent performance across the three domains of **quality**, **timeliness**, and **access**. The PIHP demonstrated its strongest performance in the **timeliness** and **access** domains, achieving full compliance on all standards. Performance in the **quality** domain was also strong, with full compliance on seven of the eight standards in this domain.

Saginaw County CMH Authority

Compliance Monitoring Results

Table 3-16 presents the results from the 2011–2012 compliance monitoring review, 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 a compliance score for each of the standards and an overall compliance score across all standards. The 2011–2012 External Quality Review Compliance Monitoring Report for **Saginaw County CMH Authority** contains a more detailed description of the results.

Table 3-16—Summary of Scores for the Standards									
Standard		Total Elements	Total Applicable Elements	Number of Elements					Total Compliance Score
				<i>M</i>	<i>SM</i>	<i>PM</i>	<i>NM</i>	<i>NA</i>	
II.	Performance Measurement and Improvement	21	21	20	1	0	0	0	99%
III.	Practice Guidelines	14	14	14	0	0	0	0	100%
VI.	Customer Services	10	10	10	0	0	0	0	100%
VIII.	Enrollee Rights and Protections	34	32	31	0	1	0	2	98%
IX.	Subcontracts and Delegation	8	8	8	0	0	0	0	100%
X.	Provider Network	12	12	12	0	0	0	0	100%
XI.	Credentialing	25	25	22	2	1	0	0	96%
XIII.	Coordination of Care	4	4	4	0	0	0	0	100%
Overall		128	126	121	3	2	0	2	99%

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

Total Elements: The total number of elements in each standard.

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

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

Strengths

Saginaw County CMH Authority received an overall compliance score of 99 percent across the eight standards reviewed. The PIHP achieved 100 percent compliance on five standards: *Practice Guidelines*, *Customer Services*, *Subcontracts and Delegation*, *Provider Network*, and *Coordination of Care*. **Saginaw County CMH Authority** also demonstrated strong performance on the standards of *Performance Measurement and Improvement*, *Enrollee Rights and Protections*, and *Credentialing*.

Recommendations

Recommendations for improving **Saginaw County CMH Authority**'s performance addressed *Performance Measurement and Improvement*, *Enrollee Rights and Protections*, and *Credentialing*. The PIHP should include in its policies the requirements for timeliness of the review of critical incidents and initiation of a root cause analysis for sentinel events. **Saginaw County CMH Authority** should ensure that written notice of termination of a contracted provider is given within 15 days after receipt or issuance of the termination notice. The PIHP should document the credentialing process consistent with MDCH credentialing and recredentialing requirements, especially regarding Medicare/Medicaid sanctions and Office of Inspector General (OIG) exclusions, and ensure that the initial credentialing process and application address all MDCH requirements.

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 PIHP demonstrated its strongest performance in the **access** domain, achieving full compliance on all standards. Performance in the **quality** domain was also strong, with full compliance on five of the eight standards in this domain. The PIHP received a recommendation for improvement on the standard addressing the **timeliness** domain.

Southwest Affiliation

Compliance Monitoring Results

Table 3-17 presents the results from the 2011–2012 compliance monitoring review, 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 a compliance score for each of the standards and an overall compliance score across all standards. The 2011–2012 External Quality Review Compliance Monitoring Report for **Southwest Affiliation** contains a more detailed description of the results.

Table 3-17—Summary of Scores for the Standards									
Standard		Total Elements	Total Applicable Elements	Number of Elements					Total Compliance Score
				<i>M</i>	<i>SM</i>	<i>PM</i>	<i>NM</i>	<i>NA</i>	
II.	Performance Measurement and Improvement	21	21	21	0	0	0	0	100%
III.	Practice Guidelines	14	14	14	0	0	0	0	100%
VI.	Customer Services	10	10	10	0	0	0	0	100%
VIII.	Enrollee Rights and Protections	34	32	32	0	0	0	2	100%
IX.	Subcontracts and Delegation	8	8	8	0	0	0	0	100%
X.	Provider Network	12	12	12	0	0	0	0	100%
XI.	Credentialing	25	25	25	0	0	0	0	100%
XIII.	Coordination of Care	4	4	4	0	0	0	0	100%
Overall		128	126	126	0	0	0	2	100%

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

Total Elements: The total number of elements in each standard.

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

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

Strengths

Southwest Affiliation received an overall compliance score of 100 percent across the eight standards reviewed. The PIHP achieved 100 percent compliance on all eight standards: *Performance Measurement and Improvement*, *Practice Guidelines*, *Customer Services*, *Enrollee Rights and Protections*, *Subcontracts and Delegation*, *Provider Network*, *Credentialing*, and *Coordination of Care*.

Recommendations

The 2011–2012 compliance review for **Southwest Affiliation** did not result in any recommendations for improvement as the PIHP demonstrated compliance with all requirements.

Summary Assessment Related to Quality, Timeliness, and Access

Southwest Affiliation demonstrated exceptional performance across the three domains of **quality**, **timeliness**, and **access**. The PIHP achieved full compliance on all standards across the three domains.

Thumb Alliance PIHP

Compliance Monitoring Results

Table 3-18 presents the results from the 2011–2012 compliance monitoring review, 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 a compliance score for each of the standards and an overall compliance score across all standards. The 2011–2012 External Quality Review Compliance Monitoring Report for **Thumb Alliance PIHP** contains a more detailed description of the results.

Standard	Total Elements	Total Applicable Elements	Number of Elements					Total Compliance Score
			<i>M</i>	<i>SM</i>	<i>PM</i>	<i>NM</i>	<i>NA</i>	
II. Performance Measurement and Improvement	21	21	19	2	0	0	0	98%
III. Practice Guidelines	14	14	14	0	0	0	0	100%
VI. Customer Services	10	10	10	0	0	0	0	100%
VIII. Enrollee Rights and Protections	34	32	30	0	0	2	2	94%
IX. Subcontracts and Delegation	8	8	7	1	0	0	0	97%
X. Provider Network	12	12	11	0	1	0	0	96%
XI. Credentialing	25	25	24	1	0	0	0	99%
XIII. Coordination of Care	4	4	3	1	0	0	0	94%
Overall	128	126	118	5	1	2	2	97%

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

Total Elements: The total number of elements in each standard.

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

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

Strengths

Thumb Alliance PIHP received an overall compliance score of 97 percent across the eight standards reviewed. The PIHP achieved 100 percent compliance on two standards: *Practice Guidelines* and *Customer Services*. **Thumb Alliance PIHP** also demonstrated strong performance on the standards of *Performance Measurement and Improvement*, *Enrollee Rights and Protections*, *Subcontracts and Delegation*, *Provider Network*, *Credentialing*, and *Coordination of Care*.

Recommendations

Recommendations for improving **Thumb Alliance PIHP**'s performance addressed *Performance Measurement and Improvement, Enrollee Rights and Protections, Subcontracts and Delegation, Provider Network, Credentialing, and Coordination of Care*. The PIHP should ensure that the processes for review of and follow-up on sentinel events are consistent with the contract requirements. **Thumb Alliance PIHP** should develop and implement processes for providing timely, written notice of the termination of a contracted provider to each affected enrollee, formalize the documentation of its processes for review and follow-up on any provider network monitoring of its subcontractors, and ensure that MDCH receives notification of any significant changes to the provider network within seven days of the change. The PIHP must include in its policy and process the requirement to report improper conduct that results in suspension or termination from the PIHP's provider network. **Thumb Alliance PIHP** should obtain a written, signed coordination agreement with each Medicaid health plan in its service area.

Summary Assessment Related to Quality, Timeliness, and Access

Thumb Alliance PIHP demonstrated strong performance across the three domains of **quality, timeliness, and access**. The PIHP achieved full compliance on two standards, which primarily addressed the **quality** domain. The 2011–2012 compliance review also resulted in recommendations for improvement in all three domains.

Venture Behavioral Health

Compliance Monitoring Results

Table 3-19 presents the results from the 2011–2012 compliance monitoring review, 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 a compliance score for each of the standards and an overall compliance score across all standards. The 2011–2012 External Quality Review Compliance Monitoring Report for **Venture Behavioral Health** contains a more detailed description of the results.

Table 3-19—Summary of Scores for the Standards									
Standard		Total Elements	Total Applicable Elements	Number of Elements					Total Compliance Score
				<i>M</i>	<i>SM</i>	<i>PM</i>	<i>NM</i>	<i>NA</i>	
II.	Performance Measurement and Improvement	21	21	21	0	0	0	0	100%
III.	Practice Guidelines	14	14	14	0	0	0	0	100%
VI.	Customer Services	10	10	10	0	0	0	0	100%
VIII.	Enrollee Rights and Protections	34	32	32	0	0	0	2	100%
IX.	Subcontracts and Delegation	8	8	8	0	0	0	0	100%
X.	Provider Network	12	12	12	0	0	0	0	100%
XI.	Credentialing	25	24	23	1	0	0	1	99%
XIII.	Coordination of Care	4	4	4	0	0	0	0	100%
Overall		128	125	124	1	0	0	3	100%

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

Total Elements: The total number of elements in each standard.

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

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

Strengths

Venture Behavioral Health received an overall compliance score of 100 percent across the eight standards reviewed. The PIHP achieved 100 percent compliance on seven standards: *Performance Measurement and Improvement*, *Practice Guidelines*, *Customer Services*, *Enrollee Rights and Protections*, *Subcontracts and Delegation*, *Provider Network*, and *Coordination of Care*. **Venture Behavioral Health** also demonstrated strong performance on the *Credentialing* standard.

Recommendations

Recommendations for improving **Venture Behavioral Health's** performance addressed *Credentialing*. The PIHP should revise its credentialing application to include an attestation by the applicant as to all elements specified in the MDCH credentialing policy.

Summary Assessment Related to Quality, Timeliness, and Access

Venture Behavioral Health demonstrated excellent performance across the three domains of **quality, timeliness, and access**. The PIHP demonstrated its strongest performance in the **timeliness** and **access** domains, achieving full compliance on all standards. Performance in the **quality** domain was also strong, with full compliance on seven of the eight standards in this 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 2011–2012 validation of performance measures review included new outcome measures as Indicators 13 and 14. In place of recipient rights complaints and sentinel events, these indicators addressed living situations for adults with mental illness or developmental disability. In addition to the new measures, MDCH changed the numbering of the indicators and included additional populations for some of the existing indicators.

The validation review periods for the indicators were as follows: first quarter of SFY 2012 for Indicators 1 through 6 and Indicator 10; SFY 2011 for Indicators 8, 9, 13, and 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; and the percentages of adults who were employed competitively, earned minimum wage or more, or lived in a private residence. 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 2012 Validation of Performance Measures Report for **Access Alliance of Michigan** includes additional details of the validation results.

Table 3-20—Performance Measure Results for Access Alliance of Michigan				
	Indicator	Reported Rate		Audit Designation
1.	Percentage of persons during the quarter receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children:	100%	Fully Compliant
		Adults:	99.34%	
2.	Percentage of new persons during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service.	MI Children:	98.96%	Fully Compliant
		MI Adults:	98.13%	
		DD Children:	100%	
		DD Adults:	100%	
		Medicaid SA:	99.40%	
		Total:	98.75%	
3.	Percentage of new persons during the quarter starting any needed ongoing service within 14 days of a non-emergent assessment with a professional.	MI Children:	97.24%	Fully Compliant
		MI Adults:	97.74%	
		DD Children:	100%	
		DD Adults:	100%	
		Medicaid SA:	100%	
		Total:	98.30%	
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).	9.08%		Fully Compliant
6.	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 that is not supports coordination (HSW rate).	94.13%		Fully Compliant
8.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of dual MI/DD adults served by the PIHP who are in competitive employment.	MI Adults:	10.67%	Fully Compliant
		DD Adults:	9.22%	
		MI/DD Adults:	12.41%	

**Table 3-20—Performance Measure Results
for Access Alliance of Michigan**

	Indicator	Reported Rate	Audit Designation
9.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of dual MI/DD adults served by the PIHP who earn minimum wage or more from employment activities.	MI Adults: 79.72%	Fully Compliant
		DD Adults: 36.29%	
		MI/DD Adults: 38.84%	
10.	Percentage of MI and DD children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children: 5.71%	Fully Compliant
		Adults: 10.58%	
13.	Percentage of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	21.04%	Fully Compliant
14.	Percentage of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	66.89%	Fully Compliant

Strengths

Access Alliance of Michigan continued to demonstrate a close working relationship with its delegates as well as comprehensive delegation oversight of affiliates’ processes and outcomes related to the PMV indicators. **Access Alliance of Michigan** implemented recommendations from the prior audit and created a series of reports for data anomalies. These anomaly reports were used to improve the quality and accuracy of the data submitted by the community mental health centers.

Recommendations

Access Alliance of Michigan should improve its oversight of the coordinating agency (CA) by trending encounter data that are passed through from the CA. This trending could potentially identify missing or incomplete CA encounter data.

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 all 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 who earned minimum wage were above the statewide rates, as were the percentages of DD and MI adults who lived in a private residence. Performance indicators related to **timeliness** of and **access** to services were *Fully Compliant* with MDCH specifications. The PIHP met the contractually required performance standards related to **timeliness** of and **access** to services provided by the PIHP for all indicators and populations. **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 all 19 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 2012 Validation of Performance Measures Report for **CMH Affiliation of Mid-Michigan** includes additional details of the validation results.

Table 3-21—Performance Measure Results for CMH Affiliation of Mid-Michigan				
	Indicator	Reported Rate		Audit Designation
1.	Percentage of persons during the quarter receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children:	97.37%	Fully Compliant
		Adults:	95.04%	
2.	Percentage of new persons during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service.	MI Children:	99.16%	Fully Compliant
		MI Adults:	99.51%	
		DD Children:	100%	
		DD Adults:	100%	
		Medicaid SA:	97.67%	
		Total:	99.00%	
3.	Percentage of new persons during the quarter starting any needed ongoing service within 14 days of a non-emergent assessment with a professional.	MI Children:	95.93%	Fully Compliant
		MI Adults:	96.27%	
		DD Children:	100%	
		DD Adults:	85.71%	
		Medicaid SA:	100%	
		Total:	96.94%	
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).	6.45%		Fully Compliant
6.	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 that is not supports coordination (HSW rate).	97.01%		Fully Compliant

**Table 3-21—Performance Measure Results
for CMH Affiliation of Mid-Michigan**

	Indicator	Reported Rate	Audit Designation
8.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of dual MI/DD adults served by the PIHP who are in competitive employment.	MI Adults: 8.96%	Fully Compliant
		DD Adults: 9.03%	
		MI/DD Adults: 10.37%	
9.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of dual MI/DD adults served by the PIHP who earn minimum wage or more from employment activities.	MI Adults: 77.93%	Fully Compliant
		DD Adults: 58.27%	
		MI/DD Adults: 55.28%	
10.	Percentage of MI and DD children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children: 6.25%	Fully Compliant
		Adults: 7.69%	
13.	Percentage of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	13.73%	Fully Compliant
14.	Percentage of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	49.75%	Fully Compliant

Strengths

CMH Affiliation of Mid-Michigan continued to maintain a strong and stable performance measures team. Processes related to encounter data processing and performance indicator reporting remained consistent over time. The PIHP staff continued to work closely with MDCH to identify—and where possible—resolve issues and challenges. Audit processes in place for the affiliate community mental health centers (CMHs) and CAs were effective. The resulting audits helped the PIHP to identify and timely address any problems at the CMH level.

Recommendations

CMH Affiliation of Mid-Michigan should continue its efforts to monitor encounter data submissions and ensure that all data are transferred to the Community Health Automated Medicaid Processing Systems (CHAMPS). As Mid-South ends its role as a CA and **CMH Affiliation of Mid-Michigan** absorbs these responsibilities, the PIHP should document the transition and any challenges it encounters related to functioning as a CA.

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 all 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 almost all above-average results. The PIHP's HSW rate exceeded the statewide rate. The rates of MI, DD, and MI/DD adults who were employed competitively or who earned minimum wage were higher than the statewide rates. The rate of MI adults living in a private residence was higher than the statewide rate, while the rate

for DD adults fell below the statewide rate. 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 all but one of the indicators related to **timeliness** of and **access** to services provided by the PIHP. The PIHP's penetration rate was lower than 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 18 of the 19 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 2012 Validation of Performance Measures Report for **CMH Affiliation of Central Michigan** includes additional details of the validation results.

Table 3-22—Performance Measure Results for CMH for Central Michigan				
	Indicator	Reported Rate		Audit Designation
1.	Percentage of persons during the quarter 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 new persons during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service.	MI Children:	98.03%	Fully Compliant
		MI Adults:	98.87%	
		DD Children:	100%	
		DD Adults:	100%	
		Medicaid SA:	100%	
		Total:	98.77%	
3.	Percentage of new persons during the quarter starting any needed ongoing service within 14 days of a non-emergent assessment with a professional.	MI Children:	91.18%	Fully Compliant
		MI Adults:	97.20%	
		DD Children:	0.00%*	
		DD Adults:	90.91%	
		Medicaid SA:	100%	
		Total:	95.13%	
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).	9.35%		Fully Compliant
6.	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 that is not supports coordination (HSW rate).	95.39%		Fully Compliant

* There were no applicable cases during the reporting period.

**Table 3-22—Performance Measure Results
for CMH for Central Michigan**

	Indicator	Reported Rate	Audit Designation
8.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of dual MI/DD adults served by the PIHP who are in competitive employment.	MI Adults: 10.42%	Fully Compliant
		DD Adults: 9.45%	
		MI/DD Adults: 5.60%	
9.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of dual MI/DD adults served by the PIHP who earn minimum wage or more from employment activities.	MI Adults: 82.00%	Substantially Compliant
		DD Adults: 21.55%	
		MI/DD Adults: 23.19%	
10.	Percentage of MI and DD children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children: 18.18%	Fully Compliant
		Adults: 9.38%	
13.	Percentage of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	30.10%	Fully Compliant
14.	Percentage of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	62.71%	Fully Compliant

Strengths

CMH for Central Michigan implemented a new system called CIGMMO, named after the counties in its service area (Clare, Isabella, Gladwin, Mecosta, Midland, and Osceola). In addition to functioning as the claims system, CIGMMO was capable of handling all aspects of quality improvement (QI) and encounter data reporting, as well as performance measure reporting. The software required all key fields to be populated for each consumer before allowing the staff to proceed with using the tool, which helped to ensure complete QI and encounter data.

Recommendations

CMH for Central Michigan should monitor its CA’s submission to help ensure data are complete prior to submitting the CA’s data to MDCH. **CMH for Central Michigan** continued to have difficulty obtaining complete data for minimum wage. Although the new system, CIGMMO, may help in capturing these data, it is expected to provide only a moderate improvement to the rate, which was well below MDCH’s 95 percent threshold.

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 Indicator 9, which received a designation of *Substantially Compliant* due to incomplete QI data. 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 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 were higher than the statewide rates, while the rate for MI/DD adults

was below the statewide rate. The rates for MI adults who earned minimum wage exceeded the statewide rate, while rates for DD and MI/DD adults fell below the statewide rates. Rates for DD and MI adults residing in a private residence exceeded the statewide rates. 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 15 of the 17 indicators 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 strong performance across all three domains of **quality**, **timeliness**, and **access** and met the minimum performance standard for 16 of the 19 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 2012 Validation of Performance Measures Report for **CMH Partnership of Southeastern Michigan** includes additional details of the validation results.

Table 3-23—Performance Measure Results for CMH Partnership of Southeastern Michigan				
	Indicator	Reported Rate		Audit Designation
1.	Percentage of persons during the quarter 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 new persons during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service.	MI Children:	100%	Fully Compliant
		MI Adults:	100%	
		DD Children:	100%	
		DD Adults:	100%	
		Medicaid SA:	96.20%	
		Total:	99.12%	
3.	Percentage of new persons during the quarter starting any needed ongoing service within 14 days of a non-emergent assessment with a professional.	MI Children:	97.75%	Fully Compliant
		MI Adults:	91.67%	
		DD Children:	100%	
		DD Adults:	100%	
		Medicaid SA:	98.75%	
		Total:	96.91%	
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children:	96.97%	Fully Compliant
		Adults:	96.30%	
4b.	Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	84.00%		Fully Compliant
5.	Percentage of Medicaid recipients having received PIHP-managed services (penetration rate).	6.08%		Fully Compliant
6.	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 that is not supports coordination (HSW rate).	44.89%		Fully Compliant

Table 3-23—Performance Measure Results for CMH Partnership of Southeastern Michigan				
	Indicator	Reported Rate		Audit Designation
8.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of dual MI/DD adults served by the PIHP who are in competitive employment.	MI Adults:	8.22%	<i>Fully Compliant</i>
		DD Adults:	9.82%	
		MI/DD Adults:	9.90%	
9.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of dual MI/DD adults served by the PIHP who earn minimum wage or more from employment activities.	MI Adults:	86.62%	<i>Substantially Compliant</i>
		DD Adults:	72.31%	
		MI/DD Adults:	88.64%	
10.	Percentage of MI and DD children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children:	5.26%	<i>Fully Compliant</i>
		Adults:	7.78%	
13.	Percentage of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	24.27%		<i>Fully Compliant</i>
14.	Percentage of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	35.89%		<i>Fully Compliant</i>

Strengths

CMH Partnership of Southeastern Michigan continued efforts toward streamlining and automating processes, both related to performance indicator reporting and overall organizational structure, to increase efficiency and accuracy. Since the transition to the PIHP’s electronic medical record system—EII—last year, **CMH Partnership of Southeastern Michigan** worked closely with its vendor and MDCH to resolve issues with encounter data submission. The use of a uniform system facilitated data accuracy, and EII’s reporting capabilities were exceptional.

Recommendations

CMH Partnership of Southeastern Michigan should work with its vendor and MDCH to resolve gaps in data affecting the completeness of QI data elements. The PIHP should follow up with MDCH related to concerns with the HSW rate reported on its behalf and should review internal systems capabilities to ensure complete data are reported per MDCH specifications. As the new Recovery-Oriented System of Care (ROSC) model is more widely implemented, **CMH Partnership of Southeastern Michigan** should continue to work to overcome challenges related to reporting requirements, so that rates may more accurately reflect true performance.

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 Indicator 9, which received a designation of *Substantially Compliant* due to incomplete QI data. 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. The rate of DD adults living in a private residence was higher than the statewide rate, while the rate for MI adults fell below the statewide rate. Performance indicators related to **timeliness** of and **access** to services were *Fully Compliant* with MDCH specifications. **CMH Partnership of Southeastern Michigan** met the contractually required performance standards for 15 of the 17 indicators related to **timeliness** of and **access** to services provided by the PIHP. The PIHP's penetration rate fell below 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 17 of the 19 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 2012 Validation of Performance Measures Report for **Detroit-Wayne County CMH Agency** includes additional details of the validation results.

Table 3-24—Performance Measure Results for Detroit-Wayne County CMH Agency				
	Indicator	Reported Rate		Audit Designation
1.	Percentage of persons during the quarter receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children:	100%	Fully Compliant
		Adults:	98.22%	
2.	Percentage of new persons during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service.	MI Children:	96.26%	Fully Compliant
		MI Adults:	95.41%	
		DD Children:	98.59%	
		DD Adults:	96.83%	
		Medicaid SA:	100%	
		Total:	96.80%	
3.	Percentage of new persons during the quarter starting any needed ongoing service within 14 days of a non-emergent assessment with a professional.	MI Children:	98.05%	Fully Compliant
		MI Adults:	97.18%	
		DD Children:	94.12%	
		DD Adults:	91.67%	
		Medicaid SA:	100%	
		Total:	97.80%	
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children:	98.63%	Fully Compliant
		Adults:	97.56%	
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).	7.16%		Fully Compliant
6.	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 that is not supports coordination (HSW rate).	96.77%		Fully Compliant

**Table 3-24—Performance Measure Results
for Detroit-Wayne County CMH Agency**

	Indicator	Reported Rate	Audit Designation
8.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of dual MI/DD adults served by the PIHP who are in competitive employment.	MI Adults: 4.26%	Fully Compliant
		DD Adults: 2.89%	
		MI/DD Adults: 3.90%	
9.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of dual MI/DD adults served by the PIHP who earn minimum wage or more from employment activities.	MI Adults: 58.72%	Fully Compliant
		DD Adults: 12.87%	
		MI/DD Adults: 31.37%	
10.	Percentage of MI and DD children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children: 11.78%	Fully Compliant
		Adults: 12.61%	
13.	Percentage of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	22.86%	Fully Compliant
14.	Percentage of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	21.56%	Fully Compliant

Strengths

Detroit-Wayne County CMH Agency had a team of experienced staff who demonstrated a thorough understanding of the performance indicators. Although the PIHP’s structure and size presented some challenges, the staff communicated well with the Managers of Comprehensive Provider Networks (MCPNs) that were contracted to provide services to its consumers.

Since the last audit, **Detroit-Wayne County CMH Agency** completed the rollout of MH-WIN, a new centralized system supported by Peter Chang Enterprises (PCE). MCPNs accessed MH-WIN through a host vendor, Pioneer. For targeted users, the centralized system had the capacity to communicate through a notification message when logging in.

Recommendations

Detroit-Wayne County CMH Agency should continue efforts to centralize and standardize processes as much as possible across the MCPNs. In addition, the PIHP should continue to research areas in the MH-WIN application where additional error messages, edits, or “help” features could be added to further facilitate valid and complete information. The PIHP should also continue its efforts to improve any rates that fall below the State’s set standards for the performance indicators.

One area for improvement identified last year still influenced the data detail provided for this year’s rates. Some MCPN groups submitted aggregated rather than detailed data. This year, the PIHP worked to rectify this issue by adding a feature in the centralized system allowing providers and their staff to directly enter information relevant to inpatient stays.

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. 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 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. While the rate for DD adults who live in a private residence exceeded the statewide rate, the rate for MI adults fell below the statewide rate. Performance indicators related to **timeliness** of and **access** to services were *Fully Compliant* with MDCH specifications. **Detroit-Wayne County CMH Agency** met 15 of the 17 contractually required performance standards for indicators related to **timeliness** of and **access** to services provided by the PIHP. The PIHP's penetration rate exceeded the statewide rate. **Detroit-Wayne County CMH Agency** demonstrated strong performance across all three domains of **quality**, **timeliness**, and **access** and met the minimum performance standard for 17 of the 19 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 2012 Validation of Performance Measures Report for **Genesee County CMH** includes additional details of the validation results.

Table 3-25—Performance Measure Results for Genesee County CMH				
	Indicator	Reported Rate		Audit Designation
1.	Percentage of persons during the quarter 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 new persons during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service.	MI Children:	97.89%	Fully Compliant
		MI Adults:	97.29%	
		DD Children:	100%	
		DD Adults:	96.15%	
		Medicaid SA:	91.41%	
		Total:	95.67%	
3.	Percentage of new persons during the quarter starting any needed ongoing service within 14 days of a non-emergent assessment with a professional.	MI Children:	99.15%	Fully Compliant
		MI Adults:	97.85%	
		DD Children:	100%	
		DD Adults:	96.15%	
		Medicaid SA:	95.29%	
		Total:	97.04%	
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children:	100%	Fully Compliant
		Adults:	98.53%	
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).	7.08%		Fully Compliant
6.	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 that is not supports coordination (HSW rate).	97.60%		Fully Compliant
8.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of dual MI/DD adults served by the PIHP who are in competitive employment.	MI Adults:	4.73%	Fully Compliant
		DD Adults:	6.65%	
		MI/DD Adults:	4.89%	

Table 3-25—Performance Measure Results for Genesee County CMH				
	Indicator	Reported Rate		Audit Designation
9.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of dual MI/DD adults served by the PIHP who earn minimum wage or more from employment activities.	MI Adults:	64.23%	Fully Compliant
		DD Adults:	16.00%	
		MI/DD Adults:	20.93%	
10.	Percentage of MI and DD children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children:	10.20%	Fully Compliant
		Adults:	11.28%	
13.	Percentage of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	7.58%		Fully Compliant
14.	Percentage of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	46.83%		Fully Compliant

Strengths

Genesee County CMH continued to refine and improve the performance indicator reporting process. All issues related to completeness of required QI data elements were resolved. As a result of last year's recommendations, the PIHP's utilization manager formally monitored data entry from crisis screening fax forms, and the PIHP continued to communicate regularly with MDCH related to questions or concerns regarding CHAMPS. Genesee County CMH staff members thoroughly monitored performance on an ongoing basis and had regular communications with PCE staff.

Recommendations

Genesee County CMH should continue to work with MDCH regarding any remaining questions or concerns related to CHAMPS and the validation process for encounter data regarding reconciliation between data the PIHP submitted to CHAMPS and data stored in MDCH's data warehouse.

Summary Assessment Related to Quality, Timeliness, and Access

Genesee County CMH'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, Genesee County CMH demonstrated mostly below-average results. The PIHP's HSW rate was higher than 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. While the rate for MI adults who live in a private residence exceeded the statewide rate, the rate for DD adults fell below the statewide rate. Performance indicators related to **timeliness** of and **access** to services were *Fully Compliant* with MDCH specifications. Genesee County CMH met the contractually required performance standards for 16 of the 17 indicators related to **timeliness** of and **access** to services provided by the PIHP. The PIHP's penetration rate exceeded 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 18 of the 19 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 2012 Validation of Performance Measures Report for **Lakeshore Behavioral Health Alliance** includes additional details of the validation results.

Table 3-26—Performance Measure Results for Lakeshore Behavioral Health Alliance				
	Indicator	Reported Rate		Audit Designation
1.	Percentage of persons during the quarter 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 new persons during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service.	MI Children:	97.54%	Fully Compliant
		MI Adults:	100%	
		DD Children:	100%	
		DD Adults:	100%	
		Medicaid SA:	90.09%	
		Total:	95.12%	
3.	Percentage of new persons during the quarter starting any needed ongoing service within 14 days of a non-emergent assessment with a professional.	MI Children:	98.81%	Fully Compliant
		MI Adults:	97.78%	
		DD Children:	100%	
		DD Adults:	76.92%	
		Medicaid SA:	98.10%	
		Total:	97.51%	
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).	3.60%		Substantially Compliant
6.	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 that is not supports coordination (HSW rate).	98.74%		Fully Compliant

**Table 3-26—Performance Measure Results
for Lakeshore Behavioral Health Alliance**

	Indicator	Reported Rate	Audit Designation
8.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of dual MI/DD adults served by the PIHP who are in competitive employment.	MI Adults: 8.04%	Fully Compliant
		DD Adults: 9.32%	
		MI/DD Adults: 8.42%	
9.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of dual MI/DD adults served by the PIHP who earn minimum wage or more from employment activities.	MI Adults: 77.33%	Fully Compliant
		DD Adults: 28.92%	
		MI/DD Adults: 28.13%	
10.	Percentage of MI and DD children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children: 0.00%	Fully Compliant
		Adults: 5.71%	
13.	Percentage of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	10.96%	Fully Compliant
14.	Percentage of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	60.31%	Fully Compliant

Strengths

Lakeshore Behavioral Health Alliance continued to improve its performance measure calculation, review, and reporting processes. Frequent communication with its affiliates and the CA, along with regular meetings and excellent documentation, all supported the performance measure reporting activity. Acting on the previous year’s recommendations, the PIHP formalized its encounter data monitoring process.

Recommendations

Although constraints with **Lakeshore Behavioral Health Alliance**’s information system, Avatar, may prohibit full automation of the performance indicator calculations for reporting purposes, the PIHP should consider working with vendor staff to explore possible improvements to enhance current capabilities. **Lakeshore Behavioral Health Alliance** should follow up with MDCH on the unexpected decline in the penetration rate and take appropriate action to ensure that the cause is identified and resolved for future reporting purposes. The PIHP should continue its close ongoing monitoring of affiliate and CA data.

Summary Assessment Related to Quality, Timeliness, and Access

Lakeshore Behavioral Health Alliance’s performance indicators related to **quality** were *Fully Compliant* with MDCH specifications. The PIHP met 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 MI, 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 rate for MI/DD adults who earned minimum wage fell below the statewide rate. While the rate for MI adults who live in a private residence exceeded the statewide rate, the rate for DD adults 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 received a designation of *Substantially Compliant* due to incomplete data, resulting in an unexpectedly low, below-average penetration rate. **Lakeshore Behavioral Health Alliance** met the contractually required performance standards for 15 of the 17 indicators related to **timeliness** of and **access** to services provided by the PIHP. **Lakeshore Behavioral Health Alliance** demonstrated strong performance across all three domains of **quality, timeliness, and access** and met the minimum performance standard for 17 of the 19 indicators.

LifeWays

Findings

Table 3-27 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2012 Validation of Performance Measures Report for **LifeWays** includes additional details of the validation results.

Table 3-27—Performance Measure Results for LifeWays				
	Indicator	Reported Rate		Audit Designation
1.	Percentage of persons during the quarter receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children:	88.24%	Fully Compliant
		Adults:	99.02%	
2.	Percentage of new persons during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service.	MI Children:	97.62%	Fully Compliant
		MI Adults:	94.03%	
		DD Children:	100%	
		DD Adults:	100%	
		Medicaid SA:	77.63%	
		Total:	89.05%	
3.	Percentage of new persons during the quarter starting any needed ongoing service within 14 days of a non-emergent assessment with a professional.	MI Children:	79.55%	Fully Compliant
		MI Adults:	92.31%	
		DD Children:	83.33%	
		DD Adults:	57.14%	
		Medicaid SA:	100%	
		Total:	90.22%	
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children:	58.33%	Fully Compliant
		Adults:	88.89%	
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).	7.17%		Fully Compliant
6.	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 that is not supports coordination (HSW rate).	92.69%		Fully Compliant
8.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of dual MI/DD adults served by the PIHP who are in competitive employment.	MI Adults:	4.69%	Fully Compliant
		DD Adults:	8.70%	
		MI/DD Adults:	4.61%	

Table 3-27—Performance Measure Results for LifeWays				
	Indicator	Reported Rate		Audit Designation
9.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of dual MI/DD adults served by the PIHP who earn minimum wage or more from employment activities.	MI Adults:	80.39%	<i>Substantially Compliant</i>
		DD Adults:	91.67%	
		MI/DD Adults:	66.67%	
10.	Percentage of MI and DD children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children:	15.38%	<i>Fully Compliant</i>
		Adults:	16.67%	
13.	Percentage of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	12.63%		<i>Fully Compliant</i>
14.	Percentage of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	39.91%		<i>Fully Compliant</i>

Strengths

LifeWays continued to incorporate quality improvements in its processes and transitioned to a new electronic medical record system developed by PCE. In addition to serving as the claims system, the new PCE system was capable of handling all aspects of the QI, encounter, and performance measure data reporting. The software required all key fields to be entered for each consumer prior to allowing the staff to advance further in the tool, which helped to ensure complete QI and encounter data.

Recommendations

LifeWays should monitor the CA’s submission to ensure data are complete prior to submission to MDCH. Many of **LifeWays’** rates fell below MDCH’s 95 percent threshold, including the QI data element for minimum wage. It is expected that the new PCE system will help in capturing these data, and rates should begin to improve.

Summary Assessment Related to Quality, Timeliness, and Access

LifeWays’ performance indicators related to **quality** were *Fully Compliant* with MDCH specifications except for Indicator 9, which received a designation of *Substantially Compliant* due to incomplete QI data. The PIHP met one 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, **LifeWays** achieved mixed results. The PIHP’s HSW rate was higher than the statewide rate. The rates for MI and MI/DD adults who were employed competitively were lower than the statewide rates. The rates for DD adults who were employed competitively and for MI, DD, and MI/DD adults who earned minimum wage were higher than the statewide rates. Rates for MI and DD adults who live in a private residence fell below the statewide rates. Performance indicators related to **timeliness** of and **access** to services were *Fully Compliant* with MDCH specifications. **LifeWays** met the contractually required performance standards for 6 of the 17 indicators related to **timeliness** of and **access** to services provided by the PIHP. The PIHP’s penetration rate exceeded the statewide rate. **LifeWays** demonstrated mixed performance across all three domains of **quality**, **timeliness**, and **access** and met the minimum performance standard for 6 of the 19 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 2012 Validation of Performance Measures Report for **Macomb County CMH Services** includes additional details of the validation results.

Table 3-28—Performance Measure Results for Macomb County CMH Services				
	Indicator	Reported Rate		Audit Designation
1.	Percentage of persons during the quarter 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 new persons during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service.	MI Children:	100%	Fully Compliant
		MI Adults:	97.96%	
		DD Children:	100%	
		DD Adults:	93.55%	
		Medicaid SA:	98.92%	
		Total:	98.54%	
3.	Percentage of new persons during the quarter starting any needed ongoing service within 14 days of a non-emergent assessment with a professional.	MI Children:	100%	Fully Compliant
		MI Adults:	96.77%	
		DD Children:	93.10%	
		DD Adults:	82.76%	
		Medicaid SA:	100%	
		Total:	97.53%	
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).	5.85%		Fully Compliant
6.	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 that is not supports coordination (HSW rate).	98.77%		Fully Compliant
8.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of dual MI/DD adults served by the PIHP who are in competitive employment.	MI Adults:	7.08%	Fully Compliant
		DD Adults:	5.86%	
		MI/DD Adults:	4.40%	

Table 3-28—Performance Measure Results for Macomb County CMH Services				
	Indicator	Reported Rate		Audit Designation
9.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of dual MI/DD adults served by the PIHP who earn minimum wage or more from employment activities.	MI Adults:	51.55%	Fully Compliant
		DD Adults:	37.42%	
		MI/DD Adults:	37.70%	
10.	Percentage of MI and DD children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children:	11.34%	Fully Compliant
		Adults:	18.42%	
13.	Percentage of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	18.15%		Fully Compliant
14.	Percentage of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	36.32%		Fully Compliant

Strengths

Macomb County CMH Services continued its commitment to accurate encounter data and performance measure reporting. The PIHP followed up on all of the auditor’s recommendations from the previous year and continued to enhance and refine its processes.

Recommendations

Macomb County CMH Services will be transitioning to an upgraded and enhanced system. The PIHP should document the processes involved in this transition including trainings, meetings with the vendor, and the overall impact of the transition. **Macomb County CMH Services** should address any system downtime that could affect the completeness of the data used for reporting.

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 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, **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 and MI and MI/DD adults who earned minimum wage fell below the statewide rates. The rate for DD adults earning minimum wage exceeded the statewide rate. Rates for MI and DD adults who live in a private residence were lower than 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 14 of the 17 indicators 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 15 of the 19 indicators.

network180

Findings

Table 3-29 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2012 Validation of Performance Measures Report for **network180** includes additional details of the validation results.

Table 3-29—Performance Measure Results for network180				
	Indicator	Reported Rate		Audit Designation
1.	Percentage of persons during the quarter receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children:	96.33%	Fully Compliant
		Adults:	98.25%	
2.	Percentage of new persons during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service.	MI Children:	96.55%	Fully Compliant
		MI Adults:	97.06%	
		DD Children:	94.74%	
		DD Adults:	100%	
		Medicaid SA:	97.20%	
		Total:	96.90%	
3.	Percentage of new persons during the quarter starting any needed ongoing service within 14 days of a non-emergent assessment with a professional.	MI Children:	91.23%	Fully Compliant
		MI Adults:	96.90%	
		DD Children:	100%	
		DD Adults:	83.33%	
		Medicaid SA:	80.17%	
		Total:	90.31%	
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:	87.61%	
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).	6.63%		Fully Compliant
6.	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 that is not supports coordination (HSW rate).	99.40%		Fully Compliant

Table 3-29—Performance Measure Results for network180				
	Indicator	Reported Rate		Audit Designation
8.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of dual MI/DD adults served by the PIHP who are in competitive employment.	MI Adults:	8.68%	<i>Substantially Compliant</i>
		DD Adults:	8.25%	
		MI/DD Adults:	10.17%	
9.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of dual MI/DD adults served by the PIHP who earn minimum wage or more from employment activities.	MI Adults:	75.87%	<i>Substantially Compliant</i>
		DD Adults:	21.02%	
		MI/DD Adults:	25.21%	
10.	Percentage of MI and DD children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children:	4.08%	<i>Fully Compliant</i>
		Adults:	20.30%	
13.	Percentage of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	11.61%		<i>Fully Compliant</i>
14.	Percentage of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	51.46%		<i>Fully Compliant</i>

Strengths

network180 continued to streamline and automate processes for reporting of performance indicators. **network180** further automated the encounter file submission process. The PIHP made improvements, such as installing a new storage appliance that uses Microsoft’s Windows Azure cloud platform for off-site storage. **network180** staff members ensured the quality of the data used for performance indicator reporting and produced detailed documentation supporting the process.

Recommendations

network180 should continue efforts to automate certain portions of the performance indicator reporting process, such as working through and validating outliers and exceptions. The PIHP should continue to explore mechanisms to obtain electronic data (beyond claims/encounter data), such as progress notes, to support a more streamlined process for calculation and reporting. Because of the incomplete employment data element, the PIHP was advised to research the issue and correct as necessary. The PIHP should continue to thoroughly monitor QI data element completeness.

Summary Assessment Related to Quality, Timeliness, and Access

network180’s performance indicators related to **quality** were *Fully Compliant* with MDCH specifications, except for Indicators 8 and 9, which received a designation of *Substantially Compliant* due to incomplete QI data. 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, **network180** demonstrated 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, as well as MI adults who earned minimum wage, were higher than the

statewide rates, while the rates for DD and MI/DD adults who earned minimum wage fell below the statewide rates. The rate for MI adults who live in a private residence was higher than the statewide rate, while the rate for DD adults fell below the statewide rate. Performance indicators related to **timeliness** of and **access** to services were *Fully Compliant* with MDCH specifications. **network180** met the contractually required performance standards for 11 of the 17 indicators related to **timeliness** of and **access** to services provided by the PIHP. The PIHP's penetration rate fell below the statewide rate. **network180** demonstrated mixed performance and met the minimum performance standard for 12 of the 19 indicators.

NorthCare

Findings

Table 3-30 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2012 Validation of Performance Measures Report for **NorthCare** includes additional details of the validation results.

Table 3-30—Performance Measure Results for NorthCare				
	Indicator	Reported Rate		Audit Designation
1.	Percentage of persons during the quarter receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children:	100%	Fully Compliant
		Adults:	99.33%	
2.	Percentage of new persons during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service.	MI Children:	100%	Fully Compliant
		MI Adults:	98.81%	
		DD Children:	100%	
		DD Adults:	100%	
		Medicaid SA:	100%	
		Total:	99.68%	
3.	Percentage of new persons during the quarter starting any needed ongoing service within 14 days of a non-emergent assessment with a professional.	MI Children:	97.10%	Fully Compliant
		MI Adults:	94.03%	
		DD Children:	100%	
		DD Adults:	100%	
		Medicaid SA:	100%	
		Total:	97.83%	
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children:	88.24%	Fully Compliant
		Adults:	97.62%	
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
6.	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 that is not supports coordination (HSW rate).	97.75%		Fully Compliant
8.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of dual MI/DD adults served by the PIHP who are in competitive employment.	MI Adults:	10.19%	Fully Compliant
		DD Adults:	5.95%	
		MI/DD Adults:	5.86%	

Table 3-30—Performance Measure Results for NorthCare				
	Indicator	Reported Rate		Audit Designation
9.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of dual MI/DD adults served by the PIHP who earn minimum wage or more from employment activities.	MI Adults:	73.27%	Fully Compliant
		DD Adults:	31.23%	
		MI/DD Adults:	41.11%	
10.	Percentage of MI and DD children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children:	17.39%	Fully Compliant
		Adults:	20.45%	
13.	Percentage of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	17.83%		Fully Compliant
14.	Percentage of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	58.11%		Fully Compliant

Strengths

NorthCare’s experienced staff members were responsible for performance measure reporting, helping to ensure that measures were interpreted and reported consistently from year to year. The PIHP used a uniform electronic medical record, ELMER, across all affiliates, which resulted in consistent data capture across affiliate boards. The vendor that supported ELMER had support staff assigned to NorthCare. There was good communication between NorthCare and the vendor related to support and customized reports for ELMER.

Recommendations

NorthCare should continue its efforts to improve rates, keeping in mind that for those measures for which rates fell below the standard, the denominators were small.

Summary Assessment Related to Quality, Timeliness, and Access

NorthCare’s performance indicators related to **quality** were *Fully Compliant* with MDCH specifications. 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, NorthCare demonstrated mostly above-average results. The PIHP’s HSW rate exceeded the statewide rate. The rates for MI adults who were employed competitively and MI, DD, and MI/DD adults who earned minimum wage were higher than the statewide rates. The rates for DD and MI/DD adults who were employed competitively fell below the statewide rates. The rate for MI adults who live in a private residence was higher than the statewide rate, while the rate for DD adults was lower. Performance indicators related to **timeliness** of and **access** to services were *Fully Compliant* with MDCH specifications. NorthCare met the contractually required performance standards for 15 of the 17 indicators related to **timeliness** of and **access** to services provided by the PIHP. The PIHP’s penetration rate exceeded the statewide rate. NorthCare demonstrated strong performance across all three domains of **quality**, **timeliness**, and **access** and met the minimum performance standard for 15 of the 19 indicators.

Northern Affiliation

Findings

Table 3-31 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2012 Validation of Performance Measures Report for **Northern Affiliation** includes additional details of the validation results.

Table 3-31—Performance Measure Results for Northern Affiliation				
	Indicator	Reported Rate		Audit Designation
1.	Percentage of persons during the quarter receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children:	100%	Fully Compliant
		Adults:	98.96%	
2.	Percentage of new persons during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service.	MI Children:	100%	Fully Compliant
		MI Adults:	100%	
		DD Children:	100%	
		DD Adults:	100%	
		Medicaid SA:	100%	
		Total:	100%	
3.	Percentage of new persons during the quarter starting any needed ongoing service within 14 days of a non-emergent assessment with a professional.	MI Children:	100%	Fully Compliant
		MI Adults:	95.24%	
		DD Children:	100%	
		DD Adults:	100%	
		Medicaid SA:	100%	
		Total:	98.60%	
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).	6.69%		Fully Compliant
6.	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 that is not supports coordination (HSW rate).	95.36%		Fully Compliant

Table 3-31—Performance Measure Results for Northern Affiliation			
	Indicator	Reported Rate	Audit Designation
8.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of dual MI/DD adults served by the PIHP who are in competitive employment.	MI Adults: 7.71%	Fully Compliant
		DD Adults: 15.48%	
		MI/DD Adults: 17.35%	
9.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of dual MI/DD adults served by the PIHP who earn minimum wage or more from employment activities.	MI Adults: 57.32%	Fully Compliant
		DD Adults: 43.98%	
		MI/DD Adults: 62.79%	
10.	Percentage of MI and DD children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children: 8.33%	Fully Compliant
		Adults: 7.41%	
13.	Percentage of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	23.80%	Fully Compliant
14.	Percentage of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	57.20%	Fully Compliant

Strengths

Northern Affiliation continued to demonstrate dedication to the performance measure reporting process. New staff members were added to enhance processes currently in place. Despite challenges with CHAMPS and the 5010 transition, the staff remained committed to resolving issues and ensuring that data were processed and submitted to the State. **Northern Affiliation** continued to be very proactive in identifying potential issues and working to resolve them.

Recommendations

Northern Affiliation should ensure that all data are processed and up to date prior to the transition to a new system by year-end. The PIHP should document the transition to the new system and issues or challenges that impact the processing and tracking of data. **Northern Affiliation** should continue to monitor the completeness of encounter data and QI data elements, especially minimum wage and employment status. While performance for the HSW measure has improved, the PIHP should continue its efforts to keep improving this measure’s performance.

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 almost all 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 DD and MI/DD adults who earned minimum wage, as well as rates of DD and MI adults who live in a private residence, were higher than the statewide rates. The rate for MI 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. **Northern Affiliation** met the contractually required performance standards for all indicators related to **timeliness** of and **access** to services provided by the PIHP. The PIHP's penetration rate fell below the statewide rate. **Northern Affiliation** demonstrated excellent performance across all three domains of **quality, timeliness, and access** and met the minimum performance standard for all 19 indicators.

Northwest CMH Affiliation

Findings

Table 3-32 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2012 Validation of Performance Measures Report for **Northwest CMH Affiliation** includes additional details of the validation results.

Table 3-32—Performance Measure Results for Northwest CMH Affiliation				
	Indicator	Reported Rate		Audit Designation
1.	Percentage of persons during the quarter receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children:	94.12%	Fully Compliant
		Adults:	100%	
2.	Percentage of new persons during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service.	MI Children:	98.82%	Fully Compliant
		MI Adults:	96.47%	
		DD Children:	100%	
		DD Adults:	100%	
		Medicaid SA:	100%	
		Total:	98.14%	
3.	Percentage of new persons during the quarter starting any needed ongoing service within 14 days of a non-emergent assessment with a professional.	MI Children:	97.14%	Fully Compliant
		MI Adults:	100%	
		DD Children:	100%	
		DD Adults:	100%	
		Medicaid SA:	100%	
		Total:	99.06%	
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).	7.66%		Fully Compliant
6.	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 that is not supports coordination (HSW rate).	95.05%		Fully Compliant

Table 3-32—Performance Measure Results for Northwest CMH Affiliation				
	Indicator	Reported Rate		Audit Designation
8.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of dual MI/DD adults served by the PIHP who are in competitive employment.	MI Adults:	9.58%	Fully Compliant
		DD Adults:	9.50%	
		MI/DD Adults:	8.43%	
9.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of dual MI/DD adults served by the PIHP who earn minimum wage or more from employment activities.	MI Adults:	94.55%	Fully Compliant
		DD Adults:	52.27%	
		MI/DD Adults:	78.40%	
10.	Percentage of MI and DD children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children:	17.65%	Fully Compliant
		Adults:	12.73%	
13.	Percentage of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	7.39%		Fully Compliant
14.	Percentage of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	58.80%		Fully Compliant

Strengths

Northwest CMH Affiliation had a team of staff members who have been working on the performance measure validation and reporting process for many years. The consistency of the team supported accurate and valid reporting. The PIHP was proactive in working with MDCH to test file layouts and troubleshoot problems. **Northwest CMH Affiliation** had good oversight of its affiliate community mental health centers and CA. The PIHP continued to improve performance of all performance indicators and QI data elements. **Northwest CMH Affiliation** produced detailed documentation, including a detailed assumptions document created for each CMH.

Recommendations

Northwest CMH Affiliation should continue working with MDCH and the other PIHPs to resolve the ongoing challenges and issues with CHAMPS and encounter data submissions. Specific to Northern Lakes CMH, efforts should continue to fully automate the process for calculating Indicators 2 and 3.

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 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, **Northwest CMH Affiliation** achieved almost all 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 exceeded the statewide rates. The rate for MI adults living in a private residence was higher than the statewide rate, while the rate for DD adults

fell below the statewide rate. 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 16 of the 17 indicators 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 strong performance across all three domains of **quality**, **timeliness**, and **access** and continued to meet the minimum performance standard for 17 of the 19 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 2012 Validation of Performance Measures Report for **Oakland County CMH Authority** includes additional details of the validation results.

Table 3-33—Performance Measure Results for Oakland County CMH Authority				
	Indicator	Reported Rate		Audit Designation
1.	Percentage of persons during the quarter receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children:	94.19%	Fully Compliant
		Adults:	93.63%	
2.	Percentage of new persons during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service.	MI Children:	98.00%	Fully Compliant
		MI Adults:	97.30%	
		DD Children:	100%	
		DD Adults:	100%	
		Medicaid SA:	100%	
		Total:	98.69%	
3.	Percentage of new persons during the quarter starting any needed ongoing service within 14 days of a non-emergent assessment with a professional.	MI Children:	99.51%	Fully Compliant
		MI Adults:	100%	
		DD Children:	100%	
		DD Adults:	100%	
		Medicaid SA:	100%	
		Total:	99.89%	
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children:	100%	Fully Compliant
		Adults:	99.41%	
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).	7.78%		Fully Compliant
6.	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 that is not supports coordination (HSW rate).	98.94%		Fully Compliant

Table 3-33—Performance Measure Results for Oakland County CMH Authority				
	Indicator	Reported Rate		Audit Designation
8.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of dual MI/DD adults served by the PIHP who are in competitive employment.	MI Adults:	8.10%	Fully Compliant
		DD Adults:	12.70%	
		MI/DD Adults:	8.92%	
9.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of dual MI/DD adults served by the PIHP who earn minimum wage or more from employment activities.	MI Adults:	61.76%	Fully Compliant
		DD Adults:	34.68%	
		MI/DD Adults:	23.39%	
10.	Percentage of MI and DD children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children:	8.00%	Fully Compliant
		Adults:	10.80%	
13.	Percentage of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	17.66%		Fully Compliant
14.	Percentage of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	34.18%		Fully Compliant

Strengths

Oakland County CMH Authority completed implementation of ODIN, a centralized electronic health record database, across the majority of the PIHP’s core providers. Having a centralized system has led to increased standardization across the core providers, allowing the PIHP to be more confident in the consistency of its data and having immediate access to information entered by core providers. The system vendor PCE provided support to **Oakland County CMH Authority** and worked with its staff to develop customized reports and edits within ODIN to enhance reliability of data in the system. The dashboard allowed for easy viewing of data relevant to many PIHP activities including those applicable to the performance indicators. In addition, the PIHP and vendor developed the Consumer Chronology Report, which allowed the PIHP to generate member-level reports showing chronological detail of all services provided.

Recommendations

Oakland County CMH Authority should continue its efforts to further enhance edits within the ODIN system. The PIHP should work with its vendor to research any other areas where performance measure reporting could be automated. Although there were no issues or concerns noted in the manual processes involved in generating the performance indicators, further automation would allow a higher degree of confidence in the rates. **Oakland County CMH Authority** should continue its efforts to improve rates that fell below the expected standards.

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 all 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 MI, DD, and MI/DD adults who were employed competitively were higher than the statewide rates. The rate for DD adults who earned minimum wage exceeded the statewide rate, while the rates for MI and MI/DD adults earning minimum wage fell below the statewide averages. Rates for MI and DD adults who live in a private residence 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 15 of the 17 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 strong performance across all three domains of **quality**, **timeliness**, and **access** and met the minimum performance standard for 17 of the 19 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 2012 Validation of Performance Measures Report for **Saginaw County CMH Authority** includes additional details of the validation results.

Table 3-34—Performance Measure Results for Saginaw County CMH Authority				
	Indicator	Reported Rate		Audit Designation
1.	Percentage of persons during the quarter 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 new persons during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service.	MI Children:	97.78%	Fully Compliant
		MI Adults:	100%	
		DD Children:	66.67%	
		DD Adults:	100%	
		Medicaid SA:	100%	
Total:	97.88%			
3.	Percentage of new persons during the quarter starting any needed ongoing service within 14 days of a non-emergent assessment with a professional.	MI Children:	84.62%	Fully Compliant
		MI Adults:	100%	
		DD Children:	85.71%	
		DD Adults:	90.00%	
		Medicaid SA:	98.91%	
Total:	95.24%			
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).	5.59%		Fully Compliant
6.	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 that is not supports coordination (HSW rate).	97.48%		Fully Compliant

Table 3-34—Performance Measure Results for Saginaw County CMH Authority			
	Indicator	Reported Rate	Audit Designation
8.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of dual MI/DD adults served by the PIHP who are in competitive employment.	MI Adults: 6.01%	Fully Compliant
		DD Adults: 11.65%	
		MI/DD Adults: 6.78%	
9.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of dual MI/DD adults served by the PIHP who earn minimum wage or more from employment activities.	MI Adults: 84.31%	Substantially Compliant
		DD Adults: 21.43%	
		MI/DD Adults: 30.77%	
10.	Percentage of MI and DD children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children: 11.11%	Fully Compliant
		Adults: 3.03%	
13.	Percentage of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	9.87%	Fully Compliant
14.	Percentage of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	34.85%	Fully Compliant

Strengths

Saginaw County CMH Authority continued to demonstrate a proactive approach to improving processes and performance indicator rates. **Saginaw County CMH Authority** conducted a comprehensive review of rates by examining all exclusions to ensure accurate reporting. **Saginaw County CMH Authority** worked diligently to maximize system customization for improved and efficient workflow processes and reporting. Extensive validation of processes included a random sampling event verification across all providers, including substance abuse data.

Recommendations

Saginaw County CMH Authority should continue to work with its providers to ensure that they enter the correct service date, overriding the automatically recorded date reflecting the time when providers entered data into the system. The PIHP should consider correcting the programming logic or provide a warning to providers as they enter data to input the correct date of service.

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 Indicator 9, which received a designation of *Substantially Compliant* due to incomplete QI data. 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, **Saginaw County CMH Authority** achieved mostly below-average results. The PIHP's HSW rate exceeded the statewide rate. The rates for DD adults who were employed competitively and MI adults who earned minimum wage exceeded the statewide rates, while the rates for MI and MI/DD adults who were employed competitively and DD and

MI/DD adults who earned minimum wage fell below the statewide rates. Rates for MI and DD adults who live in a private residence were lower than the statewide rates. Performance indicators related to **timeliness** of and **access** to services were *Fully Compliant* with MDCH specifications. **Saginaw County CMH Authority** met the contractually required performance standards for 13 of the 17 indicators 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 across the domains of **quality**, **timeliness**, and **access** and met the minimum performance standard for 15 of the 19 indicators.

Southwest Affiliation

Findings

Table 3-35 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2012 Validation of Performance Measures Report for **Southwest Affiliation** includes additional details of the validation results.

Table 3-35—Performance Measure Results for Southwest Affiliation				
	Indicator	Reported Rate		Audit Designation
1.	Percentage of persons during the quarter receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children:	96.00%	Fully Compliant
		Adults:	99.29%	
2.	Percentage of new persons during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service.	MI Children:	97.85%	Fully Compliant
		MI Adults:	99.41%	
		DD Children:	100%	
		DD Adults:	100%	
		Medicaid SA:	94.79%	
		Total:	97.92%	
3.	Percentage of new persons during the quarter starting any needed ongoing service within 14 days of a non-emergent assessment with a professional.	MI Children:	98.62%	Fully Compliant
		MI Adults:	97.44%	
		DD Children:	100%	
		DD Adults:	100%	
		Medicaid SA:	99.00%	
		Total:	98.38%	
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children:	89.74%	Substantially Compliant
		Adults:	96.94%	
4b.	Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	95.45%		Substantially Compliant
5.	Percentage of Medicaid recipients having received PIHP-managed services (penetration rate).	7.15%		Fully Compliant
6.	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 that is not supports coordination (HSW rate).	40.26%		Fully Compliant

Table 3-35—Performance Measure Results for Southwest Affiliation				
	Indicator	Reported Rate		Audit Designation
8.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of dual MI/DD adults served by the PIHP who are in competitive employment.	MI Adults:	9.09%	<i>Substantially Compliant</i>
		DD Adults:	11.45%	
		MI/DD Adults:	9.56%	
9.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of dual MI/DD adults served by the PIHP who earn minimum wage or more from employment activities.	MI Adults:	82.89%	<i>Substantially Compliant</i>
		DD Adults:	42.57%	
		MI/DD Adults:	58.18%	
10.	Percentage of MI and DD children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children:	10.87%	<i>Fully Compliant</i>
		Adults:	6.19%	
13.	Percentage of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	19.47%		<i>Fully Compliant</i>
14.	Percentage of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	59.31%		<i>Fully Compliant</i>

Strengths

Southwest Affiliation continued to have a strong, collaborative affiliate model. Because no staffing changes occurred over the years across the various affiliates, staff members continued to communicate well with each other and the PIHP staff. Although the rates were aggregated at the PIHP level, the affiliates were involved and reviewed their individual rates, which added a layer of quality assurance to the process. **Southwest Affiliation** used recommendations from the previous audit and added organizational reviews of performance indicators, including QI data completeness. **Southwest Affiliation** was in the process of migrating its affiliates to the new Streamline system. While these changes did not affect the data under review for this audit, the changes should have a positive, significant impact on future reporting.

Recommendations

Southwest Affiliation should continue to work with the non-PIHP staff in Kalamazoo to collect the demographic information required by MDCH. Although the new Streamline system will help in the collection of these data, the PIHP needs to explore additional avenues to ensure completeness of these required fields. Additional incentives or contractual requirements may be necessary to obtain the required data needed for reporting, as there was no real improvement in the completeness of the employment status field or the minimum wage field; and these data completeness rates were far below MDCH’s 95 percent minimum threshold.

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 8 and 9, which received a designation of *Substantially*

Compliant due to incomplete QI data, and Indicators 4a and 4b, for which the PIHP inadvertently used an incorrect date parameter, causing these indicators to be *Substantially Compliant*. 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 above-average results for all but one indicator: the PIHP's HSW rate fell below 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. Rates for MI and DD adults living in a private residence exceeded the statewide rates. Performance indicators related to **timeliness** of and **access** to services were *Fully Compliant* with MDCH specifications except for Indicator 4a. **Southwest Affiliation** met the contractually required performance standards for 15 of the 17 indicators 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 17 of the 19 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 2012 Validation of Performance Measures Report for **Thumb Alliance PIHP** includes additional details of the validation results.

Table 3-36—Performance Measure Results for Thumb Alliance PIHP				
	Indicator	Reported Rate		Audit Designation
1.	Percentage of persons during the quarter 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 new persons during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service.	MI Children:	99.16%	Fully Compliant
		MI Adults:	99.29%	
		DD Children:	100%	
		DD Adults:	100%	
		Medicaid SA:	100%	
3.	Percentage of new persons during the quarter starting any needed ongoing service within 14 days of a non-emergent assessment with a professional.	MI Children:	100%	Fully Compliant
		MI Adults:	100%	
		DD Children:	100%	
		DD Adults:	100%	
		Medicaid SA:	100%	
		Total:	100%	
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).	8.02%		Fully Compliant
6.	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 that is not supports coordination (HSW rate).	98.95%		Fully Compliant
8.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of dual MI/DD adults served by the PIHP who are in competitive employment.	MI Adults:	8.19%	Fully Compliant
		DD Adults:	3.93%	
		MI/DD Adults:	3.72%	

**Table 3-36—Performance Measure Results
for Thumb Alliance PIHP**

	Indicator	Reported Rate	Audit Designation
9.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of dual MI/DD adults served by the PIHP who earn minimum wage or more from employment activities.	MI Adults: 35.38%	Fully Compliant
		DD Adults: 9.69%	
		MI/DD Adults: 12.23%	
10.	Percentage of MI and DD children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children: 8.33%	Fully Compliant
		Adults: 12.05%	
13.	Percentage of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	15.84%	Fully Compliant
14.	Percentage of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	56.65%	Fully Compliant

Strengths

Thumb Alliance PIHP continued to enhance its OASIS system. The PIHP worked with PCE to add additional reporting functions for tracking and monitoring of data completeness and accuracy. **Thumb Alliance PIHP** included Data Management 101 as a component of its training curriculum for all new employees and offered the training to the clinical staff. **Thumb Alliance PIHP’s** staff membership remained unchanged, and staff members continued their dedication to accurate encounter data reporting, which was demonstrated through the close working relationship between the PIHP and the MDCH to reconcile annual monitoring reports.

Recommendations

Thumb Alliance PIHP should continue to work with MDCH to build additional reconciliation processes for tracking and monitoring encounter data and continue to monitor the completeness of quality improvement data elements.

Summary Assessment Related to Quality, Timeliness, and Access

Thumb Alliance PIHP’s performance indicators related to **quality** were *Fully Compliant* with MDCH specifications. The PIHP met all 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 adults who were employed competitively or lived in a private residence exceeded the statewide rates. The rates for DD and MI/DD adults who were employed competitively; MI, DD, and MI/DD adults who earned minimum wage; and DD adults living in a private residence 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 excellent performance across all three domains of **quality, timeliness, and access** and met the minimum performance standard for all 19 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 2012 Validation of Performance Measures Report for **Venture Behavioral Health** includes additional details of the validation results.

Table 3-37—Performance Measure Results for Venture Behavioral Health				
	Indicator	Reported Rate		Audit Designation
1.	Percentage of persons during the quarter 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 new persons during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service.	MI Children:	97.59%	Substantially Compliant
		MI Adults:	98.51%	
		DD Children:	100%	
		DD Adults:	100%	
		Medicaid SA:	95.80%	
	Total:	97.86%		
3.	Percentage of new persons during the quarter starting any needed ongoing service within 14 days of a non-emergent assessment with a professional.	MI Children:	97.79%	Substantially Compliant
		MI Adults:	98.81%	
		DD Children:	100%	
		DD Adults:	100%	
		Medicaid SA:	99.31%	
	Total:	98.76%		
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children:	100%	Fully Compliant
		Adults:	98.46%	
4b.	Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	0.00%*		Fully Compliant
5.	Percentage of Medicaid recipients having received PIHP-managed services (penetration rate).	6.92%		Fully Compliant
6.	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 that is not supports coordination (HSW rate).	96.28%		Fully Compliant

* There were no applicable cases during the reporting period.

Table 3-37—Performance Measure Results for Venture Behavioral Health				
	Indicator	Reported Rate		Audit Designation
8.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of dual MI/DD adults served by the PIHP who are in competitive employment.	MI Adults:	11.03%	<i>Fully Compliant</i>
		DD Adults:	9.29%	
		MI/DD Adults:	6.27%	
9.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of dual MI/DD adults served by the PIHP who earn minimum wage or more from employment activities.	MI Adults:	81.29%	<i>Substantially Compliant</i>
		DD Adults:	42.16%	
		MI/DD Adults:	47.62%	
10.	Percentage of MI and DD children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children:	0.00%	<i>Fully Compliant</i>
		Adults:	6.90%	
13.	Percentage of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	13.59%		<i>Fully Compliant</i>
14.	Percentage of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	50.64%		<i>Fully Compliant</i>

Strengths

Venture Behavioral Health continued to use the Streamline system across the affiliation. The use of a single system helped to ensure standardization of the data captured across affiliates. There continued to be good communication between Streamline support staff and the PIHP. The Streamline staff members were responsible for managing the practice systems for the PIHP, affiliates, and the data warehouse. The performance measures were automated, and the system allowed easy access to the performance measures as well as member-level detail and dashboard reports that were broken out by each affiliate. Each performance indicator was monitored at least monthly through reports and monthly meetings with the PIHP and Community Mental Health Service Providers (CMHSPs) in order to review both performance indicator and encounter data.

Recommendations

Venture Behavioral Health should incorporate consumer-level data validation as part of the ongoing reporting process for the performance measures. **Venture Behavioral Health** continued to fall below the MDCH threshold for completeness of minimum wage data. However, the internal calculation by **Venture Behavioral Health** showed that the QI data elements were generally more than 95 percent complete, including the QI data element for minimum wage. **Venture Behavioral Health** should continue working with MDCH to receive more detailed information on programming logic and consumers included in the minimum wage calculation since the rate calculated by MDCH and the rate calculated internally were significantly different. **Venture Behavioral Health** should also explore the possibility of obtaining the quarterly reports that once were produced by MDCH, since these reports helped with the QI and encounter data submissions.

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 Indicator 9 due to incomplete QI data. 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 and 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/DD adults who were employed was lower than the statewide rate. The rate for MI adults who live in a private residence was higher than the statewide rate, while the rate for DD adults was lower. Performance indicators related to **timeliness** of and **access** to services were *Fully Compliant* with MDCH specifications except for Indicators 2 and 3, which received a validation status of *Substantially Compliant* due to exclusion logic that could mistakenly exclude applicable cases. **Venture Behavioral Health** met the contractually required performance standards for all indicators related to **timeliness** of and **access** to services provided by the PIHP. The PIHP's penetration rate exceeded the statewide rate. **Venture Behavioral Health** demonstrated excellent performance across all three domains of **quality**, **timeliness**, and **access** and continued to meet the minimum performance standard for all 19 indicators.

Validation of Performance Improvement Projects

This section of the report presents the results of the validation of PIPs. For the 2011–2012 validation, the PIHPs produced their second-year submissions for the mandatory study topic: *Increasing the Proportion of Medicaid Eligible Adults With a Mental Illness Who Receive Peer-Delivered Services or Supports*. For the purposes of the EQR technical report, HSAG assigned this PIP to the **quality** domain. The goal of the PIP was to improve the quality of care and services as well as the likelihood of desired mental health outcomes by increasing the proportion of adults with a mental illness who receive peer-delivered services or supports.

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 2011–2012 PIP Validation Tool for **Access Alliance of Michigan**. Validation of Activities 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.

Review Activity		All Evaluation Elements (Including Critical Elements)					Critical Elements				
		Total	M	PM	NM	NA	Total	M	PM	NM	NA
I.	Select the Study Topic(s)	6	5	0	0	1	1	1	0	0	0
II.	Define the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III.	Select the Study Indicator(s)	7	4	0	0	3	3	3	0	0	0
IV.	Use a Representative and Generalizable Study Population	3	2	0	0	1	2	2	0	0	0
V.	Use Sound Sampling Techniques	6	0	0	0	6	1	0	0	0	1
VI.	Reliably Collect Data	11	5	0	0	6	1	0	0	0	1
VII.	Implement Intervention and Improvement Strategies	4	2	0	1	1	1	1	0	0	0
VIII.	Analyze Data and Interpret Study Results	9	6	1	1	1	2	1	0	0	1
IX.	Assess for Real Improvement	4	1	0	3	0	No Critical Elements				
X.	Assess for Sustained Improvement	1	Not Assessed				No Critical Elements				
Totals for All Activities		53	27	1	5	19	13	10	0	0	3

Percentage Score of Evaluation Elements <i>Met</i>	82%
Percentage Score of Critical Elements <i>Met</i>	100%
Validation Status	<i>Met</i>

Strengths

Access Alliance of Michigan demonstrated strength in its study design and study implementation for the PIP on increasing the proportion of Medicaid eligible adults with a mental illness who receive peer-delivered services or supports. The PIHP received *Met* scores for all applicable evaluation elements in Activities I through VI, indicating that the PIP was appropriately designed to measure outcomes and improvement. **Access Alliance of Michigan** continued to encourage the use of peer support specialists and provided assistance during the application process to become a certified peer support specialist.

Recommendations

HSAG identified opportunities for improvement in Activities VII—Implement Intervention and Improvement Strategies, VIII—Analyze Data and Interpret Study Results, and IX—Assess for Real Improvement. As none of the study indicators demonstrated improvement, **Access Alliance of Michigan** should revisit the causal/barrier analysis process, determine the specific barriers prohibiting improvement, and revise its interventions accordingly. **Access Alliance of Michigan** should discuss the overall success of the PIP, include a comparison of the current study indicator rate to the rate from the previous measurement period, and correctly document the number of beneficiaries who received a service in the baseline year. In Activity IX, HSAG identified opportunities for improvement because the study indicator rate decreased from baseline to Remeasurement 1, indicating that there was no improvement in outcomes.

HSAG identified additional *Points of Clarification* in Activity III and Activity VIII to strengthen the study.

Results and Summary Assessment Related to Quality, Timeliness, and Access

Access Alliance of Michigan reported a rate decrease from 11.3 percent to 10.3 percent for adults with a mental illness receiving services from the PIHP who had at least one PIHP-reported encounter in the State's data warehouse for a peer-delivered service or support. While the Remeasurement 1 rate was lower than the baseline rate, the rate decrease was not statistically significant. **Access Alliance of Michigan** met its Remeasurement 1 goal of increasing the number of members in the baseline numerator by 3.0 percent, which improved the **quality** of services provided by the PIHP. **Access Alliance of Michigan** implemented several interventions, which included updating Medicaid data tables with the correct codes, reviewing claims data to ensure proper billing, training staff to properly document services provided, and hiring peer support specialists. 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 2011–2012 PIP Validation Tool for **CMH Affiliation of Mid-Michigan**. Validation of Activities I through IX resulted in a validation status of *Met*, with an overall score of 91 percent and a score of 100 percent for critical elements. Based on the validation of this PIP, HSAG's assessment determined confidence in the PIP results.

Review Activity		All Evaluation Elements (Including Critical Elements)					Critical Elements				
		Total	M	PM	NM	NA	Total	M	PM	NM	NA
I.	Select the Study Topic(s)	6	5	0	0	1	1	1	0	0	0
II.	Define the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III.	Select the Study Indicator(s)	7	4	0	0	3	3	3	0	0	0
IV.	Use a Representative and Generalizable Study Population	3	2	0	0	1	2	2	0	0	0
V.	Use Sound Sampling Techniques	6	0	0	0	6	1	0	0	0	1
VI.	Reliably Collect Data	11	5	0	0	6	1	0	0	0	1
VII.	Implement Intervention and Improvement Strategies	4	3	0	0	1	1	1	0	0	0
VIII.	Analyze Data and Interpret Study Results	9	6	2	0	1	2	1	0	0	1
IX.	Assess for Real Improvement	4	3	0	1	0	No Critical Elements				
X.	Assess for Sustained Improvement	1	Not Assessed				No Critical Elements				
Totals for All Activities		53	30	2	1	19	13	10	0	0	3

Percentage Score of Evaluation Elements <i>Met</i>	91%
Percentage Score of Critical Elements <i>Met</i>	100%
Validation Status	<i>Met</i>

Strengths

CMH Affiliation of Mid-Michigan demonstrated strength in its study design and study implementation for the PIP on increasing the proportion of Medicaid eligible adults with a mental illness who receive peer-delivered services or supports. The PIHP received *Met* scores for all applicable evaluation elements in Activities I through VII, indicating that the PIP was appropriately designed to measure outcomes and improvement and that interventions were designed to change behavior at an institutional, practitioner, or beneficiary level. The PIP demonstrated improvement in Activity IX. The improvement in the study indicator rate appeared to be the result of planned interventions.

Recommendations

HSAG identified opportunities for improvement in Activities VIII—Analyze Data and Interpret Study Results and IX—Assess for Real Improvement. **CMH Affiliation of Mid-Michigan** should ensure that data are calculated and reported correctly. The increase in the study indicator rate was not statistically significant. The PIHP should regularly monitor interventions to determine if the interventions are having the desired effect and decide if interventions need to be modified or discontinued.

HSAG identified an additional *Point of Clarification* in Activity III to strengthen the study.

Results and Summary Assessment Related to Quality, Timeliness, and Access

CMH Affiliation of Mid-Michigan reported a rate increase from 8.4 percent to 9.3 percent for adults with a mental illness receiving services from the PIHP who had at least one PIHP-reported encounter in the State's data warehouse for a peer-delivered service or support. While the Remeasurement 1 rate was higher than the baseline rate, the rate increase was not statistically significant. **CMH Affiliation of Mid-Michigan** met its Remeasurement 1 goal of 8.5 percent, which improved the **quality** of services provided by the PIHP. **CMH Affiliation of Mid-Michigan** implemented an intervention, increasing the number of employed peer support specialists. 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 2011–2012 PIP Validation Tool for **CMH for Central Michigan**. Validation of Activities I through IX resulted in a validation status of *Met*, with an overall score of 94 percent and a score of 100 percent for critical elements. 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 Activity		All Evaluation Elements (Including Critical Elements)					Critical Elements				
		Total	M	PM	NM	NA	Total	M	PM	NM	NA
I.	Select the Study Topic(s)	6	5	0	0	1	1	1	0	0	0
II.	Define the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III.	Select the Study Indicator(s)	7	4	0	0	3	3	3	0	0	0
IV.	Use a Representative and Generalizable Study Population	3	2	0	0	1	2	2	0	0	0
V.	Use Sound Sampling Techniques	6	0	0	0	6	1	0	0	0	1
VI.	Reliably Collect Data	11	5	0	0	6	1	0	0	0	1
VII.	Implement Intervention and Improvement Strategies	4	3	0	0	1	1	1	0	0	0
VIII.	Analyze Data and Interpret Study Results	9	6	2	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	31	2	0	19	13	10	0	0	3

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

Percentage Score of Evaluation Elements <i>Met</i>	94%
Percentage Score of Critical Elements <i>Met</i>	100%
Validation Status	<i>Met</i>

Strengths

CMH for Central Michigan demonstrated strength in its study design and study implementation for the PIP on increasing the proportion of Medicaid eligible adults with a mental illness who receive peer-delivered services or supports. The PIHP received *Met* scores for all applicable evaluation elements in Activities I through VII, indicating that the PIP was appropriately designed to measure outcomes and improvement and that interventions were designed to change behavior at an institutional, practitioner, or beneficiary level. **CMH for Central Michigan** also met all evaluation elements in Activity IX, demonstrating true improvement with a statistically significant improvement in the study indicator rate that appeared to be the result of planned interventions.

Recommendations

HSAG identified opportunities for improvement in Activity VIII—Analyze Data and Interpret Study Results. **CMH for Central Michigan** should ensure accurate calculation of study results in future submissions.

Results and Summary Assessment Related to Quality, Timeliness, and Access

CMH for Central Michigan reported a rate increase from 10.8 percent to 12.8 percent for adults with a mental illness receiving services from the PIHP who had at least one PIHP-reported encounter in the State's data warehouse for a peer-delivered service or support. The Remeasurement 1 rate was higher than the baseline rate. The rate increase was statistically significant; therefore, the PIP demonstrated true improvement. **CMH for Central Michigan** met its Remeasurement 1 goal of 12.0 percent, which improved the **quality** of services provided by the PIHP. **CMH for Central Michigan** implemented several interventions, which included staff training, distribution of a consumer brochure aimed at increasing awareness about peer support services, and a short announcement broadcasted on waiting room televisions about peer support 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 2011–2012 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 94 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 3-44—PIP Validation Scores for CMH Partnership of Southeastern Michigan											
Review Activity		All Evaluation Elements (Including Critical Elements)					Critical Elements				
		Total	M	PM	NM	NA	Total	M	PM	NM	NA
I.	Select the Study Topic(s)	6	5	0	0	1	1	1	0	0	0
II.	Define the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III.	Select the Study Indicator(s)	7	4	0	0	3	3	3	0	0	0
IV.	Use a Representative and Generalizable Study Population	3	2	0	0	1	2	2	0	0	0
V.	Use Sound Sampling Techniques	6	0	0	0	6	1	0	0	0	1
VI.	Reliably Collect Data	11	5	0	0	6	1	0	0	0	1
VII.	Implement Intervention and Improvement Strategies	4	3	0	0	1	1	1	0	0	0
VIII.	Analyze Data and Interpret Study Results	9	6	0	2	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	0	2	19	13	10	0	0	3

Table 3-45—PIP Validation Status for CMH Partnership of Southeastern Michigan	
Percentage Score of Evaluation Elements <i>Met</i>	94%
Percentage Score of Critical Elements <i>Met</i>	100%
Validation Status	<i>Met</i>

Strengths

CMH Partnership of Southeastern Michigan demonstrated strength in its study design and study implementation for the PIP on increasing the proportion of Medicaid eligible adults with a mental illness who receive peer-delivered services or supports. The PIHP received *Met* scores for all applicable evaluation elements in Activities I through VII, indicating that the PIP was appropriately designed to measure outcomes and improvement and that interventions were designed to change behavior at an institutional, practitioner, or beneficiary level. **CMH Partnership of Southeastern Michigan** also met all evaluation elements in Activity IX, demonstrating true improvement with a statistically significant improvement in the study indicator rate that appeared to be the result of planned interventions.

Recommendations

HSAG identified opportunities for improvement in Activity VIII—Analyze Data and Interpret Study Results. **CMH Partnership of Southeastern Michigan**'s future submissions should include a discussion about factors that affected the ability to compare results and—if such factors were identified—measures taken to counteract any negative effects. For each measurement period, the PIHP should include an interpretation of the extent to which the PIP was successful and address any planned follow-up activities.

Results and Summary Assessment Related to Quality, Timeliness, and Access

CMH Partnership of Southeastern Michigan reported a rate increase from 4.9 percent to 16.2 percent for adults with a mental illness receiving services from the PIHP who had at least one PIHP-reported encounter in the State's data warehouse for a peer-delivered service or support. The Remeasurement 1 rate was higher than the baseline rate. The rate increase was statistically significant; therefore, the PIP demonstrated true improvement. **CMH Partnership of Southeastern Michigan** met its Remeasurement 1 goal of 5.4 percent, which improved the **quality** of services provided by the PIHP. **CMH Partnership of Southeastern Michigan** implemented several interventions to address identified barriers. These interventions included hiring of peer support staff, training staff to document peer services correctly, reviewing eligible member records to determine if peer services were appropriate, and encouraging consumers to use peer support 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 2011–2012 PIP Validation Tool for **Detroit-Wayne County CMH Agency**. Validation of Activities I through IX resulted in a validation status of *Met*, with an overall score of 100 percent and a score of 100 percent for critical elements. Based on the validation of this PIP, HSAG's assessment determined high confidence in the results.

Review Activity		All Evaluation Elements (Including Critical Elements)					Critical Elements				
		Total	M	PM	NM	NA	Total	M	PM	NM	NA
I.	Select the Study Topic(s)	6	5	0	0	1	1	1	0	0	0
II.	Define the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III.	Select the Study Indicator(s)	7	4	0	0	3	3	3	0	0	0
IV.	Use a Representative and Generalizable Study Population	3	2	0	0	1	2	2	0	0	0
V.	Use Sound Sampling Techniques	6	0	0	0	6	1	0	0	0	1
VI.	Reliably Collect Data	11	5	0	0	6	1	0	0	0	1
VII.	Implement Intervention and Improvement Strategies	4	3	0	0	1	1	1	0	0	0
VIII.	Analyze Data and Interpret Study Results	9	8	0	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	0	0	19	13	10	0	0	3

Percentage Score of Evaluation Elements <i>Met</i>	100%
Percentage Score of Critical Elements <i>Met</i>	100%
Validation Status	<i>Met</i>

Strengths

Detroit-Wayne County CMH Agency's demonstrated strength in its study design and study implementation for the PIP on increasing the proportion of Medicaid eligible adults with a mental illness who receive peer-delivered services or supports. The PIHP received *Met* scores for all applicable evaluation elements in Activities I through IX, indicating that the PIP was appropriately designed to measure outcomes and improvement. The interventions were designed to change behavior at an institutional, practitioner, or beneficiary level. **Detroit-Wayne County CMH Agency** appropriately analyzed data and interpreted study results. The PIP demonstrated true improvement in Activity IX. The improvement in the study indicator rate was statistically significant and appeared to be the result of planned interventions.

Recommendations

HSAG identified one *Point of Clarification* in Activity VII as an opportunity for improvement during the Remeasurement 1 validation period. **Detroit-Wayne County CMH Agency** reported an incorrect value for the increase in the Certified Support Specialist employment rate. Future submissions should correct this discrepancy.

Results and Summary Assessment Related to Quality, Timeliness, and Access

Detroit-Wayne reported a rate increase from 12.7 percent to 16.8 percent for adults with a mental illness receiving services from the PIHP who had at least one PIHP-reported encounter in the State's data warehouse for a peer-delivered service or support. The Remeasurement 1 rate was higher than the baseline rate. The rate increase was statistically significant; therefore, the PIP demonstrated true improvement. **Detroit-Wayne County CMH Agency** met its Remeasurement 1 goal of 13.9 percent, which improved the **quality** of services provided by the PIHP. **Detroit-Wayne County CMH Agency** implemented several interventions, which included educating consumers about peer support services and training providers to use the correct codes when documenting peer support 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 2011–2012 PIP Validation Tool for **Genesee County CMH**. Validation of Activities I through IX resulted in a validation status of *Met*, with an overall score of 91 percent and a score of 100 percent for critical elements. 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 Activity		All Evaluation Elements (Including Critical Elements)					Critical Elements				
		Total	M	PM	NM	NA	Total	M	PM	NM	NA
I.	Select the Study Topic(s)	6	5	0	0	1	1	1	0	0	0
II.	Define the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III.	Select the Study Indicator(s)	7	4	0	0	3	3	3	0	0	0
IV.	Use a Representative and Generalizable Study Population	3	2	0	0	1	2	2	0	0	0
V.	Use Sound Sampling Techniques	6	0	0	0	6	1	0	0	0	1
VI.	Reliably Collect Data	11	5	0	0	6	1	0	0	0	1
VII.	Implement Intervention and Improvement Strategies	4	2	1	0	1	1	1	0	0	0
VIII.	Analyze Data and Interpret Study Results	9	7	1	0	1	2	1	0	0	1
IX.	Assess for Real Improvement	4	3	0	1	0	No Critical Elements				
X.	Assess for Sustained Improvement	1	Not Assessed				No Critical Elements				
Totals for All Activities		53	30	2	1	19	13	10	0	0	3

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

Percentage Score of Evaluation Elements <i>Met</i>	91%
Percentage Score of Critical Elements <i>Met</i>	100%
Validation Status	<i>Met</i>

Strengths

Genesee County CMH demonstrated strength in its study design and study implementation for the PIP on increasing the proportion of Medicaid eligible adults with a mental illness who receive peer-delivered services or supports. The PIHP received *Met* scores for all applicable evaluation elements in Activities I through VI, indicating that the PIP was appropriately designed to measure outcomes and improvement and interventions were designed to change behavior at an institutional, practitioner, or beneficiary level. **Genesee County CMH** also demonstrated improvement in Activity IX, and the improvement in the study indicator rate appeared to be the result of planned interventions.

Recommendations

HSAG identified opportunities for improvement in Activity VII—Implement Intervention and Improvement Strategies, Activity VIII—Analyze Data and Interpret Study Results, and Activity IX—Assess for Real Improvement. The PIHP should document monitoring of interventions and discuss if successful interventions are standardized. In future submissions, **Genesee County CMH** should set a goal for Remeasurement 2 based on the Remeasurement 1 rate and include a discussion comparing the Remeasurement 2 goal to the actual Remeasurement 2 rate. The PIHP should regularly monitor interventions to determine if the interventions produce the desired effect and modify or discontinue interventions that are not successful.

HSAG identified an additional *Point of Clarification* in Activities III and VIII to strengthen the study.

Results and Summary Assessment Related to Quality, Timeliness, and Access

Genesee County CMH reported a rate increase from 9.4 percent to 10.6 percent for adults with a mental illness receiving services from the PIHP who had at least one PIHP-reported encounter in the State's data warehouse for a peer-delivered service or support. The Remeasurement 1 rate was higher than the baseline rate. The rate increase was not statistically significant; therefore, the PIP did not provide statistical evidence that the observed improvement was true improvement. **Genesee County CMH** did not establish a Remeasurement 1 goal. **Genesee County CMH** implemented several interventions, which included developing procedures to identify peer services in encounters and claims, and implementing a Crisis Intervention Response Team (CIRT) and a recovery center that included peer 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 2011–2012 PIP Validation Tool for **Lakeshore Behavioral Health Alliance**. Validation of Activities I through IX resulted in a validation status of *Met*, with an overall score of 100 percent and a score of 100 percent for critical elements. Based on the validation of this PIP, HSAG's assessment determined high confidence in the results.

Table 3-50—PIP Validation Scores for Lakeshore Behavioral Health Alliance											
Review Activity		All Evaluation Elements (Including Critical Elements)					Critical Elements				
		Total	M	PM	NM	NA	Total	M	PM	NM	NA
I.	Select the Study Topic(s)	6	5	0	0	1	1	1	0	0	0
II.	Define the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III.	Select the Study Indicator(s)	7	4	0	0	3	3	3	0	0	0
IV.	Use a Representative and Generalizable Study Population	3	2	0	0	1	2	2	0	0	0
V.	Use Sound Sampling Techniques	6	0	0	0	6	1	0	0	0	1
VI.	Reliably Collect Data	11	5	0	0	6	1	0	0	0	1
VII.	Implement Intervention and Improvement Strategies	4	3	0	0	1	1	1	0	0	0
VIII.	Analyze Data and Interpret Study Results	9	8	0	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	0	0	19	13	10	0	0	3

Table 3-51—PIP Validation Status for Lakeshore Behavioral Health Alliance	
Percentage Score of Evaluation Elements <i>Met</i>	100%
Percentage Score of Critical Elements <i>Met</i>	100%
Validation Status	<i>Met</i>

Strengths

Lakeshore Behavioral Health Alliance demonstrated strength in its study design and study implementation for the PIP on increasing the proportion of Medicaid eligible adults with a mental illness who receive peer-delivered services or supports. The PIHP received *Met* scores for all applicable evaluation elements in Activities I through IX, indicating that the PIP was appropriately designed and implemented to measure outcomes and improvement. The interventions were designed to change behavior at an institutional, practitioner, or beneficiary level. **Lakeshore Behavioral Health Alliance** appropriately analyzed data and interpreted study results. The PIP demonstrated true improvement in Activity IX, in which the study indicator rate improvement was statistically significant and appeared to be the result of planned interventions.

Recommendations

HSAG identified a *Point of Clarification* in Activity VIII of the PIP as an opportunity for improvement. **Lakeshore Behavioral Health Alliance** should ensure the rate reported in the PIP narrative matches the rate presented in the PIP results table.

Results and Summary Assessment Related to Quality, Timeliness, and Access

Lakeshore Behavioral Health Alliance reported a rate increase from 9.6 percent to 15.3 percent for adults with a mental illness receiving services from the PIHP who had at least one PIHP-reported encounter in the State's data warehouse for a peer-delivered service or support. The Remeasurement 1 rate was higher than the baseline rate. The rate increase was statistically significant; therefore, the PIP demonstrated true improvement. **Lakeshore Behavioral Health Alliance** met its Remeasurement 1 goal of 15.0 percent, which improved the **quality** of services provided by the PIHP. **Lakeshore Behavioral Health Alliance** implemented interventions, which included hiring of additional peer support staff, initiating peer-led empowerment groups, facilitating a dialectical behavior therapy group, and obtaining a grant to add a peer support staff position. As **Lakeshore Behavioral Health Alliance** 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 2011–2012 PIP Validation Tool for **LifeWays**. Validation of Activities 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.

Review Activity		All Evaluation Elements (Including Critical Elements)					Critical Elements				
		Total	M	PM	NM	NA	Total	M	PM	NM	NA
I.	Select the Study Topic(s)	6	5	0	0	1	1	1	0	0	0
II.	Define the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III.	Select the Study Indicator(s)	7	4	0	0	3	3	3	0	0	0
IV.	Use a Representative and Generalizable Study Population	3	2	0	0	1	2	2	0	0	0
V.	Use Sound Sampling Techniques	6	0	0	0	6	1	0	0	0	1
VI.	Reliably Collect Data	11	5	0	0	6	1	0	0	0	1
VII.	Implement Intervention and Improvement Strategies	4	3	0	0	1	1	1	0	0	0
VIII.	Analyze Data and Interpret Study Results	9	5	3	0	1	2	1	0	0	1
IX.	Assess for Real Improvement	4	1	0	3	0	No Critical Elements				
X.	Assess for Sustained Improvement	1	Not Assessed				No Critical Elements				
Totals for All Activities		53	27	3	3	19	13	10	0	0	3

Percentage Score of Evaluation Elements <i>Met</i>	82%
Percentage Score of Critical Elements <i>Met</i>	100%
Validation Status	<i>Met</i>

Strengths

LifeWays demonstrated strength in its study design and study implementation for the PIP on increasing the proportion of Medicaid eligible adults with a mental illness who receive peer-delivered services or supports. The PIHP received *Met* scores for all applicable evaluation elements in Activities I through VII, indicating that the PIP was appropriately designed to measure outcomes and improvement. **LifeWays** expected its interventions to result in permanent change and documented a renewed effort to target and develop new interventions designed to increase the number of consumers receiving peer support services.

Recommendations

HSAG identified opportunities for improvement in Activity VIII—Analyze Data and Interpret Study Results and Activity IX—Assess for Real Improvement. **LifeWays** should ensure that results are calculated correctly and address whether or not there were any factors that affected the ability to compare results between the measurement periods. As none of the study indicators demonstrated improvement, **LifeWays** should revisit its causal/barrier analysis to determine what barriers are preventing the PIHP from achieving the desired improvement. The PIHP should also regularly monitor interventions to determine if the interventions are having the desired effect and decide if interventions need to be modified or discontinued.

Results and Summary Assessment Related to Quality, Timeliness, and Access

LifeWays reported a rate decrease from 6.7 percent to 6.5 percent for adults with a mental illness receiving services from the PIHP who had at least one PIHP-reported encounter in the State's data warehouse for a peer-delivered service or support. While the Remeasurement 1 rate was lower than the baseline rate, the rate decrease was not statistically significant. **LifeWays** did not meet its Remeasurement 1 goal of 10.0 percent. The PIHP implemented several interventions, which included increasing reimbursement rates, delivering provider network education, conducting certification training for consumers, and establishing a new certified peer support specialist program. 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 2011–2012 PIP Validation Tool for **Macomb County CMH Services**. Validation of Activities I through IX resulted in a validation status of *Met*, with an overall score of 73 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 3-54—PIP Validation Scores for Macomb County CMH Services											
Review Activity		All Evaluation Elements (Including Critical Elements)					Critical Elements				
		Total	M	PM	NM	NA	Total	M	PM	NM	NA
I.	Select the Study Topic(s)	6	4	1	0	1	1	1	0	0	0
II.	Define the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III.	Select the Study Indicator(s)	7	4	0	0	3	3	3	0	0	0
IV.	Use a Representative and Generalizable Study Population	3	2	0	0	1	2	2	0	0	0
V.	Use Sound Sampling Techniques	6	0	0	0	6	1	0	0	0	1
VI.	Reliably Collect Data	11	4	0	1	6	1	0	0	0	1
VII.	Implement Intervention and Improvement Strategies	4	2	1	0	1	1	1	0	0	0
VIII.	Analyze Data and Interpret Study Results	9	3	3	2	1	2	1	0	0	1
IX.	Assess for Real Improvement	4	3	0	1	0	No Critical Elements				
X.	Assess for Sustained Improvement	1	Not Assessed				No Critical Elements				
Totals for All Activities		53	24	5	4	19	13	10	0	0	3

Table 3-55—PIP Validation Status for Macomb County CMH Services	
Percentage Score of Evaluation Elements <i>Met</i>	73%
Percentage Score of Critical Elements <i>Met</i>	100%
Validation Status	<i>Partially Met</i>

Strengths

Macomb County CMH Services demonstrated strength in its study design and study implementation for the PIP on increasing the proportion of Medicaid eligible adults with a mental illness who receive peer-delivered services or supports. The PIHP received *Met* scores for all applicable evaluation elements in Activities II through V, indicating that the PIHP developed a strong study design and foundation. The PIP demonstrated improvement in Activity IX, in which the study indicator rate improvement appeared to be the result of planned interventions.

Recommendations

HSAG identified opportunities for improvement in Activity I—Select the Study Topic, Activity VI—Reliably Collect Data, Activity VII—Implement Intervention and Improvement Strategies, Activity VIII—Analyze Data and Interpret Study Results, and Activity IX—Assess for Real Improvement. **Macomb County CMH Services** should include historical data that support the selection of the study topic, include timelines for the collection of baseline and remeasurement data, and document plans to standardize and monitor successful interventions. Future submissions should include an interpretation of the comparison between baseline and Remeasurement 1 results, as well as a discussion of the extent to which the study was successful. **Macomb County CMH Services** should ensure that statistical testing results are complete and accurate and document a resolution to any factor that could affect the ability to compare rates across measurement periods. The PIHP should ensure that all elements for Activity VIII are properly documented. As the rate increase from baseline to Remeasurement 1 was not statistically significant, **Macomb County CMH Services** should regularly monitor interventions to determine if the interventions are having the desired effect and decide if interventions need to be modified or discontinued.

Results and Summary Assessment Related to Quality, Timeliness, and Access

Macomb County CMH Services reported a rate increase from 0.7 percent to 1.0 percent for adults with a mental illness receiving services from the PIHP who had at least one PIHP-reported encounter in the State's data warehouse for a peer-delivered service or support. While the Remeasurement 1 rate was higher than the baseline rate, the rate increase was not statistically significant. **Macomb County CMH Services** did not meet its documented Remeasurement 1 goal of 1.2 percent. **Macomb County CMH Services** implemented several interventions, which included establishing a recovery training program, hiring certified peer support specialists, and continuing to perform barrier analysis. 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 2011–2012 PIP Validation Tool for **network180**. Validation of Activities I through IX resulted in a validation status of *Met*, with an overall score of 91 percent and a score of 100 percent for critical elements. Based on the validation of this PIP, HSAG's assessment determined confidence in the results.

Table 3-56—PIP Validation Scores for network180											
Review Activity		All Evaluation Elements (Including Critical Elements)					Critical Elements				
		Total	M	PM	NM	NA	Total	M	PM	NM	NA
I.	Select the Study Topic(s)	6	5	0	0	1	1	1	0	0	0
II.	Define the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III.	Select the Study Indicator(s)	7	4	0	0	3	3	3	0	0	0
IV.	Use a Representative and Generalizable Study Population	3	2	0	0	1	2	2	0	0	0
V.	Use Sound Sampling Techniques	6	0	0	0	6	1	0	0	0	1
VI.	Reliably Collect Data	11	5	0	0	6	1	0	0	0	1
VII.	Implement Intervention and Improvement Strategies	4	3	0	0	1	1	1	0	0	0
VIII.	Analyze Data and Interpret Study Results	9	8	0	0	1	2	1	0	0	1
IX.	Assess for Real Improvement	4	1	0	3	0	No Critical Elements				
X.	Assess for Sustained Improvement	1	Not Assessed				No Critical Elements				
Totals for All Activities		53	30	0	3	19	13	10	0	0	3

Table 3-57—PIP Validation Status for network180	
Percentage Score of Evaluation Elements <i>Met</i>	91%
Percentage Score of Critical Elements <i>Met</i>	100%
Validation Status	<i>Met</i>

Strengths

network180 demonstrated strength in its study design and study implementation for the PIP on increasing the proportion of Medicaid eligible adults with a mental illness who receive peer-delivered services or supports. The PIHP received *Met* scores for all applicable evaluation elements in Activities I through VIII, indicating that the PIP was appropriately designed to measure outcomes and improvement. **network 180** documented that it will continue to focus on peer involvement to ensure that consumers and peers are involved in certified peer support specialist planning at local and State levels.

Recommendations

HSAG identified opportunities for improvement in Activity IX—Assess for Real Improvement. As the study indicator did not show improvement, **network180** should revisit the causal/barrier analysis process, determine the specific barriers prohibiting improvement, and revise its interventions accordingly. **network180** should regularly monitor interventions to determine if the interventions are having the desired effect and decide if interventions need to be modified or discontinued.

To strengthen the study, **network180** should address the *Points of Clarification* in Activities IV, VII, and VIII.

Results and Summary Assessment Related to Quality, Timeliness, and Access

network 180 reported a Remeasurement 1 rate of 4.9 percent for adults with a mental illness receiving services from the PIHP who had at least one PIHP-reported encounter in the State's data warehouse for a peer-delivered service or support, which was essentially the same as the baseline rate. The Remeasurement 1 rate was less than 1 percentage point lower than the baseline rate. The minor rate decrease was not statistically significant. **network 180** did not meet its documented Remeasurement 1 goal of 6.0 percent. The PIHP implemented several interventions, which included hiring of peer support specialists, increasing consumer involvement through focus groups, providing staff training, and adding billing codes for peer support specialists to improve the collection of encounter data. 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 2011–2012 PIP Validation Tool for **NorthCare**. Validation of Activities I through IX resulted in a validation status of *Met*, with an overall score of 88 percent and a score of 100 percent for critical elements. Based on the validation of this PIP, HSAG's assessment determined confidence in the results.

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

Review Activity		All Evaluation Elements (Including Critical Elements)					Critical Elements				
		Total	M	PM	NM	NA	Total	M	PM	NM	NA
I.	Select the Study Topic(s)	6	5	0	0	1	1	1	0	0	0
II.	Define the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III.	Select the Study Indicator(s)	7	4	0	0	3	3	3	0	0	0
IV.	Use a Representative and Generalizable Study Population	3	2	0	0	1	2	2	0	0	0
V.	Use Sound Sampling Techniques	6	0	0	0	6	1	0	0	0	1
VI.	Reliably Collect Data	11	5	0	0	6	1	0	0	0	1
VII.	Implement Intervention and Improvement Strategies	4	3	0	0	1	1	1	0	0	0
VIII.	Analyze Data and Interpret Study Results	9	5	2	1	1	2	1	0	0	1
IX.	Assess for Real Improvement	4	3	0	1	0	No Critical Elements				
X.	Assess for Sustained Improvement	1	Not Assessed				No Critical Elements				
Totals for All Activities		53	29	2	2	19	13	10	0	0	3

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

Percentage Score of Evaluation Elements <i>Met</i>	88%
Percentage Score of Critical Elements <i>Met</i>	100%
Validation Status	<i>Met</i>

Strengths

NorthCare demonstrated strength in its study design and study implementation for the PIP on increasing the proportion of Medicaid eligible adults with a mental illness who receive peer-delivered services or supports. The PIHP received *Met* scores for all applicable evaluation elements in Activities I through VII, indicating that the PIP was appropriately designed to measure outcomes and improvement. The interventions were designed to change behavior at an institutional, practitioner, or beneficiary level. The PIP demonstrated improvement in Activity IX, in which the improvement appeared to be the result of planned interventions. **NorthCare** documented that it will continue its process to develop effective interventions.

Recommendations

HSAG identified opportunities for improvement in Activity VIII—Analyze Data and Interpret Study Results and Activity IX—Assess for Real Improvement. **NorthCare** should ensure that study results are calculated correctly. As the rate increase from baseline to Remeasurement 1 was not statistically significant, **NorthCare** should regularly monitor interventions to determine if the interventions are having the desired effect and decide if interventions need to be modified or discontinued.

Results and Summary Assessment Related to Quality, Timeliness, and Access

NorthCare reported a rate increase from 9.8 percent to 10.1 percent for members with a mental illness receiving services from the PIHP who had at least one PIHP-reported encounter in the State's data warehouse for a peer-delivered service or support. The Remeasurement 1 rate was higher than the baseline rate. The rate increase was not statistically significant. **NorthCare** did not meet its documented Remeasurement 1 goal of 12.0 percent. **NorthCare** implemented several interventions, which included hiring of peer support staff and providing peer support training and education fiscally supported through a recovery grant. 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 2011–2012 PIP Validation Tool for **Northern Affiliation**. Validation of Activities I through IX resulted in a validation status of *Met*, with an overall score of 100 percent and a score of 100 percent for critical elements. Based on the validation of this PIP, HSAG's assessment determined high confidence in the results.

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

Review Activity		All Evaluation Elements (Including Critical Elements)					Critical Elements				
		Total	M	PM	NM	NA	Total	M	PM	NM	NA
I.	Select the Study Topic(s)	6	5	0	0	1	1	1	0	0	0
II.	Define the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III.	Select the Study Indicator(s)	7	4	0	0	3	3	3	0	0	0
IV.	Use a Representative and Generalizable Study Population	3	2	0	0	1	2	2	0	0	0
V.	Use Sound Sampling Techniques	6	0	0	0	6	1	0	0	0	1
VI.	Reliably Collect Data	11	5	0	0	6	1	0	0	0	1
VII.	Implement Intervention and Improvement Strategies	4	3	0	0	1	1	1	0	0	0
VIII.	Analyze Data and Interpret Study Results	9	8	0	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	0	0	19	13	10	0	0	3

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

Percentage Score of Evaluation Elements <i>Met</i>	100%
Percentage Score of Critical Elements <i>Met</i>	100%
Validation Status	<i>Met</i>

Strengths

Northern Affiliation demonstrated strength in its study design and study implementation for the PIP on increasing the proportion of Medicaid eligible adults with a mental illness who receive peer-delivered services or supports. The PIHP received *Met* scores for all applicable evaluation elements in Activities I through IX, indicating that the PIP was appropriately designed to measure outcomes and improvement, and interventions were designed to change behavior at an institutional, practitioner, or beneficiary level. **Northern Affiliation** appropriately analyzed data and interpreted study results. The PIP demonstrated true improvement in Activity IX, in which the study indicator rate improvement was statistically significant and appeared to be the result of planned interventions.

Recommendations

HSAG identified a *Point of Clarification* in Activity VIII—Analyze Data and Interpret Study Results as an opportunity for improvement. **Northern Affiliation** should correctly identify the rate increase as a percentage point increase instead of a percent increase.

Results and Summary Assessment Related to Quality, Timeliness, and Access

Northern Affiliation reported a rate increase from 2.1 percent to 3.3 percent for adults with a mental illness receiving services from the PIHP who had at least one PIHP-reported encounter in the State's data warehouse for a peer-delivered service or support. The Remeasurement 1 rate was higher than the baseline rate, and the rate increase was statistically significant. **Northern Affiliation** met its documented Remeasurement 1 goal of 2.9 percent, which improved the **quality** of services provided by the PIHP. **Northern Affiliation** implemented several interventions, which included hiring of consumer advocates and peer support staff, creating a job opportunity career path for peer support staff, and providing additional support to consumers pursuing peer support specialist certification. 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 2011–2012 PIP Validation Tool for **Northwest CMH Affiliation**. Validation of Activities I through IX resulted in a validation status of *Met*, with an overall score of 91 percent and a score of 100 percent for critical elements. Based on the validation of this PIP, HSAG's assessment determined confidence in the results.

Table 3-62—PIP Validation Scores for Northwest CMH Affiliation											
Review Activity		All Evaluation Elements (Including Critical Elements)					Critical Elements				
		Total	M	PM	NM	NA	Total	M	PM	NM	NA
I.	Select the Study Topic(s)	6	5	0	0	1	1	1	0	0	0
II.	Define the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III.	Select the Study Indicator(s)	7	4	0	0	3	3	3	0	0	0
IV.	Use a Representative and Generalizable Study Population	3	2	0	0	1	2	2	0	0	0
V.	Use Sound Sampling Techniques	6	0	0	0	6	1	0	0	0	1
VI.	Reliably Collect Data	11	5	0	0	6	1	0	0	0	1
VII.	Implement Intervention and Improvement Strategies	4	3	0	0	1	1	1	0	0	0
VIII.	Analyze Data and Interpret Study Results	9	8	0	0	1	2	1	0	0	1
IX.	Assess for Real Improvement	4	1	0	3	0	No Critical Elements				
X.	Assess for Sustained Improvement	1	Not Assessed				No Critical Elements				
Totals for All Activities		53	30	0	3	19	13	10	0	0	3

Table 3-63—PIP Validation Status for Northwest CMH Affiliation	
Percentage Score of Evaluation Elements <i>Met</i>	91%
Percentage Score of Critical Elements <i>Met</i>	100%
Validation Status	<i>Met</i>

Strengths

Northwest CMH Affiliation demonstrated strength in its study design and study implementation for the PIP on increasing the proportion of Medicaid eligible adults with a mental illness who receive peer-delivered services or supports. The PIHP received *Met* scores for all applicable evaluation elements in Activities I through VIII, indicating that the PIP was appropriately designed to measure outcomes and improvement. The PIHP appropriately analyzed data and interpreted study results. **Northwest CMH Affiliation** stated that it will continue its barrier analysis process and will monitor interventions to assess the success of implemented interventions.

Recommendations

HSAG identified opportunities for improvement in Activity IX—Assess for Real Improvement. As the study indicator did not show improvement, **Northwest CMH Affiliation** should revisit its causal/barrier analysis to determine what barriers are preventing the PIHP from achieving the desired improvement. **Northwest CMH Affiliation** should also regularly monitor interventions to determine if the interventions are having the desired effect and decide if interventions need to be modified or discontinued.

HSAG identified an additional *Point of Clarification* in Activity III to strengthen the study.

Results and Summary Assessment Related to Quality, Timeliness, and Access

Northwest CMH Affiliation reported a rate decrease from 6.4 percent to 5.4 percent for adults with a mental illness receiving services from the PIHP who had at least one PIHP-reported encounter in the State's data warehouse for a peer-delivered service or support. While the Remeasurement 1 rate was lower than the baseline rate, the rate decrease was not statistically significant. **Northwest CMH Affiliation** did not meet its documented Remeasurement 1 goal of increasing the rate by 20.0 percent. **Northwest CMH Affiliation** implemented several interventions, which included requesting and reviewing peer support services improvement plans, hiring of additional peer support staff, discussion of peer support services in consumer groups, improving access to required peer support specialist training, and hiring of a peer support supervisor. 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 2011–2012 PIP Validation Tool for **Oakland County CMH Authority**. Validation of Activities I through IX resulted in a validation status of *Met*, with an overall score of 91 percent and a score of 100 percent for critical elements. Based on the validation of this PIP, HSAG's assessment determined confidence in the results.

Review Activity		All Evaluation Elements (Including Critical Elements)					Critical Elements				
		Total	M	PM	NM	NA	Total	M	PM	NM	NA
I.	Select the Study Topic(s)	6	5	0	0	1	1	1	0	0	0
II.	Define the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III.	Select the Study Indicator(s)	7	4	0	0	3	3	3	0	0	0
IV.	Use a Representative and Generalizable Study Population	3	2	0	0	1	2	2	0	0	0
V.	Use Sound Sampling Techniques	6	0	0	0	6	1	0	0	0	1
VI.	Reliably Collect Data	11	5	0	0	6	1	0	0	0	1
VII.	Implement Intervention and Improvement Strategies	4	3	0	0	1	1	1	0	0	0
VIII.	Analyze Data and Interpret Study Results	9	8	0	0	1	2	1	0	0	1
IX.	Assess for Real Improvement	4	1	0	3	0	No Critical Elements				
X.	Assess for Sustained Improvement	1	Not Assessed				No Critical Elements				
Totals for All Activities		53	30	0	3	19	13	10	0	0	3

Percentage Score of Evaluation Elements <i>Met</i>	91%
Percentage Score of Critical Elements <i>Met</i>	100%
Validation Status	<i>Met</i>

Strengths

Oakland County CMH Authority demonstrated strength in its study design and study implementation for the PIP on increasing the proportion of Medicaid eligible adults with a mental illness who receive peer-delivered services or supports. The PIHP received *Met* scores for all applicable evaluation elements in Activities I through VIII, indicating that the PIP was appropriately designed to measure outcomes and improvement. **Oakland County CMH Authority** appropriately analyzed data and interpreted study results.

Recommendations

HSAG identified opportunities for improvement in Activity IX—Assess for Real Improvement. As the study indicator did not show improvement, **Oakland County CMH Authority** should revisit its causal/barrier analysis to determine what barriers are preventing the PIHP from achieving the desired improvement. **Oakland County CMH Authority** should also regularly monitor interventions to determine if the interventions are having the desired effect and decide if interventions need to be modified or discontinued.

Results and Summary Assessment Related to Quality, Timeliness, and Access

Oakland County CMH Authority reported a rate decrease from 27.6 percent to 19.8 percent for adults with a mental illness receiving services from the PIHP who had at least one PIHP-reported encounter in the State's data warehouse for a peer-delivered service or support. The Remeasurement 1 rate was lower than the baseline rate. The rate decrease was statistically significant. **Oakland County CMH Authority** did not meet its documented Remeasurement 1 goal of 29.3 percent. The PIHP implemented several interventions, which included recruiting peer support specialists, aiming efforts at reducing the rate of turnover among peer support specialists, expanding services provided by peer support specialists, and increasing efforts to inform consumers about the availability of peer support 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 2011–2012 PIP Validation Tool for **Saginaw County CMH Authority**. Validation of Activities 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.

Review Activity		All Evaluation Elements (Including Critical Elements)					Critical Elements				
		Total	M	PM	NM	NA	Total	M	PM	NM	NA
I.	Select the Study Topic(s)	6	5	0	0	1	1	1	0	0	0
II.	Define the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III.	Select the Study Indicator(s)	7	4	0	0	3	3	3	0	0	0
IV.	Use a Representative and Generalizable Study Population	3	2	0	0	1	2	2	0	0	0
V.	Use Sound Sampling Techniques	6	0	0	0	6	1	0	0	0	1
VI.	Reliably Collect Data	11	4	1	0	6	1	0	0	0	1
VII.	Implement Intervention and Improvement Strategies	4	3	0	0	1	1	1	0	0	0
VIII.	Analyze Data and Interpret Study Results	9	4	3	1	1	2	1	0	0	1
IX.	Assess for Real Improvement	4	1	0	3	0	No Critical Elements				
X.	Assess for Sustained Improvement	1	Not Assessed				No Critical Elements				
Totals for All Activities		53	25	4	4	19	13	10	0	0	3

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

Strengths

Saginaw County CMH Authority demonstrated strength in its study design for the PIP on increasing the proportion of Medicaid eligible adults with a mental illness who receive peer-delivered services or supports. The PIHP received *Met* scores for all applicable evaluation elements in Activities I through V and VII, indicating that the PIP was appropriately designed to measure outcomes and improvement. The PIHP indicated that during Remeasurement 2, it will train network providers about using the proper code to document peer support services.

Recommendations

HSAG identified opportunities for improvement in Activities VI—Reliably Collect Data, VIII—Analyze Data and Interpret Study Results, and IX—Assess for Real Improvement. **Saginaw County CMH Authority** should ensure that the PIP timeline is consistent throughout the study documentation, compare the remeasurement rate to the stated goal, and recalculate the statistical results. Future submissions should include a discussion of factors that could affect the ability to compare measurement periods. As the study indicator did not show improvement, **Saginaw County CMH Authority** should revisit its causal/barrier analysis to determine what barriers are preventing the PIHP from achieving the desired improvement. **Saginaw County CMH Authority** should regularly monitor interventions to determine if the interventions are having the desired effect and decide if interventions need to be modified or discontinued.

HSAG identified an additional *Point of Clarification* in Activity VII to strengthen the study.

Results and Summary Assessment Related to Quality, Timeliness, and Access

Saginaw County CMH Authority reported a rate decrease from 17.6 percent to 13.2 percent for adults with a mental illness receiving services from the PIHP who had at least one PIHP-reported encounter in the State's data warehouse for a peer-delivered service or support. The Remeasurement 1 rate was lower than the baseline rate. The rate decrease was statistically significant. The PIHP did not meet its documented Remeasurement 1 goal of a 1.0 percent increase. **Saginaw County CMH Authority** implemented an intervention and revised the psychiatric inpatient preadmission screening to include an item assessing whether the consumer had been seen by a peer support specialist. 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 2011–2012 PIP Validation Tool for **Southwest Affiliation**. Validation of Activities I through IX resulted in a validation status of *Met*, with an overall score of 100 percent and a score of 100 percent for critical elements. Based on the validation of this PIP, HSAG's assessment determined high confidence in the results.

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

Review Activity		All Evaluation Elements (Including Critical Elements)					Critical Elements				
		Total	M	PM	NM	NA	Total	M	PM	NM	NA
I.	Select the Study Topic(s)	6	5	0	0	1	1	1	0	0	0
II.	Define the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III.	Select the Study Indicator(s)	7	4	0	0	3	3	3	0	0	0
IV.	Use a Representative and Generalizable Study Population	3	2	0	0	1	2	2	0	0	0
V.	Use Sound Sampling Techniques	6	0	0	0	6	1	0	0	0	1
VI.	Reliably Collect Data	11	5	0	0	6	1	0	0	0	1
VII.	Implement Intervention and Improvement Strategies	4	3	0	0	1	1	1	0	0	0
VIII.	Analyze Data and Interpret Study Results	9	8	0	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	0	0	19	13	10	0	0	3

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

Percentage Score of Evaluation Elements <i>Met</i>	100%
Percentage Score of Critical Elements <i>Met</i>	100%
Validation Status	<i>Met</i>

Strengths

Southwest Affiliation demonstrated strength in its study design and study implementation for the PIP on increasing the proportion of Medicaid eligible adults with a mental illness who receive peer-delivered services or supports. The PIHP received *Met* scores for all applicable evaluation elements in Activities I through IX, indicating that the PIP was appropriately designed to measure outcomes and improvement. The PIHP appropriately analyzed data and interpreted study results, and interventions were designed to change behavior at an institutional, practitioner, or beneficiary level. The PIP demonstrated true improvement in Activity IX, in which the improvement in study indicator rate was statistically significant and appeared to be the result of planned interventions.

Recommendations

HSAG identified one *Point of Clarification* in Activity VIII to strengthen the study. **Southwest Affiliation** should recalculate the Remeasurement 1 rate and correct any discrepancies in future submissions.

Results and Summary Assessment Related to Quality, Timeliness, and Access

Southwest Affiliation reported a rate increase from 19.8 percent to 24.8 percent for adults with a mental illness receiving services from the PIHP who had at least one PIHP-reported encounter in the State's data warehouse for a peer-delivered service or support. The Remeasurement 1 rate was higher than the baseline rate. The rate increase was statistically significant. **Southwest Affiliation** met its Remeasurement 1 goal of 22.0 percent, which improved the **quality** of services provided by the PIHP. **Southwest Affiliation** implemented several interventions, which included increasing the number of peer support specialists, updating the peer support specialist job description, conducting organizational assessments to identify areas in need of improvement, starting a support group for peer support specialists, and increasing the number of peers employed across the affiliation. 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 2011–2012 PIP Validation Tool for **Thumb Alliance PIHP**. Validation of Activities I through IX resulted in a validation status of *Not Met*, with an overall score of 73 percent and a score of 90 percent for critical elements. Based on the validation of this PIP, HSAG's assessment determined that the reported results were not credible.

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

Review Activity		All Evaluation Elements (Including Critical Elements)					Critical Elements				
		Total	M	PM	NM	NA	Total	M	PM	NM	NA
I.	Select the Study Topic(s)	6	5	0	0	1	1	1	0	0	0
II.	Define the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III.	Select the Study Indicator(s)	7	4	0	0	3	3	3	0	0	0
IV.	Use a Representative and Generalizable Study Population	3	1	0	1	1	2	1	0	1	0
V.	Use Sound Sampling Techniques	6	0	0	0	6	1	0	0	0	1
VI.	Reliably Collect Data	11	5	0	0	6	1	0	0	0	1
VII.	Implement Intervention and Improvement Strategies	4	3	0	0	1	1	1	0	0	0
VIII.	Analyze Data and Interpret Study Results	9	4	3	1	1	2	1	0	0	1
IX.	Assess for Real Improvement	4	0	0	4	0	No Critical Elements				
X.	Assess for Sustained Improvement	1	Not Assessed				No Critical Elements				
Totals for All Activities		53	24	3	6	19	13	9	0	1	3

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

Percentage Score of Evaluation Elements <i>Met</i>	73%
Percentage Score of Critical Elements <i>Met</i>	90%
Validation Status	<i>Not Met</i>

Strengths

Thumb Alliance PIHP demonstrated strength in its study design for the PIP on increasing the proportion of Medicaid eligible adults with a mental illness who receive peer-delivered services or supports. The PIHP received *Met* scores for all applicable evaluation elements in Activities I through III and V through VII, indicating strengths related to the study topic, study question, study indicator, data collection, and intervention and improvement strategies.

Recommendations

HSAG identified opportunities for improvement in Activities IV—Use a Representative and Generalizable Study Population, VIII—Analyze Data and Interpret Study Results, and IX—Assess for Real Improvement. **Thumb Alliance PIHP** received a *Not Met* validation score because the PIHP used its FY2010 baseline denominator for the Remeasurement 1 period, resulting in a *Not Met* score for a critical element. The PIHP should calculate the denominator as the number of Medicaid eligible adults with a mental illness receiving services from the PIHP who have at least one PIHP-reported encounter to the State's data warehouse during the measurement year. **Thumb Alliance PIHP** should update the interpretation of findings and statistical differences to reflect the current measurement year data. Use of denominators that correspond to the current measurement year will allow the PIHP to assess if real improvement was accomplished. Future submissions should include a discussion of factors that affect the ability to compare results between measurement periods.

Results and Summary Assessment Related to Quality, Timeliness, and Access

Thumb Alliance PIHP reported a rate increase from 16.1 percent to 19.7 percent for members with a mental illness receiving services from the PIHP who had at least one PIHP-reported encounter in the State's data warehouse for a peer-delivered service or support. **Thumb Alliance PIHP** results were not considered meaningful due to use of the FY2010 baseline denominator for Remeasurement 1 rate calculations. **Thumb Alliance PIHP** documented a Remeasurement 1 goal of 15.0 percent. The PIHP implemented several interventions, which included coordinating peer support specialist certification training, employing non-certified peer support specialists as a prelude to certified peer support specialist training, and conducting regular administrative support meetings. 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 2011–2012 PIP Validation Tool for **Venture Behavioral Health**. 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.

Review Activity		All Evaluation Elements (Including Critical Elements)					Critical Elements				
		Total	M	PM	NM	NA	Total	M	PM	NM	NA
I.	Select the Study Topic(s)	6	5	0	0	1	1	1	0	0	0
II.	Define the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III.	Select the Study Indicator(s)	7	4	0	0	3	3	3	0	0	0
IV.	Use a Representative and Generalizable Study Population	3	2	0	0	1	2	2	0	0	0
V.	Use Sound Sampling Techniques	6	0	0	0	6	1	0	0	0	1
VI.	Reliably Collect Data	11	5	0	0	6	1	0	0	0	1
VII.	Implement Intervention and Improvement Strategies	4	3	0	0	1	1	1	0	0	0
VIII.	Analyze Data and Interpret Study Results	9	7	0	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	32	0	1	19	13	10	0	0	3

Percentage Score of Evaluation Elements <i>Met</i>	97%
Percentage Score of Critical Elements <i>Met</i>	100%
Validation Status	<i>Met</i>

Strengths

Venture Behavioral Health demonstrated strength in its study design and study implementation for the PIP on increasing the proportion of Medicaid eligible adults with a mental illness who receive peer-delivered services or supports. The PIHP received *Met* scores for all applicable evaluation elements in Activities I through VII, indicating that the PIP was appropriately designed to measure outcomes and improvement. The interventions were designed to change behavior at an institutional, practitioner, or beneficiary level. **Venture Behavioral Health** also appropriately analyzed data and interpreted study results. The PIP demonstrated true improvement in Activity IX, in which the improvement in the study indicator rate was statistically significant and appeared to be the result of planned interventions. **Venture Behavioral Health** documented performing context and process evaluations to determine barriers and examine the performance of interventions during the measurement period.

Recommendations

HSAG identified an opportunity for improvement in Activity VIII—Analyze Data and Interpret Study Results. In future submissions, **Venture Behavioral Health** should identify all factors that affect the ability to compare results between measurement periods. If the PIHP concludes that there were no such factors, **Venture Behavioral Health** should include a statement to that effect.

Results and Summary Assessment Related to Quality, Timeliness, and Access

Venture Behavioral Health reported a rate increase from 4.7 percent to 6.9 percent for adults with a mental illness receiving services from the PIHP who had at least one PIHP-reported encounter in the State's data warehouse for a peer-delivered service or support. The Remeasurement 1 rate was higher than the baseline rate. The rate increase was statistically significant. **Venture Behavioral Health** exceeded its Remeasurement 1 goal of increasing the denominator by 100, which improved the **quality** of services provided by the PIHP. **Venture Behavioral Health** implemented several interventions, which included capacity building, expanded availability of peer support services, increased peer support staff, and review of submitted encounter data to ensure peer support services are properly documented. The PIHP stated that it will promote increasing the number of peer support specialists while continuing to review the types of peer-delivered services that are available. 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 the EQR activities.

The 2011–2012 compliance monitoring reviews addressed the PIHP's compliance with requirements related to eight of the previously assessed standards. This section presents a summary of the PIHPs' progress in addressing continued recommendations identified in the 2009–2010 follow-up review of compliance standards.

The validation of performance measures assessed the PIHPs' processes related to the reporting of performance indicator data and oversight of subcontractors' performance indicator reporting activities. This section presents each PIHP's status of addressing the recommendations identified in the 2010–2011 validation cycle.

For the 2011–2012 validation, the PIHPs continued the PIP on *Increasing the Proportion of Medicaid Eligible Adults With a Mental Illness Who Receive Peer-Delivered Services or Supports*. This section presents an assessment of the PIHPs' follow-up on recommendations from the 2010–2011 validation cycle.

Access Alliance of Michigan

Compliance Monitoring

The previous compliance monitoring review for **Access Alliance of Michigan** determined that the PIHP achieved full compliance on all standards. There were no continued recommendations for improvement.

Validation of Performance Measures

Access Alliance of Michigan implemented recommendations from last year's audit by creating a series of reports for data anomalies. The PIHP used these reports to improve the quality and accuracy of data submitted by the PIHP's subcontracted community mental health centers. Review of the data during the on-site visit showed a marked improvement in quality.

Validation of Performance Improvement Projects

The 2010–2011 validation of performance improvement projects for **Access Alliance of Michigan** identified one *Point of Clarification* for Activity VIII—Analyze Data and Interpret Study Results. In its 2011–2012 PIP submission, the PIHP compared the results to the established goal for the measurement period and commented on whether it reached the goal, successfully addressing the recommendation.

CMH Affiliation of Mid-Michigan

Compliance Monitoring

The previous compliance monitoring review for **CMH Affiliation of Mid-Michigan** determined that the PIHP achieved full compliance on all standards. There were no continued recommendations for improvement.

Validation of Performance Measures

As recommended, **CMH Affiliation of Mid-Michigan** continued to work with MDCH to resolve issues with quality indicators and the Community Health Automated Medicaid Processing System (CHAMPS) encounter data. The coordinating agencies (CAs) continued to experience some challenges in reporting their Treatment Episode Data Set (TEDS) and encounter data, but all of these issues were identified and resolved. **CMH Affiliation of Mid-Michigan** closely monitored its HSW data, which continued to be affected by the delay in receiving HSW eligibility notifications during the month. The PIHP continued to monitor these HSW members and data to improve performance on this measure.

Validation of Performance Improvement Projects

The 2010–2011 validation of performance improvement projects for **CMH Affiliation of Mid-Michigan** identified one *Point of Clarification* for Activity VIII—Analyze Data and Interpret Study Results. In its 2011–2012 PIP submission, the PIHP corrected the baseline goal using the data provided by HSAG and successfully addressed the recommendation. **CMH Affiliation of Mid-Michigan** should use the most recent value for the goal (as reflected in the 2011–2012 validation tool) in its future submissions.

CMH Affiliation for Central Michigan

Compliance Monitoring

The previous compliance monitoring review for **CMH for Central Michigan** determined that the PIHP achieved full compliance on all standards. There were no continued recommendations for improvement.

Validation of Performance Measures

As a result of HSAG's prior recommendations for more robust performance indicator-specific validation and improved process documentation, **CMH for Central Michigan** continued to integrate additional data validation checks prior to submission of encounter files to ensure that all required data elements were present and valid. The PIHP expects the change to the new Web-based electronic health record system (CIGMMO) to lead to more complete and accurate data in future reporting years.

Validation of Performance Improvement Projects

The 2010–2011 validation of performance improvement projects for **CMH for Central Michigan** did not identify any opportunities for improvement.

CMH Partnership of Southeastern Michigan

Compliance Monitoring

The previous compliance monitoring review for **CMH Partnership of Southeastern Michigan** determined that the PIHP achieved full compliance on the eight standards included in the 2011–2012 review cycle. There were no continued recommendations for improvement.

Validation of Performance Measures

CMH Partnership of Southeastern Michigan took action to address the previous year's recommendations by updating its documentation to reflect the new electronic medical record system (EII). The PIHP continued monitoring any issues related to the system transition to EII.

Validation of Performance Improvement Projects

The 2010–2011 validation of performance improvement projects for **CMH Partnership of Southeastern Michigan** did not identify any opportunities for improvement.

Detroit-Wayne County CMH Agency

Compliance Monitoring

The previous compliance monitoring review for **Detroit-Wayne County CMH Agency** determined that the PIHP achieved full compliance on all eight standards included in the 2011–2012 review cycle. There were no continued recommendations for improvement.

Validation of Performance Measures

Detroit-Wayne County CMH Agency continued its efforts to capture line item details and monitor activities of the Managers of Comprehensive Provider Networks (MCPNs) to ensure full capture of elements necessary for reporting. The PIHP added a feature to the centralized data system allowing providers and staff to enter information relevant to inpatient stays.

Detroit-Wayne County CMH Agency continued efforts to identify all barriers and issues related to incomplete data and to document the implementation of quality initiatives. Discussions during monthly quality operations meetings addressed issues with incomplete data. The PIHP conducted root cause analysis and—as a result of its findings—proposed performance-based contracting in the future. **Detroit-Wayne County CMH Agency** implemented an improved demographic form, published report cards, and granted providers access to their own reports to allow them to review and revise their own data.

Validation of Performance Improvement Projects

The 2010–2011 validation of performance improvement projects for **Detroit-Wayne County CMH Agency** identified two *Points of Clarification* for Activity VIII—Analyze Data and Interpret Study Results. In its 2011–2012 PIP submission, the PIHP compared the results to the established goal for the measurement period, commented on whether it reached the goal, and documented the measurement period date ranges in the results table. **Detroit-Wayne County CMH Agency** successfully addressed the recommendations.

Genesee County CMH

Compliance Monitoring

The previous compliance monitoring review for **Genesee County CMH** determined that the PIHP achieved full compliance on all standards. There were no continued recommendations for improvement.

Validation of Performance Measures

Genesee County CMH took action related to the previous year's recommendation by continuing efforts to overcome any barriers related to the CHAMPS transition. The PIHP maintained frequent communication with MDCH to address any questions or concerns. **Genesee County CMH** implemented a formal process for oversight of the crisis screening data entry activity.

Validation of Performance Improvement Projects

The 2010–2011 validation of performance improvement projects for **Genesee County CMH** identified two *Points of Clarification*. In its 2011–2012 PIP submission, the PIHP included the baseline and remeasurement periods in the PIP Summary Form, successfully addressing the recommendation for Activity VI—Reliably Collect Data. **Genesee County CMH** should continue its efforts to address the recommendation for Activity VIII—Analyze Data and Interpret Study Results, as the PIHP did not establish a goal for the measurement period or comment on whether it reached the goal.

Lakeshore Behavioral Health Alliance

Compliance Monitoring

The previous compliance monitoring review for **Lakeshore Behavioral Health Alliance** determined that the PIHP achieved full compliance on six of the eight standards included in the 2011–2012 review cycle. The PIHP implemented corrective actions and successfully addressed the two continued recommendations for improvement. For Standard II—Performance Measurement and Improvement, the PIHP ensured that providers and beneficiaries received information about the results of the consumer satisfaction survey. For Standard VIII—Enrollee Rights and Protections, **Lakeshore Behavioral Health Alliance** provided beneficiaries with information about their rights as required.

Validation of Performance Measures

Lakeshore Behavioral Health Alliance continued its efforts for full automation of performance indicator (PI) data. Limitations of the Avatar system may result in continued need for a manual component. One affiliate included data entry validation in its process document. The number of providers who submit data electronically increased; therefore, the volume of manual data entry was quite small.

Validation of Performance Improvement Projects

The 2010–2011 validation of performance improvement projects for **Lakeshore Behavioral Health Alliance** identified one opportunity for improvement for Activity VIII—Analyze Data and Interpret Study Results. In its 2011–2012 PIP submission, the PIHP addressed factors that could affect the validity of the study, stating that no factors threatened the external or internal validity of the findings. **Lakeshore Behavioral Health Alliance** successfully addressed the recommendation.

LifeWays

Compliance Monitoring

The previous compliance monitoring review for **LifeWays** determined that the PIHP achieved full compliance on the eight standards included in the 2011–2012 review cycle. There were no continued recommendations for improvement.

Validation of Performance Measures

During the prior year's audit, a review of primary source verification resulted in the recommendation that **LifeWays** conduct a formal validation of data manually entered by staff. It was also recommended that **LifeWays** continue its efforts to meet minimum data completeness standards for the QI data elements. By migrating to the new data system, **LifeWays** has addressed these concerns. Although some rates remain low, the migration to the new system was completed; and rates are expected to improve by the next full reporting cycle.

Validation of Performance Improvement Projects

The 2010–2011 validation of performance improvement projects for **LifeWays** identified four *Points of Clarification* for Activity I—Select the Study Topic, Activity III—Select the Study Indicator, Activity VI—Reliably Collect Data, and Activity VIII—Analyze Data and Interpret Study Results. In its 2011–2012 PIP submission, the PIHP stated its expectation that the study will improve the health and functional status of adults with mental illness who are receiving services, revised the benchmark, corrected the ending dates for the measurement periods, restated the study goal to accurately reflect a 100 percent increase, and reported denominators for each measurement period. **LifeWays** successfully addressed all recommendations.

Macomb County CMH Services

Compliance Monitoring

The previous compliance monitoring review for **Macomb County CMH Services** determined that the PIHP achieved full compliance on seven of the eight standards included in the 2011–2012 review cycle. The PIHP implemented corrective actions and successfully addressed the two continued recommendations for improvement for Standard VI—Customer Services. **Macomb County CMH Services** ensured that the customer handbook included all state-required template language and topics, including the hours of operation for the customer services unit.

Validation of Performance Measures

Macomb County CMH Services continued efforts to increase the completeness of its QI data elements and to meet the 95 percent standard set by MDCH. The PIHP implemented an edit that required fields to be completed before the record could be closed. The PIHP provided education to clinical staff on the importance of capturing these data fields.

Validation of Performance Improvement Projects

The 2010–2011 validation of performance improvement projects for **Macomb County CMH Services** identified two *Points of Clarification* for Activity I—Select the Study Topic and Activity VIII—Analyze Data and Interpret Study Results. In its 2011–2012 PIP submission, the PIHP did not address the recommendations to document historical data or correctly report the baseline result. **Macomb County CMH Services** should continue its efforts to correct these issues.

network180

Compliance Monitoring

The previous compliance monitoring review for **network180** determined that the PIHP achieved full compliance on seven of the eight standards included in the 2011–2012 review cycle. The PIHP implemented corrective actions and successfully addressed the continued recommendation for improvement for Standard XI—Credentialing. **network180** revised its credentialing policy to describe how findings of the PIHP’s QAPIP are incorporated into the recredentialing process.

Validation of Performance Measures

network180 acted on the previous year’s recommendations by continuing its efforts toward automation of the processes for calculation of the performance indicators for reporting purposes. In addition, the PIHP continued to work on internal quality initiatives and participated in various work groups.

Validation of Performance Improvement Projects

The 2010–2011 validation of performance improvement projects for **network180** identified opportunities for improvement and *Points of Clarification* for Activity III—Select the Study Indicator, Activity VI—Reliably Collect Data, Activity VII—Implement Intervention and Improvement Strategies, and Activity VIII—Analyze Data and Interpret Study Results. In its 2011–2012 PIP submission, the PIHP reported the baseline goal as a number and a percentage, specified the baseline and remeasurement periods, and detailed the steps in the production of the study indicators. **network180** corrected the implementation dates for some of the interventions; included an interpretation of the findings for the study indicator; and reported numerators, denominators, and resulting percentages for each measurement period. **network180** successfully addressed all recommendations.

NorthCare

Compliance Monitoring

The previous compliance monitoring review for **NorthCare** determined that the PIHP achieved full compliance on the eight standards included in the 2011–2012 review cycle. There were no continued recommendations for improvement.

Validation of Performance Measures

NorthCare took action related to the previous year’s recommendation to assist the CA with resolving difficulties with its data integration vendor regarding electronic claims submissions. The CA completed a contract addendum to produce the 837 files and finalized the submission process. The ISCAT submitted for the current validation cycle demonstrated that sufficient processes were in place and well documented.

Validation of Performance Improvement Projects

The 2010–2011 validation of performance improvement projects for **NorthCare** did not identify any opportunities for improvement.

Northern Affiliation

Compliance Monitoring

The previous compliance monitoring review for **Northern Affiliation** determined that the PIHP achieved full compliance on the eight standards included in the 2011–2012 review cycle. There were no continued recommendations for improvement.

Validation of Performance Measures

Northern Affiliation acted upon recommendations made as part of last year's audit. The PIHP implemented processes to review all data elements required to be 95 percent complete. This initiative resulted in data completeness for most elements near or at 100 percent for the current-year validation. The PIHP continued its efforts to further increase performance of employment and minimum wage indicators, both of which showed improvement from previous years.

Validation of Performance Improvement Projects

The 2010–2011 validation of performance improvement projects for **Northern Affiliation** identified one *Point of Clarification* for Activity VIII—Analyze Data and Interpret Study Results. In its 2011–2012 PIP submission, the PIHP identified and discussed factors that threatened the internal or external validity of the findings and included the impact and resolution of these factors, successfully addressing the recommendation.

Northwest CMH Affiliation

Compliance Monitoring

The previous compliance monitoring review for **Northwest CMH Affiliation** determined that the PIHP achieved full compliance on the eight standards included in the 2011–2012 review cycle. There were no continued recommendations for improvement.

Validation of Performance Measures

Northwest CMH Affiliation acted on all recommendations from last year's audit. The PIHP conducted a review of attachments to the ISCAT and updated the documents to reflect the current reporting year. The PIHP continued its efforts to automate all performance indicator reporting. **Northwest CMH Affiliation** collaborated with other PIHPs and MDCH to address ongoing CHAMPS issues.

Validation of Performance Improvement Projects

The 2010–2011 validation of performance improvement projects for **Northwest CMH Affiliation** did not identify any opportunities for improvement.

Oakland County CMH Authority

Compliance Monitoring

The previous compliance monitoring review for **Oakland County CMH Authority** determined that the PIHP achieved full compliance on all standards. There were no continued recommendations for improvement.

Validation of Performance Measures

Oakland County CMH Authority addressed the recommendations from last year's audit. The PIHP included the implementation of the Oakland Data and Information Network (ODIN) for the one remaining provider as one of the major initiatives of the PIHP's Central System Project.

Validation of Performance Improvement Projects

The 2010–2011 validation of performance improvement projects for **Oakland County CMH Authority** identified one Point of Clarification for Activity VI—Reliably Collect Data. In its 2011–2012 PIP submission, the PIHP specified the baseline and remeasurement periods, successfully addressing the recommendation.

Saginaw County CMH Authority

Compliance Monitoring

The previous compliance monitoring review for **Saginaw County CMH Authority** determined that the PIHP achieved full compliance on seven of the eight standards included in the 2011–2012 review cycle. The PIHP implemented corrective actions and successfully addressed the two continued recommendations for improvement for Standard VIII—Enrollee Rights and Protections. **Saginaw County CMH Authority** ensured that beneficiaries received information in an easy-to-understand manner and format and notified them of their right to request and obtain information about beneficiary rights and protections as required.

Validation of Performance Measures

Saginaw County CMH Authority continued to address difficulties with consistency in the collection of the minimum wage data element. The PIHP tracked this rate internally and observed results higher than the MDCH calculations, but completeness of the minimum wage data continued to fall below the required 95 percent completeness level.

It was also identified during the prior on-site visit that for Indicator 2, rescheduled appointments were not included in the measure because exclusions were not clearly understood. **Saginaw County CMH Authority** corrected the programming for this measure, ensuring that rescheduled appointments were included in the calculation and reported appropriately.

Validation of Performance Improvement Projects

The 2010–2011 validation of performance improvement projects for **Saginaw County CMH Authority** identified opportunities for improvement and *Points of Clarification* for Activity I—Select the Study Topic, Activity VI—Reliably Collect Data, Activity VII—Implement Intervention and Improvement Strategies, and Activity VIII—Analyze Data and Interpret Study Results. In its 2011–2012 PIP submission, the PIHP included plan-specific data in Activity I, stated that all eligible populations that meet the study criteria will be included, and addressed the study’s potential to affect consumer satisfaction through promoting a recovery environment. While the PIHP’s PIP documentation included the development of the steps in the production of the study indicators and identified and discussed factors that threatened the internal or external validity of the findings, **Saginaw County CMH Authority** did not include timelines for the collection of remeasurement data or document how the remeasurement rate compared to the goal. **Saginaw County CMH Authority** should continue its efforts to address the remaining recommendations.

Southwest Affiliation

Compliance Monitoring

The previous compliance monitoring review for **Southwest Affiliation** determined that the PIHP achieved full compliance on the eight standards included in the 2011–2012 review cycle. There were no continued recommendations for improvement.

Validation of Performance Measures

Southwest Affiliation addressed the recommendation to require all affiliates to capture the start and stop times in the MS Excel reporting template used to report performance measures to the PIHP. The PIHP incorporated a QI validator program that required 95 percent field compliance. In addition, during the on-site review of primary source verification, no blank fields were observed.

Southwest Affiliation progressed in implementing the recommendations to move toward automating performance measure reporting and requiring affiliates to provide the PIHP with member-level detail for all of the performance measures for primary source verification purposes. While these recommendations were not completely addressed for this year, the migration to the Streamline system for the PIHP and all affiliates will greatly enhance validation efforts and reporting.

Validation of Performance Improvement Projects

The 2010–2011 validation of performance improvement projects for **Southwest Affiliation** did not identify any opportunities for improvement.

Thumb Alliance PIHP

Compliance Monitoring

The previous compliance monitoring review for **Thumb Alliance PIHP** determined that the PIHP achieved full compliance on the eight standards included in the 2011–2012 review cycle. There were no continued recommendations for improvement.

Validation of Performance Measures

Thumb Alliance PIHP acted on the recommendations made as a result of last year's audit. It was recommended that the PIHP continue to improve and enhance the OASIS system. **Thumb Alliance PIHP** addressed this recommendation, and the enhancements made included more reporting and tracking capabilities. **Thumb Alliance PIHP** continued to monitor quality indicator elements for completeness on an ongoing basis. **Thumb Alliance PIHP** was able to maintain and slightly improve performance for some indicators.

Validation of Performance Improvement Projects

The 2010–2011 validation of performance improvement projects for **Thumb Alliance PIHP** identified one *Point of Clarification* for Activity I—Select the Study Topic. In its 2011–2012 PIP submission, the PIHP discussed historical plan-specific data, successfully addressing the recommendation.

Venture Behavioral Health

Compliance Monitoring

The previous compliance monitoring review for **Venture Behavioral Health** determined that the PIHP achieved full compliance on seven of the eight standards included in the 2011–2012 review cycle. The PIHP implemented corrective actions and successfully addressed the continued recommendation for improvement on Standard II—Performance Measurement and Improvement. The PIHP ensured that persons involved in the review of sentinel events had the appropriate credentials to review the scope of care.

Validation of Performance Measures

Venture Behavioral Health addressed the prior year’s recommendation to continue working with MDCH to ensure that all encounters and claims submitted by the PIHP to MDCH were reflected in MDCH’s system. **Venture Behavioral Health** maintained a working relationship with MDCH and sought to obtain information from MDCH on how the indicators are calculated. Mirroring MDCH’s programming logic will allow **Venture Behavioral Health** to specifically target how data are collected and reported by its staff.

Validation of Performance Improvement Projects

The 2010–2011 validation of performance improvement projects for **Venture Behavioral Health** identified one *Point of Clarification* for Activity VIII—Analyze Data and Interpret Study Results. In its 2011–2012 PIP submission, the PIHP compared the results to the established goal for the measurement period and commented on whether it reached the goal, successfully addressing the recommendation.

Appendix A. Summary Tables of External Quality Review Activity Results

Introduction

This section of the report presents results for the compliance monitoring reviews, 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 2011–2012 compliance monitoring reviews compared to the results of previous reviews to provide an overview of the PIHP and statewide performance trends on the eight compliance monitoring standards addressed in the 2011–2012 review cycle.

Compliance Monitoring Standards

Figure A-1 through Figure A-8 present compliance scores for each of the 18 PIHPs for the following standards:

- ◆ Standard II—Performance Measurement and Improvement
- ◆ Standard III—Practice Guidelines
- ◆ Standard VI—Customer Services
- ◆ Standard VIII—Enrollee Rights and Protections
- ◆ Standard IX—Subcontracts and Delegation
- ◆ Standard X—Provider Network
- ◆ Standard XI—Credentialing
- ◆ Standard XIII—Coordination of Care

The figures present the PIHPs' performance for the prior review cycles, showing combined scores after each follow-up review. Standards I through VIII were reviewed in 2004–2005, with a follow-up review in 2005–2006. Standards IX through XIV were reviewed in 2006–2007, with a follow-up review in 2007–2008. All 14 standards were reviewed again in 2008–2009, with a follow-up review in 2009–2010. The graphs also show the PIHP-specific results of the current 2011–2012 reviews, as well as the statewide score for each of the eight compliance monitoring standards included in the 2011–2012 review.

Figure A-1—Standard II: Performance Measurement and Improvement

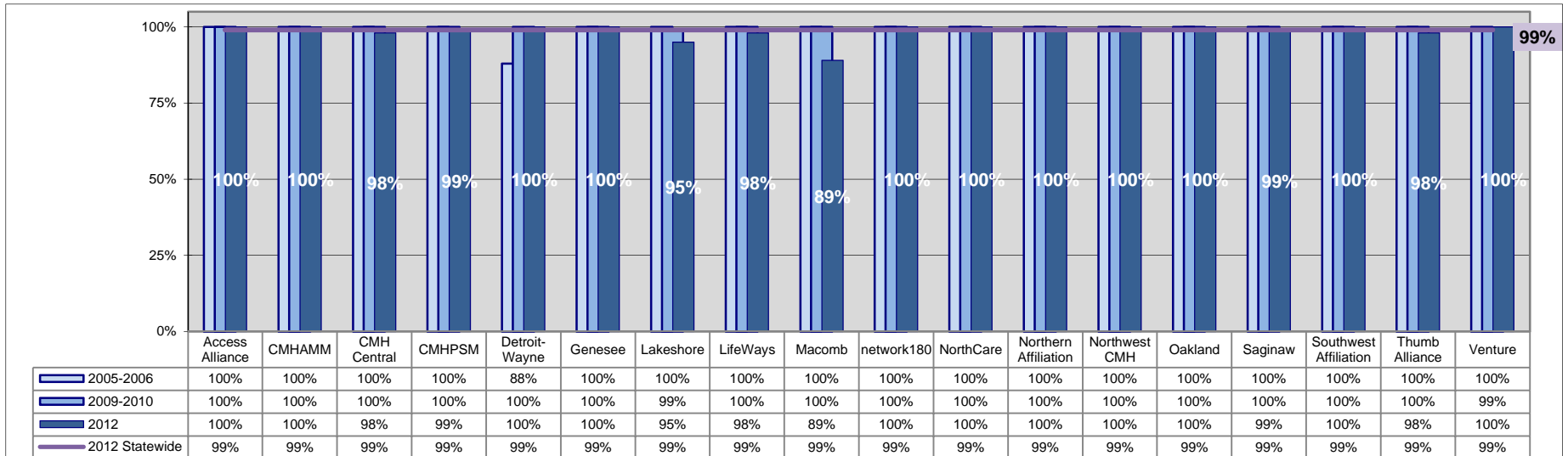


Figure A-2—Standard III: Practice Guidelines

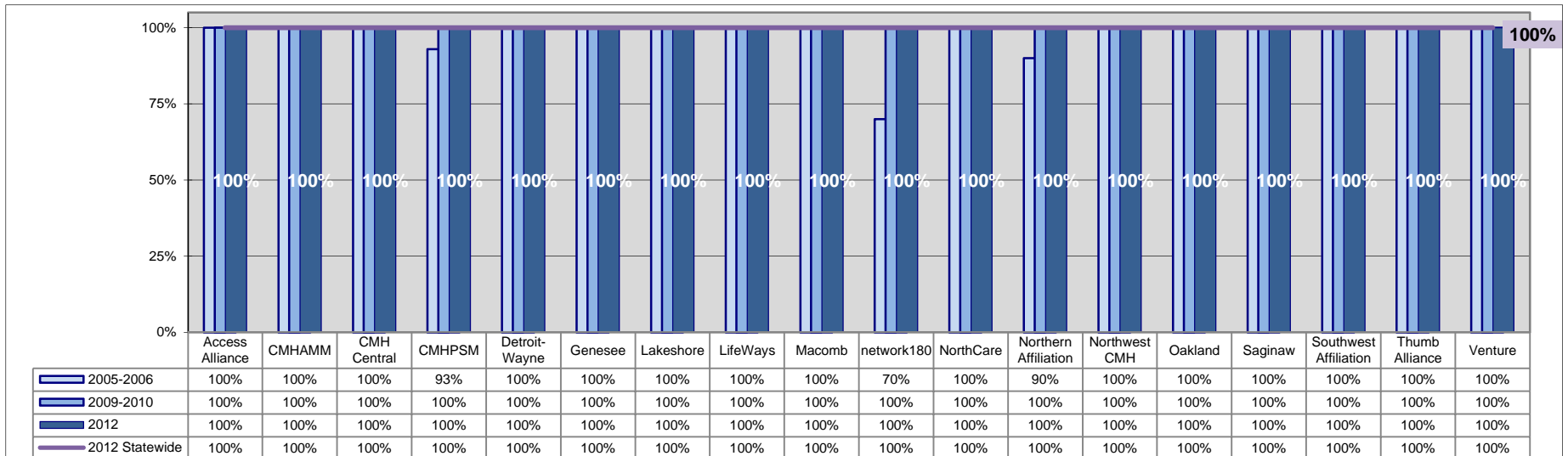


Figure A-3—Standard VI: Customer Services

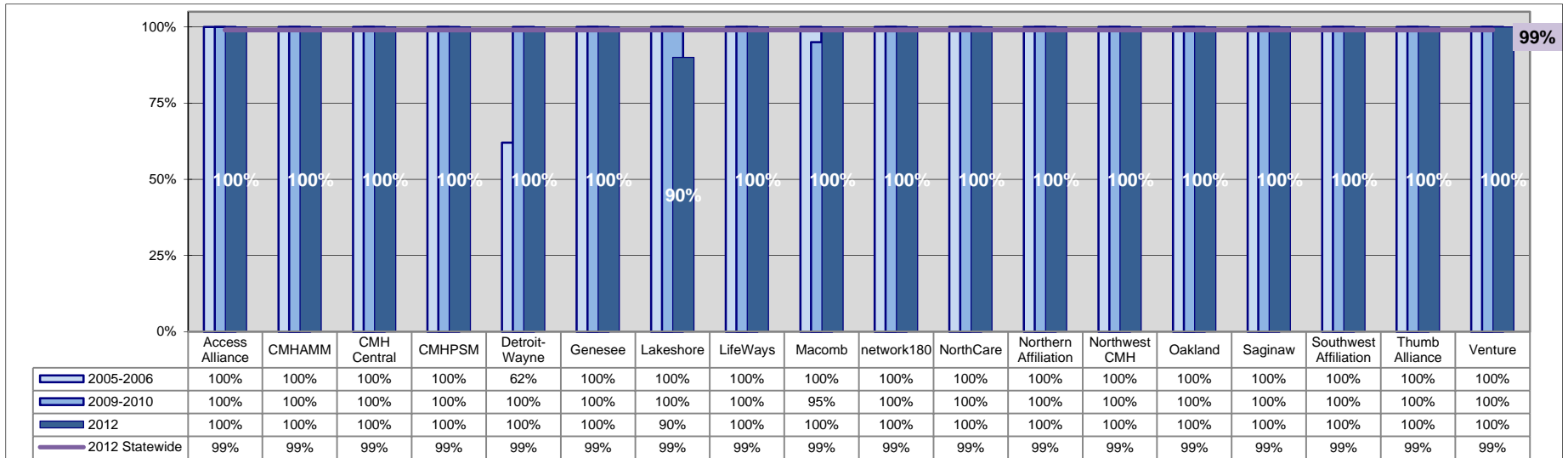


Figure A-4—Standard VIII: Enrollee Rights and Protections

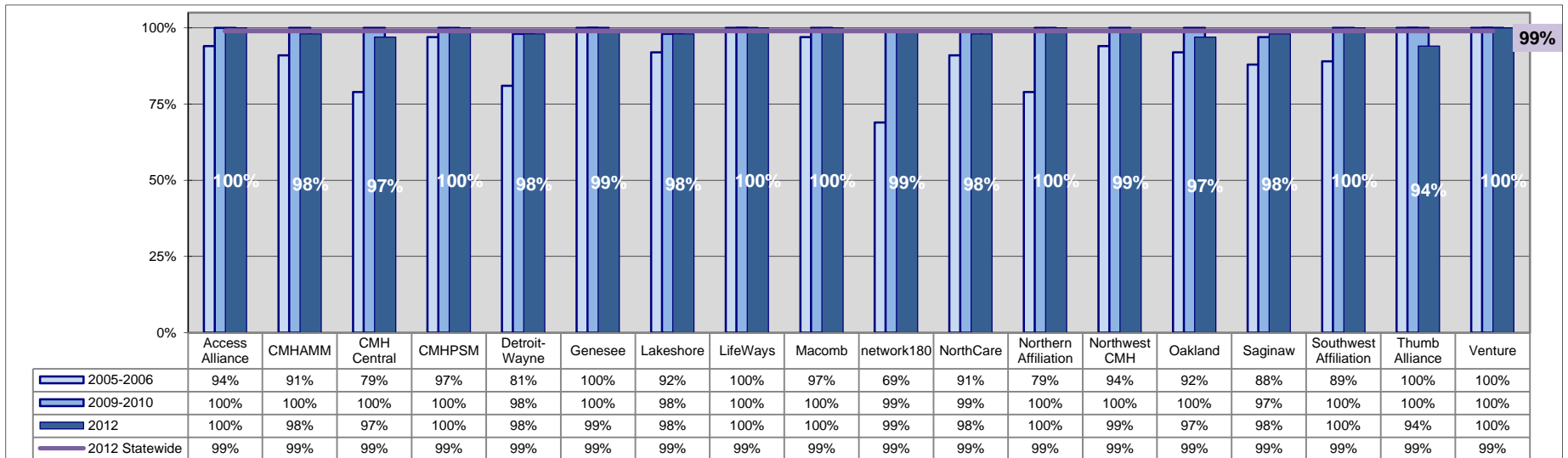


Figure A-5—Standard IX: Subcontracts and Delegation

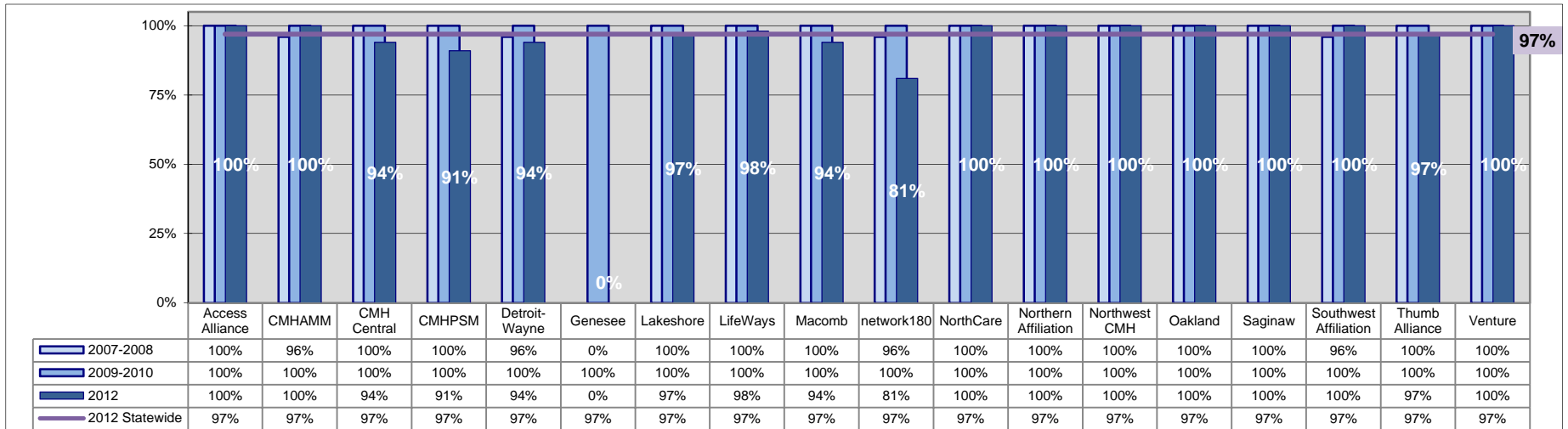


Figure A-6—Standard X: Provider Network

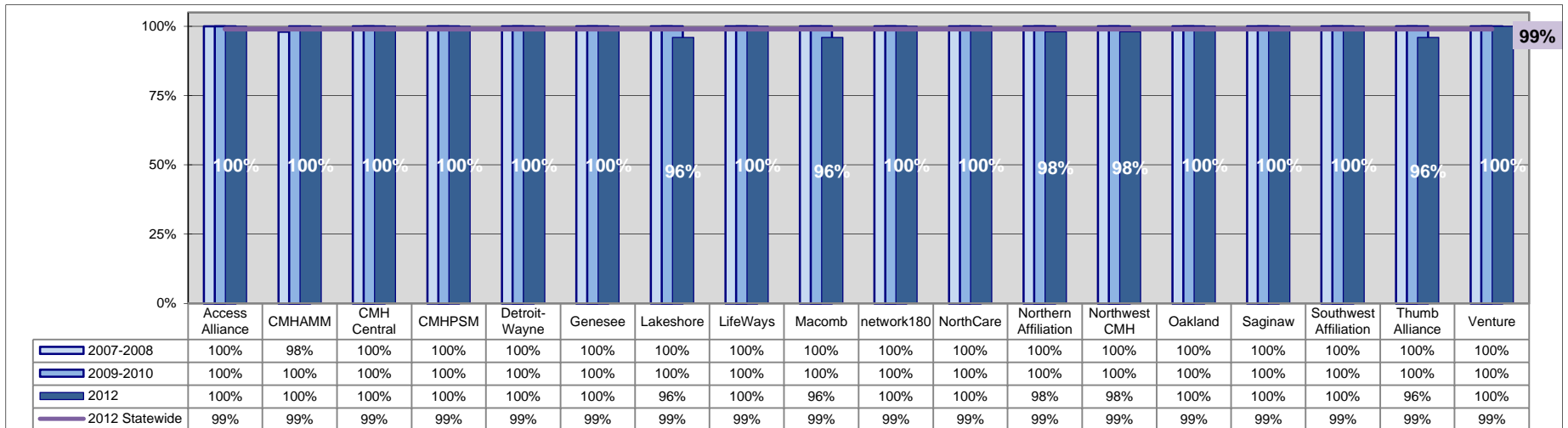


Figure A-7—Standard XI: Credentialing

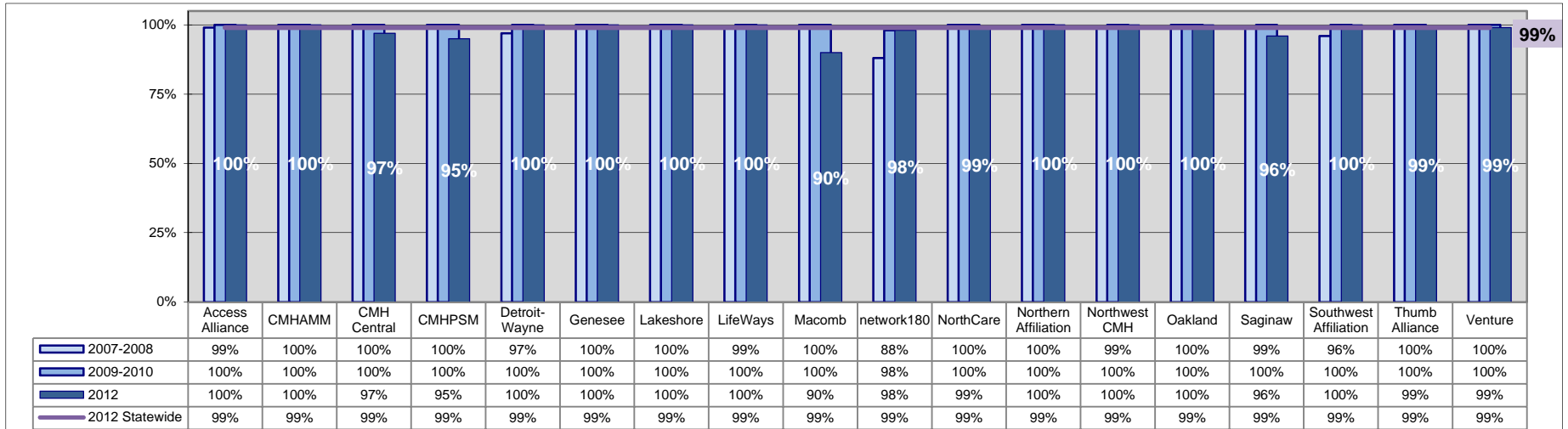
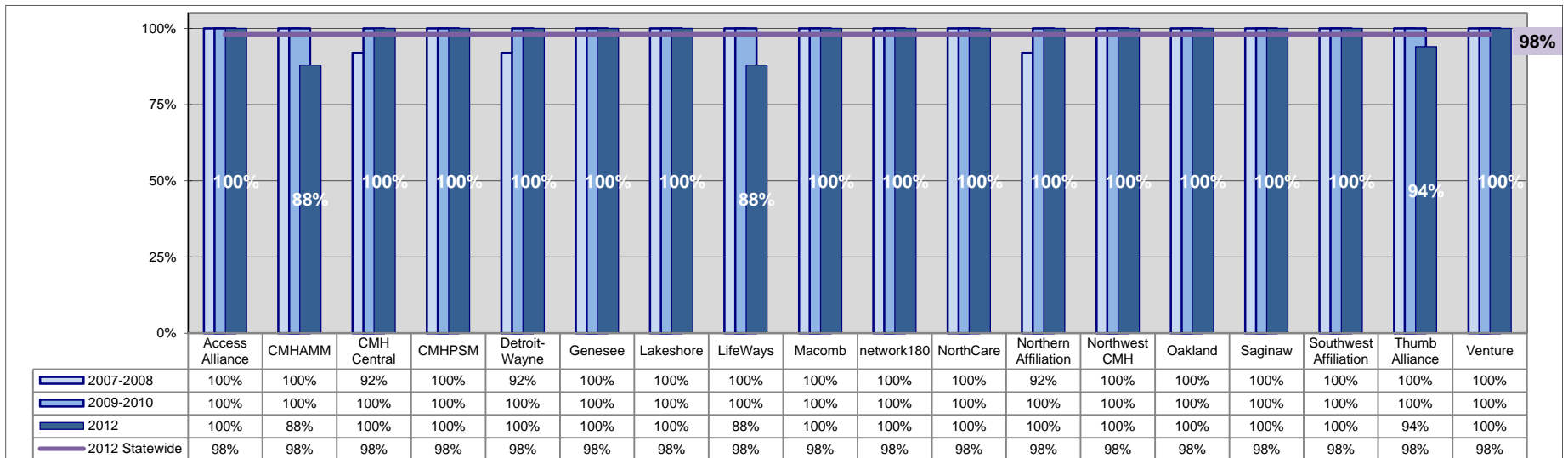


Figure A-8—Standard XIII: Coordination of Care



PIHP Compliance

Table A-1 presents the compliance scores for all 18 PIHPs on the eight compliance monitoring standards reviewed in 2011–2012 (Standards II, III, VI, VIII, IX, X, XI, and XIII). The remaining standards will be addressed in the next compliance review cycle.

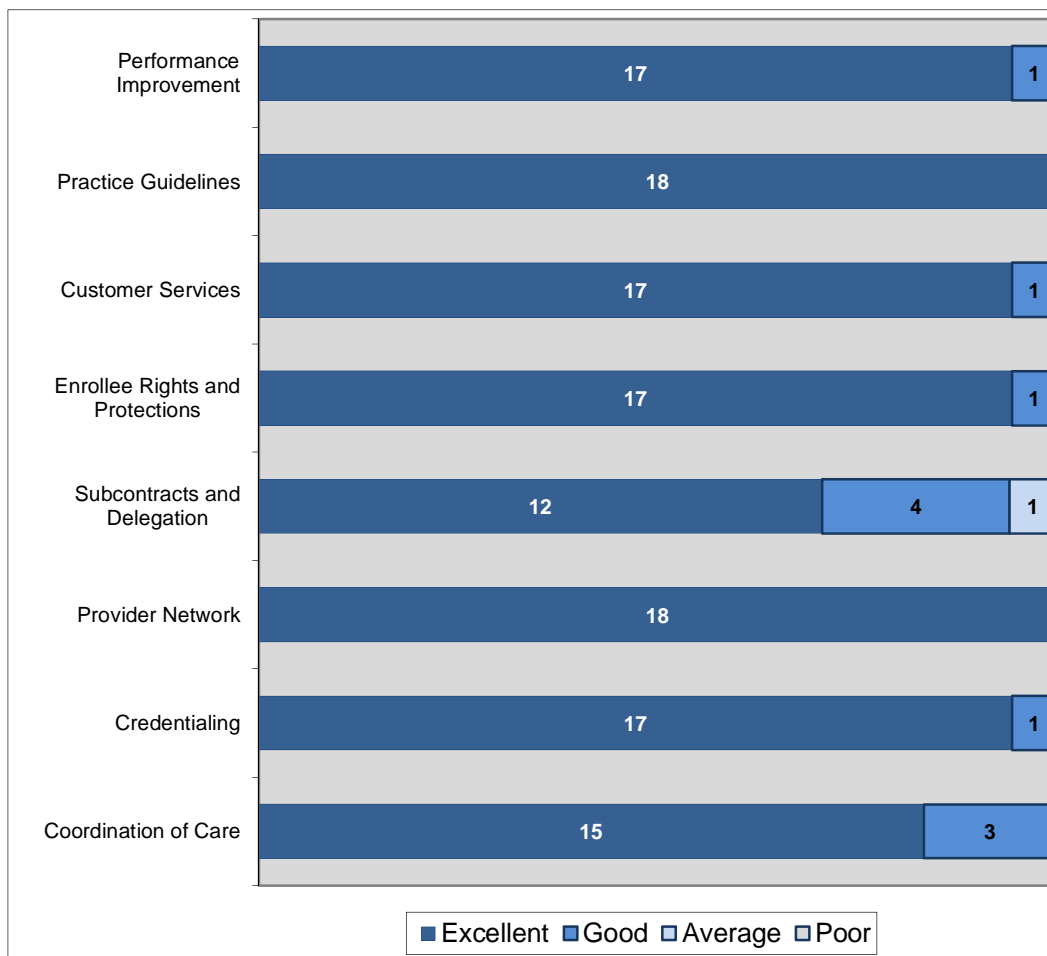
Table A-1—Summary of PIHP Compliance Scores (Percentage of Compliance)														
PIHP	I. QAPIP Plan and Structure	II. Performance Measurement and Improvement	III. Practice Guidelines	IV. Staff Qualifications and Training	V. Utilization Management	VI. Customer Services	VII. Enrollee Grievance Process	VIII. Enrollee Rights	IX. Subcontracts and Delegation	X. Provider Network	XI. Credentialing	XII. Access and Availability	XIII. Coordination of Care	XIV. Appeals
Access Alliance		100	100			100		100	100	100	100		100	
CMHAMM		100	100			100		98	100	100	100		88	
CMH Central		98	100			100		97	94	100	97		100	
CMHPSM		99	100			100		100	91	100	95		100	
Detroit-Wayne		100	100			100		100	94	100	100		100	
Genesee		100	100			100		99	NA	100	100		100	
Lakeshore		95	100			90		98	97	96	100		100	
LifeWays		98	100			100		100	100	100	100		88	
Macomb		89	100			100		100	94	96	90		100	
network180		100	100			100		99	81	100	100		100	
NorthCare		100	100			100		98	100	100	99		100	
Northern Affiliation		100	100			100		100	100	98	100		100	
Northwest CMH		100	100			100		99	100	98	100		100	
Oakland		100	100			100		97	100	100	100		100	
Saginaw		99	100			100		98	100	100	96		100	
Southwest Affiliation		100	100			100		100	100	100	100		100	
Thumb Alliance		98	100			100		94	97	96	99		94	
Venture		100	100			100		100	100	100	99		100	
Statewide Score		99	100			99		99	97	99	99		98	

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-9 presents the number of PIHPs receiving *Excellent/Good/Average/Poor* compliance scores for the 2011–2012 review for each of the eight standards.

Figure A-9—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 the 2011–2012 validation, MDCH revised the numbering of some of the indicators, replaced some of the indicators, and added new populations to two of the measures. This section presents results only for performance indicators validated by HSAG in 2010–2011 and 2011–2012.

Table A-2—Degree of Compliance for Performance Measures							
Indicator		Percentage of PIHPs					
		Fully Compliant		Substantially Compliant		Not Valid	
		2010 – 2011	2011 – 2012	2010 – 2011	2011 – 2012	2010 – 2011	2011 – 2012
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.	94%	94%	6%	6%	0%	0%
3.	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional.	94%	94%	6%	6%	0%	0%
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	94%	94%	6%	6%	0%	0%
4b.	Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	100%	94%	0%	6%	0%	0%
5.	Percentage of Medicaid recipients having received PIHP-managed services (penetration rate).	89%	94%	0%	6%	11%	0%
6.	Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination (HSW rate).	100%	100%	0%	0%	0%	0%
8.	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.	56%	89%	44%	11%	0%	0%
9.	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.	56%	61%	44%	39%	0%	0%
10.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	100%	100%	0%	0%	0%	0%

Table A-3 presents a two-year comparison of the statewide results for the validated performance indicators.

Table A-3—Statewide Performance Measure Rates				
Indicator			Reported Rate	
			2010–2011	2011–2012
1.	Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Adults	98%	99%
		Children	99%	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%	98%
3.	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional.		97%	97%
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Adults	97%	97%
		Children	96%	98%
4b.	Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.		99%	99%
5.	Percentage of Medicaid recipients having received PIHP-managed services (penetration rate).		6%	7%
6.	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%	89%
8.	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 MI	8%	7%
		Adults with DD	9%	8%
		Adults With MI/DD	10%	8%
9.	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 MI	75%	71%
		Adults with DD	29%	29%
		Adults With MI/DD	38%	38%
10.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Adults	8%	10%
		Children	11%	12%

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 (2010–2011) and Current-Year (2011–2012) 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	6. HSW Rate	8. Competitive Employment			9. Earning Minimum Wage			10. 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
Access Alliance	P	100	100	99.40	99.10	100	100	100	7.50	94.03	10.89	9.81	11.05	80.26	42.25	36.63	6.98	13.64
	C	100	99.34	98.96	98.30	100	100	100	9.08	94.13	10.67	9.22	12.41	79.72	36.29	38.84	5.71	10.58
CMHAMM	P	98.86	96.71	99.25	95.19	100	93.10	100	5.99	98.15	8.84	7.78	9.13	83.08	59.54	61.36	23.33	11.59
	C	97.37	95.04	99.00	96.94	100	100	100	6.45	97.01	8.96	9.03	10.37	77.93	58.27	55.28	6.25	7.69
CMH Central	P	100	98.58	98.67	99.12	100	100	100	8.44	96.94	10.55	11.87	8.60	81.77	29.05	33.33	0.00	0.00
	C	100	100	98.77	95.13	100	100	100	9.35	95.39	10.42	9.45	5.60	82.00	21.55	23.19	18.18	9.38
CMHPSM	P	100	100	96.90	94.33	92.31	94.44	0.00*	NV	79.45	9.42	15.11	17.94	90.87	74.64	87.50	12.90	6.80
	C	100	100	99.12	96.91	96.97	96.30	84.00	6.08	44.89	8.22	9.82	9.90	89.62	72.31	88.64	5.26	7.78
Detroit-Wayne	P	100	97.87	97.88	97.64	98.13	97.14	100	6.27	96.22	4.95	2.43	4.39	60.00	12.20	20.65	6.67	9.99
	C	100	98.22	96.80	97.80	98.63	97.56	100	7.16	96.77	4.26	2.89	3.90	58.72	12.87	31.37	11.78	12.61
Genesee	P	100	99.86	98.60	98.11	100	95.12	95.24	6.39	92.11	5.04	5.07	3.36	84.24	69.77	66.67	7.69	7.30
	C	100	100	95.67	97.04	100	98.53	100	7.08	97.60	4.73	6.65	4.89	64.23	16.00	20.93	10.20	11.28
Lakeshore	P	100	96.43	99.05	93.28	100	100	100	4.87	97.93	8.90	11.86	11.97	76.33	36.11	28.37	5.26	5.88
	C	100	100	95.12	97.51	100	100	100	3.60	98.74	8.04	9.32	8.42	77.33	28.92	28.13	0.00	5.71
LifeWays	P	92.04	96.84	91.37	95.28	100	98.21	100	6.81	89.31	6.62	11.27	6.46	80.77	92.86	78.57	17.65	19.48
	C	88.24	99.02	89.05	90.22	58.33	88.89	100	7.17	92.69	4.69	8.70	4.61	80.39	91.67	66.67	15.38	16.67
Macomb	P	100	100	99.34	98.81	98.72	99.35	98.31	5.23	98.39	7.50	5.82	5.00	61.82	38.97	40.88	12.05	22.91
	C	100	100	98.54	97.53	100	100	100	5.85	98.77	7.08	5.86	4.40	51.55	37.42	37.70	11.34	18.42
network180	P	97.85	99.34	99.91	87.83	100	83.46	100	5.68	97.04	9.51	8.57	12.14	74.33	18.92	22.05	2.38	16.00
	C	96.33	98.25	96.90	90.31	95.56	87.61	100	6.63	99.40	8.68	8.25	10.17	75.87	21.02	25.21	4.08	20.30

Notes: * No discharges during the reporting period NV = Rate was *Not Valid*

**Table A-4—PIHP Performance Measure Results—Percentage Scores
Comparison of Prior-Year (2010–2011) and Current-Year (2011–2012) 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	6. HSW Rate	8. Competitive Employment			9. Earning Minimum Wage			10. 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	98.40	98.38	98.18	92.31	100	100	7.09	97.55	10.83	5.99	6.05	72.26	34.26	34.29	15.63	19.05
	C	100	99.33	99.68	97.83	88.24	97.62	100	7.51	97.75	10.19	5.95	5.86	73.27	31.23	41.11	17.39	20.45
Northern Affiliation	P	98.15	98.55	98.46	97.95	88.46	97.44	100	5.35	95.43	9.24	13.49	17.33	66.67	46.67	66.30	8.33	5.45
	C	100	98.96	100	98.60	100	100	100	6.69	95.36	7.71	15.48	17.35	57.32	43.98	62.79	8.33	7.41
Northwest CMH	P	96.15	100	98.07	98.43	100	98.08	100	7.09	93.62	9.24	9.93	8.92	94.51	90.91	87.01	0.00	4.11
	C	94.12	100	98.14	99.06	100	100	100	7.66	95.05	9.58	9.50	8.43	94.55	52.27	78.40	17.65	12.73
Oakland	P	89.66	94.97	99.03	100	92.86	95.10	100	7.30	98.62	8.25	18.19	17.74	65.29	33.41	23.16	7.69	12.86
	C	94.19	93.63	98.69	99.89	100	99.41	100	7.78	98.94	8.10	12.70	8.92	61.76	34.68	23.39	8.00	10.80
Saginaw	P	100	100	99.42	96.92	62.50	100	73.33	5.21	100	7.15	13.85	9.20	87.76	24.07	26.92	0.00	19.44
	C	100	100	97.88	95.24	100	100	100	5.59	97.48	6.01	11.65	6.78	84.31	21.43	30.77	11.11	3.03
Southwest Affiliation	P	95.12	98.69	97.72	97.52	100	98.21	100	NV	93.35	7.96	14.75	12.39	85.11	76.15	87.80	9.38	8.45
	C	96.00	99.29	97.92	98.38	89.74	96.94	95.45	7.15	40.26	9.09	11.45	9.56	82.89	42.57	58.18	10.87	6.19
Thumb Alliance	P	100	99.47	100	99.74	100	97.37	100	7.42	99.66	8.61	3.54	2.60	37.27	9.38	8.46	8.82	9.80
	C	100	100	99.55	100	100	100	100	8.02	98.95	8.19	3.93	3.72	35.38	9.69	12.23	8.33	12.05
Venture	P	97.96	100	98.36	97.49	100	100	100	6.33	97.84	10.77	9.21	8.17	96.04	53.00	61.26	9.52	6.54
	C	100	100	97.86	98.76	100	98.46	0.00*	6.92	96.28	11.03	9.29	6.27	81.29	42.16	47.62	0.00	6.90

Notes: * No discharges during the reporting period NV = Rate was *Not Valid*

Results for Validation of Performance Improvement Projects

Table A-5 presents a two-year comparison of the PIHPs' validation status for the PIP on *Increasing the Proportion of Medicaid Eligible Adults with a Mental Illness Who Receive Peer-Delivered Services or Supports*.

Validation Status	Number of PIPs	
	2010–2011	2011–2012
<i>Met</i>	18	15
<i>Partially Met</i>	0	2
<i>Not Met</i>	0	1

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.

Validation Activity	Number of PIPs Meeting All Evaluation Elements/ Number Reviewed		Number of PIPs Meeting All Critical Elements/ Number Reviewed	
	2010–2011	2011–2012	2010–2011	2011–2012
I. Select the Study Topic(s)	17/18	17/18	18/18	18/18
II. Define the Study Question(s)	18/18	18/18	18/18	18/18
III. Select the Study Indicator(s)	18/18	18/18	18/18	18/18
IV. Use a Representative and Generalizable Study Population	18/18	17/18	18/18	17/18
V. Use Sound Sampling Techniques	NA	NA	NA	NA
VI. Reliably Collect Data	16/18	16/18	NA	NA
VII. Implement Intervention and Improvement Strategies	10/10	15/18	10/10	18/18
VIII. Analyze Data and Interpret Study Results	15/18	7/18	18/18	18/18
IX. Assess for Real Improvement	0/0	7/18	<i>No critical elements</i>	
X. Assess for Sustained Improvement	0/0	0/0	<i>No critical elements</i>	

*HSAG scored all elements for Activity V and the critical element in Activity VI *Not Applicable* 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 <i>Met</i>		% of All Critical Elements <i>Met</i>		Validation Status	
	2010–2011	2011–2012	2010–2011	2011–2012	2010–2011	2011–2012
Access Alliance	100%	82%	100%	100%	<i>Met</i>	<i>Met</i>
CMHAMM	100%	91%	100%	100%	<i>Met</i>	<i>Met</i>
CMH Central	100%	94%	100%	100%	<i>Met</i>	<i>Met</i>
CMHPSM	100%	94%	100%	100%	<i>Met</i>	<i>Met</i>
Detroit-Wayne	100%	100%	100%	100%	<i>Met</i>	<i>Met</i>
Genesee	100%	91%	100%	100%	<i>Met</i>	<i>Met</i>
Lakeshore	96%	100%	100%	100%	<i>Met</i>	<i>Met</i>
LifeWays	100%	82%	100%	100%	<i>Met</i>	<i>Met</i>
Macomb	100%	73%	100%	100%	<i>Met</i>	<i>Partially Met</i>
network180	88%	91%	100%	100%	<i>Met</i>	<i>Met</i>
NorthCare	100%	88%	100%	100%	<i>Met</i>	<i>Met</i>
Northern Affiliation	100%	100%	100%	100%	<i>Met</i>	<i>Met</i>
Northwest CMH	100%	91%	100%	100%	<i>Met</i>	<i>Met</i>
Oakland	100%	91%	100%	100%	<i>Met</i>	<i>Met</i>
Saginaw	82%	76%	100%	100%	<i>Met</i>	<i>Partially Met</i>
Southwest Affiliation	100%	100%	100%	100%	<i>Met</i>	<i>Met</i>
Thumb Alliance	100%	73%	100%	90%	<i>Met</i>	<i>Not Met</i>
Venture	100%	97%	100%	100%	<i>Met</i>	<i>Met</i>

The compliance monitoring tool appendix follows this cover page.



Appendix B: Documentation Request and Evaluation Tool
Michigan Department of Community Health (MDCH)
Prepaid Inpatient Health Plans (PIHPs)
for <PIHP-Full>

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: <div style="text-align: right;">42 CFR 438.240(c) MDCH Contract Attachment P6.7.1.1</div>		
a. Access		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
b. Efficiency		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
c. Outcome		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings



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Michigan Department of Community Health (MDCH)
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Standard II—Performance Measurement and Improvement

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
2. Minimum Performance Levels MDCH Contract 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.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
b. The PIHP analyzes the causes of negative statistical outliers when they occur.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> 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) MDCH Contract Attachment P6.7.1.1		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings



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Standard II—Performance Measurement and Improvement

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
4. Review of Sentinel Events MDCH Contract Attachment P6.7.1.1		
a. The QAPIP describes the process for the <u>review</u> of sentinel events.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
b. The QAPIP describes the process for <u>follow-up</u> of sentinel events.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> 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. MDCH Contract Attachment P6.7.1.1		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings



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Standard II—Performance Measurement and Improvement		
Requirement	Evidence/Documentation as Submitted by the PIHP	Score
6. Assessments of Beneficiary Experiences with Services		
MDCH Contract Attachment P6.7.1.1		
a. The QAPIP includes periodic <u>qualitative</u> assessments of beneficiaries’ experiences with its services.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
b. The QAPIP includes periodic <u>quantitative</u> assessments of beneficiaries’ experiences with its services.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
c. Assessments represent persons served and services and supports offered.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
d. The assessments address issues of the <u>quality</u> of care.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
e. The assessments address issues of the <u>availability</u> of care.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



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



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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. MDCH Contract Attachment P6.7.1.1		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> 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 =					



Appendix B: Documentation Request and Evaluation Tool
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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: <div style="text-align: right; margin-right: 100px;">MDCH Contract Attachment P6.7.1.1 42 CFR 438.236</div>		
a. Adoption process		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
b. Development process		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
c. Implementation		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
d. Continuous monitoring		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
e. Evaluation		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



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Standard III—Practice Guidelines

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: <div style="text-align: right;">42 CFR 438.236(b)</div>		
a. Practice guidelines are based on valid and reliable clinical evidence or consensus of health care professionals.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
b. Practice guidelines consider the <u>needs of beneficiaries</u> .		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
c. Practice guidelines are adopted in <u>consultation</u> with contracting health care professionals.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
d. Practice guidelines are <u>reviewed and updated</u> periodically, as appropriate.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



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Standard III—Practice Guidelines

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
3. Practice Guideline Dissemination <div style="text-align: right;">42 CFR 438.236(c)</div>		
a. Practice guidelines are disseminated to all affected <u>providers</u> .		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
b. Practice guidelines are disseminated, upon request, to <u>beneficiaries</u> and potential beneficiaries.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

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Standard III—Practice Guidelines		
Requirement	Evidence/Documentation as Submitted by the PIHP	Score
4. Application of Practice Guidelines <div style="text-align: right;">42 CFR 438.236(d)</div>		
a. Decisions for <u>utilization management</u> are consistent with the guidelines.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
b. Decisions for <u>beneficiary education</u> are consistent with the guidelines.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
c. Decisions for <u>coverage of services</u> are consistent with the guidelines.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
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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						=	



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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. MDCH Contract Attachment P6.3.1.1		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
2. Phone Access MDCH Contract Attachment P6.3.1.1		
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.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> 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.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

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Standard VI—Customer Services

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>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. The customer services unit or function will operate minimally eight hours daily, Monday through Friday, except for Holidays.</p> <p align="right">MDCH Contract Attachment P6.3.1.1</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>4. Customer Handbook The customer handbook includes:</p> <ul style="list-style-type: none"> ◆ 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). <p align="right">MDCH Contract Attachment P6.3.1.1</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

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Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>5. 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.</p> <p align="right">MDCH Contract Attachment P6.3.1.1</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>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.</p> <p align="right">MDCH Contract Attachment P6.3.1.1</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

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Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>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.</p> <p align="right">MDCH Contract Attachment P6.3.1.1</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings

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Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>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:</p> <p align="right">MDCH Contract Attachment P6.3.1.1</p>		
<p>a. Working Knowledge About:</p> <ul style="list-style-type: none"> ◆ 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 		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



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- 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						=	



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Standard VIII—Enrollee Rights and Protections

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
1. Written Policies <div style="text-align: right;">42 CFR 438.100 (a)(1) 42 CFR 438.100(a)(2)</div>		
a. The PIHP has written policies regarding enrollee rights.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> 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.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

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Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>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)</p>		
<p>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.</p> <p>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) MDCH Contract 6.3.3</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p>b. The PIHP makes its written information available in the prevalent, non-English languages in its service area. 42 CFR 438.10(c)(3) MDCH Contract 6.3.3</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p>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) MDCH Contract 6.3.3 LEP Policy Guidance (Executive Order 13166 of August 11, 2002) Federal Register Vol 65, August 16, 2002.</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



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<p>d. The PIHP notifies its enrollees that <u>oral interpretation</u> is available for any language.</p> <p align="right">42 CFR 438.10(c)(5)(i and ii) MDCH Contract 6.3.3</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p>e. The PIHP notifies its enrollees that <u>written information</u> is available in prevalent languages.</p> <p align="right">42 CFR 438.10(c)(5)(i and ii) MDCH Contract 6.3.3</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p>f. The PIHP notifies its enrollees that written information is available about how to <u>access</u> those services.</p> <p align="right">42 CFR 438.10(c)(5)(i and ii) MDCH Contract 6.3.3</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p>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.</p> <p align="right">42 CFR 438.10(d)(1)(ii), MDCH Contract 6.3.3 Americans with Disabilities Act (ADA)</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p>h. Enrollees and potential enrollees are <u>informed</u> that information is available in alternative formats.</p> <p align="right">42 CFR 438.10(d)(2) MDCH Contract 6.3.3</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p>i. Enrollees and potential enrollees are informed about how to <u>access</u> those formats.</p> <p align="right">42 CFR 438.10(d)(2) MDCH Contract 6.3.3</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



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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: <div style="text-align: right;">42 CFR 438.10(f)(3)</div>		
a. A listing of contracted providers that identifies provider name, locations, telephone numbers, any non-English languages spoken, and whether they are accepting new patients. This includes, at a minimum, information about primary service providers (e.g., case managers, psychiatrists, primary therapist, etc.). A written copy of this listing must be provided to each beneficiary annually, unless the beneficiary has expressly informed the PIHP that accessing the listing through an available Web site or customer services line is acceptable. <div style="text-align: right;">MDCH Contract 6.3.3</div>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
b. Any restrictions on the enrollee’s freedom of choice among network providers. <div style="text-align: right;">42 CFR 438.10(f)(6)(ii) MDCH Contract 6.3.3</div>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



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<p>c. Grievance, appeal, and fair hearing procedures and timeframes that include:</p> <ul style="list-style-type: none"> ◆ 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. <p align="right">42 CFR 438.10(g)(1)(vi)(A) MDCH Contract 6.3.3</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p>d. 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.</p> <p align="right">42 CFR 438.10(f)(6)(v) MDCH Contract 6.3.3</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



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<p>e. Procedures for obtaining benefits, including authorization requirements.</p> <p align="right">42 CFR 438.10(f)(6)(vi) MDCH Contract 6.3.3</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p>f. The extent to which, and how, enrollees may obtain benefits from out-of-network providers.</p> <p align="right">42 CFR 438.10(f)(6)(vii) MDCH Contract 6.3.3</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p>g. The extent to which, and how, after-hours and emergency coverage is provided, including:</p> <ul style="list-style-type: none"> ◆ 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. <p align="right">42 CFR 438.10(f)(6)(viii) MDCH Contract 6.3.3</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



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<p>h. Cost sharing, if any.</p> <p align="right">42 CFR 438.10(f)(6)(xi)</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p>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.</p> <p align="right">42 CFR 438.10 (e)(2)(ii)(E)</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p>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.</p> <p align="right">42 CFR 438.10(g)(2), 42 CFR 438.6(i) MDCH Contract 6.8.6</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p>k. The PIHP provides to the beneficiary annually (e.g., at the time of person-centered planning) the estimated cost to the PIHP of each covered support and service he or she is receiving.</p> <p align="right">MDCH Contract 6.3.3</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p>l. 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.</p> <p align="right">42 CFR 438.10(g)(3)(i) 42 CFR 438.6(h) MDCH Contract 6.3.3</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

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Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>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).</p> <p align="right">42 CFR 438.10(f)(4) MDCH Contract 6.3.3</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>5. Notice of Termination of Providers</p> <p align="right">42 CFR 438.10(f)(5) MDCH Contract 6.3.3</p>		
<p>a. The PIHP makes a good faith effort to give <u>written notice</u> 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.</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p>b. The PIHP makes a good faith effort to give written notice of termination of a contracted provider <u>within 15 days</u> after receipt or issuance of the termination notice.</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

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Requirement	Evidence/Documentation as Submitted by the PIHP	Score
6. Right to Request and Obtain Information <div style="text-align: right;">42 CFR 438.10(f)(2)</div>		
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.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
b. This information includes the information described in 3 a-1 on the previous pages.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> 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. <div style="text-align: right;">42 CFR 438.100(b)(1)(2)(ii)</div>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

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Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>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.</p> <p align="right">42 CFR 438.100(b)(2)(iii)</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>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:</p> <ul style="list-style-type: none"> ◆ 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. <p align="right">42 CFR 438.102(a)</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

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Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>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:</p> <ul style="list-style-type: none"> ◆ 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.) <p align="right">42 CFR 438.102(a)(2)(b)(1)</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>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.</p> <p align="right">42 CFR 438,100(b)(2)(iv)</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

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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. <div style="text-align: right;">42 CFR 438.100(b)(2)(v)</div>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> 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		=				



Appendix B: Documentation Request and Evaluation Tool
Michigan Department of Community Health (MDCH)
Prepaid Inpatient Health Plans (PIHPs)
for <PIHP-Full>

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. <div align="right">438.230(b)</div>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> 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. <div align="right">438.230(b)(2)</div>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings



Appendix B: Documentation Request and Evaluation Tool
Michigan Department of Community Health (MDCH)
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for <PIHP-Full>

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. <div style="text-align: right;">438.230(b)(2)(i) MDCH Contract 6.4.2</div>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> 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. <div style="text-align: right;">438.230(b)(2)(i) MDCH Contract 6.4.2</div>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> 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. <div style="text-align: right;">438.230(b)(2)(ii)</div>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
Findings		



Appendix B: Documentation Request and Evaluation Tool
Michigan Department of Community Health (MDCH)
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Standard IX—Subcontracts and Delegation		
Requirement	Evidence/Documentation as Submitted by the PIHP	Score
6. Monitoring of Delegates The PIHP annually monitors affiliates, as applicable, and provider networks who perform delegated functions to assure quality and performance with the standards in the Quality Assessment and Performance Improvement Technical Requirement (PIHP Contract Attachment P6.7.1.1). <div style="text-align: right;">438.230(b)(3) MDCH Contract 6.4(J)</div>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> 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. <div style="text-align: right;">438.230(b)(4)</div>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
Findings		
Requirement	Evidence/Documentation as Submitted by the PIHP	Score
8. PIHP Oversight The PIHP must review and follow up on any provider network monitoring of its subcontractors. <div style="text-align: right;">MDCH Contract 6.4(J) MDCH Contract Attachment P6.7.1.1</div>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
Findings		



Appendix B: Documentation Request and Evaluation Tool
Michigan Department of Community Health (MDCH)
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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					=	



Appendix B: Documentation Request and Evaluation Tool
Michigan Department of Community Health (MDCH)
Prepaid Inpatient Health Plans (PIHPs)
for <PIHP-Full>

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. <div style="text-align: right;">438.206(b)(1)</div>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> 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. <div style="text-align: right;">438.206(b)(1)</div>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> 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. <div style="text-align: right;">438.106(b)(2)</div>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
Findings		



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Michigan Department of Community Health (MDCH)
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Standard X—Provider Network

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>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.</p> <p align="right">438.106(c)</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings

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Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>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.</p> <p align="right">438.206(b)(1)(i-v)</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings

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Appendix B: Documentation Request and Evaluation Tool
Michigan Department of Community Health (MDCH)
Prepaid Inpatient Health Plans (PIHPs)
for <PIHP-Full>

Standard X—Provider Network

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>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:</p> <ul style="list-style-type: none"> ◆ Within 30 miles or 30 minutes of the recipient's residence in urban areas. ◆ Within 60 miles or 60 minutes in rural areas. <p align="right">MDCH Contract 3.1</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>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.</p> <p align="right">438.214(d)</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings



Appendix B: Documentation Request and Evaluation Tool
Michigan Department of Community Health (MDCH)
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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. <div style="text-align: right;">438.12 MDCH Contract 6.4.1</div>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> 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. <div style="text-align: right;">438.207(c)(2) MDCH Contract 6.4(F)</div>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> 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. <div style="text-align: right;">438.206(b)(4) MDCH Contract 3.4.7</div>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
Findings		



Appendix B: Documentation Request and Evaluation Tool
Michigan Department of Community Health (MDCH)
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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. <div style="text-align: right;">438.206(b)(5)</div>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> 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. <div style="text-align: right;">438.206(b)(3) MDCH Contract 3.4.6</div>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> 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 =						



Appendix B: Documentation Request and Evaluation Tool
Michigan Department of Community Health (MDCH)
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for <PIHP-Full>

Standard XI—Credentialing		
Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>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.</p> <p align="right">438.214(b)(2) MDCH Contract 6.4.3</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
Findings		
Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>2. Health Care Professionals The PIHP’s processes for credentialing and recredentialing are conducted and documented for at least the following health care professionals:</p> <ul style="list-style-type: none"> ◆ 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 <p align="right">MDCH Contract Attachment P6.4.3.1</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
Findings		



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Michigan Department of Community Health (MDCH)
Prepaid Inpatient Health Plans (PIHPs)
for <PIHP-Full>

Standard XI—Credentialing		
Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>3. Written Policy—Criteria, Scope, Timeline, and Process The credentialing policy reflects the scope, criteria, timeliness, and process for credentialing and recredentialing providers.</p> <p align="right">MDCH Contract Attachment P6.4.3.1</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
Findings		
Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>4. Provider Discrimination The PIHP has processes to ensure:</p> <ul style="list-style-type: none"> ◆ That the credentialing and recredentialing processes do not discriminate against: <ul style="list-style-type: none"> ▪ 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. <p align="right">438.12 and 438.214(c) MDCH Contract 6.4.1 MDCH Contract Attachment P6.4.3.1</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
Findings		



Appendix B: Documentation Request and Evaluation Tool
Michigan Department of Community Health (MDCH)
Prepaid Inpatient Health Plans (PIHPs)
for <PIHP-Full>

Standard XI—Credentialing		
Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>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.</p> <p align="right">MDCH Contract Attachment P6.4.3.1</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
Findings		
Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>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.</p> <p align="right">MDCH Contract Attachment P6.4.3.1</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
Findings		
Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>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.</p> <p align="right">MDCH Contract Attachment P6.4.3.1</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
Findings		



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Michigan Department of Community Health (MDCH)
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for <PIHP-Full>

Standard XI—Credentialing		
Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>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.</p> <p align="right">MDCH Contract Attachment P6.4.3.1</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
Findings		
Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>9. Written Policy—Provider Role The policy describes any use of participating providers in making credentialing decisions.</p> <p align="right">MDCH Contract Attachment P6.4.3.1</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
Findings		
Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>10. Credentialing Files The PIHP’s processes require that an individual file be maintained for each credentialed provider and that each file include:</p> <ul style="list-style-type: none"> ◆ 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. <p align="right">MDCH Contract Attachment P6.4.3.1</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



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Michigan Department of Community Health (MDCH)
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Standard XI—Credentialing

Findings

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Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>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:</p> <ul style="list-style-type: none"> ◆ 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 <p align="right">MDCH Contract Attachment P6.4.3.1</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings

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Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>12. Initial Credentialing—Requirements The PIHP’s policy and procedures require that the initial credentialing of an applicant include:</p> <ul style="list-style-type: none"> ◆ 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: <ul style="list-style-type: none"> ▪ A minimum five-year history of professional liability claims resulting in a judgment or settlement 		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



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Michigan Department of Community Health (MDCH)
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Standard XI—Credentialing

<ul style="list-style-type: none"> ▪ Disciplinary status with a regulatory board or agency ▪ A Medicare/Medicaid sanctions query <p>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.</p> <p align="right">MDCH Contract Attachment P6.4.3.1</p>		
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Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>13. Temporary/Provisional Credentialing of Individual Practitioners</p> <p align="right">MDCH Contract Attachment P6.4.3.1</p>		
<p>a. Policies and Limitations</p> <p>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.</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p>b. Application</p> <p>The PIHP’s policy and procedures require that, at a minimum, a provider must complete a signed application that includes the following items:</p> <ul style="list-style-type: none"> ◆ 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 		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



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Standard XI—Credentialing

<p>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:</p> <ul style="list-style-type: none"> ◆ Licensure or certification ◆ Board certification, if applicable, or the highest level of credential attained ◆ Medicare/Medicaid sanctions 		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p>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.</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>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.</p> <p align="right">MDCH Contract Attachment P6.4.3.1</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings



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Michigan Department of Community Health (MDCH)
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for <PIHP-Full>

Standard XI—Credentialing

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>15. Recredentialing Requirements for Individual Practitioners The PIHP’s policy and procedures for recredentialing require, at a minimum:</p> <ul style="list-style-type: none"> ◆ 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: <ul style="list-style-type: none"> ▪ Medicare/Medicaid sanctions. ▪ State sanctions or limitations on licensure, registration, or certification. ▪ Beneficiary concerns, which include grievances (complaints) and appeals information. ▪ PIHP quality issues <p align="right">MDCH Contract Attachment P6.4.3.1</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>16. Delegation of PIHP Responsibilities for Credentialing/ Recredentialing If responsibilities for credentialing/recredentialing are delegated by the PIHP, the PIHP:</p> <ul style="list-style-type: none"> ◆ 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. <p>Is responsible for oversight of delegated credentialing or recredentialing decisions.</p> <p align="right">MDCH Contract Attachment P6.4.3.1</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



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Michigan Department of Community Health (MDCH)
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for <PIHP-Full>

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. MDCH Contract Attachment P6.4.3.1		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> 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). MDCH Contract Attachment P6.4.3.1		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings



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Michigan Department of Community Health (MDCH)
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for <PIHP-Full>

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. MDCH Contract Attachment P6.4.3.1		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> 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. MDCH Contract Attachment P6.4.3.1		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> 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. MDCH Contract Attachment P6.4.3.1		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
Findings		



Appendix B: Documentation Request and Evaluation Tool
Michigan Department of Community Health (MDCH)
Prepaid Inpatient Health Plans (PIHPs)
for <PIHP-Full>

Standard XI—Credentialing		
Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>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 or 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. MDCH Contract Attachment P6.4.3.1</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> 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 =						



Appendix B: Documentation Request and Evaluation Tool
Michigan Department of Community Health (MDCH)
Prepaid Inpatient Health Plans (PIHPs)
for <PIHP-Full>

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 Contract 6.4.4 and 6.8.3		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> 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)		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> 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)		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings



Appendix B: Documentation Request and Evaluation Tool
Michigan Department of Community Health (MDCH)
Prepaid Inpatient Health Plans (PIHPs)
for <PIHP-Full>

Standard XIII—Coordination of Care

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
4. Coordination Agreements The PIHP has a written, functioning coordination agreement with each MHP serving any part of the PIHP’s service area. At a minimum, these arrangements must address integration of physical and mental health plans. <p align="right">MDCH Contract 6.4.5</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> 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 =						

Appendix C. Performance Measure Validation Tool

The performance measure validation tools follow 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 PIHPs for any applicable Coordinating Agencies.

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).

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 2011 _____

July 2011 _____

August 2011 _____

September 2011 _____

October 2011 _____

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.

G. Please provide a brief summary of your PIHP's experience in working with the state CHAMPS system in the past year, including any challenges your PIHP has faced related to data reporting/data acquisition through CHAMPS.

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?

II. INFORMATION SYSTEMS: DATA PROCESSING PROCEDURES AND PERSONNEL

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.**

III. DATA ACQUISITION CAPABILITIES

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)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sub-Panel Provider (for a CMH contract agency)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Off-Panel Provider (for out-of-network providers, incl. COFR)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hospital	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

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)	<input type="checkbox"/>	<input type="checkbox"/>
Sub-Panel Provider (for a CMH contract agency)	<input type="checkbox"/>	<input type="checkbox"/>
Off-Panel Provider (for out-of-network providers, incl. COFR)	<input type="checkbox"/>	<input type="checkbox"/>
Hospital	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>

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.)

CODING SCHEME	INSTITUTIONAL		PROFESSIONAL	
	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 functions are manual and which are automated.

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?**

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?

Indicator	Measure	Subcontractors
1.	The percent of all Medicaid adult and children beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. (1 st Quarter FY2012)	_____
2.	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.	_____
3.	The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional.	_____
4a.	The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	_____
4b.	The percent of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	_____
5.	The percent of Medicaid recipients having received PIHP managed services. (MI adults, MI children, DD adults, DD children, and SA). (1 st quarter FY 2012)	_____
6.	The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination. (1 st quarter FY 2012)	_____
8.	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. (FY 2011)	_____
9.	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. (FY 2011)	_____

III. DATA ACQUISITION CAPABILITIES

10.	The percent of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	_____
13.	The percent of adults with developmental disabilities served, who live in a private residence alone, with a spouse or non-relative(s).	_____
14.	The percent of adults with serious mental illness served, who live in a private residence alone, with a spouse, or non-relative(s).	_____

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
<i>EXAMPLE:</i> CMHSP #1—All mental health services for blank population	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> A <input checked="" type="checkbox"/> B <input type="checkbox"/> C	<input checked="" type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<i>Volumes of encounters not consistent from month to month.</i>
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> 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%

III. DATA ACQUISITION CAPABILITIES

- 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?**

IV. Outsourced or Delegated Functions

This section requests information on your PIHP ensuring the quality of the performance measure data collected or processed by delegated entities.

Quality of Data Used for Performance Measure Reporting

1. For the purposes of performance measure reporting, were any external entities responsible for providing data used for the generation of performance measure rates?

Yes

No

If so, please answer the following questions.

1a. How many entities are responsible for reporting administrative data to the PIHP? Describe each entities role in the collection of claims and encounter data.

1b. Describe how these administrative data are provided to the PIHP (if applicable).

1c. Describe how claims and encounter data submitted are integrated into your data repository.

1d. Please describe how your PIHP ensures the accuracy and completeness of the data received.

2. For purposes of performance measure reporting, were external entities responsible for calculating individual performance measure rates, denominators or numerators?

Yes No

If so, please answer the following questions.

2a. Please describe each entities role in performance measure reporting.

2b. Please describe how the performance measure information generated by each entity is integrated into your performance measure reporting.

2c. Please describe how your PIHP ensures the accuracy and completeness of data received.

IV. Outsourced or Delegated Functions

3. Is there any additional information that you would like to provide about how your PIHP ensures the quality of data being provided by these delegated entities?

Vendor Oversight

4. Describe how your PIHP ensures that contracted delegated entities meet performance measure reporting standards and time frames.

5. Does your PIHP have any standards of delegation which address frequency and timeliness of reporting?

Yes

No

If so, please answer the following questions.

5a. Please describe your delegated entity reporting standards/requirements. Include examples of language from contracts.

5b. How is delegated entity performance measured against those standards? Provide documentation of periodic monitoring of the timeliness of reporting.

5c. If a deficiency is discovered, how is it addressed?

IV. Outsourced or Delegated Functions

6. Does your PIHP have any standards of delegation which address data accuracy, completeness, and timeliness of submission?

Yes

No

If so, please answer the following questions.

6a. Please describe your external entities' data accuracy, completeness, and timeliness standards/requirements. Include examples of language from vendor contracts.

6b. How is delegated entity performance measured against those standards? Provide documentation of periodic monitoring of the accuracy and completeness of reporting.

6c. If a deficiency is discovered, how is it addressed?

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

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
Health Information System Configuration for Network	Attachment 8	8
Continuous Enrollment Source Code	Any computer programming code used to calculate continuous enrollment, if applicable.	9
Reporting Requirements for Delegated Entities	Provide excerpts from delegated entity contracts that document requirements for (1) the frequency and timeliness of reporting to your PIHP and (2) the accuracy and completeness of data reported to your PIHP	10
Documentation of Vendor Monitoring	Please provide documentation of how you monitor vendors/delegated entities against contract requirements for timeliness, accuracy, and completeness of data reporting.	11
Other/Describe: _____	_____	12

Comments: _____

Appendix C: Michigan Department of Community Health Mini-Information Systems Capabilities Assessment (ISCA) for Prepaid Inpatient Health Plans (PIHPs)—Coordinating Agency Version

I. GENERAL INFORMATION

Please provide the following general information:

Note: As a subcontractor to a PIHP, you are required to complete the mini-ISCA. When completing this ISCA, answer the questions in the context of the performance measures reported to MDCH, and the QI and encounter data submitted to MDCH only. If a question does not apply whatsoever to the performance measure calculation and reporting, QI data, or encounter data submission, enter an N/A response.

A. Contact Information

Please insert (or verify the accuracy of) the PIHP subcontractor identification information below, including the organization name, contact name and title, mailing address, telephone and fax numbers, and e-mail address, if applicable.

Organization 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. Organizational Information

Please indicate what type of organization:

- Community Mental Health Services Program (CMHSP)
- Managed Comprehensive Provider Network (MCPN) – Wayne County
- Coordinating Agency (CA)
- Other (describe):

Please indicate model type (if other, please specify):

- Group model
- Network model
- Mixed model
- Other (describe)

Please provide a brief description of your organization structure: _____

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. In an attachment to the ISCA, please describe how your organization’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 sub-panel providers, provider groups, etc.). 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 organization and will help make the validation process run smoothly and efficiently.

Note: Complete Section II – Information Systems: Data Processing Procedures and Personnel and III - Data Acquisition Capabilities of the ISCA if your organization calculates any performance indicators required by MDCH and submits the performance indicator results to the PIHP. If your organization has delegated any Medicaid claims/encounter processing to a subcontractor, you must arrange for the subcontractor to complete a copy of Section III of the ISCA and include it with your mini-ISCA submission. Skip to Section III if your organization is responsible only for claims/encounter processing.

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/claim/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?

The intent of this question is to help the reviewers understand how the performance indicators are calculated by the PIHP and its subcontractors. A *programmer* is defined as an individual who develops and/or runs computer programs or queries to manipulate data for QI or encounter data submission or performance measure reporting.

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.

_____ %

7. What is the average experience, in years, of programmers in your organization?

_____ years

8. 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 performance measure reporting.

II. INFORMATION SYSTEMS: DATA PROCESSING PROCEDURES AND PERSONNEL

9. Staffing

9a. Describe the Medicaid claims/encounter/service 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).

9b. Describe claims/encounter data processor training from new hire to refresher courses for seasoned processors:

9c. What is the average tenure of the staff?

9d. What is the annual turnover?

10. Security (Note: The intent of this section is to ensure that your organization 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.)

10a. How is the loss of Medicaid claim and encounter data prevented in the event of system failure?

How frequently are system back-ups performed?

Where are back-up data stored?

II. INFORMATION SYSTEMS: DATA PROCESSING PROCEDURES AND PERSONNEL

10b. What is done to minimize the corruption of Medicaid data due to system failure or program error?

10c. 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.

10d. 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

10e. What other individuals have access to your computer system that contains performance indicator data?

- Consumers
- Providers

10f. 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 organization 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
Direct CMH Programs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sub-Panel/Contract Agency	<input type="checkbox"/>	<input type="checkbox"/>	_____
Off-Panel/COFR Providers	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hospitals	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other:	<input type="checkbox"/>	<input type="checkbox"/>	_____

III. DATA ACQUISITION CAPABILITIES

2. We would like to understand how claims or encounters are submitted to your organization. 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 organization 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	Direct CMH Programs	Sub-Panel/ Contract Agency	Off-Panel/COFR Providers	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	Direct CMH Programs	Sub-Panel/ Contract Agency	Off-Panel/COFR Providers	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 diagnosis is not coded, is the claims examiner required by the system to use an online software product like AutoCoder to determine the correct ICD-9 code?

Institutional Data: _____

Professional Data: _____

III. DATA ACQUISITION CAPABILITIES

7. Under what circumstances can claims processors change Medicaid claims/encounter 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
Direct CMH Programs	<input type="checkbox"/>	<input type="checkbox"/>
Sub-Panel/Contract Agency	<input type="checkbox"/>	<input type="checkbox"/>
Off-Panel/COFR Providers	<input type="checkbox"/>	<input type="checkbox"/>
Hospital:	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>

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.)

CODING SCHEME	INSTITUTIONAL		PROFESSIONAL	
	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 the PIHP.

Your response should start with the systems used by those who handle data after a service is performed, through the point where your organization receives the data and forwards it to the 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 the reporting period?

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 to 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. 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), Legislative Boiler Plate Report (CAs), 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			

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

If any Medicaid services/providers are capitated, have you performed studies on the completeness of the information collected on capitated services?

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?

If no providers are paid via capitation, how do you ensure that all services are represented within the information system?

23. Claims/Encounters Systems

24a. 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.

24b. Please provide a detailed description of each system or process that is involved in adjudicating:

- Professional encounter(s) for a capitated service

For example, how do you confirm encounter reporting when processing the reimbursement of a capitated claim? _____

Are there any services that are paid on an FFS basis that are provided during a capitated encounter? If so, how would this be processed? _____

- Inpatient stays (with or without authorization) _____

III. DATA ACQUISITION CAPABILITIES

24c. Discuss which decisions in processing a Medicaid claims/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 functions are manual and which are automated.

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 organization: *(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 organization. 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 organization 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. How does your organization uniquely identify consumers?

3. How does your organization assign unique consumer IDs? Is this number assigned by the PIHP only or does your organization also assign unique consumer IDs?

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 subcontractor providers, large provider groups (etc.).

Note: Complete the remainder of Section III - Data Acquisition Capabilities of the ISCA if your organization calculates any performance indicators required by MDCH and submits the performance indicator results to the PIHP. Skip to Section III – Data Acquisition Capabilities – E. Provider Compensation if your organization is responsible only for claims/encounter processing.

1. Does your organization incorporate data from subcontractors to calculate any of the following Medicaid quality measures? If so, which measures require subcontractor data?

Indicator	Measure	Subcontractors
1.	The percent of all Medicaid adult and children beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. (1 st Quarter FY2012)	_____
2.	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.	_____
3.	The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional.	_____
4a.	The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	_____
4b.	The percent of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	_____
5.	The percent of Medicaid recipients having received PIHP managed services. (MI adults, MI children, DD adults, DD children, and SA). (1 st quarter FY 2012)	_____
6.	The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination. (1 st quarter FY 2012)	_____
8.	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. (FY 2011)	_____

III. DATA ACQUISITION CAPABILITIES

9.	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. (FY 2011)	_____
10.	The percent of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	_____
13.	The percent of adults with developmental disabilities served, who live in a private residence alone, with a spouse or non-relative(s).	_____
14.	The percent of adults with serious mental illness served, who live in a private residence alone, with a spouse, or non-relative(s).	_____

III. DATA ACQUISITION CAPABILITIES

2. Discuss any concerns you may have about the quality or completeness of any subcontractor data.

3. Please identify which mental health services are adjudicated through a separate system that belongs to a subcontractor.

4. Describe the kinds of information sources available to your organization 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 organization integrates Medicaid claims, encounter, 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 how your organization receives Medicaid eligibility data, and tracks Medicaid eligibility over time.

4. 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).

4a. How many different types of data are merged together to create reports?

4b. 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?

4c. 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)?

4d. 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)?

4e. 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?

5. 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

6. Are any algorithms used to check the reasonableness of data integrated to report Medicaid performance measures?

- Yes
- No

If yes, describe:

7. 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?

8. 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

9. **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 organization 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 your organization’s 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
<i>EXAMPLE: Large provider group #1</i>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> A <input checked="" type="checkbox"/> B <input type="checkbox"/> C	<input checked="" type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<i>Volumes of encounters not consistent from month to month.</i>
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> 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 organization uses a performance measure repository, please answer the following question. Otherwise, skip to the Report Production section.

10. If your organization 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

11. Please describe your Medicaid report production logs and run controls. Please describe your Medicaid performance measure report generation process.

12. How are Medicaid report generation programs documented? Is there a type of version control in place?

13. Is testing completed on the development efforts used to generate Medicaid performance measure reports?

14. Are Medicaid performance measure reporting programs reviewed by supervisory staff?

15. 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 of physicians, other licensed professionals, and non-licensed services staff who are compensated by each payment mechanism listed in the first column. Each column should total 100%.

Payment Mechanism	Direct CMH Programs	Sub-Panel/ Contract Agency	Off-Panel/ CORF Providers	Hospital	Other
1. Salaried	___%	___%	___%	___%	___%
2. Fee-for-Service—no withhold or bonus	___%	___%	___%	___%	___%
3. Fee-for-Service, with withhold. Please specify % withhold:	___%	___%	___%	___%	___%
4. Fee-for-Service with bonus. Bonus range:	___%	___%	___%	___%	___%
5. Capitated—no withhold or bonus	___%	___%	___%	___%	___%
6. Capitated with withhold. Please specify % withhold:	___%	___%	___%	___%	___%
7. Capitated with bonus. Bonus range:	___%	___%	___%	___%	___%
8. Other	___%	___%	___%	___%	___%
TOTAL	100%	100%	100%	100%	100%

III. DATA ACQUISITION CAPABILITIES

- 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 organization for the last 4 quarters.	1
Organizational Chart	Please attach an organizational chart for your organization. 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

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
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 follow this cover page.



Appendix D: Michigan 2011–2012 PIP Validation Tool:
<PIP Topic>
for <PIHP Full Name>

DEMOGRAPHIC INFORMATION

Health Plan Name: <PIHP Full Name>

Study Leader Name: _____ Title: _____

Telephone Number: _____ E-mail Address: _____

Name of Project/Study: <PIP Topic>

Type of Study: Clinical Nonclinical
 Collaborative HEDIS

Date of Study: _____ to _____

Type of Delivery System : PIHP

Number of Medicaid Beneficiaries in PIHP: _____

Number of Medicaid Beneficiaries in 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 Activity _____

Year 2 validated through Activity _____

Year 3 validated through Activity _____

Appendix D: Michigan 2011–2012 PIP Validation Tool:
<PIP Topic>
for <PIHP Full Name>

EVALUATION ELEMENTS	SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation		
I.	Select the Study Topic(s): Topics selected for the study should reflect the Medicaid-enrolled 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. 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 <input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>	
—	2. Is selected following collection and analysis of data. <i>NA</i> is not applicable to this element for scoring. <input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>	
—	3. Addresses a broad spectrum of care and services The score for this element will be Met or Not Met. <input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>	
—	4. Includes all eligible populations that meet the study criteria. <i>NA</i> is not applicable to this element for scoring. <input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>	
—	5. Does not exclude beneficiaries with special health care needs. The score for this element will be Met or Not Met. <input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>	



Appendix D: Michigan 2011–2012 PIP Validation Tool:
<PIP Topic>
for <PIHP Full Name>

EVALUATION ELEMENTS	SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation		
I.	Select the Study Topic(s): Topics selected for the study should reflect the Medicaid-enrolled 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. 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 .	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>

Results for Activity I									
Total Evaluation Elements					Critical Elements				
Total Evaluation Elements**	<i>Met</i>	<i>Partially Met</i>	<i>Not Met</i>	<i>NA</i>	Critical Elements***	<i>Met</i>	<i>Partially Met</i>	<i>Not Met</i>	<i>NA</i>
6	0	0	0	0	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 activity.

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

Appendix D: Michigan 2011–2012 PIP Validation Tool:
<PIP Topic>
for <PIHP Full Name>

EVALUATION ELEMENTS	SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation		
II.	Define 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. <i>NA</i> is not applicable to this element for scoring.	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>
C	2. Is answerable. <i>NA</i> is not applicable to this element for scoring.	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>

Results for Activity II

Total Evaluation Elements					Critical Elements				
Total Evaluation Elements	<i>Met</i>	<i>Partially Met</i>	<i>Not Met</i>	<i>NA</i>	Critical Elements	<i>Met</i>	<i>Partially Met</i>	<i>Not Met</i>	<i>NA</i>
2	0	0	0	0	2	0	0	0	0

Appendix D: Michigan 2011–2012 PIP Validation Tool:
<PIP Topic>
for <PIHP Full Name>

EVALUATION ELEMENTS		SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation			
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 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.	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>	
—	2. Are based on current, evidence-based practice guidelines, pertinent peer-reviewed literature, or consensus expert panels.	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>	
C	3. Allow for the study question to be answered. NA is not applicable to this element for scoring.	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>	
—	4. Measure changes (outcomes) in health or functional status, satisfaction, or valid process alternatives. NA is not applicable to this element for scoring.	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>	
C	5. Have available data that can be collected on each indicator. NA is not applicable to this element for scoring.	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>	
—	6. Are nationally recognized measures such as HEDIS technical specifications, when appropriate. The scoring for this element will be Met or NA .	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>	

Appendix D: Michigan 2011–2012 PIP Validation Tool:
<PIP Topic>
for <PIHP Full Name>

EVALUATION ELEMENTS	SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation		
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 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.	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>

Results for Activity III									
Total Evaluation Elements					Critical Elements				
Total Evaluation Elements	<i>Met</i>	<i>Partially Met</i>	<i>Not Met</i>	<i>NA</i>	Critical Elements	<i>Met</i>	<i>Partially Met</i>	<i>Not Met</i>	<i>NA</i>
7	0	0	0	0	3	0	0	0	0

Appendix D: Michigan 2011–2012 PIP Validation Tool:
<PIP Topic>
for <PIHP Full Name>

EVALUATION ELEMENTS		SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation			
IV.	Use a Representative and Generalizable Study Population: The selected topic should represent the entire eligible Medicaid-enrolled population, with systemwide measurement and improvement efforts to which the study indicators apply. The study population:		
C	1. Is accurately and completely defined. <i>NA</i> is not applicable to this element for scoring.	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>	
—	2. Includes requirements for the length of a beneficiary's enrollment in the PIHP.	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>	
C	3. Captures all beneficiaries to whom the study question applies. <i>NA</i> is not applicable to this element for scoring.	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>	

Results for Activity IV									
Total Evaluation Elements					Critical Elements				
Total Evaluation Elements	<i>Met</i>	<i>Partially Met</i>	<i>Not Met</i>	<i>NA</i>	Critical Elements	<i>Met</i>	<i>Partially Met</i>	<i>Not Met</i>	<i>NA</i>
3	0	0	0	0	2	0	0	0	0



Appendix D: Michigan 2011–2012 PIP Validation Tool:
<PIP Topic>
for <PIHP Full Name>

EVALUATION ELEMENTS		SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation			
V.	Use Sound Sampling Techniques: (This activity is only scored 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.	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>	
—	2. Identify the sample size.	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>	
—	3. Specify the confidence level.	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>	
—	4. Specify the acceptable margin of error.	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>	
C	5. Ensure a representative sample of the eligible population.	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>	
—	6. Are in accordance with generally accepted principles of research design and statistical analysis.	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>	

Results for Activity V

Total Evaluation Elements					Critical Elements				
Total Evaluation Elements	<i>Met</i>	<i>Partially Met</i>	<i>Not Met</i>	<i>NA</i>	Critical Elements	<i>Met</i>	<i>Partially Met</i>	<i>Not Met</i>	<i>NA</i>
6	0	0	0	0	1	0	0	0	0

Appendix D: Michigan 2011–2012 PIP Validation Tool:
<PIP Topic>
for <PIHP Full Name>

EVALUATION ELEMENTS		SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation			
VI.	Reliably Collect Data: 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. <i>NA</i> is not applicable to this element for scoring.	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>	
—	2. The identification of specified sources of data. <i>NA</i> is not applicable to this element for scoring.	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>	
—	3. A defined and systematic process for collecting Baseline and remeasurement data.	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>	
—	4. A timeline for the collection of Baseline and remeasurement data. <i>NA</i> is not applicable to this element for scoring.	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>	
—	5. Qualified staff and personnel to abstract manual data.	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>	
C	6. A manual data collection tool that ensures consistent and accurate collection of data according to indicator specifications.	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>	
—	7. A manual data collection tool that supports interrater reliability.	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>	
—	8. Clear and concise written instructions for completing the manual data collection tool.	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>	
—	9. An overview of the study in written instructions.	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>	
—	10. Administrative data collection algorithms/ flow charts that show activities in the production of indicators.	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>	

Appendix D: Michigan 2011–2012 PIP Validation Tool:
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EVALUATION ELEMENTS	SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation		
VI.	Reliably Collect Data: 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 = <50percent or not provided	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>

Results for Activity VI									
Total Evaluation Elements					Critical Elements				
Total Evaluation Elements	<i>Met</i>	<i>Partially Met</i>	<i>Not Met</i>	<i>NA</i>	Critical Elements	<i>Met</i>	<i>Partially Met</i>	<i>Not Met</i>	<i>NA</i>
11	0	0	0	0	1	0	0	0	0

Appendix D: Michigan 2011–2012 PIP Validation Tool:
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EVALUATION ELEMENTS		SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation			
VII.	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. 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. <i>NA</i> is not applicable to this element for scoring.	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>	
—	2. System changes that are likely to induce permanent change.	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>	
—	3. Revised if the original interventions are not successful.	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>	
—	4. Standardized and monitored if interventions are successful.	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>	

Results for Activities VII

Total Evaluation Elements					Critical Elements				
Total Evaluation Elements	<i>Met</i>	<i>Partially Met</i>	<i>Not Met</i>	<i>NA</i>	Critical Elements	<i>Met</i>	<i>Partially Met</i>	<i>Not Met</i>	<i>NA</i>
4	0	0	0	0	1	0	0	0	0

Appendix D: Michigan 2011–2012 PIP Validation Tool:
<PIP Topic>
for <PIHP Full Name>

EVALUATION ELEMENTS		SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation			
VIII.	Analyze Data and Interpret 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. <i>NA</i> is not applicable to this element for scoring.	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>	
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 <i>NA</i> .	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>	
—	3. Identify factors that threaten internal or external validity of findings. <i>NA</i> is not applicable to this element for scoring.	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>	
—	4. Include an interpretation of findings. <i>NA</i> is not applicable to this element for scoring.	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>	
—	5. Are presented in a way that provides accurate, clear, and easily understood information. <i>NA</i> is not applicable to this element for scoring.	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>	
—	6. Identify the initial measurement and the remeasurement of the study indicators.	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>	
—	7. Identify statistical differences between the initial measurement and the remeasurement.	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>	
—	8. Identify factors that affect the ability to compare the initial measurement with the remeasurement.	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>	



Appendix D: Michigan 2011–2012 PIP Validation Tool:
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for <PIHP Full Name>

EVALUATION ELEMENTS	SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation		
VIII.	Analyze Data and Interpret 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.	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>

Results for Activity VIII									
Total Evaluation Elements					Critical Elements				
Total Evaluation Elements	<i>Met</i>	<i>Partially Met</i>	<i>Not Met</i>	<i>NA</i>	Critical Elements	<i>Met</i>	<i>Partially Met</i>	<i>Not Met</i>	<i>NA</i>
9	0	0	0	0	2	0	0	0	0



Appendix D: Michigan 2011–2012 PIP Validation Tool:
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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.	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>	
—	2. There is documented improvement in processes or outcomes of care.	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>	
—	3. The improvement appears to be the result of planned intervention(s).	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>	
—	4. There is statistical evidence that observed improvement is true improvement.	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>	

Results for Activity IX									
Total Evaluation Elements					Critical Elements				
Total Evaluation Elements	<i>Met</i>	<i>Partially Met</i>	<i>Not Met</i>	<i>NA</i>	Critical Elements	<i>Met</i>	<i>Partially Met</i>	<i>Not Met</i>	<i>NA</i>
4	0	0	0	0	0	0	0	0	0

Appendix D: Michigan 2011–2012 PIP Validation Tool:
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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.	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>	

Results for Activity X									
Total Evaluation Elements					Critical Elements				
Total Evaluation Elements	<i>Met</i>	<i>Partially Met</i>	<i>Not Met</i>	<i>NA</i>	Critical Elements	<i>Met</i>	<i>Partially Met</i>	<i>Not Met</i>	<i>NA</i>
1	0	0	0	0	0	0	0	0	0

Appendix D: Michigan 2011–2012 PIP Validation Tool:
<PIP Topic>
for <PIHP Full Name>

Table 1—2011–2012 PIP Validation Report Scores
for <PIP Topic>
for <PIHP Full Name>

Review Activity	Total Possible Evaluation Elements (Including Critical Elements)	Total Met	Total Partially Met	Total Not Met	Total NA	Total Possible Critical Elements	Total Critical Elements Met	Total Critical Elements Partially Met	Total Critical Elements Not Met	Total Critical Elements NA
I. Select the Study Topic(s)	6					1				
II. Define the Study Question(s)	2					2				
III. Select the Study Indicator(s)	7					3				
IV. Use a Representative and Generalizable Study Population	3					2				
V. Use Sound Sampling Techniques	6					1				
VI. Reliably Collect Data	11					1				
VII. Implement Intervention and Improvement Strategies	4					1				
VIII. Analyze Data and Interpret 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 Activities	53					13				

Table 2—2011–2012 PIP Validation Report 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 high confidence/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 2011–2012 PIP Validation Tool:
<PIP Topic>
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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 protocols for validating PIPs. HSAG also assessed whether the State should have confidence in the reported PIP findings.

Met = High confidence/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:

Activities 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.



Appendix D: Michigan 2011–2012 PIP Summary Form:
Peer Delivered Services
for <PIHP Full Name>

DEMOGRAPHIC INFORMATION

PIHP Name: <PIHP Full Name>

Study Leader Name: _____

Title: _____

Telephone Number: _____

E-mail Address: _____

Name of Project/Study: *Increasing the Proportion of Medicaid Eligible Adults With a Mental Illness Who Receive Peer-Delivered Services or Supports*

Type of Study:

- Clinical Nonclinical
 Collaborative HEDIS

Type of Delivery System: PIHP

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 Activity _____

Year 2 validated through Activity _____

Year 3 validated through Activity _____



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A. Activity I: Select the study topic(s). 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:



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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: Michigan 2011–2012 PIP Summary Form:
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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	
Baseline Goal	



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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.

Remeasurement 1 Period	
Remeasurement 2 Period	
Benchmark	
Source of Benchmark	



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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: Michigan 2011–2012 PIP Summary Form:
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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:



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E. Activity V: Use sound sampling techniques. 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 (<i>Describe</i>)	Sampling Method (<i>Describe</i>)



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F. Activity VIa: Reliably collect data. 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 _____



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F. Activity VIb: Determine the data collection cycle.	Determine the data analysis cycle.
<input type="checkbox"/> Once a year <input type="checkbox"/> Twice a year <input type="checkbox"/> Once a season <input type="checkbox"/> Once a quarter <input type="checkbox"/> Once a month <input type="checkbox"/> Once a week <input type="checkbox"/> Once a day <input type="checkbox"/> Continuous <input type="checkbox"/> Other (list and describe): <hr/> <hr/> <hr/>	<input type="checkbox"/> Once a year <input type="checkbox"/> Once a season <input type="checkbox"/> Once a quarter <input type="checkbox"/> Once a month <input type="checkbox"/> Continuous <input type="checkbox"/> Other (list and describe): <hr/> <hr/> <hr/> <hr/>

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:

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G. Activity VIIa: Implement intervention and 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



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G. Activity VIIa: Implement intervention and 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
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Describe the process used for the casual/barrier analyses that led to the development of the interventions:



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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:



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H. Activity VIIIa: Analyze data. 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:



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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:



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I. Activity IX: Assess for real 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 <i>p</i> value
	<i>Baseline:</i>					
	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 <i>p</i> value
	<i>Baseline:</i>					
	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):



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I. Activity IX: Assess for real 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 <i>p</i> value
	<i>Baseline:</i>					
	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):



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J. Activity X: Assess for 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:

Appendix E. **Coordination of Care/Medical Services Utilization Focused Study**

The Executive Summary of the 2010–2011 Coordination of Care/Medical Services Utilization Focused Study follows this cover page. For additional details, please refer to the 2010–2011 Coordination of Care/Medical Services Utilization Focused Study Report, dated March 2012.

Appendix E. Executive Summary of the 2010–2011 Coordination of Care/Medical Services Utilization Focused Study Report

Purpose

In its efforts to develop a service system that supports consumers with behavioral health and mental health conditions, the Michigan Department of Community Health (MDCH) contracts with public mental health agencies to ensure that services provided to these individuals are coordinated. These contracts require that the coordination would include Medicaid Health Plans (MHPs) that provide primary health care and other agencies in the community that are serving the individual. Public mental health agencies are to share medical information with these providers and identify and integrate any primary health care needs into the consumer's person-centered plan. In addition, the public mental health agencies are to oversee their subcontracted providers to ensure compliance with the requirements and have monitoring tools and processes in place for evaluating the providers' performance related to the requirement.

In FY 2010–2011, MDCH contracted Health Services Advisory Group, Inc. (HSAG), to conduct a focused study to describe the level of medical care utilization among consumers with developmental disability (DD) and serious mental illness (SMI). The study addresses three major questions:

1. What are the general medical service utilization patterns among beneficiaries diagnosed with SMI or DD?
2. To what extent are the medical service utilization patterns different between frequent users and non-frequent users of inpatient and emergency services?
3. What are the two most prevalent chronic conditions among these populations? To what extent are the medical service utilization patterns among these members suggestive of some level of care/service coordination?

In addition, HSAG also conducted two supplemental analyses:

1. Level of agreement between disability conditions submitted in MDCH's Quality Improvement (QI) file and those identified using claims files
2. Impact of continuous MHP enrollment on service utilization patterns

Methods

HSAG used Medicaid eligibility, MHP enrollment, and claims and encounters files to determine the study population. Consumers included in this study were at least 21 years of age as of September 30, 2010; continuously enrolled in the same MHPs for at least 320 days from October 1, 2009, through September 30, 2010.; and had a qualifying SMI or DD diagnosis based on claims or

encounters between October 1, 2008, and September 30, 2010.^{E-1} Approximately 30,000 (n=29,932) PIHP consumers in FY 2010 were included in the current focused study. Nearly 80 percent (78.8 percent) had a diagnosis of serious mental illness (SMI) and another 9.3 percent had a developmental disability (DD). One in 11 PIHP consumers had both diagnoses. Slightly more than one third of the study population (35.0 percent) was cared for by the Detroit-Wayne PIHP while the remaining two-thirds were served by the other 17 PIHPs with percentages of PIHP consumers ranging from 2.1 percent to 7.0 percent.

Findings

To examine the medical service utilization patterns for each disability group (DD, SMI, and dual diagnoses), HSAG reported the percentage of consumers using preventive/ambulatory, emergency room, and inpatient admission services during FY 2010. HSAG also described the average service use (e.g., number of ambulatory or ER visits or inpatient length of stay) per user.

At least 85 percent of consumers across all disability groups used preventive/ambulatory services, with SMI consumers having four more ambulatory visits than DD and two more visits than dual diagnoses consumers. SMI consumers were also more likely to have ER visits (about six out of 10 versus about 30 percent for DD and 40 percent for dual diagnoses) and had a higher number of ER visits during the study period (3.78 versus 2.27 for DD and 3.16 for dual diagnoses).

The majority of inpatient admissions with diagnoses excluding disability conditions were admissions for physical health care. Although SMI consumers had a higher likelihood of inpatient admissions (17.3 percent, versus 7.6 percent for DD and 9.1 for dual diagnoses), their frequency of use (total number of admissions and inpatient length of stay) was not statistically significantly different than the other two groups.

Frequent inpatient/ER users for each disability group were defined based on their corresponding frequency distribution of inpatient/ER usage. Although frequent users of inpatient/emergency room services in general accounted for 6 to 7 percent of each population with a disability condition, consumers with DD and dual diagnoses had a higher proportion of inpatient/ER users who were considered as frequent users than those with SMI (19.6 percent and 14.8 percent, respectively, versus 9.1 percent). Frequent inpatient/ER users were significantly more likely to use preventive/ambulatory services and had significantly more visits than non-frequent users for all disability groups. Comparing across the three disability groups, frequent inpatient/ER users with SMI had a significantly lower likelihood of using ambulatory services but had significantly more visits than the other two disability groups' frequent users.

HSAG identified disorders of lipid metabolism and essential hypertension as the two most prevalent chronic conditions across all three disability groups. Comparing the service utilization profiles among consumers with these conditions, consumers with essential hypertension were likely to use costly services (i.e., ER and inpatient). Consumers without these conditions are in general less likely to use preventive/ambulatory, emergency room, or inpatient services than those with at least

^{E-1} ICD-9-CM Diagnosis codes 290–313 and 316 were used to identify individuals with serious mental illness and codes 314–315 and 317–319 to identify individuals with developmental disabilities from the claims/encounter data.

one of these conditions. Their frequency of service use for these services was also lower than those who had these conditions.

Although over 85 percent of PIHP consumers identified as using claims/encounters had the same disability categorization in the Quality Improvement (QI) file, there were wide variations of level of agreement across disability groups. Consumers identified as having dual diagnoses had the lowest agreement (37.6 percent) in the QI file. For these consumers, the reason for the majority of mismatched disability categories was because only the DD or the SMI diagnosis was identified for these individuals in the QI file. For SMI consumers, more than one-third of the mismatches occurred because the consumers were identified as having DD or dual diagnoses in the QI file.

In evaluating the impact of continuous MHP enrollment on service utilization, HSAG found that the only significant difference identified across all disability groups was noted in the likelihood of using preventive/ambulatory services. Consumers with continuous MHP enrollment were significantly more likely to use preventive/ambulatory services than those with continuous FFS enrollment regardless of whether the consumers had a diagnosis of DD, SMI, or DD/SMI. Without taking statistical significance into account, consumers with continuous MHP enrollment were more likely to use ambulatory or emergency room services and less likely to use inpatient services than those with at least some FFS enrollment. At the same time, this group also had a higher number of ER visits and inpatient admissions. While these differences in utilization patterns could be related to different demographic and clinical characteristics associated with each enrollment group and disability condition, these findings should be interpreted with caution. Since only Medicaid claims and encounters were used for this study, the service utilization pattern for consumers with at least some FFS enrollment who are dually eligible for Medicare and Medicaid might not be complete.