Michigan Department of Community Health

MDCH

Rick Snyder, Governor
James K. Haveman, Director

Behavioral Health and Developmental Disabilities Administration

2012–2013 External Quality Review Technical Report

for

Prepaid Inpatient Health Plans

December 2013

HSAG Health Services Advisory Group

3133 East Camelback Road, Suite 300 ◆ Phoenix, AZ 85016
Phone 602.264.6382 ◆ Fax 602.241.0757

HSAG HEALTH SERVICES ADVISORY GROUP

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Purpose of Report

The Balanced Budget Act of 1997 (BBA), Public Law 105-33, requires states to prepare an annual technical report that describes the manner in which data from activities conducted in accordance with 42 Code of Federal Regulations (CFR) 438.358 were aggregated and analyzed. The report must describe how conclusions were drawn as to the quality and timeliness of and access to care furnished by the states' managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs). The report of results must also contain an assessment of the strengths and weaknesses of the 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)

During fiscal year 2012–2013, MDCH defined new regional boundaries for the PIHPs' service areas and issued an Application for Participation (AFP) for re-procurement of the PIHPs for these

new regions, through which MDCH contracted to provide Medicaid funded mental health, substance use disorder, and developmental disabilities supports and services. The AFP stated as one of its goals that "the new regional structure must consolidate authority and core functions, while simultaneously promoting local responsiveness."[1-1] The 10 new regional entities have been selected and are to begin operations effective January 1, 2014.

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 2012–2013 compliance monitoring review was designed to determine the PIHPs' compliance with their contract and with State and federal regulations through review of performance in six compliance standards: Quality Assessment and Performance Improvement Program (QAPIP) Plan and Structure, Staff Qualifications and Training, Utilization Management, Enrollee Grievance Process, Access and Availability, and Appeals.
- **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.

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."[1-2] 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] Michigan Department of Community Health Behavioral Health & Developmental Disabilities Administration, *2013 Application for Participation for Specialty Prepaid Inpatient Health Plans.*

[1-2] 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."[1-3]

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."[1-4] 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,[1-5] 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.

[1-3] Department of Health and Human Services Centers for Medicare & Medicaid Services. *Federal Register. Code of Federal Regulations*. Title 42, Vol. 3, October 1, 2005.
[1-4] National Committee on Quality Assurance. 2006 Standards and Guidelines for MBHOs and MCOs.
[1-5] Department of Health and Human Services Centers for Medicare & Medicaid Services. *Federal Register*, Vol. 67, No. 115, June 14, 2002.

Quality

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

Table 1-1—Measures Assessing Quality					
Measure			Statewide Score	PIHP Low Score	PIHP High Score
Compliance Monitoring Standards					
Standard I.	QAPIP Plan and Structure		100%	97%	100%
Standard IV.	Staff Qualifications and Training		100%	100%	100%
Standard VII.	Enrollee Grievance Process		97%	92%	100%
Standard XIV.	Appeals		96%	88%	100%
Performance Measure Indicators					
Indicator 4a:	Follow-Up Care	Children	97%	85%	100%
		Adults	97%	86%	100%
Indicator 4b:	Follow-Up Care After Detox		98%	50%	100%
Indicator 6:	Habilitation Supports Waiver (HSW) Rate		99%	98%	100%
Indicator 8:	Competitive Employment	MI Adults	7%	4%	10%
		DD Adults	7%	2%	13%
		MI/DD Adults	7%	3%	18%
Indicator 9:	Earning Minimum Wage	MI Adults	71%	53%	91%
		DD Adults	28%	12%	64%
		MI/DD Adults	36%	11%	78%
Indicator 10†:	Readmission Rate	Children	10%	26%	0%
		Adults	15%	19%	2%
Indicator 13:	Adults with DD living in a private residence		18%	7%	29%
Indicator 14:	Adults with MI living in a private residence		39%	21%	61%
Performance Improvement Projects					
		All evaluation elements *Met*	92%	79%	100%
		Critical elements *Met*	100%	100%	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. Four of the six standards included in the 2012–2013 review cycle addressed this domain. PIHP performance was strongest on Standard I—QAPIP Plan and Structure, and Standard IV—Staff Qualifications and Training, with statewide scores of 100 percent. Performance on the remaining two standards in the **quality** domain was also strong, with statewide scores of 97 percent for Standard VII—Enrollee Grievance Process and 96 percent for Standard XIV—Appeals.

The PIPs reviewed in this validation cycle, designed to increase the likelihood of desired mental health outcomes by providing beneficiaries with a peer-delivered service or support, addressed the **quality** of services. Therefore, for the purposes of the EQR technical report, HSAG assigned the

PIPs to the **quality** domain. For this third validation cycle of 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 X for most studies. Six PIPs were validated through Activity IX only, as they had not yet progressed to the assessment for sustained improvement in Activity X. All but one of the PIHPs received a validation status of *Met*, demonstrating compliance with the CMS PIP protocol requirements for these activities. The findings indicated that the PIHPs designed, conducted, and reported their PIP in a methodologically sound manner, allowing real improvements in care and giving confidence in the reported results.

The PIHPs continued to demonstrate strength in their validation results for performance measures related to **quality** of care and services as well as improvement in compliance with MDCH specifications. Fifteen PIHPs achieved validation findings of *Report* for all indicators in the **quality** domain, reflecting that the indicators were fully compliant with MDCH specifications. Seven of the eight indicators in the **quality** domain received validation ratings of *Report* across all PIHPs. The PIHPs demonstrated an improved ability to report data on the employment status of their enrollees, with all 18 PIHPs receiving a validation status of *Report* for this indicator. However, the minimum wage indicator continued to represent an opportunity for improvement, with three PIHPs receiving a validation status of *Not Report* for Indicator 9 due to low data completeness, resulting in understated rates.

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 for follow-up care and readmissions for children remained essentially unchanged from the prior year, while the readmission rate for adults increased by 3 percentage points. PIHPs demonstrated strong performance, with eight PIHPs meeting 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 for all three populations (Indicator 8) were essentially unchanged from the prior year, as were the rates for minimum wage earners (Indicator 9) for DD and MI/DD adults. The rate for MI/DD adults earning minimum wage declined by about 2 percentage points. The statewide HSW rate (Indicator 6) saw the largest change from the prior-year rate, with a greater than 10 percentage point increase. Rates for Indicators 13 and 14—Living in a Private Residence declined by less than 2 percentage points.

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 V. Utilization Management		98%	91%	100%
Standard VII. Enrollee Grievance Process		97%	92%	100%
Standard XII. Access and Availability		90%	38%	100%
Standard XIV. Appeals		96%	88%	100%
Performance Measure Indicators				
Indicator 1: Preadmission Screening	Children	99%	90%	100%
	Adults	98%	89%	100%
Indicator 2: Face-to-Face Assessment	MI Children	98%	73%	100%
	MI Adults	99%	82%	100%
	DD Children	98%	86%	100%
	DD Adults	99%	89%	100%
	SA	98%	78%	100%
	Total	98%	84%	100%
Indicator 3: First Service	MI Children	95%	75%	100%
	MI Adults	97%	87%	100%
	DD Children	97%	57%	100%
	DD Adults	97%	71%	100%
	SA	99%	85%	100%
	Total	97%	84%	99%
Indicator 4a: Follow-Up Care	Children	97%	85%	100%
	Adults	97%	86%	100%
Indicator 4b: Follow-Up Care After Detox		98%	50%	100%
SA = Medicaid beneficiaries with substance use disorders				

Statewide performance on the compliance monitoring standard in the **timeliness** domain was strong, with statewide scores of 98 percent for Standard V—Utilization Management, 97 percent for Standard VII—Enrollee Grievance Process, and 96 percent for Standard XIV—Appeals. Performance on Standard XII—Access and Availability was lower, with a statewide score of 90 percent. While most PIHPs achieved full compliance on the utilization management standard, the 2012–2013 compliance reviews identified opportunities for improvement for the majority of PIHPs on the remaining standards in this domain. Almost all of the recommendations from the 2012–2013 compliance reviews addressed the **timeliness** domain.

Timeliness, as addressed by the validation of performance measures, continued to represent a statewide strength. All 18 PIHPs received validation findings reflecting full compliance with MDCH specifications for all indicators related to **timeliness** of care and services. All 17 indicators related to **timeliness** of care and services achieved statewide averages that exceeded the minimum performance level as specified by MDCH. The statewide rates for timely preadmission screenings for children and adults, timeliness of face-to-face assessments or first service, and follow-up care for beneficiaries discharged from a psychiatric inpatient or detox unit showed little change from their prior-year levels. Only the rate for timeliness of first service for DD adults saw a marked change with a greater than 4 percentage point increase. Six PIHPs met all minimum performance standards in the **timeliness** domain; and statewide, over 88 percent of all rates in this domain met the MDCH benchmarks.

Access

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

Table 1-3—Measures Assessing Access

Measure			Statewide Score	PIHP Low Score	PIHP High Score
Compliance Monitoring Standards					
Standard V.	Utilization Management		98%	91%	100%
Standard XII.	Access and Availability		90%	38%	100%
Performance Measure Indicators					
Indicator 1:	Preadmission Screening	Children	99%	90%	100%
		Adults	98%	89%	100%
Indicator 2:	Face-to-Face Assessment	MI Children	98%	73%	100%
		MI Adults	99%	82%	100%
		DD Children	98%	86%	100%
		DD Adults	99%	89%	100%
		SA	98%	78%	100%
		Total	98%	84%	100%
Indicator 3:	First Service	MI Children	95%	75%	100%
		MI Adults	97%	87%	100%
		DD Children	97%	57%	100%
		DD Adults	97%	71%	100%
		SA	99%	85%	100%
		Total	97%	84%	99%
Indicator 4a:	Follow-Up Care	Children	97%	85%	100%
		Adults	97%	86%	100%
Indicator 4b:	Follow-Up Care After Detox		98%	50%	100%
Indicator 5:	Penetration Rate		7%	5%	10%

Overall, PIHP performance on the compliance monitoring standards in the **access** domain continued to reflect another statewide strength. Statewide scores for the two standards in the **access** domain were 90 percent for Standard XII—Access and Availability, and 98 percent for Standard V—Utilization Management. Standards assessing **access** to care and services also represented opportunities for improvement, as many of the recommendations from the 2012–2013 compliance review cycle addressed this domain.

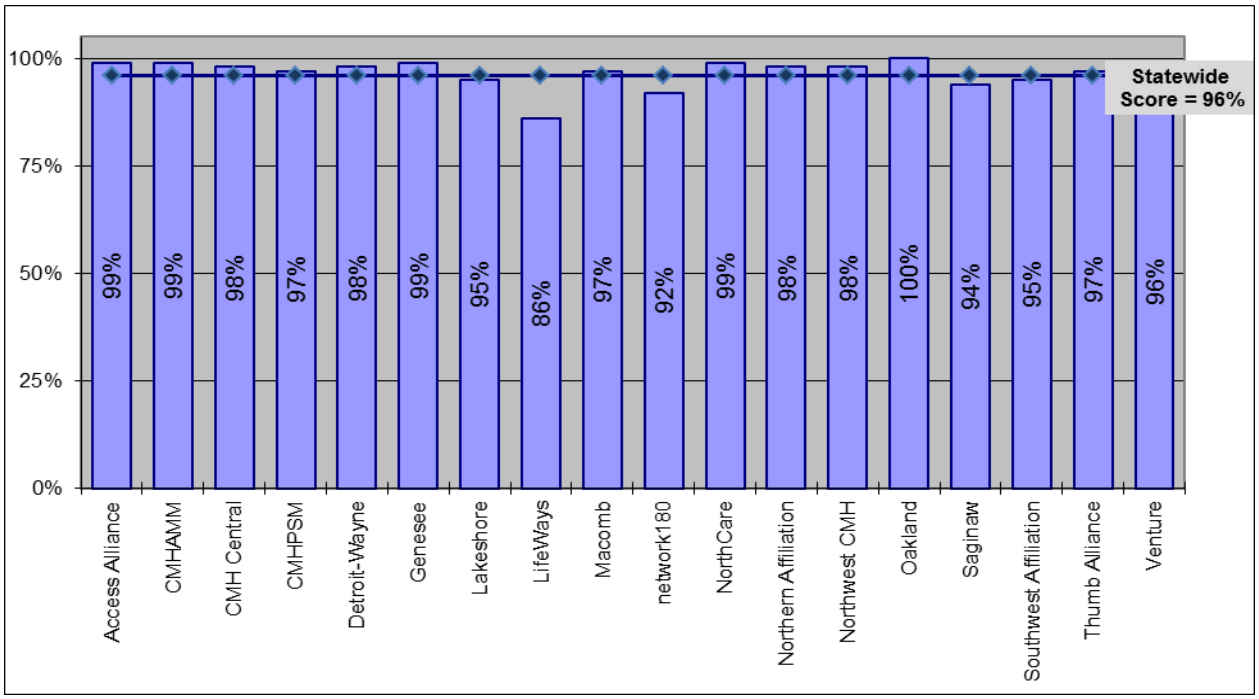
Access, as assessed by the validation of performance measures, indicated a statewide strength. All PIHPs received a validation designation of *Report* for all indicators related to **access** to care and services. Statewide rates exceeded the minimum performance standard for all of the indicators in 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 remained at the level of the prior-year rate.

Findings for the Compliance Monitoring Reviews

The regulatory provisions addressed in the 2012–2013 compliance monitoring reviews included Quality Assessment and Performance Improvement Program (42 CFR 438.240); Access Standards, Coverage and Authorization of Services (42 CFR 438.210); Enrollee Grievance System (42 CFR 438.228, 438.400–408, and 438.414); Access and Availability (42 CFR 438.206); and Appeals (42 CFR 438.402, 438.406, 438.408, and 438.410). One area from the MDCH contract that was related but not specific to BBA regulations was also included in this review: Staff Qualifications and Training.

Figure 1-1 displays PIHP scores for overall compliance across all compliance monitoring standards.

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



The overall compliance rating across all standards for the 18 PIHPs was 96 percent, with individual PIHP scores ranging from 86 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*.

Of the 18 PIHPs, 15 performed at an overall *Excellent* level, with one PIHP receiving an overall compliance score of 100 percent. Three PIHPs had overall compliance scores at the *Good* level. None of the PIHPs had overall compliance scores in the *Average* or *Poor* range, reflecting statewide strong performance on the compliance monitoring standards.

While the PIHPs demonstrated high levels of compliance with federal and contractual requirements in all areas assessed, performance was strongest on Standard IV—Staff Training and Qualifications, with all 18 PIHPs demonstrating compliance with all requirements. The PIHPs demonstrated compliance with requirements for staff training and ensuring that employed and contracted staff members have appropriate qualifications.

All 18 PIHPs performed at the *Excellent* level on Standard I—QAPIP Plan and Structure. The PIHPs demonstrated that they had written QAPIP descriptions and adequate organizational structures to support their QAPIPs, included providers and beneficiaries in their performance improvement activities, and conducted an annual verification process to ensure that services reimbursed by Medicaid were actually furnished to beneficiaries.

Performance on Standard V—Utilization Management was also strong, with 16 PIHPs performing in the *Excellent* range and two PIHPs performing in the *Good* range. Eleven PIHPs demonstrated compliance with all requirements, achieving compliance scores of 100 percent on this standard. All PIHPs demonstrated that they had utilization program descriptions that addressed procedures to evaluate medical necessity, included criteria used in making decisions, and detailed the process used to review and approve the provision of services. Opportunities for improvement identified for this standard addressed various aspects of procedures for utilization management decisions (e.g., the requirement to document the reason for the denial or send notification of the denial to the provider).

Standard VII—Enrollee Grievance Process and Standard XIV—Appeals represented statewide strengths, with 13 and 12 PIHPs, respectively, performing in the *Excellent* range. All PIHPs demonstrated that they had a process in place for grievances and appeals; provided beneficiaries and providers with information about the right to file grievances and appeals as well as related requirements, time frames, and procedures; and maintained records of grievances and appeals. Recommendations related to this standard addressed the process for handling grievances and appeals, including acknowledgement of receipt of the grievance or appeal, timely resolution of all grievances and appeals, and the content of the notices of disposition.

For the Access and Availability standard, the PIHPs continued to demonstrate mixed performance. Seven PIHPs performed in the *Excellent* range, with three PIHPs receiving scores of 100 percent compliance. Eight PIHPs received scores in the *Good* range, one PIHP performed at the *Average* level, and two PIHPs received a score in the *Poor* range. All PIHPs met the requirements for regular reporting of performance indicator data to MDCH and oversight of subcontractors to ensure that

providers meet State standards for timely access to care and services. Most recommendations in this area focused on continued efforts to improve performance on the standard for access to ongoing services within 14 days of a nonemergent assessment with a professional.

Table 1-4 presents the PIHPs' 2012–2013 compliance monitoring scores (percentage of compliance) on each of the eight standards reviewed as well as an overall compliance score across all eight standards.

Table 1-4—Summary of Compliance Monitoring Scores

PIHP	I. QAPIP Program and Structure	IV. Staff Qualifications and Training	V. Utilization Management	VII. Enrollee Grievance Process	XII. Access and Availability	XIV. Appeals	Overall
Access Alliance	100%	100%	99%	98%	97%	98%	99%
CMHAMM	100%	100%	100%	100%	94%	100%	99%
CMH Central	100%	100%	100%	100%	88%	100%	98%
CMHPSM	100%	100%	100%	96%	94%	95%	97%
Detroit-Wayne	100%	100%	100%	98%	94%	98%	98%
Genesee	100%	100%	100%	98%	97%	98%	99%
Lakeshore	100%	100%	92%	96%	91%	93%	95%
LifeWays	99%	100%	97%	96%	38%	93%	86%
Macomb	100%	100%	100%	100%	88%	97%	97%
network180	100%	100%	100%	94%	71%	88%	92%
NorthCare	100%	100%	96%	100%	97%	100%	99%
Northern Affiliation	99%	100%	95%	98%	100%	97%	98%
Northwest CMH	100%	100%	96%	98%	97%	98%	98%
Oakland	100%	100%	100%	100%	100%	100%	100%
Saginaw	100%	100%	100%	94%	79%	90%	94%
Southwest Affiliation	100%	100%	91%	94%	94%	92%	95%
Thumb Alliance	97%	100%	100%	92%	100%	95%	97%
Venture	100%	100%	100%	92%	94%	92%	96%
Statewide Score	**100%**	**100%**	**98%**	**97%**	**90%**	**96%**	**96%**

Note: Shaded cells indicate performance below the statewide score.

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

Findings for the 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 *Report* (the indicator was compliant with the State's specifications, and the rate can be reported); *Not Reported* (this designation was assigned to measures for which the rate was materially biased, or the PIHP was not required to report); or *No Benefit* (the indicator was not reported because the PIHP did not offer the benefit required by the indicator).

Table 1-5 below presents the validation results for the 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—Overall Performance Indicator Compliance With MDCH Specifications Across All PIHPs

Validation Finding	Percent
Report (R)	99%
Not Reported (NR)	1%
No Benefit (NB)	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		
		R	*NR*	*NB*
1.	The percentage of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	100%	0%	0%
2.	The percentage of new Medicaid beneficiaries during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service.	100%	0%	0%
3.	The percentage of new Medicaid beneficiaries during the quarter starting any needed ongoing service within 14 days of a non-emergent face-to-face assessment with a professional.	100%	0%	0%
4a.	The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.	100%	0%	0%
4b.	The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.	100%	0%	0%

Table 1-6—Performance Measure Results—Validation Status				
Performance Measure Indicator		Percentage of PIHPs		
		R	*NR*	*NB*
5.	The percent of Medicaid recipients having received PIHP managed services.	100%	0%	0%
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.	100%	0%	0%
8.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who are employed competitively.	100%	0%	0%
9.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.	83%	17%	0%
10.	The percentage of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.	100%	0%	0%
13.	The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	100%	0%	0%
14.	The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	100%	0%	0%
R = Report, NR = Not Reported, NB= No Benefit				

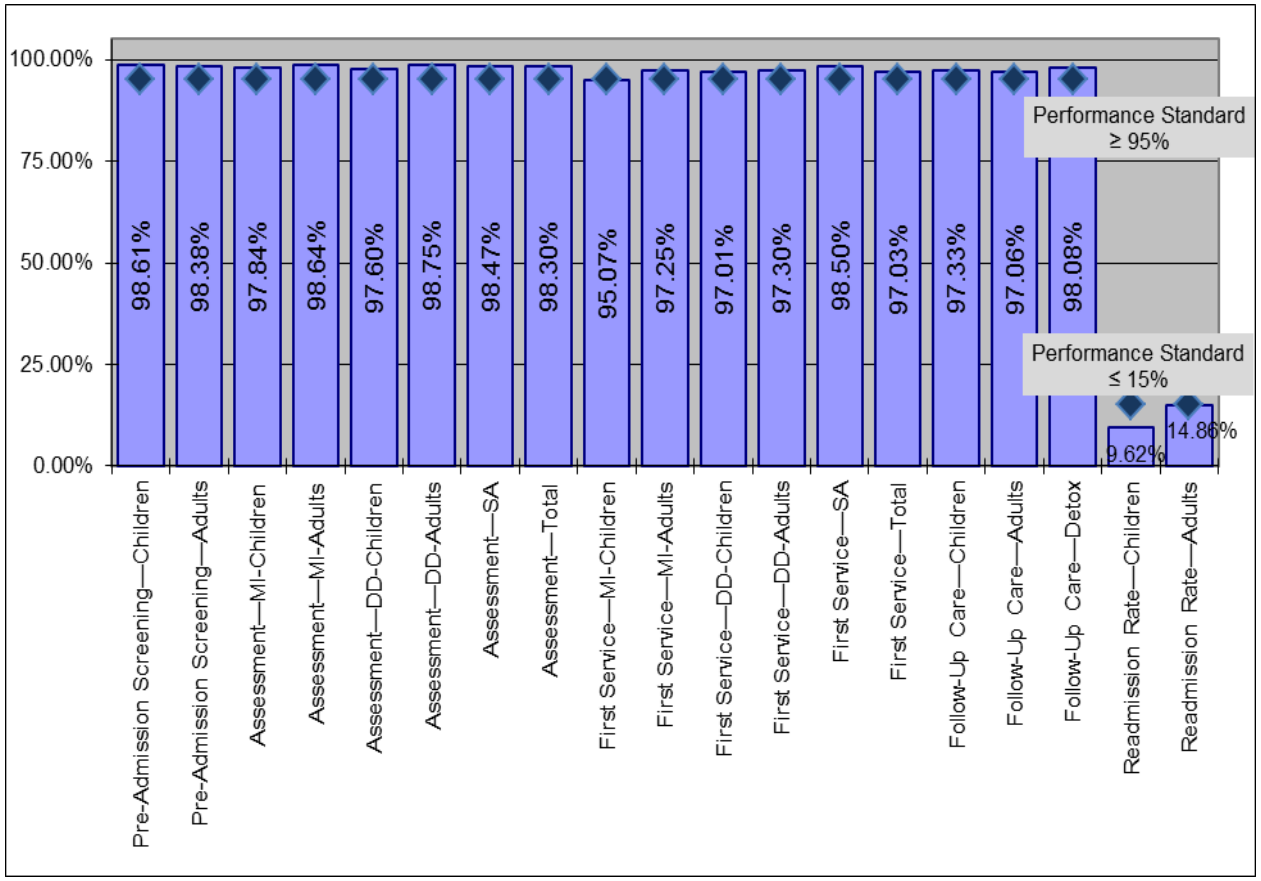
Eleven of the 12 measures were *Fully Compliant* for all PIHPs. Fifteen PIHPs received validation findings of *Report* for all indicators. Three PIHPs received findings of *Not Reported* for Indicator 9. These results reflect continued improvement over the prior-year results, as the percentage of rates in compliance with MDCH specifications increased. The PIHPs improved their collection of complete QI data for beneficiaries' employment status and minimum wage earners. For three of the PIHPs, low levels of data completeness for the minimum wage data element continued to result in understated rates for Indicator 9. Overall, the PIHPs demonstrated compliance with technical requirements and specifications in their collection and reporting of performance indicators.

The PIHPs continued to demonstrate strengths in their processes for calculating performance indicators. The current validation did not identify any issues with the PIHPs' data integration, data control, or performance indicator documentation. The PIHPs demonstrated sound processes for the collection, validation, and submission of quality improvement and encounter data to MDCH. Statewide, PIHP oversight of affiliate community mental health centers and coordinating agencies (CAs), when applicable, was strong. Noted strengths included thorough documentation of processes and procedures for calculating and reporting of performance indicator and quality improvement data; PIHP-wide information systems to ensure uniform data reporting and enabling streamlined analysis and monitoring of data; continued development of enhanced reporting and analytical capabilities; established, well-informed staff involved in the performance indicator collection and reporting processes; and continued efforts to automate submissions to MDCH of encounter and quality improvement data. During the reporting period, several PIHPs upgraded their system to comply with CMS' Meaningful Use requirements and planned or completed their transition to new

information or electronic medical record systems. As the PIHPs undergo restructuring into regions, the regional entities should maintain thorough documentation of any changes to processes or procedures that occur as a result of the new structure. Several PIHPs should continue efforts to collect and report National Provider Identifier and financial cost data, create formal processes for evaluating the accuracy of data entry and claims processing, or review and monitor reported exceptions to ensure consistent application of the criteria and presence of documentation to support the exception.

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 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 indicators. Indicators 2d and 2b—Face-to-Face Assessment for DD and MI adults, Indicator 1a—Preadmission Screenings for Children, and Indicator 3e—Timeliness of First Service for

Medicaid Substance Abuse adults showed the highest statewide rates. Indicators for timely preadmission screenings for adults; initial assessments for MI children, MI adults, SA beneficiaries, and Total Rate; timely first service for SA beneficiaries, and the readmission rate for children demonstrated the strongest performance, with 17 of the 18 PIHPs meeting or exceeding the 95 percent standard. Indicator 4a—Follow-Up Care for Children had the lowest number of PIHPs meeting the MDCH minimum performance standard.

Table 1-7 and Table 1-8 display the 2012–2013 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) 2013. Indicators 8, 9, 13, and 14 were reported and validated for SFY 2012.

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	98.00	97.81	99.33	100	100	100	100	99.83	96.27	98.27	100	100	100	98.35	96.55	100	100
CMHAMM	100	97.78	99.20	99.45	100	100	96.67	98.72	99.47	98.50	100	92.86	100	99.22	100	91.36	100
CMH Central	100	97.12	96.73	98.45	100	100	100	97.94	95.98	99.47	100	100	100	98.10	100	96.77	100
CMHPSM	100	100	99.36	100	100	100	95.12	98.81	100	95.71	100	96.30	97.06	97.82	100	99.01	50.00
Detroit-Wayne	100	97.49	97.18	95.36	98.04	97.73	99.89	97.94	99.10	96.74	97.26	96.34	99.87	98.58	99.19	99.22	100
Genesee	98.60	99.78	99.29	100	100	100	95.51	98.65	98.94	97.79	100	100	95.62	97.34	95.65	95.88	96.34
Lakeshore	100	100	98.51	100	100	100	96.48	98.12	97.47	98.33	100	100	97.94	97.98	100	100	100
LifeWays	94.12	96.77	73.13	82.43	92.86	88.89	100	84.36	74.65	96.05	57.14	81.82	100	87.79	93.33	95.12	100
Macomb	98.66	99.48	98.18	99.32	85.71	95.24	100	98.62	98.80	99.35	95.45	100	100	99.39	98.73	93.85	100
network180	98.68	95.88	98.44	98.71	100	100	99.48	98.72	81.91	87.01	100	100	85.09	84.17	85.37	85.71	92.59
NorthCare	100	99.34	97.94	98.99	100	100	99.09	98.81	98.67	98.77	100	100	100	99.31	87.50	97.14	100
Northern Affiliation	100	100	99.34	98.86	100	91.67	100	99.05	98.85	97.56	100	100	100	98.82	100	100	100
Northwest CMH	96.30	100	99.29	99.35	100	100	100	99.47	97.92	91.59	100	71.43	100	95.32	93.10	90.20	100
Oakland	90.16	89.06	98.58	100	100	100	99.63	99.57	98.65	100	100	100	98.76	99.26	100	97.03	100
Saginaw	100	100	100	100	100	100	100	100	95.00	96.55	100	100	98.02	97.27	91.67	100	100
Southwest Affiliation	100	100	99.30	99.21	90.91	100	77.55	96.00	98.98	100	85.71	100	98.28	98.90	95.00	98.72	100
Thumb Alliance	100	100	100	100	100	100	100	100	94.29	95.15	100	100	99.13	96.85	95.65	100	100
Venture	95.77	99.27	96.81	99.82	96.15	100	95.17	98.03	96.09	98.78	100	100	98.59	98.16	100	96.67	100
Statewide Rate	**98.61**	**98.38**	**97.84**	**98.64**	**97.60**	**98.75**	**98.47**	**98.30**	**95.07**	**97.25**	**97.01**	**97.30**	**98.50**	**97.03**	**97.33**	**97.06**	**98.08**
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.																	

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	8.99	99.46	10.18	9.63	9.66	82.71	38.12	41.91	8.82	7.62	20.65	61.30
CMHAMM	6.88	99.73	9.91	9.81	8.31	82.16	60.54	56.69	10.00	13.83	13.87	47.80
CMH Central	10.09	99.81	10.13	8.21	4.57	79.14	15.80	13.85	0.00	12.12	28.57	56.10
CMHPSM	6.93	98.06	9.14	9.29	6.76	87.35	72.43	77.50	9.52	11.11	24.90	32.59
Detroit-Wayne	7.41	99.67	4.18	2.45	3.61	58.33	11.81	32.14	10.62	17.78	21.84	21.16
Genesee	7.11	98.92	4.25	6.10	4.23	60.75	13.56	20.93	1.89	14.77	6.53	43.24
Lakeshore	5.71	98.74	8.29	8.94	8.24	74.36	29.44	28.03	10.34	14.06	9.68	55.67
LifeWays	7.02	100	5.98	5.06	5.18	72.13	63.64	64.29	13.33	13.79	16.03	41.02
Macomb	5.97	99.59	6.86	6.20	4.32	58.33	38.50	29.09	11.63	18.88	15.94	34.80
network180	7.12	99.40	9.76	6.48	9.27	81.31	18.91	27.98	4.65	17.14	10.41	49.85
NorthCare	8.03	98.90	10.45	7.33	3.51	76.65	32.39	35.53	7.69	15.79	18.18	54.70
Northern Affiliation	7.52	99.08	9.14	13.25	18.40	58.41	38.07	60.92	2.78	2.13	24.11	55.89
Northwest CMH	7.99	98.92	9.04	6.95	6.93	91.07	50.91	72.95	12.50	12.33	6.95	55.34
Oakland	8.48	99.77	8.35	11.68	9.07	57.14	34.67	24.93	3.03	11.90	16.68	34.93
Saginaw	5.17	100	5.58	8.09	2.65	77.19	25.45	31.58	13.64	14.29	9.29	31.56
Southwest Affiliation	6.64	99.78	8.28	10.15	10.64	80.69	40.52	60.94	8.33	7.53	27.45	59.53
Thumb Alliance	8.23	99.64	7.33	4.15	4.12	52.61	11.85	10.69	25.71	13.33	15.63	52.43
Venture	7.80	99.69	10.37	8.22	5.23	71.43	52.54	48.60	9.52	6.02	14.19	47.08
Statewide Rate	**7.34**	**99.39**	**7.39**	**6.96**	**6.90**	**71.35**	**28.20**	**36.22**	**9.62**	**14.86**	**18.47**	**39.42**
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 third-year submission, 94 percent (17 of 18) of the PIPs received a *Met* validation status.

Table 1-9—PIP Validation Status

Validation Status	Number of PIHPs
Met	17
Partially Met	1
Not Met	0

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, while 12 of the PIPs 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.

Table 1-10—Summary of Data From Validation of Performance Improvement Projects

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)	18/18	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	18/18	18/18
V.	Use Sound Sampling Techniques*	NA	NA
VI.	Reliably Collect Data	17/18	NA
VII.	Implement Intervention and Improvement Strategies	14/18	18/18
VIII.	Analyze Data and Interpret Study Results	6/18	18/18
IX.	Assess for Real Improvement	5/18	No Critical Elements
X.	Assess for Sustained Improvement	12/12	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 and achieved scores of *Met* for all applicable critical elements, including those in Activity VIII.

The PIPs continued to meet all requirements related to the study questions, study indicators, and study populations. The PIP submissions reflected accurate and complete data collection processes. All PIHPs selected improvement strategies that were related to the causes and barriers identified through data analysis and the PIHP's quality improvement processes and were likely to induce permanent change at the system, provider, or beneficiary level. In the third year of this PIP, the studies progressed to the second remeasurement period. Most of the opportunities for improvement identified in this validation cycle addressed Activity VIII—Analyze Data and Interpret Study Results and Activity IX—Assess for Real Improvement. Several PIP submissions included inaccurate data or presented results or conclusions in the narrative that were not consistent with the data shown in tables. A few PIHPs did not address factors that could affect the ability to compare results between measurement periods. Statistical testing of the remeasurement results represented the largest opportunity for improvement, affecting more than half of the PIPs. PIHPs should correct errors; recalculate the statistical testing results, as they could not be replicated during the validation; or conduct statistical testing between additional measurement periods. In Activity IX, 13 of the 18 PIPs demonstrated improvement in the outcomes of care that appeared to be the result of the planned and implemented interventions. However, only five of the PIPs documented statistically significant improvement. Five of the PIPs showed a decline in the study indicator outcomes from the first to the second remeasurement period. All 12 PIPs that progressed to Activity X—Assess for Sustained Improvement demonstrated that improvements achieved were sustained over repeated measurements. They achieved two or more remeasurement results that were better than the baseline results without a statistically significant decrease in performance, or the PIPs had a statistically significant decline between remeasurement periods but performance was still significantly better than the baseline results.

Table 1-11 presents the results of the 2012–2013 PIP validation.

Table 1-11—PIP Validation Results by PIHP

PIHP	% of All Elements *Met*	% of All Critical Elements *Met*	Validation Status
Access Alliance	91%	100%	*Met*
CMHAMM	97%	100%	*Met*
CMH Central	94%	100%	*Met*
CMHPSM	91%	100%	*Met*
Detroit-Wayne	100%	100%	*Met*
Genesee	91%	100%	*Met*
Lakeshore	85%	100%	*Met*
LifeWays	88%	100%	*Met*
Macomb	91%	100%	*Met*
network180	82%	100%	*Met*
NorthCare	97%	100%	*Met*
Northern Affiliation	100%	100%	*Met*
Northwest CMH	94%	100%	*Met*

Table 1-11—PIP Validation Results by PIHP			
PIHP	% of All Elements *Met*	% of All Critical Elements *Met*	Validation Status
Oakland	88%	100%	*Met*
Saginaw	79%	100%	*Partially Met*
Southwest Affiliation	94%	100%	*Met*
Thumb Alliance	100%	100%	*Met*
Venture	94%	100%	*Met*

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

Conclusions

Findings from the 2012–2013 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 six standards included in the 2012–2013 review cycle, as reflected in the high statewide scores and the large number of PIHPs that received scores of *Met* on the elements assessed. 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, resulting in all but one of the indicators being fully compliant with MDCH specifications across all PIHPs. Statewide rates for all indicators exceeded the MDCH-specified minimum performance standard. The PIHPs continued to demonstrate strong performance, with 88 percent of individual PIHP rates exceeding the respective MDCH benchmark for the indicator.

For the 2012–2013 validation cycle, HSAG validated all 10 activities for 12 of the 18 PIPs on increasing the proportion of Medicaid eligible adults with a mental illness who receive peer-delivered services or supports. The PIHPs demonstrated high levels of compliance with the requirements of the CMS PIP protocol, achieving a validation status of *Met* for all but one PIP. Opportunities for improvement continued to exist for many PIPs in Activity VIII—Analyze Data and Interpret Study Results and Activity IX—Assess for Real Improvement. The results of the 2012–2013 validation suggest that the PIHPs designed and implemented PIPs intended to improve care and service outcomes for Medicaid beneficiaries and in most PIPs achieved improvement as a result of the planned and implemented interventions.

2. External Quality Review Activities

Introduction

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

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

Compliance Monitoring

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 2012–2013 compliance monitoring reviews evaluated the PIHPs' compliance with federal and State regulations and with contractual requirements related to the following standards:

- Standard I. QAPIP Plan and Structure
- Standard IV. Staff Qualifications and Training
- Standard V. Utilization Management
- Standard VII. Enrollee Grievance Process
- Standard XII. Access and Availability
- Standard XIV. Appeals

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

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

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

For each of the PIHP reviews in 2012–2013, 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.
- **Record Reviews:** HSAG developed record review tools for the review of utilization management (UM) denials, grievances, and beneficiary appeals. HSAG requested audit samples based on data files supplied by each PIHP. These files included logs of UM denials, grievances, and beneficiary appeals for the period of January 1, 2012, through September 30, 2012. From each of these logs, HSAG selected random samples of files for review.
- **Compliance Monitoring Reviews:** The 2012–2013 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 (QAPIP) 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, utilization 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) 2012 to Date of Review
Information From Interviews Conducted	State Fiscal Year (SFY) 2012 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 evaluated and scored each element addressed in the compliance monitoring review as *Met (M), Substantially Met (SM), Partially Met (PM), Not Met (NM),* or *Not Applicable (NA),* except that *Substantially Met* was not applicable to the Access and Availability standard. The overall score for each of the six standards was determined by totaling the number of *Met* (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, then dividing the summed score by the total number of applicable elements for that standard. Using the same methodology, HSAG determined the overall score across all standards for each PIHP and the statewide scores, summing the values of the ratings and dividing that sum by the total number of applicable elements.

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

Table 2-2—Assignment of Standards to Performance Domains

Standard		Quality	Timeliness	Access
I.	QAPIP Plan and Structure	✓		
IV.	Staff Qualifications and Training	✓		
V.	Utilization Management		✓	✓
VII.	Enrollee Grievance Process	✓	✓	
XII.	Access and Availability		✓	✓
XIV.	Appeals	✓	✓	

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 *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.

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 5 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 2012
Source Code/Programming Language for Performance Measures (From PIHPs and MDCH) or Description of the Performance Measure Calculation Process (From PIHPs)	SFY 2012
Previous Performance Measure Results Reports (From MDCH)	SFY 2012
Performance Measure Results (From PIHPs and MDCH)	First Quarter of SFY 2013
Supporting Documentation (From PIHPs and MDCH)	SFY 2012
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 Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	PIHP	First Quarter SFY 2013
2.	The percentage of new Medicaid beneficiaries during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service.	PIHP	First Quarter SFY 2013
3.	The percentage of new Medicaid beneficiaries during the quarter starting any needed ongoing service within 14 days of a non-emergent face-to-face assessment with a professional.	PIHP	First Quarter SFY 2013
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 2013
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 2013
5.	The percentage of Medicaid recipients having received PIHP managed services.	MDCH	First Quarter SFY 2013
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 2013
8.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who are employed competitively.	MDCH	SFY 2012
9.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who earn minimum wage or more from employment activities.	MDCH	SFY 2012
10.	The percentage of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.	PIHP	First Quarter SFY 2013
13.	The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	MDCH	SFY 2012
14.	The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	MDCH	SFY 2012

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.

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

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 2012–2013 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 2012–2013 validation cycle, HSAG provided technical assistance to one PIHP prior to the submission of the PIPs for validation.

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*: 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.

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
Increasing the Proportion of Medicaid Eligible Adults With a Mental Illness Who Receive Peer-Delivered Services or Supports	✓		

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 2012–2013 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 2012–2013 compliance monitoring reviews. These reviews evaluated the PIHPs' compliance with federal and State regulations and contractual requirements related to the following six standards: Quality Assessment and Performance Improvement Program (QAPIP) Plan and Structure, Staff Training and Qualifications, Utilization Management, Enrollee Grievance Process, Access and Availability, and Appeals.

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

Table 3-1—Compliance Monitoring Standards

Standard		Quality	Timeliness	Access
I.	QAPIP Plan and Structure	✓		
IV.	Staff Qualifications and Training	✓		
V.	Utilization Management		✓	✓
VII.	Enrollee Grievance Process	✓	✓	
XII.	Access and Availability		✓	✓
XIV.	Appeals	✓	✓	

Access Alliance of Michigan

Compliance Monitoring Results

Table 3-2 presents the results from the 2012–2013 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 2012–2013 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
				M	*SM*	*PM*	*NM*	*NA*	
I	*QAPIP Plan and Structure*	19	19	19	0	0	0	0	**100%**
IV	*Staff Qualifications and Training*	6	6	6	0	0	0	0	**100%**
V	*Utilization Management*	19	19	18	1	0	0	0	**99%**
VII	*Enrollee Grievance Process*	13	13	12	1	0	0	0	**98%**
XII	*Access and Availability*	17	17	16	0	1	0	0	**97%**
XIV	*Appeals*	15	15	14	1	0	0	0	**98%**
	Overall	**89**	**89**	**85**	**3**	**1**	**0**	**0**	**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

Access Alliance of Michigan received an overall compliance score of 99 percent across the six standards reviewed. The PIHP achieved 100 percent compliance on two standards: *QAPIP Plan and Structure* and *Staff Qualifications and Training*. **Access Alliance of Michigan** also demonstrated strong performance on the *Utilization Management*, *Enrollee Grievance Process*, *Access and Availability*, and *Appeals* standards.

Recommendations

The 2012–2013 recommendations for improving **Access Alliance of Michigan**'s performance addressed *Utilization Management*, *Enrollee Grievance Process*, *Access and Availability*, and *Appeals*. The PIHP should ensure that the reason for an adverse utilization management decision is

clearly documented and that all members receive information in the consumer handbook regarding the right to file grievances. **Access Alliance of Michigan** should continue efforts to ensure that developmentally disabled children start needed, ongoing service within 14 days of a nonemergent assessment at least 95 percent of the time, and resolve all appeals within the required time frame.

Summary Assessment Related to Quality, Timeliness, and Access

Access Alliance of Michigan demonstrated excellent performance across the three domains of **quality**, **timeliness**, and **access**. The PIHP demonstrated its strongest performance in the **quality** domain, achieving full compliance on two of the four standards. Performance in the **access** and **timeliness** domains was also strong, with compliance scores of 97 percent and higher on the standards in these domains.

CMH Affiliation of Mid-Michigan

Compliance Monitoring Results

Table 3-3 presents the results from the 2012–2013 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 2012–2013 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
				M	*SM*	*PM*	*NM*	*NA*	
I	*QAPIP Plan and Structure*	19	19	19	0	0	0	0	**100%**
IV	*Staff Qualifications and Training*	6	6	6	0	0	0	0	**100%**
V	*Utilization Management*	19	19	19	0	0	0	0	**100%**
VII	*Enrollee Grievance Process*	13	13	13	0	0	0	0	**100%**
XII	*Access and Availability*	17	17	16	0	0	1	0	**94%**
XIV	*Appeals*	15	15	15	0	0	0	0	**100%**
	Overall	**89**	**89**	**88**	**0**	**0**	**1**	**0**	**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 six standards reviewed. The PIHP achieved 100 percent compliance on five standards: *QAPIP Plan and Structure*, *Staff Qualifications and Training*, *Utilization Management*, *Enrollee Grievance Process*, and *Appeals*. **CMH Affiliation of Mid-Michigan** also demonstrated strong performance on the *Access and Availability* standard.

Recommendations

Recommendations for improving **CMH Affiliation of Mid-Michigan**'s performance addressed *Access and Availability*. The PIHP should continue efforts to ensure that new beneficiaries—

children with a mental illness and children and adults with a developmental disability—start needed, ongoing services within 14 days of a nonemergent assessment with a professional.

Summary Assessment Related to Quality, Timeliness, and Access

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

CMH for Central Michigan

Compliance Monitoring Results

Table 3-4 presents the results from the 2012–2013 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 2012–2013 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
				M	*SM*	*PM*	*NM*	*NA*	
I	*QAPIP Plan and Structure*	19	19	19	0	0	0	0	**100%**
IV	*Staff Qualifications and Training*	6	6	6	0	0	0	0	**100%**
V	*Utilization Management*	19	18	18	0	0	0	1	**100%**
VII	*Enrollee Grievance Process*	13	13	13	0	0	0	0	**100%**
XII	*Access and Availability*	17	17	14	0	2	1	0	**88%**
XIV	*Appeals*	15	15	15	0	0	0	0	**100%**
	Overall	**89**	**88**	**85**	**0**	**2**	**1**	**1**	**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 six standards reviewed. The PIHP achieved 100 percent compliance on five standards: *QAPIP Plan and Structure*, *Staff Qualifications and Training*, *Utilization Management*, *Enrollee Grievance Process*, *Access and Availability*, and *Appeals*. **CMH for Central Michigan** also demonstrated strong performance on the *Access and Availability* standard.

Recommendations

Recommendations for improving **CMH for Central Michigan**'s performance addressed *Access and Availability*. The PIHP should continue efforts to ensure that children with a mental illness as

well as children and adults with a developmental disability start needed, ongoing services within 14 days of a nonemergent assessment with a professional.

Summary Assessment Related to Quality, Timeliness, and Access

CMH for Central Michigan demonstrated excellent performance across the three domains of **quality**, **timeliness**, and **access**. The PIHP demonstrated its strongest performance in the **quality** domain and achieved full compliance on all four standards. Performance in the **timeliness** domain was also strong, with full compliance on three of the four standards. **CMH for Central Michigan** achieved 100 percent compliance on one of the two standards addressing the **access** domain.

CMH Partnership of Southeastern Michigan

Compliance Monitoring Results

Table 3-5 presents the results from the 2012–2013 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 2012–2013 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
				M	*SM*	*PM*	*NM*	*NA*	
I	*QAPIP Plan and Structure*	19	19	19	0	0	0	0	**100%**
IV	*Staff Qualifications and Training*	6	6	6	0	0	0	0	**100%**
V	*Utilization Management*	19	19	19	0	0	0	0	**100%**
VII	*Enrollee Grievance Process*	13	13	12	0	1	0	0	**96%**
XII	*Access and Availability*	17	17	16	0	0	1	0	**94%**
XIV	*Appeals*	15	15	13	1	1	0	0	**95%**
	Overall	**89**	**89**	**85**	**1**	**2**	**1**	**0**	**97%**

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

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

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

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

Strengths

CMH Partnership of Southeastern Michigan received an overall compliance score of 97 percent across the six standards reviewed. The PIHP achieved 100 percent compliance on three standards: *QAPIP Plan and Structure, Staff Qualifications and Training,* and *Utilization Management*. **CMH Partnership of Southeastern Michigan** also demonstrated strong performance on the *Enrollee Grievance Process, Access and Availability,* and *Appeals* standards.

Recommendations

Recommendations for improving **CMH Partnership of Southeastern Michigan**'s performance addressed *Enrollee Grievance Process, Access and Availability,* and *Appeals*. The PIHP should ensure that it regularly reports data on grievances and appeals to the PIHP's QAPIP. **CMH**

Partnership of Southeastern Michigan should continue efforts to ensure that beneficiaries discharged from a substance abuse detoxification unit are seen for follow-up care within seven days.

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 **quality** domain, achieving full compliance on two of the four standards. Performance in the **access** and **timeliness** domains was also strong, with full compliance on one standard in each of these domains and compliance scores of 94 percent and above on the remaining standards.

Detroit-Wayne County CMH Agency

Compliance Monitoring Results

Table 3-6 presents the results from the 2012–2013 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 2012–2013 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
				M	*SM*	*PM*	*NM*	*NA*	
I	*QAPIP Plan and Structure*	19	19	19	0	0	0	0	**100%**
IV	*Staff Qualifications and Training*	6	6	6	0	0	0	0	**100%**
V	*Utilization Management*	19	19	19	0	0	0	0	**100%**
VII	*Enrollee Grievance Process*	13	13	12	1	0	0	0	**98%**
XII	*Access and Availability*	17	17	15	0	2	0	0	**94%**
XIV	*Appeals*	15	15	14	1	0	0	0	**98%**
	Overall	**89**	**89**	**85**	**2**	**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

Detroit-Wayne County CMH Agency received an overall compliance score of 98 percent across the six standards reviewed. The PIHP achieved 100 percent compliance on three standards: *QAPIP Plan and Structure*, *Staff Qualifications and Training*, and *Utilization Management*. **Detroit-Wayne County CMH Agency** also demonstrated strong performance on the *Enrollee Grievance Process*, *Access and Availability*, and *Appeals* standards.

Recommendations

The recommendation for improving **Detroit-Wayne County CMH Agency**'s performance addressed *Enrollee Grievance Process*, *Access and Availability*, and *Appeals*. The PIHP should ensure that its written notices of disposition include all required information (i.e., the date of the

resolution for grievances and an explanation of the resolution for appeals). **Detroit-Wayne County CMH Agency** should continue efforts to ensure that developmentally disabled children and adults start needed, ongoing service within 14 days of a nonemergent assessment with a professional.

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 **quality** domain, achieving full compliance on two of the four standards. Performance in the **access** and **timeliness** domains was also strong, with full compliance on one standard in each of these domains and compliance scores of 94 percent and above on the remaining standards.

Genesee County CMH

Compliance Monitoring Results

Table 3-7 presents the results from the 2012–2013 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 2012–2013 External Quality Review Compliance Monitoring Report for **Genesee County CMH** contains a more detailed description of the results.2

Table 3-7—Summary of Scores for the Standards

Standard		Total Elements	Total Applicable Elements	Number of Elements					Total Compliance Score
				M	*SM*	*PM*	*NM*	*NA*	
I	*QAPIP Plan and Structure*	19	19	19	0	0	0	0	**100%**
IV	*Staff Qualifications and Training*	6	6	6	0	0	0	0	**100%**
V	*Utilization Management*	19	18	18	0	0	0	1	**100%**
VII	*Enrollee Grievance Process*	13	13	12	1	0	0	0	**98%**
XII	*Access and Availability*	17	17	16	0	1	0	0	**97%**
XIV	*Appeals*	15	15	14	1	0	0	0	**98%**
	Overall	**89**	**88**	**85**	**2**	**1**	**0**	**1**	**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

Genesee County CMH received an overall compliance score of 99 percent across the six standards reviewed. The PIHP achieved 100 percent compliance on three standards: *QAPIP Plan and Structure*, *Staff Qualifications and Training*, and *Utilization Management*. **Genesee County CMH** also demonstrated strong performance on the *Enrollee Grievance Process*, *Access and Availability*, and *Appeals* standards.

Recommendations

The recommendation for improving **Genesee County CMH**'s performance addressed *Enrollee Grievance Process*, *Access and Availability*, and *Appeals*. The PIHP should ensure that notices of disposition for grievances and appeals include the date of the resolution. **Genesee County CMH**

should continue efforts to ensure that beneficiaries with a substance use disorder receive a face-to-face assessment with a professional within 14 days of a nonemergency request for service.

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 **quality** domain, achieving full compliance on two of the four standards. Performance in the **access** and **timeliness** domains was also strong, with full compliance on one standard in each of these domains and compliance scores of 97 percent and above on the remaining standards.

Lakeshore Behavioral Health Alliance

Compliance Monitoring Results

Table 3-8 presents the results from the 2012–2013 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 2012–2013 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
				M	*SM*	*PM*	*NM*	*NA*	
I	*QAPIP Plan and Structure*	19	19	19	0	0	0	0	**100%**
IV	*Staff Qualifications and Training*	6	6	6	0	0	0	0	**100%**
V	*Utilization Management*	19	19	16	0	3	0	0	**92%**
VII	*Enrollee Grievance Process*	13	13	11	2	0	0	0	**96%**
XII	*Access and Availability*	17	17	15	0	1	1	0	**91%**
XIV	*Appeals*	15	15	11	4	0	0	0	**93%**
	Overall	**89**	**89**	**78**	**6**	**4**	**1**	**0**	**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

Lakeshore Behavioral Health Alliance received an overall compliance score of 95 percent across the six standards reviewed. The PIHP achieved 100 percent compliance on two standards: *QAPIP Plan and Structure* and *Staff Qualifications and Training*. **Lakeshore Behavioral Health Alliance** also demonstrated strong performance on the *Utilization Management, Enrollee Grievance Process, Access and Availability,* and *Appeals* standards.

Recommendations

Recommendations for improving **Lakeshore Behavioral Health Alliance**'s performance addressed *Utilization Management, Enrollee Grievance Process, Access and Availability,* and *Appeals*. The PIHP should continue to provide oversight to its affiliates to ensure that decisions to deny or reduce

services are made by health care professionals who have the appropriate clinical expertise to treat the beneficiary's condition, that the reasons for denials are clearly documented, and that notification of a denial is sent to the provider. **Lakeshore Behavioral Health Alliance** should ensure that all beneficiaries receive acknowledgement of receipt of the grievance in compliance with the PIHP's policies and procedures and that the notice of disposition for grievances accurately reflects the required information. The PIHP should ensure that beneficiaries receive accurate information about the time frames for filing appeals and the right to examine the appeal case file. **Lakeshore Behavioral Health Alliance** should ensure that notices of disposition for appeals include all required information and are distributed within 45 days from the date of receipt of the standard appeal. The PIHP should continue efforts to ensure that beneficiaries with a substance use disorder receive a face-to-face assessment with a professional within 14 days of a nonemergency request for service and that developmentally disabled adults start needed, ongoing service within 14 days of a nonemergent assessment.

Summary Assessment Related to Quality, Timeliness, and Access

Lakeshore Behavioral Health Alliance 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 two of the four standards. Performance in the **access** and **timeliness** domains was also strong, with compliance scores of 91 percent and above on the standards in these domains.

LifeWays

Compliance Monitoring Results

Table 3-9 presents the results from the 2012–2013 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 2012–2013 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
				M	*SM*	*PM*	*NM*	*NA*	
I	*QAPIP Plan and Structure*	19	19	18	1	0	0	0	**99%**
IV	*Staff Qualifications and Training*	6	6	6	0	0	0	0	**100%**
V	*Utilization Management*	19	19	17	2	0	0	0	**97%**
VII	*Enrollee Grievance Process*	13	13	12	0	1	0	0	**96%**
XII	*Access and Availability*	17	17	5	0	3	9	0	**38%**
XIV	*Appeals*	15	15	13	0	2	0	0	**93%**
	Overall	**89**	**89**	**71**	**3**	**6**	**9**	**0**	**86%**

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 86 percent across the six standards reviewed. The PIHP achieved 100 percent compliance on one of the six standards, *Staff Qualifications and Training*. **LifeWays** also demonstrated strong performance on the standards of *QAPIP Plan and Structure*, *Utilization Management*, *Enrollee Grievance Process*, and *Appeals*.

Recommendations

Recommendations for improving **LifeWays**' performance addressed *QAPIP Plan and Structure*, *Utilization Management*, *Enrollee Grievance Process*, *Access and Availability*, and *Appeals*. The PIHP should ensure that the review of data from the Behavior Treatment Committee and procedures for utilization management denials meet contractual requirements. **LifeWays** should revise its grievance and appeals procedure to include procedures specific to all requirements for handling

grievances and ensure that these procedures are followed. The PIHP should ensure that notices of disposition for appeals include all required information. **LifeWays** should continue efforts to ensure that contractual access standards for preadmission screenings, face-to-face assessments, ongoing services, and follow-up care after discharge are met.

Summary Assessment Related to Quality, Timeliness, and Access

LifeWays demonstrated mixed performance across the three domains of **quality**, **timeliness**, and **access**. The PIHP demonstrated its strongest performance in the **quality** domain, achieving full compliance on one of the four standards. Performance in the **access** and **timeliness** domains was mixed, with the lowest of the compliance scores for a standard addressing these domains and scores of 93 percent and above for the remaining standards.

Macomb County CMH Services

Compliance Monitoring Results

Table 3-10 presents the results from the 2012–2013 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 2012–2013 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
				M	*SM*	*PM*	*NM*	*NA*	
I	*QAPIP Plan and Structure*	19	19	19	0	0	0	0	**100%**
IV	*Staff Qualifications and Training*	6	6	6	0	0	0	0	**100%**
V	*Utilization Management*	19	19	19	0	0	0	0	**100%**
VII	*Enrollee Grievance Process*	13	13	13	0	0	0	0	**100%**
XII	*Access and Availability*	17	17	13	0	4	0	0	**88%**
XIV	*Appeals*	15	15	14	0	1	0	0	**97%**
	Overall	**89**	**89**	**84**	**0**	**5**	**0**	**0**	**97%**

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

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

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

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

Strengths

Macomb County CMH Services received an overall compliance score of 97 percent across the six standards reviewed. The PIHP achieved 100 percent compliance on four standards: *QAPIP Plan and Structure*, *Staff Qualifications and Training*, *Utilization Management*, and *Enrollee Grievance Process*. **Macomb County CMH Services** also demonstrated strong performance on the *Access and Availability* and *Appeals* standards.

Recommendations

Recommendations for improving **Macomb County CMH Services**' performance addressed *Access and Availability* and *Appeals*. The PIHP should ensure that it consistently follows the process for denial of an expedited resolution of an appeal as detailed in its policies and the MDCH contract.

Macomb County CMH Services should continue efforts to ensure that developmentally disabled children and adults receive a face-to-face assessment with a professional within 14 days of a nonemergency request for service, and that they start needed, ongoing service within 14 days of a nonemergent assessment with a professional.

Summary Assessment Related to Quality, Timeliness, and Access

Macomb County CMH Services 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 three of the four standards. Performance in the **timeliness** domain was also strong, with full compliance on two of the four standards. **Macomb County CMH Services** achieved 100 percent compliance on one of the two standards addressing the **access** domain.

network180

Compliance Monitoring Results

Table 3-11 presents the results from the 2012–2013 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 2012–2013 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
				M	*SM*	*PM*	*NM*	*NA*	
I	*QAPIP Plan and Structure*	19	19	19	0	0	0	0	**100%**
IV	*Staff Qualifications and Training*	6	6	6	0	0	0	0	**100%**
V	*Utilization Management*	19	19	19	0	0	0	0	**100%**
VII	*Enrollee Grievance Process*	13	13	11	1	1	0	0	**94%**
XII	*Access and Availability*	17	17	10	0	4	3	0	**71%**
XIV	*Appeals*	15	15	12	1	1	1	0	**88%**
	Overall	**89**	**89**	**77**	**2**	**6**	**4**	**0**	**92%**

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 92 percent across the six standards reviewed. The PIHP achieved 100 percent compliance on three standards: *QAPIP Plan and Structure*, *Staff Qualifications and Training*, and *Utilization Management.* **network180** also demonstrated strong performance on the *Enrollee Grievance Process* and *Appeals* standards.

Recommendations

Recommendations for improving **network180**'s performance addressed *Enrollee Grievance Process*, *Access and Availability*, and *Appeals*. The PIHP should maintain a complete log of all grievances and appeals and ensure that notices of disposition for grievances include all required information. **network180** should ensure that receipt of appeals is acknowledged, appeal disposition notices are provided within the required time frame, and appeals data are reported to the PIHP's

QAPIP. The PIHP should continue efforts to ensure compliance with access standards for ongoing services and follow-up care after discharge from a psychiatric inpatient unit.

Summary Assessment Related to Quality, Timeliness, and Access

network180 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 two of the four standards. Performance in the **timeliness** and **access** domains was mixed, with full compliance on one standard addressing these domains.

NorthCare

Compliance Monitoring Results

Table 3-12 presents the results from the 2012–2013 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 2012–2013 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
				M	*SM*	*PM*	*NM*	*NA*	
I	*QAPIP Plan and Structure*	19	19	19	0	0	0	0	**100%**
IV	*Staff Qualifications and Training*	6	6	6	0	0	0	0	**100%**
V	*Utilization Management*	19	19	17	1	1	0	0	**96%**
VII	*Enrollee Grievance Process*	13	13	13	0	0	0	0	**100%**
XII	*Access and Availability*	17	17	16	0	1	0	0	**97%**
XIV	*Appeals*	15	15	15	0	0	0	0	**100%**
	Overall	**89**	**89**	**86**	**1**	**2**	**0**	**0**	**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 six standards reviewed. The PIHP achieved 100 percent compliance on four standards: *QAPIP Plan and Structure, Staff Qualifications and Training, Enrollee Grievance Process,* and *Appeals*. **NorthCare** also demonstrated strong performance on the *Utilization Management* and *Access and Availability* standards.

Recommendations

Recommendations for improving **NorthCare**'s performance addressed *Utilization Management* and *Access and Availability*. The PIHP should ensure that beneficiaries and providers receive correct notification of a denial. **NorthCare** should continue efforts to ensure that children discharged from a psychiatric inpatient unit are seen for follow-up care within seven days.

Summary Assessment Related to Quality, Timeliness, and Access

NorthCare demonstrated excellent performance across the three domains of **quality**, **timeliness**, and **access**. The PIHP demonstrated its strongest performance in the **quality** domain, achieving full compliance for all standards in this domain. Performance in the **timeliness** and **access** domains was also strong, with full compliance on two of the four standards in the **timeliness** domain and compliance scores of 96 percent and above in the **access** domain.

Northern Affiliation

Compliance Monitoring Results

Table 3-13 presents the results from the 2012–2013 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 2012–2013 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
				M	*SM*	*PM*	*NM*	*NA*	
I	*QAPIP Plan and Structure*	19	19	18	1	0	0	0	**99%**
IV	*Staff Qualifications and Training*	6	6	6	0	0	0	0	**100%**
V	*Utilization Management*	19	19	15	4	0	0	0	**95%**
VII	*Enrollee Grievance Process*	13	13	12	1	0	0	0	**98%**
XII	*Access and Availability*	17	17	17	0	0	0	0	**100%**
XIV	*Appeals*	15	15	13	2	0	0	0	**97%**
	Overall	**89**	**89**	**81**	**8**	**0**	**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

Northern Affiliation received an overall compliance score of 98 percent across the six standards reviewed. The PIHP achieved 100 percent compliance on two standards: *Staff Qualifications and Training* and *Access and Availability*. **Northern Affiliation** also demonstrated strong performance on the *QAPIP Plan and Structure*, *Utilization Management*, *Enrollee Grievance Process*, and *Appeals* standards.

Recommendations

The recommendation for improving **Northern Affiliation**'s performance addressed *QAPIP Plan and Structure*, *Utilization Management*, *Enrollee Grievance Process*, and *Appeals*. The PIHP should ensure compliance with the requirements for review of data from the Behavior Treatment

Committee and procedures for utilization management decisions. **Northern Affiliation** should ensure that all notices of disposition for grievances include the results of the grievance process and the date the grievance was completed. The PIHP should ensure that receipt of all appeals is acknowledged and that notices of disposition for appeals not resolved in favor of the beneficiary include all required information.

Summary Assessment Related to Quality, Timeliness, and Access

Northern Affiliation demonstrated excellent performance across the three domains of **quality**, **timeliness**, and **access**. The PIHP achieved full compliance on one standard in each of the domains and compliance scores of 95 percent and above on the remaining standards across the domains of **quality**, **timeliness**, and **access**.

Northwest CMH Affiliation

Compliance Monitoring Results

Table 3-14 presents the results from the 2012–2013 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 2012–2013 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
				M	*SM*	*PM*	*NM*	*NA*	
I	*QAPIP Plan and Structure*	19	19	19	0	0	0	0	**100%**
IV	*Staff Qualifications and Training*	6	6	6	0	0	0	0	**100%**
V	*Utilization Management*	19	19	16	3	0	0	0	**96%**
VII	*Enrollee Grievance Process*	13	13	12	1	0	0	0	**98%**
XII	*Access and Availability*	17	17	16	0	1	0	0	**97%**
XIV	*Appeals*	15	15	14	1	0	0	0	**98%**
	Overall	**89**	**89**	**833**	**5**	**1**	**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

Northwest CMH Affiliation received an overall compliance score of 98 percent across the six standards reviewed. The PIHP achieved 100 percent compliance on two standards: *QAPIP Plan and Structure* and *Staff Qualifications and Training*. **Northwest CMH Affiliation** also demonstrated strong performance on the standards of *Utilization Management, Enrollee Grievance Process, Access and Availability,* and *Appeals.*

Recommendations

Recommendations for improving **Northwest CMH Affiliation**'s performance addressed *Utilization Management, Enrollee Grievance Process, Access and Availability,* and *Appeals.* The PIHP should ensure compliance with the requirements for utilization management denials, provide timely

acknowledgement of receipt of all grievances, and ensure that all appeals are resolved within the required time frame. **Northwest CMH Affiliation** should continue efforts to ensure that adults discharged from a psychiatric inpatient unit are seen for follow-up care within seven days.

Summary Assessment Related to Quality, Timeliness, and Access

Northwest CMH Affiliation demonstrated excellent performance across the three domains of **quality**, **timeliness**, and **access**. The PIHP achieved full compliance on two of the four standards in the **quality** domain. Performance in the **timeliness** and **access** domains was also strong, with compliance scores of 96 percent and above on the standards in these domains.

Oakland County CMH Authority

Compliance Monitoring Results

Table 3-15 presents the results from the 2012–2013 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 2012–2013 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
				M	*SM*	*PM*	*NM*	*NA*	
I	*QAPIP Plan and Structure*	19	19	19	0	0	0	0	**100%**
IV	*Staff Qualifications and Training*	6	6	6	0	0	0	0	**100%**
V	*Utilization Management*	19	19	19	0	0	0	0	**100%**
VII	*Enrollee Grievance Process*	13	13	13	0	0	0	0	**100%**
XII	*Access and Availability*	17	17	17	0	0	0	0	**100%**
XIV	*Appeals*	15	15	15	0	0	0	0	**100%**
	Overall	**89**	**89**	**89**	**0**	**0**	**0**	**0**	**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

Oakland County CMH Authority received an overall compliance score of 100 percent across the six standards reviewed. The PIHP achieved 100 percent compliance on all six standards: *QAPIP Plan and Structure*, *Staff Qualifications and Training*, *Utilization Management*, *Enrollee Grievance Process*, *Access and Availability*, and *Appeals*.

Recommendations

The 2012–2013 compliance review did not identify any opportunities for improvement for **Oakland County CMH Authority** as the PIHP demonstrated full compliance with all requirements addressed in this review cycle.

Summary Assessment Related to Quality, Timeliness, and Access

Oakland County CMH Authority demonstrated exceptional performance across the three domains of **quality**, **timeliness**, and **access**. The PIHP achieved full compliance on all standards.

Saginaw County CMH Authority

Compliance Monitoring Results

Table 3-16 presents the results from the 2012–2013 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 2012–2013 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
				M	*SM*	*PM*	*NM*	*NA*	
I	*QAPIP Plan and Structure*	19	19	19	0	0	0	0	**100%**
IV	*Staff Qualifications and Training*	6	6	6	0	0	0	0	**100%**
V	*Utilization Management*	19	19	19	0	0	0	0	**100%**
VII	*Enrollee Grievance Process*	13	13	10	3	0	0	0	**94%**
XII	*Access and Availability*	17	17	12	0	3	2	0	**79%**
XIV	*Appeals*	15	15	12	2	0	1	0	**90%**
	Overall	**89**	**89**	**78**	**5**	**3**	**3**	**0**	**94%**

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 94 percent across the six standards reviewed. The PIHP achieved 100 percent compliance on three standards: *QAPIP Plan and Structure*, *Staff Qualifications and Training*, and *Utilization Management*. **Saginaw County CMH Authority** also demonstrated strong performance on the *Enrollee Grievance Process* and *Appeals* standards.

Recommendations

Recommendations for improving **Saginaw County CMH Authority**'s performance addressed *Enrollee Grievance Process*, *Access and Availability*, and *Appeals*. The PIHP should ensure acknowledgement of receipt, timely resolution, and notices of disposition with all required

information for all grievances and appeals. **Saginaw County CMH Authority** should continue efforts to ensure compliance with access standards for face-to-face assessments, ongoing services, and follow-up care after discharge from a psychiatric inpatient facility.

Summary Assessment Related to Quality, Timeliness, and Access

Saginaw County CMH Authority 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 two of the four standards. Performance in the **timeliness** and **access** domains was also strong, with full compliance on one standard addressing these domains and compliance scores of 90 percent and above on all but one of the remaining standards.

Southwest Affiliation

Compliance Monitoring Results

Table 3-17 presents the results from the 2012–2013 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 2012–2013 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
				M	*SM*	*PM*	*NM*	*NA*	
I	*QAPIP Plan and Structure*	19	19	19	0	0	0	0	**100%**
IV	*Staff Qualifications and Training*	6	6	6	0	0	0	0	**100%**
V	*Utilization Management*	19	19	16	1	1	1	0	**91%**
VII	*Enrollee Grievance Process*	13	13	11	1	1	0	0	**94%**
XII	*Access and Availability*	17	17	15	0	2	0	0	**94%**
XIV	*Appeals*	15	15	12	1	2	0	0	**92%**
	Overall	**89**	**89**	**79**	**3**	**6**	**1**	**0**	**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

Southwest Affiliation received an overall compliance score of 95 percent across the six standards reviewed. The PIHP achieved 100 percent compliance on two standards: *QAPIP Plan and Structure* and *Staff Qualifications and Training*. **Southwest Affiliation** also demonstrated strong performance on the *Utilization Management*, *Enrollee Grievance Process*, *Access and Availability*, and *Appeals* standards.

Recommendations

Recommendations for improving **Southwest Affiliation**'s performance addressed *Utilization Management*, *Enrollee Grievance Process*, *Access and Availability*, and *Appeals*. **Southwest Affiliation** should ensure compliance with requirements for utilization management decisions, timeliness of resolution of grievances and appeals, and content of notices of disposition for

grievances and appeals. The PIHP should continue efforts to ensure that beneficiaries with a substance use disorder receive a face-to-face assessment with a professional within 14 days of a nonemergency request for service, and that they start needed, ongoing service within 14 days of a nonemergent assessment.

Summary Assessment Related to Quality, Timeliness, and Access

Southwest Affiliation 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 two of the four standards. Performance in the **timeliness** and **access** domains was also strong, with compliance scores of 91 percent or better on the standards in these domains.

Thumb Alliance PIHP

Compliance Monitoring Results

Table 3-18 presents the results from the 2012–2013 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 2012–2013 External Quality Review Compliance Monitoring Report for **Thumb Alliance PIHP** contains a more detailed description of the results.

Table 3-18—Summary of Scores for the Standards

Standard		Total Elements	Total Applicable Elements	Number of Elements					Total Compliance Score
				M	*SM*	*PM*	*NM*	*NA*	
I	*QAPIP Plan and Structure*	19	19	18	0	1	0	0	**97%**
IV	*Staff Qualifications and Training*	6	6	6	0	0	0	0	**100%**
V	*Utilization Management*	19	19	19	0	0	0	0	**100%**
VII	*Enrollee Grievance Process*	13	13	11	0	2	0	0	**92%**
XII	*Access and Availability*	17	17	17	0	0	0	0	**100%**
XIV	*Appeals*	15	15	13	1	1	0	0	**95%**
	Overall	**89**	**89**	**84**	**1**	**4**	**0**	**0**	**97%**

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

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

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

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

Strengths

Thumb Alliance PIHP received an overall compliance score of 97 percent across the six standards reviewed. The PIHP achieved 100 percent compliance on three standards: *Staff Qualifications and Training*, *Utilization Management*, and *Access and Availability*. **Thumb Alliance PIHP** also demonstrated strong performance on the standards of *QAPIP Plan and Structure*, *Enrollee Grievance Process*, and *Appeals.*

Recommendations

Recommendations for improving **Thumb Alliance PIHP**'s performance addressed *QAPIP Plan and Structure*, *Enrollee Grievance Process*, and *Appeals*. The PIHP should ensure compliance with the requirements for review of data from the Behavior Treatment Committee and acknowledgement

of receipt of grievances and appeals. **Thumb Alliance PIHP** should ensure that notices of disposition for grievances and appeals include all required information.

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 demonstrated its strongest performance in the **access** domain, achieving full compliance on all standards. Performance in the **timeliness** and **quality** domains was also strong, with full compliance on three standards in these domains and compliance scores of 92 percent and above on the remaining standards.

Venture Behavioral Health

Compliance Monitoring Results

Table 3-19 presents the results from the 2012–2013 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 2012–2013 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
				M	*SM*	*PM*	*NM*	*NA*	
I	*QAPIP Plan and Structure*	19	19	19	0	0	0	0	**100%**
IV	*Staff Qualifications and Training*	6	6	6	0	0	0	0	**100%**
V	*Utilization Management*	19	19	19	0	0	0	0	**100%**
VII	*Enrollee Grievance Process*	13	13	10	2	1	0	0	**92%**
XII	*Access and Availability*	17	16	14	0	2	0	1	**94%**
XIV	*Appeals*	15	15	11	3	1	0	0	**92%**
	Overall	**89**	**88**	**79**	**5**	**4**	**0**	**1**	**96%**

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 96 percent across the six standards reviewed. The PIHP achieved 100 percent compliance on three standards: *QAPIP Plan and Structure*, *Staff Qualifications and Training*, and *Utilization Management*. **Venture Behavioral Health** also demonstrated strong performance on the *Enrollee Grievance Process*, *Access and Availability*, and *Appeals* standards.

Recommendations

Recommendations for improving **Venture Behavioral Health**'s performance addressed *Enrollee Grievance Process*, *Access and Availability*, and *Appeals*. The PIHP should ensure compliance with requirements for acknowledgement of receipt, timely resolution, and content of notices of

disposition for grievances and appeals and provide beneficiaries with information about the right to examine the case file considered during the appeal process. **Venture Behavioral Health** should continue efforts to ensure that children and beneficiaries with a substance use disorder receive a face-to-face assessment with a professional within 14 days of a nonemergency request for service.

Summary Assessment Related to Quality, Timeliness, and Access

Venture Behavioral Health 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 two of the four standards. Performance in the **timeliness** and **access** domains was also strong, with full compliance on one standard addressing these domains and compliance scores of 92 percent and above on the remaining standards.

Validation of Performance Measures

This section of the report presents the results for the validation of performance measures. The tables show validation findings and reported rates for each measure. The CMS Performance Measure Validation Protocol identifies three possible validation finding designations for performance indicators—*Report* (*R*), *Not Reported* (*NR*), and *No Benefit* (*NB*). Section 2 of this report provides a more detailed explanation of these indicator designations. The 2012–2013 validation of performance measures review included the same measures that were reported in 2011–2012.

The validation review periods for the indicators were as follows: first quarter of SFY 2013 for Indicators 1 through 6 and Indicator 10; SFY 2012 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 2013 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		Indicator Designation
1.	The percentage of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children:	98.00%	*R*
		Adults:	97.81%	
2.	The percentage of new Medicaid beneficiaries 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:	99.33%	*R*
		MI Adults:	100%	
		DD Children:	100%	
		DD Adults:	100%	
		Medicaid SA:	100%	
		Total:	99.83%	
3.	The percentage of new Medicaid beneficiaries during the quarter starting any needed ongoing service within 14 days of a non-emergent face-to-face assessment with a professional.	MI Children:	96.27%	*R*
		MI Adults:	98.27%	
		DD Children:	100%	
		DD Adults:	100%	
		Medicaid SA:	100%	
		Total:	98.35%	
4a.	The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days	Children:	96.55%	*R*
		Adults:	100%	
4b.	The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.	100%		*R*
5.	The percent of Medicaid recipients having received PIHP managed services.	8.99%		*R*
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.	99.46%		*R*
8.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who are employed competitively.	MI Adults:	10.18%	*R*
		DD Adults:	9.63%	
		MI/DD Adults:	9.66%	

Table 3-20—Performance Measure Results *for* Access Alliance of Michigan			
	Indicator	**Reported Rate**	**Indicator Designation**
9.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.	MI Adults: 82.71% DD Adults: 38.12% MI/DD Adults: 41.91%	*R*
10.	The percentage of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge	Children: 8.82% Adults: 7.62%	*R*
13.	The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	20.65%	*R*
14.	The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	61.30%	*R*

Strengths

Access Alliance of Michigan implemented a line-by-line reconciliation with CA encounter submissions to ensure all billed encounters were submitted to the State. The PIHP increased oversight of affiliate encounter submissions, assisting in trending encounter submission volumes. **Access Alliance of Michigan** staff overcame multiple challenges related to the system transition from CMHC Systems software to ShareCare during the measurement period.

Recommendations

Access Alliance of Michigan should review and update the ISCAT and all attachments according to current business practices. As the PIHP and several of its affiliates will be transitioning to new information and electronic medical record systems within the next year, each entity should carefully document system and process changes. As **Access Alliance of Michigan** and some affiliates move to these new systems, they should consider phasing out the performance indicator database and use capabilities within the new systems for integrated performance indicator data capture.

Summary Assessment Related to Quality, Timeliness, and Access

Access Alliance of Michigan's performance indicators across the domains of **quality**, **timeliness**, and **access** received validation findings of *Report*, reflecting that the indicators were compliant with MDCH specifications and rates could be reported. 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. The PIHP met all 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 met the minimum performance standard for all 19 indicators; achieved rates above the statewide averages for all 10 indicators without a specified performance benchmark; and demonstrated outstanding performance across the three domains of **quality**, **timeliness**, and **access**.

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 2013 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		Indicator Designation
1.	The percentage of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children:	100%	*R*
		Adults:	97.78%	
2.	The percentage of new Medicaid beneficiaries 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:	99.20%	*R*
		MI Adults:	99.45%	
		DD Children:	100%	
		DD Adults:	100%	
		Medicaid SA:	96.67%	
		Total:	98.72%	
3.	The percentage of new Medicaid beneficiaries during the quarter starting any needed ongoing service within 14 days of a non-emergent face-to-face assessment with a professional.	MI Children:	99.47%	*R*
		MI Adults:	98.50%	
		DD Children:	100%	
		DD Adults:	92.86%	
		Medicaid SA:	100%	
		Total:	99.22%	
4a.	The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days	Children:	100%	*R*
		Adults:	91.36%	
4b.	The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.	100%		*R*
5.	The percent of Medicaid recipients having received PIHP managed services.	6.88%		*R*
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.	99.73%		*R*
8.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who are employed competitively.	MI Adults:	9.91%	*R*
		DD Adults:	9.81%	
		MI/DD Adults:	8.31%	

Table 3-21—Performance Measure Results *for* CMH Affiliation of Mid-Michigan				
	Indicator	Reported Rate		Indicator Designation
9.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.	MI Adults:	82.16%	*R*
		DD Adults:	60.54%	
		MI/DD Adults:	56.69%	
10.	The percentage of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge	Children:	10.00%	*R*
		Adults:	13.83%	
13.	The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	13.87%		*R*
14.	The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	47.80%		*R*

Strengths

CMH Affiliation of Mid-Michigan's excellent processes to monitor the activities of its CMHSPs and CAs were well documented. It was evident that the PIHP worked actively with the affiliates to identify ways to improve performance. **CMH Affiliation of Mid-Michigan** maintained a consistent staff whose members were responsible for performance indicator reporting and who were experienced and well-versed regarding the data and processes necessary to report complete and accurate rates. Staff members were proactive in addressing areas of concern where potential indicators were vague and required clarification prior to implementation.

Recommendations

HSAG noted no issues or concerns with the processes in place at **CMH Affiliation of Mid-Michigan** that would require a corrective action. The organization worked proactively with its CMHSPs to identify areas where performance could be improved. The PIHP should continue its efforts to deal with the challenge of obtaining detailed information from MDCH so it can reconcile its data to Community Health Automated Medicaid Processing System (CHAMPS). As Mid-South Substance Abuse Commission (Mid-South) ends its role as a CA and **CMH Affiliation of Mid-Michigan** assumes this role, the PIHP should document the transition and any challenges it encounters.

Summary Assessment Related to Quality, Timeliness, and Access

CMH Affiliation of Mid-Michigan's performance indicators across the domains of **quality**, **timeliness**, and **access** received validation findings of *Report*, reflecting that the indicators were compliant with MDCH specifications and rates could be reported. The PIHP met four of the five contractually required performance standards related to the **quality** of services provided by the PIHP, falling below the 95 percent threshold for timely follow-up care for adults after discharge from a psychiatric inpatient unit. 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 for MI, DD, and MI/DD adults who were employed competitively or who earned minimum wage were above the statewide rates, as was the percentage of MI adults who lived in a private residence. However, the rate of DD adults living in a private residence fell below the statewide average. **CMH Affiliation of Mid-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, with below-standard rates for timeliness of first service for DD adults and follow-up care for adults discharged from a psychiatric inpatient unit. The PIHP's penetration rate was lower than the statewide rate.

CMH Affiliation of Mid-Michigan met the minimum performance standard for 17 of the 19 indicators; achieved rates above the statewide average for eight of the 10 indicators without a specified performance benchmark; and demonstrated strong performance across the three domains of **quality**, **timeliness**, and **access**.

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 2013 Validation of Performance Measures Report for **CMH for Central Michigan** includes additional details of the validation results.

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

	Indicator	Reported Rate		Indicator Designation
1.	The percentage of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children:	100%	*R*
		Adults:	97.12%	
2.	The percentage of new Medicaid beneficiaries 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:	96.73%	*R*
		MI Adults:	98.45%	
		DD Children:	100%	
		DD Adults:	100%	
		Medicaid SA:	100%	
		Total:	97.94%	
3.	The percentage of new Medicaid beneficiaries during the quarter starting any needed ongoing service within 14 days of a non-emergent face-to-face assessment with a professional.	MI Children:	95.98%	*R*
		MI Adults:	99.47%	
		DD Children:	100%	
		DD Adults:	100%	
		Medicaid SA:	100%	
		Total:	98.10%	
4a.	The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days	Children:	100%	*R*
		Adults:	96.77%	
4b.	The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.	100%		*R*
5.	The percent of Medicaid recipients having received PIHP managed services.	10.09%		*R*
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.	99.81%		*R*
8.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who are employed competitively.	MI Adults:	10.13%	*R*
		DD Adults:	8.21%	
		MI/DD Adults:	4.57%	

Table 3-22—Performance Measure Results *for* CMH for Central Michigan			
Indicator		**Reported Rate**	**Indicator Designation**
9.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.	MI Adults: 79.14% DD Adults: 15.80% MI/DD Adults: 13.85%	*R*
10.	The percentage of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge	Children: 0.00% Adults: 12.12%	*R*
13.	The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	28.57%	*R*
14.	The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	56.10%	*R*

Strengths

CMH for Central Michigan used a uniform Web-based electronic health record (EHR) system called CIGMMO, named after the counties in its service area (Clare, Isabella, Gladwin, Mecosta, Midland, and Osceola) to facilitate data reporting and analysis efforts. The staff members responsible for the PIHP's performance indicator data were well experienced in the reporting process. Most data were received electronically and submissions to MDCH of encounter and quality improvement (QI) data were highly automated. The PIHP's oversight of QI data completeness and performance indicator rates was exceptional, with dramatic improvement in the completeness of the minimum wage data element. The PIHP conducted an annual on-site review of the CA to ensure compliance with contract requirements.

Recommendations

CMH for Central Michigan could consider implementing formal oversight of the accuracy of claims data entry. Although the volume of paper claims was small, a formal process to review even a small percentage of entries was recommended. Alternatively, **CMH for Central Michigan** could employ optical character recognition (OCR) technology as a means to electronically capture data submitted on paper claims, which would further reduce manual data entry. **CMH for Central Michigan** should consider reviewing detail behind the CA's reported exceptions to ensure there is documentation to support the exceptions. The PIHP should continue to work with MDCH to enhance its ability to view warehouse data and enable comprehensive reconciliation activities. **CMH for Central Michigan** should create step-by-step documentation of its process for reviewing, validating, and submitting performance indicator data.

Summary Assessment Related to Quality, Timeliness, and Access

CMH for Central Michigan's performance indicators across the domains of **quality**, **timeliness**, and **access** received validation findings of *Report*, reflecting that the indicators were compliant with MDCH specifications and rates could be reported. The PIHP met all contractually required

performance standards related to the **quality** of services provided by the PIHP. For the remaining indicators in the **quality** domain, **CMH for Central Michigan** demonstrated mostly above-average results. The PIHP's HSW rate exceeded the statewide rate. The rates for MI and DD adults who were employed competitively were higher than the statewide rates, while the rate for MI/DD adults was lower than the statewide rate. The rate 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. **CMH for Central Michigan** 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.

CMH for Central Michigan met the minimum performance standard for all 19 indicators; achieved rates above the statewide average for seven of the 10 indicators without a specified performance benchmark; and demonstrated excellent performance across the three domains of **quality**, **timeliness**, and **access**.

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 2013 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		Indicator Designation
1.	The percentage of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children:	100%	*R*
		Adults:	100%	
2.	The percentage of new Medicaid beneficiaries 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:	99.36%	*R*
		MI Adults:	100%	
		DD Children:	100%	
		DD Adults:	100%	
		Medicaid SA:	95.12%	
		Total:	98.81%	
3.	The percentage of new Medicaid beneficiaries during the quarter starting any needed ongoing service within 14 days of a non-emergent face-to-face assessment with a professional.	MI Children:	100%	*R*
		MI Adults:	95.71%	
		DD Children:	100%	
		DD Adults:	96.30%	
		Medicaid SA:	97.06%	
		Total:	97.82%	
4a.	The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days	Children:	100%	*R*
		Adults:	99.01%	
4b.	The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.	50.00%		*R*
5.	The percent of Medicaid recipients having received PIHP managed services.	6.93%		*R*
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.	98.06%		*R*
8.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who are employed competitively.	MI Adults:	9.14%	*R*
		DD Adults:	9.29%	
		MI/DD Adults:	6.76%	

Table 3-23—Performance Measure Results *for* CMH Partnership of Southeastern Michigan				
	Indicator	**Reported Rate**		**Indicator Designation**
9.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.	MI Adults:	87.35%	*NR*
		DD Adults:	72.43%	
		MI/DD Adults:	77.50%	
10.	The percentage of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge	Children:	9.52%	*R*
		Adults:	11.11%	
13.	The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	24.90%		*R*
14.	The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	32.59%		*R*

Strengths

CMH Partnership of Southeastern Michigan demonstrated continued strength by using a uniform data system. Nearly all claims and encounter data were received by affiliates electronically, mitigating concerns with data entry errors. While the E.II system upgrade to meet CMS' Meaningful Use Standards requirements occurred in 2012, no downtime or loss of data occurred. Careful planning and volume comparisons ensured no data were compromised. **CMH Partnership of Southeastern Michigan** worked closely with its vendor during this time, achieving a successful outcome. The PIHP continued to refine processes related to quality and performance indicator review.

Recommendations

CMH Partnership of Southeastern Michigan must work quickly and aggressively to resolve the systematic issues related to incomplete minimum wage data. MDCH and the PIHP's vendor may be of great assistance in identifying the source of the issue. While the recovery-oriented system of care (ROSC) for consumers with substance abuse issues has proven to be successful, the PIHP should continue to resolve data-reporting challenges it faces because of this change. **CMH Partnership of Southeastern Michigan** should consider performing an ad-hoc review of exception documentation by affiliates to ensure that interpretation of exception criteria continues to be uniform, and that documentation supports the exceptions. The PIHP should continue its efforts to closely monitor performance for quality improvement and performance indicator data. As the regional structure changes, the PIHP should carefully document any process, system, or data oversight changes that occur as a result of this shift.

Summary Assessment Related to Quality, Timeliness, and Access

CMH Partnership of Southeastern Michigan's performance indicators related to **quality** were compliant with MDCH specifications, except for Indicator 9, which received a designation of *Not Reported* 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, falling below the 95 percent threshold for timely follow-up care for adults after discharge from a detox unit. 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 and DD adults who were employed competitively were higher than the statewide rates, while the rate for MI/DD fell below the statewide score. The rates for MI, DD, and MI/DD adults who earned minimum wage exceeded the statewide rates. The rate of DD adults living in a private residence was higher that 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 compliant with MDCH specifications. **CMH Partnership of Southeastern Michigan** met the contractually required performance standards for 16 of the 17 indicators related to **timeliness** of and **access** to services provided by the PIHP, with a below-standard rate for timely follow-up care for adults after discharge from a detox unit. The PIHP's penetration rate fell below the statewide rate.

CMH Partnership of Southeastern Michigan met the minimum performance standard for 18 of the 19 indicators; achieved rates above the statewide average for six of the 10 indicators without a specified performance benchmark; and demonstrated strong performance across the three domains of **quality**, **timeliness**, and **access**.

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 2013 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		Indicator Designation
1.	The percentage of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children:	100%	*R*
		Adults:	97.49%	
2.	The percentage of new Medicaid beneficiaries 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:	97.18%	*R*
		MI Adults:	95.36%	
		DD Children:	98.04%	
		DD Adults:	97.73%	
		Medicaid SA:	99.89%	
		Total:	97.94%	
3.	The percentage of new Medicaid beneficiaries during the quarter starting any needed ongoing service within 14 days of a non-emergent face-to-face assessment with a professional.	MI Children:	99.10%	*R*
		MI Adults:	96.74%	
		DD Children:	97.26%	
		DD Adults:	96.34%	
		Medicaid SA:	99.87%	
		Total:	98.58%	
4a.	The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days	Children:	99.19%	*R*
		Adults:	99.22%	
4b.	The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.	100%		*R*
5.	The percent of Medicaid recipients having received PIHP managed services.	7.41%		*R*
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.	99.67%		*R*
8.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who are employed competitively.	MI Adults:	4.18%	*R*
		DD Adults:	2.45%	
		MI/DD Adults:	3.61%	

Table 3-24—Performance Measure Results *for* Detroit-Wayne County CMH Agency				
	Indicator	**Reported Rate**		**Indicator Designation**
9.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.	MI Adults:	58.33%	*R*
		DD Adults:	11.81%	
		MI/DD Adults:	32.14%	
10.	The percentage of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge	Children:	10.62%	*R*
		Adults:	17.78%	
13.	The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	21.84%		*R*
14.	The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	21.16%		*R*

Strengths

Detroit-Wayne County CMH Agency had a stable and dedicated team responsible for the quality of services provided to its consumers and for performance indicator reporting. It was evident that the staff members were well acquainted with the performance indicators, and were actively monitoring performance and exploring ways to further enhance care and performance. Active monitoring processes included root cause analysis for below-standard performance and work groups to troubleshoot issues as they were identified. **Detroit-Wayne County CMH Agency** had good communication with its Managers of Comprehensive Provider Networks (MCPNs). The PIHP contracted with Peter Chang Enterprises, Inc. (PCE), a provider of electronic health record solutions to several of Michigan's behavioral health organizations. The use of systems constructed by the same vendor helped to ensure the standardization of data used for performance indicator reporting across the PIHP. **Detroit-Wayne County CMH Agency** used MH-WIN, a centralized system supported by PCE. MCPNs accessed MH-WIN through a host vendor, Pioneer. For targeted users, the centralized system had the capacity to communicate through instant messaging.

Recommendations

Detroit-Wayne County CMH Agency should work with MDCH to reconcile the quality improvement data elements. **Detroit-Wayne County CMH Agency** should also continue its efforts to identify areas of concern and focus efforts on improving performance where rates fall below MDCH's expected thresholds. The PIHP should also continue its efforts to educate providers to run their own reports to better manage performance.

Summary Assessment Related to Quality, Timeliness, and Access

Detroit-Wayne County CMH Agency's performance indicators across the domains of **quality**, **timeliness**, and **access** received validation findings of *Report*, reflecting that the indicators were compliant with MDCH specifications and rates could be reported. The PIHP met four of the five contractually required performance standards related to the **quality** of services provided by the

PIHP, exceeding the standard for readmission for adults. 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. **Detroit-Wayne County CMH Agency** met all 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 met the minimum performance standard for 18 of the 19 indicators; achieved rates above the statewide average for three of the 10 indicators without a specified performance benchmark; and demonstrated strong performance across the three domains of **quality**, **timeliness**, and **access**.

Genesee County CMH

Findings

Table 3-25 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2013 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		Indicator Designation
1.	The percentage of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children:	98.60%	*R*
		Adults:	99.78%	
2.	The percentage of new Medicaid beneficiaries 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:	99.29%	*R*
		MI Adults:	100%	
		DD Children:	100%	
		DD Adults:	100%	
		Medicaid SA:	95.51%	
		Total:	98.65%	
3.	The percentage of new Medicaid beneficiaries during the quarter starting any needed ongoing service within 14 days of a non-emergent face-to-face assessment with a professional.	MI Children:	98.94%	*R*
		MI Adults:	97.79%	
		DD Children:	100%	
		DD Adults:	100%	
		Medicaid SA:	95.62%	
		Total:	97.34%	
4a.	The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days	Children:	95.65%	*R*
		Adults:	95.88%	
4b.	The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.	96.34%		*R*
5.	The percent of Medicaid recipients having received PIHP managed services.	7.11%		*R*
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.	98.92%		*R*
8.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who are employed competitively.	MI Adults:	4.25%	*R*
		DD Adults:	6.10%	
		MI/DD Adults:	4.23%	

Table 3-25—Performance Measure Results *for* Genesee County CMH			
	Indicator	**Reported Rate**	**Indicator Designation**
9.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.	MI Adults: 60.75% DD Adults: 13.56% MI/DD Adults: 20.93%	*R*
10.	The percentage of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge	Children: 1.89% Adults: 14.77%	*R*
13.	The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	6.53%	*R*
14.	The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	43.24%	*R*

Strengths

Genesee County CMH's system remained stable, with few changes to processes over the past year. Sound procedures governed encounter, quality, and eligibility data, with the majority of the data being collected or transmitted electronically, enhancing data accuracy. The PIHP continued to explore ways to enhance performance and quality improvement activities, and also expanded opportunities for data analytics and reporting. **Genesee County CMH** produced exception reports monthly in order to closely monitor providers that may need more follow-up or who need education or reinforcement for documentation requirements. The PIHP continued to research and communicate issues and challenges related to Community Health Automated Medicaid Processing System (CHAMPS) to MDCH. While the same issues and challenges **Genesee County CMH** faced with CHAMPS last year have not been resolved, the PIHP was proactive and consistent in its communications to MDCH and used available reports to mitigate those challenges.

Recommendations

Genesee County CMH should continue to communicate concerns and barriers regarding CHAMPS' limitations to MDCH. The PIHP should continue its close monitoring of completeness for encounter, quality improvement, and performance indicator data. As the PIHP's regional structure changes take place, **Genesee County CMH** should carefully document any process, system, or data oversight changes that result from this shift.

Summary Assessment Related to Quality, Timeliness, and Access

Genesee County CMH's performance indicators across the domains of **quality**, **timeliness**, and **access** received validation findings of *Report*, reflecting that the indicators were compliant with MDCH specifications and rates could be reported. 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 lower 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. **Genesee County CMH** 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.

Genesee County CMH met the minimum performance standard for all 19 indicators; achieved rates above the statewide average for one of the 10 indicators without a specified performance benchmark; and demonstrated excellent performance across the three domains of **quality**, **timeliness**, and **access**.

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 2013 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		Indicator Designation
1.	The percentage of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children:	100%	*R*
		Adults:	100%	
2.	The percentage of new Medicaid beneficiaries 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:	98.51%	*R*
		MI Adults:	100%	
		DD Children:	100%	
		DD Adults:	100%	
		Medicaid SA:	96.48%	
		Total:	98.12%	
3.	The percentage of new Medicaid beneficiaries during the quarter starting any needed ongoing service within 14 days of a non-emergent face-to-face assessment with a professional.	MI Children:	97.47%	*R*
		MI Adults:	98.33%	
		DD Children:	100%	
		DD Adults:	100%	
		Medicaid SA:	97.94%	
		Total:	97.98%	
4a.	The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days	Children:	100%	*R*
		Adults:	100%	
4b.	The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.	100%		*R*
5.	The percent of Medicaid recipients having received PIHP managed services.	5.71%		*R*
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.	98.74%		*R*
8.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who are employed competitively.	MI Adults:	8.29%	*R*
		DD Adults:	8.94%	
		MI/DD Adults:	8.24%	

Table 3-26—Performance Measure Results *for* Lakeshore Behavioral Health Alliance				
	Indicator	**Reported Rate**		**Indicator Designation**
9.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.	MI Adults:	74.36%	*R*
		DD Adults:	29.44%	
		MI/DD Adults:	28.03%	
10.	The percentage of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge	Children:	10.34%	*R*
		Adults:	14.06%	
13.	The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	9.68%		*R*
14.	The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	55.67%		*R*

Strengths

Lakeshore Behavioral Health Alliance, its affiliates, and the CA continued to demonstrate a strong, collaborative approach to data quality for claims/encounter, eligibility, quality improvement, and performance indicator data. Frequent communications, thorough documentation, and consistent processes facilitated data review, quality improvement, and performance indicator reporting efforts. Acting on the prior year's recommendation, the PIHP was able to identify and correct the gap in encounter data submission responsible for the decline in its penetration rate the previous year.

Recommendations

Lakeshore Behavioral Health Alliance was encouraged to document any changes made to processes as a result of the restructuring of the PIHPs into regions. As plans take shape in the restructuring, meeting minutes, testing, or other documentation should be retained for auditors' review next year. As the Muskegon CMH/PIHP considers implementing a new clinical system in the next year, planning, testing, and thorough documentation will help ensure a successful transition. The PIHP should continue its close monitoring of performance indicator rates as well as affiliate and CA data quality.

Summary Assessment Related to Quality, Timeliness, and Access

Lakeshore Behavioral Health Alliance's performance indicators across the domains of **quality**, **timeliness**, and **access** received validation findings of *Report*, reflecting that the indicators were compliant with MDCH specifications and rates could be reported. 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 was lower than the statewide rate. The rates for MI, DD, and MI/DD adults who were employed competitively were higher than the statewide rates. The rates for MI and DD adults who earned minimum wage exceeded the statewide rates, while the rate for MI/DD adults 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. The PIHP's penetration rate was lower than the statewide rate. **Lakeshore Behavioral Health Alliance** met the contractually required performance standards for all indicators related to **timeliness** of and **access** to services provided by the PIHP.

Lakeshore Behavioral Health Alliance met the minimum performance standard for all 19 indicators; achieved rates above the statewide average for six of the 10 indicators without a specified performance benchmark; and demonstrated excellent performance across the three domains of **quality**, **timeliness**, and **access**.

LifeWays

Findings

Table 3-27 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2013 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		Indicator Designation
1.	The percentage of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children:	94.12%	*R*
		Adults:	96.77%	
2.	The percentage of new Medicaid beneficiaries 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:	73.13%	*R*
		MI Adults:	82.43%	
		DD Children:	92.86%	
		DD Adults:	88.89%	
		Medicaid SA:	100%	
		Total:	84.36%	
3.	The percentage of new Medicaid beneficiaries during the quarter starting any needed ongoing service within 14 days of a non-emergent face-to-face assessment with a professional.	MI Children:	74.65%	*R*
		MI Adults:	96.05%	
		DD Children:	57.14%	
		DD Adults:	81.82%	
		Medicaid SA:	100%	
		Total:	87.79%	
4a.	The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days	Children:	93.33%	*R*
		Adults:	95.12%	
4b.	The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.	100%		*R*
5.	The percent of Medicaid recipients having received PIHP managed services.	7.02%		*R*
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.	100%		*R*
8.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who are employed competitively.	MI Adults:	5.98%	*R*
		DD Adults:	5.06%	
		MI/DD Adults:	5.18%	

Table 3-27—Performance Measure Results *for* LifeWays			
Indicator		**Reported Rate**	**Indicator Designation**
9.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.	MI Adults: 72.13% DD Adults: 63.64% MI/DD Adults: 64.29%	*R*
10.	The percentage of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge	Children: 13.33% Adults: 13.79%	*R*
13.	The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	16.03%	*R*
14.	The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	41.02%	*R*

Strengths

LifeWays took action as a result of the previous year's recommendations to review and improve performance indicator rates, which were quite low at that time. The PIHP conducted a "lean" process improvement assessment and discovered opportunities for streamlining existing, redundant processes. Through its monitoring process, **LifeWays** staff discovered continued deficiencies for some performance indicators and proactively submitted a corrective action plan to MDCH. **LifeWays** increased its monitoring of quality improvement data completeness, including education and "report cards" for providers, resulting in a significant improvement in the capture of required data elements.

Recommendations

LifeWays should continue to collaborate with the system vendor, PCE, to explore additional automated methods to streamline compilation and review processes for performance indicator data (e.g., building edits or other mechanisms in the system to facilitate performance indicator clean-up efforts). Because there were some late encounter submissions by the CA, the PIHP should consider using an MS Outlook calendar reminder to check for CA encounter data submissions. **LifeWays** should develop a step-by-step document outlining the performance indicator review and submission process in addition to an updated policy and procedure, and work toward expanding validation efforts to include all events to verify that clinical notes reflect the event accurately. **LifeWays** should research the issue observed during primary source verification related to transport services counting toward a face-to-face, ongoing service visit to ensure that this particular code no longer counts as a numerator event.

Summary Assessment Related to Quality, Timeliness, and Access

LifeWays' performance indicators across the domains of **quality**, **timeliness**, and **access** received validation findings of *Report*, reflecting that the indicators were compliant with MDCH specifications and rates could be reported. The PIHP met four of the five contractually required

performance standards related to the **quality** of services provided by the PIHP, falling below the 95 percent benchmark for follow-up care for children discharged from a psychiatric unit. 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, DD, and MI/DD adults who were employed competitively were lower than the statewide rates. The rates for MI, DD, and MI/DD adults who earned minimum wage were higher than the statewide rates. The rate for MI adults who live in a private residence was higher than the statewide score, while the rate for DD adults fell below the statewide rate. **LifeWays** met the contractually required performance standards for six of the 17 indicators related to **timeliness** of and **access** to services provided by the PIHP. The PIHP's penetration rate was higher than the statewide rate.

LifeWays met the minimum performance standard for eight of the 19 indicators and achieved rates above the statewide average for six of the 10 indicators without a specified performance benchmark, suggesting opportunities for improvement across the three domains of **quality**, **timeliness**, and **access**.

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 2013 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		Indicator Designation
1.	The percentage of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children:	98.66%	*R*
		Adults:	99.48%	
2.	The percentage of new Medicaid beneficiaries 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:	98.18%	*R*
		MI Adults:	99.32%	
		DD Children:	85.71%	
		DD Adults:	95.24%	
		Medicaid SA:	100%	
		Total:	98.62%	
3.	The percentage of new Medicaid beneficiaries during the quarter starting any needed ongoing service within 14 days of a non-emergent face-to-face assessment with a professional.	MI Children:	98.80%	*R*
		MI Adults:	99.35%	
		DD Children:	95.45%	
		DD Adults:	100%	
		Medicaid SA:	100%	
		Total:	99.39%	
4a.	The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days	Children:	98.73%	*R*
		Adults:	93.85%	
4b.	The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.	100%		*R*
5.	The percent of Medicaid recipients having received PIHP managed services.	5.97%		*R*
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.	99.59%		*R*
8.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who are employed competitively.	MI Adults:	6.86%	*R*
		DD Adults:	6.20%	
		MI/DD Adults:	4.32%	

Table 3-28—Performance Measure Results *for* Macomb County CMH Services			
	Indicator	**Reported Rate**	**Indicator Designation**
9.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.	MI Adults: 58.33% DD Adults: 38.50% MI/DD Adults: 29.09%	*R*
10.	The percentage of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge	Children: 11.63% Adults: 18.88%	*R*
13.	The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	15.94%	*R*
14.	The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	34.80%	*R*

Strengths

Macomb County CMH Services upgraded its system, FOCUS, to comply with Meaningful Use requirements. The PIHP worked closely with the vendor to ensure that back-end data changes were not apparent to system users, and changes to the front-end interface and forms for data collection were clearly communicated to users. The PIHP planned effectively for the transition by adding a position for a help desk staff member to assist with issues and funnel them to the appropriate staff to address. Thorough testing and volume comparisons ensured data consistency and completeness. **Macomb County CMH Services** took action to improve the completeness of the minimum wage data element, which increased to well above the 95 percent threshold.

Recommendations

Macomb County CMH Services should consider preparing exception reports more frequently to monitor agencies that continue to need the most follow-up. As the shift to transfer data collection from CareNet to FOCUS occurs, **Macomb County CMH Services** should maintain thorough documentation of any changes to systems or processes for auditor review. The PIHP should continue efforts to collect and report National Provider Identifier (NPI) and financial cost data to MDCH, ensuring compliance with MDCH expectations and timelines.

Summary Assessment Related to Quality, Timeliness, and Access

Macomb County CMH Services' performance indicators across the domains of **quality**, **timeliness**, and **access** received validation findings of *Report*, reflecting that the indicators were compliant with MDCH specifications and rates could be reported. The PIHP met three of the five contractually required performance standards related to the **quality** of services provided by the PIHP, falling below the 95 percent benchmark for follow-up care for adults discharged from a psychiatric inpatient and exceeding the 15 percent standard for the readmission rate for adults. 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. **Macomb County CMH Services** met the contractually required performance standards for 15 of the 17 indicators related to **timeliness** of and **access** to services provided by the PIHP, with below-standard rates for timely assessments for DD children and follow-up care for MI adults. The PIHP's penetration rate was lower than the statewide rate.

Macomb County CMH Services met the minimum performance standard for 16 of the 19 indicators; achieved rates above the statewide average for two of the 10 indicators without a specified performance benchmark; and demonstrated strong performance across the three domains of **quality**, **timeliness**, and **access**.

network180

Findings

Table 3-29 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2013 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		Indicator Designation
1.	The percentage of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children:	98.68%	*R*
		Adults:	95.88%	
2.	The percentage of new Medicaid beneficiaries 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:	98.44%	*R*
		MI Adults:	98.71%	
		DD Children:	100%	
		DD Adults:	100%	
		Medicaid SA:	99.48%	
		Total:	98.72%	
3.	The percentage of new Medicaid beneficiaries during the quarter starting any needed ongoing service within 14 days of a non-emergent face-to-face assessment with a professional.	MI Children:	81.91%	*R*
		MI Adults:	87.01%	
		DD Children:	100%	
		DD Adults:	100%	
		Medicaid SA:	85.09%	
		Total:	84.17%	
4a.	The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days	Children:	85.37%	*R*
		Adults:	85.71%	
4b.	The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.	92.59%		*R*
5.	The percent of Medicaid recipients having received PIHP managed services.	7.12%		*R*
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.	99.40%		*R*
8.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who are employed competitively.	MI Adults:	9.76%	*R*
		DD Adults:	6.48%	
		MI/DD Adults:	9.27%	

Table 3-29—Performance Measure Results *for* network180				
	Indicator	**Reported Rate**		**Indicator Designation**
9.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.	MI Adults:	81.31%	*R*
		DD Adults:	18.91%	
		MI/DD Adults:	27.98%	
10.	The percentage of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge	Children:	4.65%	*R*
		Adults:	17.14%	
13.	The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	10.41%		*R*
14.	The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	49.85%		*R*

Strengths

network180 continued to explore ways to improve systems and processes. The PIHP was actively and carefully planning its transition to a new electronic clinical record (ECR) system, with the transition scheduled to occur within the next year. Information technology and clinical staff were proactively planning what they want to gain from the new system. **network180** will require ECR use by its contracted agencies in the future. Staff members responsible for performance measure reporting were meticulous about data accuracy, and documentation of **network180**'s process for measure reporting was thorough.

Recommendations

network180 was encouraged to thoroughly document not only the transition to the new ECR but also any changes made to processes resulting from the restructuring of the PIHPs into regions. The PIHP should continue its efforts to incorporate electronic mechanisms in its system for exception tracking. **network180** should continue to focus efforts on improving performance for indicator rates.

Summary Assessment Related to Quality, Timeliness, and Access

network180's performance indicators across the domains of **quality**, **timeliness**, and **access** received validation findings of *Report*, reflecting that the indicators were compliant with MDCH specifications and rates could be reported. The PIHP met one of the five contractually required performance standards related to the **quality** of services provided by the PIHP, meeting the 15 percent benchmark for the readmission rate for children. For the remaining indicators in the **quality** domain, **network180** demonstrated mixed results. The PIHP's HSW rate was slightly higher than the statewide rate. The rates for MI 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 competitively employed DD adults as well as 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. **network180** met the contractually required performance standards for 10 of the 17 indicators related to **timeliness** of and **access** to services provided by the PIHP, falling below the 95 percent standard for all indicators of follow-up care as well as most indicators for timeliness of first service. The PIHP's penetration rate fell below the statewide rate.

network180 met the minimum performance standard for 11 of the 19 indicators; achieved rates above the statewide average for five of the 10 indicators without a specified performance benchmark; and demonstrated mixed performance across the three domains of **quality**, **timeliness**, and **access**.

NorthCare

Findings

Table 3-30 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2013 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		Indicator Designation
1.	The percentage of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children:	100%	*R*
		Adults:	99.34%	
2.	The percentage of new Medicaid beneficiaries 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:	97.94%	*R*
		MI Adults:	98.99%	
		DD Children:	100%	
		DD Adults:	100%	
		Medicaid SA:	99.09%	
		Total:	98.81%	
3.	The percentage of new Medicaid beneficiaries during the quarter starting any needed ongoing service within 14 days of a non-emergent face-to-face assessment with a professional.	MI Children:	98.67%	*R*
		MI Adults:	98.77%	
		DD Children:	100%	
		DD Adults:	100%	
		Medicaid SA:	100%	
		Total:	99.31%	
4a.	The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days	Children:	87.50%	*R*
		Adults:	97.14%	
4b.	The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.	100%		*R*
5.	The percent of Medicaid recipients having received PIHP managed services.	8.03%		*R*
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.	98.90%		*R*
8.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who are employed competitively.	MI Adults:	10.45%	*R*
		DD Adults:	7.33%	
		MI/DD Adults:	3.51%	

Table 3-30—Performance Measure Results *for* NorthCare			
Indicator		**Reported Rate**	**Indicator Designation**
9.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.	MI Adults: 76.65% DD Adults: 32.39% MI/DD Adults: 35.53%	*R*
10.	The percentage of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge	Children: 7.69% Adults: 15.79%	*R*
13.	The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	18.18%	*R*
14.	The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	54.70%	*R*

Strengths

NorthCare and its affiliates shared the same information system structure through PCE to facilitate uniform data reporting and enable streamlined analysis and monitoring of data. The CA continued to use the NetSmart system, which has been stable and reliable. The PIHP continued to perform well on all performance indicators and demonstrate full compliance with requirements for the completeness of quality improvement data. Thorough documentation was a noted strength for **NorthCare** and helped to ensure that processes and procedures would continue to be followed seamlessly in the event of a staff vacancy. **NorthCare** proactively planned for new State requirements and monitored its vendor, PCE. The PIHP and CA were integrated and collaborated closely on quality and performance indicator reporting requirements.

Recommendations

NorthCare should carefully document any changes to systems, processes, or staff as a result of the migration to PIHP regions and the eventual absorption of the CA. If the NetSmart system is phased out, the PIHP should explore ways to obtain legacy CA data as it moves forward in absorbing CA functions and consider reporting implications as this change occurs. **NorthCare** should continue its diligent monitoring of performance indicator rates.

Summary Assessment Related to Quality, Timeliness, and Access

NorthCare's performance indicators across the domains of **quality**, **timeliness**, and **access** received validation findings of *Report*, reflecting that the indicators were compliant with MDCH specifications and rates could be reported. The PIHP met three of the five contractually required performance standards related to the **quality** of services provided by the PIHP, falling below the 95 percent standard for follow-up care for children and exceeding the 15 percent benchmark for adult readmissions. For the remaining indicators in the **quality** domain, **NorthCare** demonstrated mixed results. The PIHP's HSW rate fell below the statewide rate. The rates for MI and DD adults who were employed competitively or earned minimum wage were higher than the statewide rates. The

rates for MI/DD adults for both measures 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. **NorthCare** met the contractually required performance standards for 16 of the 17 indicators related to **timeliness** of and **access** to services provided by the PIHP, with a below-standard rate for follow-up care for children. The PIHP's penetration rate exceeded the statewide rate.

NorthCare met the minimum performance standard for 17 of the 19 indicators; achieved rates above the statewide average for six of the 10 indicators without a specified performance benchmark; and demonstrated strong performance across the three domains of **quality**, **timeliness**, and **access**.

Northern Affiliation

Findings

Table 3-31 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2013 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		Indicator Designation
1.	The percentage of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children:	100%	*R*
		Adults:	100%	
2.	The percentage of new Medicaid beneficiaries 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:	99.34%	*R*
		MI Adults:	98.86%	
		DD Children:	100%	
		DD Adults:	91.67%	
		Medicaid SA:	100%	
		Total:	99.05%	
3.	The percentage of new Medicaid beneficiaries during the quarter starting any needed ongoing service within 14 days of a non-emergent face-to-face assessment with a professional.	MI Children:	98.85%	*R*
		MI Adults:	97.56%	
		DD Children:	100%	
		DD Adults:	100%	
		Medicaid SA:	100%	
		Total:	98.82%	
4a.	The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days	Children:	100%	*R*
		Adults:	100%	
4b.	The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.	100%		*R*
5.	The percent of Medicaid recipients having received PIHP managed services.	7.52%		*R*
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.	99.08%		*R*
8.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who are employed competitively.	MI Adults:	9.14%	*R*
		DD Adults:	13.25%	
		MI/DD Adults:	18.40%	

Table 3-31—Performance Measure Results *for* Northern Affiliation			
Indicator		**Reported Rate**	**Indicator Designation**
9.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.	MI Adults: 58.41% DD Adults: 38.07% MI/DD Adults: 60.92%	*R*
10.	The percentage of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge	Children: 2.78% Adults: 2.13%	*R*
13.	The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	24.11%	*R*
14.	The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	55.89%	*R*

Strengths

Northern Affiliation and its affiliates used a uniform system, facilitating data reporting and organizational oversight activities. Clear communication, frequent monitoring of the affiliates and the CA, and diverse reports enhanced quality and performance improvement efforts. The PIHP was proactive in identifying opportunities to drill down and analyze available data for a variety of purposes. **Northern Affiliation** was able to resolve the issues it had experienced with CHAMPS during the previous year, and the penetration rate reflected increased completeness of encounter data.

Recommendations

Northern Affiliation should ensure that its affiliates continue efforts to monitor all quality improvement and performance indicator encounter data. As the shift to consolidate PIHPs occurs, the PIHP should maintain thorough documentation of any changes to systems, processes, and reporting structures for auditor review. The PIHP should continue efforts to obtain National Provider Identifiers for all appropriate providers and submit those encounters to the department as soon as it is feasible.

Summary Assessment Related to Quality, Timeliness, and Access

Northern Affiliation's performance indicators across the domains of **quality**, **timeliness**, and **access** received validation findings of *Report*, reflecting that the indicators were compliant with MDCH specifications and rates could be reported. 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 was lower than 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. **Northern**

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, with a below-standard rate for timely assessments for DD adults. The PIHP's penetration rate exceeded the statewide rate.

Northern Affiliation met the minimum performance standard for 18 of the 19 indicators; achieved rates above the statewide average for eight of the 10 indicators without a specified performance benchmark; and demonstrated excellent performance across the three domains of **quality**, **timeliness**, and **access**.

Northwest CMH Affiliation

Findings

Table 3-32 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2013 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		Indicator Designation
1.	The percentage of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children:	96.30%	*R*
		Adults:	100%	
2.	The percentage of new Medicaid beneficiaries 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:	99.29%	*R*
		MI Adults:	99.35%	
		DD Children:	100%	
		DD Adults:	100%	
		Medicaid SA:	100%	
		Total:	99.47%	
3.	The percentage of new Medicaid beneficiaries during the quarter starting any needed ongoing service within 14 days of a non-emergent face-to-face assessment with a professional.	MI Children:	97.92%	*R*
		MI Adults:	91.59%	
		DD Children:	100%	
		DD Adults:	71.43%	
		Medicaid SA:	100%	
		Total:	95.32%	
4a.	The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days	Children:	93.10%	*R*
		Adults:	90.20%	
4b.	The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.	100%		*R*
5.	The percent of Medicaid recipients having received PIHP managed services.	7.99%		*R*
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.	98.92%		*R*
8.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who are employed competitively.	MI Adults:	9.04%	*R*
		DD Adults:	6.95%	
		MI/DD Adults:	6.93%	

Table 3-32—Performance Measure Results *for* Northwest CMH Affiliation				
	Indicator	Reported Rate		Indicator Designation
9.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.	MI Adults:	91.07%	*R*
		DD Adults:	50.91%	
		MI/DD Adults:	72.95%	
10.	The percentage of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge	Children:	12.50%	*R*
		Adults:	12.33%	
13.	The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	6.95%		*R*
14.	The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	55.34%		*R*

Strengths

Northwest CMH Affiliation and its affiliates continued to work well together to ensure complete and accurate encounter, quality improvement, and performance indicator data were submitted to MDCH. Documentation to support each activity was readily accessible and thorough, and there was sufficient communication between the Community Mental Health (CMH) agencies, the CA, and the PIHP to ensure consistency in data submission and that reporting requirements were met.

Recommendations

Northwest CMH Affiliation should ensure that the CMHs and the CA continue efforts to monitor all encounter, quality improvement, and performance indicator data. As the shift to consolidate PIHPs occurs, each entity should maintain thorough documentation of any changes to systems, processes, or reporting structures for auditor review. The PIHP and the CMHs should continue efforts to obtain National Provider Identifiers for all providers and submit those encounters to MDCH.

Summary Assessment Related to Quality, Timeliness, and Access

Northwest CMH Affiliation's performance indicators across the domains of **quality**, **timeliness**, and **access** received validation findings of *Report*, reflecting that the indicators were compliant with MDCH specifications and rates could be reported. The PIHP met three of the five contractually required performance standards related to the **quality** of services provided by the PIHP, falling below the 95 percent standard for follow-up care for adults and children discharged from a psychiatric inpatient unit. For the remaining indicators in the **quality** domain, **Northwest CMH Affiliation** achieved mostly above-average results. The PIHP's HSW rate was lower than the statewide rate. The rates for MI and MI/DD adults who were employed competitively exceeded the statewide rates, while the rate for DD adults was lower than the statewide score. The rates for MI, DD, and MI/DD adults who 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. **Northwest CMH Affiliation** met the contractually required performance standards for 13 of the 17 indicators related to **timeliness** of and **access** to services provided by the PIHP, with below-standard rates for follow-up care for adults and children and timely first service for MI and DD adults. The PIHP's penetration rate exceeded the statewide rate.

Northwest CMH Affiliation met the minimum performance standard for 15 of the 19 indicators; achieved rates above the statewide average for seven of the 10 indicators without a specified performance benchmark; and demonstrated strong performance across the three domains of **quality**, **timeliness**, and **access**.

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 2013 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		Indicator Designation
1.	The percentage of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children:	90.16%	*R*
		Adults:	89.06%	
2.	The percentage of new Medicaid beneficiaries 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:	98.58%	*R*
		MI Adults:	100%	
		DD Children:	100%	
		DD Adults:	100%	
		Medicaid SA:	99.63%	
		Total:	99.57%	
3.	The percentage of new Medicaid beneficiaries during the quarter starting any needed ongoing service within 14 days of a non-emergent face-to-face assessment with a professional.	MI Children:	98.65%	*R*
		MI Adults:	100%	
		DD Children:	100%	
		DD Adults:	100%	
		Medicaid SA:	98.76%	
		Total:	99.26%	
4a.	The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days	Children:	100%	*R*
		Adults:	97.03%	
4b.	The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.	100%		*R*
5.	The percent of Medicaid recipients having received PIHP managed services.	8.48%		*R*
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.	99.77%		*R*
8.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who are employed competitively.	MI Adults:	8.35%	*R*
		DD Adults:	11.68%	
		MI/DD Adults:	9.07%	

Table 3-33—Performance Measure Results *for* Oakland County CMH Authority				
	Indicator	Reported Rate		Indicator Designation
9.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.	MI Adults:	57.14%	*R*
		DD Adults:	34.67%	
		MI/DD Adults:	24.93%	
10.	The percentage of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge	Children:	3.03%	*R*
		Adults:	11.90%	
13.	The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	16.68%		*R*
14.	The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	34.93%		*R*

Strengths

Oakland County CMH Authority successfully transitioned one of its core providers to its electronic medical record/transactional system—Oakland Data and Information Network (ODIN)—in October 2012 with no issues or data loss. The PIHP had previously transitioned all but one of its core providers to ODIN, and the use of a uniform system for capturing claims/encounter and clinical data continued to be a noted strength for this PIHP. **Oakland County CMH Authority** continued to develop dashboard reports with drill-down capabilities, enhancing its ability to review data completeness and other key operational tasks. Upon identifying poor performance by its crisis intake provider, the PIHP required a corrective action plan, and it has observed much better performance as a result. **Oakland County CMH Authority**'s approach to data analytics for use in achieving strategic goals and monitoring reporting requirements was among the industry's best.

Recommendations

Oakland County CMH Authority should carefully document any change to data capture and data oversight, as well as any system upgrades (i.e., implementing changes for Meaningful Use) that occur prior to the next on-site visit. **Oakland County CMH Authority** should develop a step-by-step performance indicator review and validation document so that additional staff can easily step into the role and understand the task if needed. **Oakland County CMH Authority** should continue to work with MDCH on any challenges with CHAMPS (i.e., reconciliation capabilities) and should continue to pursue information related to MDCH's calculation of quality indicator data completeness.

Summary Assessment Related to Quality, Timeliness, and Access

Oakland County CMH Authority's performance indicators across the domains of **quality**, **timeliness**, and **access** received validation findings of *Report*, reflecting that the indicators were compliant with MDCH specifications and rates could be reported. 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. **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, with below-standard rates for timely preadmission screenings for children and adults. The PIHP's penetration rate exceeded the statewide rate.

Oakland County CMH Authority met the minimum performance standard for 17 of the 19 indicators; achieved rates above the statewide average for six of the 10 indicators without a specified performance benchmark; and demonstrated strong performance across the three domains of **quality**, **timeliness**, and **access**.

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 2013 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		Indicator Designation
1.	The percentage of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children:	100%	*R*
		Adults:	100%	
2.	The percentage of new Medicaid beneficiaries 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%	*R*
		MI Adults:	100%	
		DD Children:	100%	
		DD Adults:	100%	
		Medicaid SA:	100%	
		Total:	100%	
3.	The percentage of new Medicaid beneficiaries during the quarter starting any needed ongoing service within 14 days of a non-emergent face-to-face assessment with a professional.	MI Children:	95.00%	*R*
		MI Adults:	96.55%	
		DD Children:	100%	
		DD Adults:	100%	
		Medicaid SA:	98.02%	
		Total:	97.27%	
4a.	The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days	Children:	91.67%	*R*
		Adults:	100%	
4b.	The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.	100%		*R*
5.	The percent of Medicaid recipients having received PIHP managed services.	5.17%		*R*
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.	100%		*R*
8.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who are employed competitively.	MI Adults:	5.58%	*R*
		DD Adults:	8.09%	
		MI/DD Adults:	2.65%	

Table 3-34—Performance Measure Results *for* Saginaw County CMH Authority				
	Indicator	Reported Rate		Indicator Designation
9.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.	MI Adults:	77.19%	*NR*
		DD Adults:	25.45%	
		MI/DD Adults:	31.58%	
10.	The percentage of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge	Children:	13.64%	*R*
		Adults:	14.29%	
13.	The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	9.29%		*R*
14.	The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	31.56%		*R*

Strengths

Saginaw County CMH Authority staff members responsible for performance indicator reporting had longevity with the PIHP and were familiar with performance indicator reporting processes. The PIHP provided thorough documentation and excellent validation of performance indicator data. After discovering a deficiency in its quality improvement file with minimum wage data element completeness for first quarter SFY 2013, the PIHP successfully corrected missing or invalid data and demonstrated during the on-site visit that it had achieved completeness above the 95 percent threshold. **Saginaw County CMH Authority** routinely produced and reviewed encounter trend reports that included CA data, enhancing the PIHP's ability to monitor and identify atypical trends.

Recommendations

Saginaw County CMH Authority should create a formal process for evaluating data entry and claims processing accuracy or consider acquiring OCR software, eliminating manual data entry as resources allow. The PIHP should build on its excellent oversight of CA data by incorporating performance indicator validation during ongoing on-site reviews of substance abuse providers and continue close monitoring of indicator rate performance.

Summary Assessment Related to Quality, Timeliness, and Access

Saginaw County CMH Authority's performance indicators related to **quality** were compliant with MDCH specifications except for Indicator 9, which received a designation of *Not Reported* 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, falling below the 95 percent standard for follow-up care for children. 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 compliant with MDCH specifications. **Saginaw County CMH Authority** met the contractually required performance standards for 16 of the 17 indicators related to **timeliness** of and **access** to services provided by the PIHP, with a below-standard rate for follow-up care for children. The PIHP's penetration rate was lower than the statewide rate.

Saginaw County CMH Authority met the minimum performance standard for 18 of the 19 indicators; achieved rates above the statewide average for three of the 10 indicators without a specified performance benchmark; and demonstrated strong performance across the three domains of **quality**, **timeliness**, and **access**.

Southwest Affiliation

Findings

Table 3-35 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2013 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		Indicator Designation
1.	The percentage of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children:	100%	*R*
		Adults:	100%	
2.	The percentage of new Medicaid beneficiaries 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:	99.30%	*R*
		MI Adults:	99.21%	
		DD Children:	90.91%	
		DD Adults:	100%	
		Medicaid SA:	77.55%	
		Total:	96.00%	
3.	The percentage of new Medicaid beneficiaries during the quarter starting any needed ongoing service within 14 days of a non-emergent face-to-face assessment with a professional.	MI Children:	98.98%	*R*
		MI Adults:	100%	
		DD Children:	85.71%	
		DD Adults:	100%	
		Medicaid SA:	98.28%	
		Total:	98.90%	
4a.	The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days	Children:	95.00%	*R*
		Adults:	98.72%	
4b.	The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.	100%		*R*
5.	The percent of Medicaid recipients having received PIHP managed services.	6.64%		*R*
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.	99.78%		*R*
8.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who are employed competitively.	MI Adults:	8.28%	*R*
		DD Adults:	10.15%	
		MI/DD Adults:	10.64%	

Table 3-35—Performance Measure Results *for* Southwest Affiliation			
Indicator		**Reported Rate**	**Indicator Designation**
9.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.	MI Adults: 80.69% DD Adults: 40.52% MI/DD Adults: 60.94%	*NR*
10.	The percentage of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge	Children: 8.33% Adults: 7.53%	*R*
13.	The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	27.45%	*R*
14.	The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	59.53%	*R*

Strengths

Southwest Affiliation and most of its affiliates used a uniform system, which facilitated data collection and extraction, analysis, and quality improvement efforts. Effective communication continued between the affiliates and the PIHP related to encounter, eligibility, quality improvement (QI), and performance indicator data. **Southwest Affiliation** and its affiliates worked diligently during the measurement period to ensure the transition from the PIHP's previous data system to its current behavioral health information system (Streamline) did not result in any loss of data.

Recommendations

Southwest Affiliation should continue to closely monitor QI data completeness The PIHP is encouraged to thoroughly document any changes made to processes as a result of the impending restructuring of the PIHPs. Because one affiliate had recently transitioned to the same system used by the other affiliates, it should document system changes and ensure no data are lost. The information technology staff should continue its efforts to cross-train individuals to validate the process of preparing performance indicator data.

Summary Assessment Related to Quality, Timeliness, and Access

Southwest Affiliation's performance indicators related to **quality** were compliant with MDCH specifications except for Indicator 9, which received a designation of *Not Reported* 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, **Southwest Affiliation** achieved above-average results for all indicators. 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 compliant with MDCH specifications. **Southwest Affiliation** met the contractually required performance standards for 14 of the 17 indicators related to **timeliness** of and **access** to services provided by the PIHP,

falling below the 95 percent standard for timely assessments for DD and SA adults and first service for DD children. The PIHP's penetration rate was lower than the statewide rate.

Southwest Affiliation met the minimum performance standard for 16 of the 19 indicators; achieved rates above the statewide average for nine of the 10 indicators without a specified performance benchmark; and demonstrated strong performance across the three domains of **quality**, **timeliness**, and **access**.

Thumb Alliance PIHP

Findings

Table 3-36 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2013 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		Indicator Designation
1.	The percentage of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children:	100%	*R*
		Adults:	100%	
2.	The percentage of new Medicaid beneficiaries 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%	*R*
		MI Adults:	100%	
		DD Children:	100%	
		DD Adults:	100%	
		Medicaid SA:	100%	
		Total:	100%	
3.	The percentage of new Medicaid beneficiaries during the quarter starting any needed ongoing service within 14 days of a non-emergent face-to-face assessment with a professional.	MI Children:	94.29%	*R*
		MI Adults:	95.15%	
		DD Children:	100%	
		DD Adults:	100%	
		Medicaid SA:	99.13%	
		Total:	96.85%	
4a.	The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days	Children:	95.65%	*R*
		Adults:	100%	
4b.	The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.	100%		*R*
5.	The percent of Medicaid recipients having received PIHP managed services.	8.23%		*R*
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.	99.64%		*R*
8.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who are employed competitively.	MI Adults:	7.33%	*R*
		DD Adults:	4.15%	
		MI/DD Adults:	4.12%	

Table 3-36—Performance Measure Results *for* Thumb Alliance PIHP			
	Indicator	**Reported Rate**	**Indicator Designation**
9.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.	MI Adults: 52.61% DD Adults: 11.85% MI/DD Adults: 10.69%	*R*
10.	The percentage of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge	Children: 25.71% Adults: 13.33%	*R*
13.	The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	15.63%	*R*
14.	The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	52.43%	*R*

Strengths

Thumb Alliance PIHP and its affiliates used a uniform system, facilitating data reporting and organizational oversight activities. During first quarter fiscal year 2013, **Thumb Alliance PIHP** upgraded its system, OASIS, to comply with Meaningful Use requirements. Thorough testing ensured data consistency and completeness. Clear communication, frequent monitoring of the affiliates, and diverse reports enhanced quality and performance improvement efforts, and the PIHP was proactive in identifying opportunities to drill down and analyze available data for a variety of purposes. **Thumb Alliance PIHP** continued its efforts to work proactively with MDCH to ensure it was compliant with data submission requirements. The PIHP continued to monitor encounter, quality improvement, and performance indicator data as a part of its operations.

Recommendations

Thumb Alliance PIHP and its affiliates should continue efforts to monitor all quality improvement and performance indicator encounter data as the new regional organization changes take place. In addition, as the shift to consolidate PIHPs occurs, **Thumb Alliance PIHP** should maintain thorough documentation of any changes to systems, processes, and reporting structures for auditor review.

Summary Assessment Related to Quality, Timeliness, and Access

Thumb Alliance PIHP's performance indicators across the domains of **quality**, **timeliness**, and **access** received validation findings of *Report*, reflecting that the indicators were compliant with MDCH specifications and rates could be reported. The PIHP met four of the five contractually required performance standards related to the **quality** of services provided by the PIHP, not meeting the 15 percent benchmark for readmissions for children. For the remaining indicators in the **quality** domain, **Thumb Alliance PIHP** demonstrated mostly below-average results. The PIHP's HSW rate exceeded the statewide rate. The rates for MI, DD, and MI/DD adults who were employed competitively or earned minimum wage were lower than the statewide rates. 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 score. **Thumb Alliance PIHP** met the contractually required performance standards for 16 of the 17 performance measures related to **timeliness** of and **access** to services provided by the PIHP, with a below-standard rate for first services for MI children. The PIHP's penetration rate exceeded the statewide rate.

Thumb Alliance PIHP met the minimum performance standard for 17 of the 19 indicators; achieved rates above the statewide average for three of the 10 indicators without a specified performance benchmark; and demonstrated strong performance across the three domains of **quality**, **timeliness**, and **access**.

Venture Behavioral Health

Findings

Table 3-37 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2013 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		Indicator Designation
1.	The percentage of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children:	95.77%	*R*
		Adults:	99.27%	
2.	The percentage of new Medicaid beneficiaries 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:	96.81%	*R*
		MI Adults:	99.82%	
		DD Children:	96.15%	
		DD Adults:	100%	
		Medicaid SA:	95.17%	
		Total:	98.03%	
3.	The percentage of new Medicaid beneficiaries during the quarter starting any needed ongoing service within 14 days of a non-emergent face-to-face assessment with a professional.	MI Children:	96.09%	*R*
		MI Adults:	98.78%	
		DD Children:	100%	
		DD Adults:	100%	
		Medicaid SA:	98.59%	
		Total:	98.16%	
4a.	The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days	Children:	100%	*R*
		Adults:	96.67%	
4b.	The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.	100%		*R*
5.	The percent of Medicaid recipients having received PIHP managed services.	7.80%		*R*
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.	99.69%		*R*
8.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who are employed competitively.	MI Adults:	10.37%	*R*
		DD Adults:	8.22%	
		MI/DD Adults:	5.23%	

Table 3-37—Performance Measure Results *for* Venture Behavioral Health			
	Indicator	**Reported Rate**	**Indicator Designation**
9.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.	MI Adults: 71.43% DD Adults: 52.54% MI/DD Adults: 48.60%	*R*
10.	The percentage of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge	Children: 9.52% Adults: 6.02%	*R*
13.	The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	14.19%	*R*
14.	The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	47.08%	*R*

Strengths

Venture Behavioral Health continued its relationship with its vendor, Streamline, which provided a system used across all affiliates. The vendor continued to support the Practice Management Database used by the affiliates, the Care Management Database used by the PIHP, and the Regional Data Warehouse. Between these sophisticated systems, all necessary data elements required for performance indicator reporting were captured. Consistent processes, systems, and staff at the PIHP and vendor helped to ensure the performance indicators were well understood. The performance indicators were automated, and the system allowed easy access to the data including member-level detail and dashboard reports that were broken out by each affiliate. **Venture Behavioral Health** monitored performance indicators and quality improvement data elements regularly and communicated with the affiliates on an ongoing basis to ensure data were complete.

Recommendations

HSAG noted no issues or concerns with the processes in place at **Venture Behavioral Health** that would require a corrective action. The PIHP worked proactively with its affiliates to identify areas where performance could be improved. **Venture Behavioral Health** should continue its efforts to deal with the challenge of obtaining detailed information from MDCH so it can reconcile its data to the State's Medicaid processing system, CHAMPS.

Summary Assessment Related to Quality, Timeliness, and Access

Venture Behavioral Health's performance indicators across the domains of **quality**, **timeliness**, and **access** received validation findings of *Report*, reflecting that the indicators were compliant with MDCH specifications and rates could be reported. 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 competitively employed MI/DD adults 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. **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 met the minimum performance standard for all 19 indicators; achieved rates above the statewide average for eight of the 10 indicators without a specified performance benchmark; and demonstrated excellent performance across the three domains of **quality**, **timeliness**, and **access**.

Validation of Performance Improvement Projects

This section of the report presents the results of the validation of PIPs. For the 2012–2013 validation, the PIHPs presented their third-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 2012–2013 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 91 percent and a score of 100 percent for critical elements. Based on the validation of this PIP, HSAG's assessment determined confidence in the results.

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

Review 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	4	0	0	0	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**	**31**	**2**	**1**	**18**	**13**	**10**	**0**	**0**	**3**

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

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

Strengths

Access Alliance 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 the PIP was appropriately designed and implemented and the interventions were designed to change behavior at a system, provider, or beneficiary level. **Access Alliance** implemented the following interventions during Remeasurement 2: The PIHP reviewed the number of peer specialists being trained in the region, requested specific information from providers about the use of peer specialists, identified program and service types indicative of peer-directed services, explored additional ways to use peer support specialists, and made modifications to its electronic record system to allow the use of the billing code modifier HE.

Recommendations

HSAG identified one *Point of Clarification*, two *Partially Met* scores, and one *Not Met* score as opportunities for improvement in Activities III, VIII, and IX. The *Point of Clarification* in Activity III suggested that **Access Alliance** reset its goal to align with a demonstrated increase over the baseline rate. The Remeasurement 2 goal set by the PIHP was lower than the baseline rate. In Activity VIII, the PIHP received two *Partially Met* scores because the interpretation of findings documented by the PIHP was not supported by the data, and the statistical test results included discrepancies. **Access Alliance** received a *Not Met* score in Activity IX because the study indicator did not demonstrate statistically significant improvement. **Access Alliance** should revisit its causal/barrier analysis process to determine if the correct barriers are being addressed. The PIHP should develop problem-solving techniques to identify the reasons for the continuing decline in outcomes.

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

During Remeasurement 2, **Access Alliance** reported a rate increase from 10.3 percent to 11.6 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 to Remeasurement 2 rate increase of 1.3 percentage points was not statistically significant. Because the Remeasurement 1 rate was below the baseline, **Access Alliance** needs to report an additional measurement period to be assessed for sustained improvement. From baseline to Remeasurement 2, the outcomes showed a 2.7 percent increase in the results. **Access Alliance** did not conclusively demonstrate that implemented interventions had an impact on the **quality** of care and services by improving the outcomes or positively affecting consumer health, functional status, or satisfaction.

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 2012–2013 PIP Validation Tool for **CMH Affiliation of Mid-Michigan**. Validation of Activities I through X 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 PIP results.

Table 3-40—PIP Validation Scores *for* CMH Affiliation of Mid-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	4	0	0	0	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	4	0	0	0	No Critical Elements				
X.	Assess for Sustained Improvement	1	1	0	0	0	No Critical Elements				
Totals for All Activities		**53**	**34**	**1**	**0**	**18**	**13**	**10**	**0**	**0**	**3**

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

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

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 real improvement in Activity IX and sustained improvement in Activity X. **CMH Affiliation of Mid-Michigan** implemented a new intervention during Remeasurement 2 and increased the number of full-time peer support specialists to allow for expanded access to peer support services. The PIHP documented that it will continue to promote the use of peer support specialists.

Recommendations

HSAG identified one *Partially Met* score in Activity VIII as an opportunity for improvement for **CMH Affiliation of Mid-Michigan**. The PIHP did not correct the *p* value discrepancies noted in last year's review. The Remeasurement 2 *p* value appeared to have been calculated correctly but documented incorrectly. **CMH Affiliation of Mid-Michigan** should make any necessary corrections and ensure that the correct *p* values are reported for the remeasurement periods.

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

During this measurement period, **CMH Affiliation of Mid-Michigan** reported a rate increase from 9.3 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 rate increase from Remeasurement 1 to Remeasurement 2 was statistically significant. **CMH Affiliation of Mid-Michigan** provided statistical evidence that observed improvement was true improvement and demonstrated sustained improvement in Activity X during Remeasurement 2. The PIHP increased the rate of peer-delivered services or supports for adults with a mental illness from a baseline rate of 8.4 percent to a Remeasurement 2 rate of 10.6 percent. From baseline to Remeasurement 2, the **CMH Affiliation of Mid-Michigan** peer-delivered services PIP showed a measured 26.2 percent improvement in the outcomes and demonstrated the potential to positively affect consumer health, functional status, or satisfaction and impact the **quality** of care and services. **CMH Affiliation of Mid-Michigan** should continue to regularly evaluate all implemented interventions to determine their efficacy and conduct causal/barrier analyses to ensure that the appropriate barriers are being addressed.

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 2012–2013 PIP Validation Tool for **CMH for Central Michigan**. Validation of Activities I through X 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	4	0	0	0	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	1	0	0	0	No Critical Elements				
Totals for All Activities		**53**	**33**	**1**	**1**	**18**	**13**	**10**	**0**	**0**	**3**

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

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

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** documented that it created a Peer Support Data Team to identify barriers and solutions for the process of documenting the peer support services. The PIHP implemented the following interventions during Remeasurement 2: **CMH for Central Michigan** simplified the processes for authorization and documentation of peer support services and placed digital signage in each office to display information about accessing available peer support services.

Recommendations

HSAG identified one *Point of Clarification,* one *Partially Met* score, and one *Not Met* score in Activities VIII and IX as opportunities for improvement. In Activity VIII, HSAG recommended that the PIHP recalculate the Remeasurement 2 *p* value and percentage/percentage point changes and correct all noted discrepancies. **CMH for Central Michigan** should ensure that the Activity VIII narrative corresponds to the data reported in the Activity IX table. In Activity IX, the study indicator rate did not demonstrate statistically significant improvement contrary to the Activity IX narrative. The PIHP should ensure the PIP narrative accurately reflects the PIP outcomes. **CMH for Central Michigan** should continue to revisit its causal/barrier analysis process and regularly evaluate the efficacy of implemented interventions. Interventions that are not positively impacting the rate or performing as expected should be revised or discontinued.

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

During this measurement period, **CMH for Central Michigan** reported a rate increase from 12.8 percent to 13.6 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 rate increase was not statistically significant; therefore, the PIP did not demonstrate true improvement from Remeasurement 1 to Remeasurement 2. **CMH for Central Michigan** did not meet its Remeasurement 2 goal of 13.9 percent, but it did demonstrate sustained improvement over comparable time periods in Activity X. **CMH for Central Michigan** increased the rate of peer-delivered services or supports for adults with a mental illness from a baseline rate of 10.8 percent to a Remeasurement 2 rate of 13.6 percent. From baseline to Remeasurement 2, the **CMH for Central Michigan** peer-delivered services PIP showed a measured 25.9 percent improvement in the outcomes and demonstrated the potential to positively affect consumer health, functional status, or satisfaction and impact the **quality** of care and services.

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 2012–2013 PIP Validation Tool for **CMH Partnership of Southeastern Michigan**. Validation of Activities I through X 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 3-44—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	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	1	0	0	0	No Critical Elements				
Totals for All Activities		**53**	**31**	**0**	**3**	**19**	**13**	**10**	**0**	**0**	**3**

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

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

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 VIII, indicating the PIP was appropriately designed to measure outcomes and improvement. The interventions were designed to change behavior at a system, provider, or beneficiary level. **CMH Partnership of Southeastern Michigan** appropriately analyzed and interpreted the data. The PIHP implemented the following interventions during Remeasurement 2: **CMH Partnership of Southeastern Michigan** trained staff on the authorization, documentation, and billing of peer support services; encouraged consumers to use peer support services; and actively recruited and hired additional peer support staff.

Recommendations

HSAG identified three *Not Met* scores as opportunities for improvement in Activity IX. In Activity IX, the rate for the **CMH Partnership of Southeastern Michigan** PIP did not demonstrate improvement as the rate declined from Remeasurement 1 to Remeasurement 2. The rate decline was not statistically significant but may be indicative of ineffective interventions. The PIHP should revisit its causal/barrier analysis process to determine if the barriers originally identified are still applicable. To ensure the interventions have a significant impact on the outcomes, the interventions should be clearly linked to the barriers identified by the PIHP. **CMH Partnership of Southeastern Michigan** should also regularly evaluate the efficacy of its implemented interventions. Interventions that are not positively impacting the rate or performing as expected should be revised or discontinued.

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

During this measurement period, **CMH Partnership of Southeastern Michigan** reported a rate decrease from 7.7 percent to 7.1 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 to Remeasurement 2 rate decrease was not statistically significant; therefore, the PIP demonstrated sustained improvement in Activity X. **CMH Partnership of Southeastern Michigan** did not meet its Remeasurement 2 goal of 8.48 percent. The PIHP significantly increased the rate of peer-delivered services or supports for adults with a mental illness, from a baseline rate of 3.4 percent to a Remeasurement 2 rate of 7.1 percent. From baseline to Remeasurement 2, **CMH Partnership of Southeastern Michigan**'s PIP on peer-delivered services showed a measured 108.8 percent improvement in the outcomes and demonstrated the potential to positively affect consumer health, functional status, or satisfaction and impact the **quality** of care and services.

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 2012–2013 PIP Validation Tool for **Detroit-Wayne County CMH Agency**. Validation of Activities I through X resulted in a validation status of *Met*, with an overall score of 100 percent and a score of 100 percent for critical elements. Based on the validation of this PIP, HSAG's assessment determined high confidence in the results.

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

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	4	0	0	0	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	1	0	0	0	No Critical Elements				
Totals for All Activities		**53**	**35**	**0**	**0**	**18**	**13**	**10**	**0**	**0**	**3**

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

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

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 X, indicating the PIP was appropriately designed to measure outcomes and improvement. The interventions were designed to change behavior at a system, provider, or beneficiary level. **Detroit-Wayne County CMH Agency** appropriately analyzed data and interpreted study results. The PIP demonstrated true improvement in Activity IX and sustained improvement in Activity X. **Detroit-Wayne County CMH Agency** implemented several interventions during Remeasurement 2. The PIHP took steps to place peer support specialists in a hospital setting to facilitate the transition process from inpatient to outpatient settings, advocated for improved wages for peer support specialists, and collaborated with the State to develop and implement training sessions for peer support specialists. **Detroit-Wayne County CMH Agency** updated the consumer satisfaction survey to include questions about the impact of peer specialists on the consumer's recovery process.

Recommendations

HSAG identified a *Point of Clarification* as an opportunity for improvement in Activity VIII during the Remeasurement 2 validation period. In its next PIP submission, **Detroit-Wayne County CMH Agency** should document the specific statistical test that was used to calculate the reported *p* value.

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

During this measurement period, **Detroit-Wayne County CMH Agency** reported a rate increase from 16.8 percent to 17.5 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. The rate increase from Remeasurement 1 to Remeasurement 2 was statistically significant; therefore, the PIP demonstrated true improvement. Although **Detroit-Wayne County CMH Agency** did not meet its Remeasurement 2 goal of 18.5 percent, repeated measurements over comparable time periods demonstrated sustained improvement. The PIHP increased the rate of peer-delivered service or support for adults with a mental illness from a baseline rate of 12.7 percent to a Remeasurement 2 rate of 17.5 percent. From baseline to Remeasurement 2, the **Detroit-Wayne County CMH Agency** peer-delivered services PIP showed a measured 37.8 percent improvement in the outcomes and demonstrated the potential to positively affect consumer health, functional status, or satisfaction and impact the **quality** of care and services. **Detroit-Wayne County CMH Agency** should continue to evaluate interventions to monitor that the interventions are having the desired effect on the outcomes.

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 2012–2013 PIP Validation Tool for **Genesee County CMH**. Validation of Activities I through X 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

		All Evaluation Elements (Including Critical Elements)					Critical Elements				
Review Activity		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	4	0	0	0	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	1	0	0	0	No Critical Elements				
Totals for All Activities		**53**	**32**	**2**	**1**	**18**	**13**	**10**	**0**	**0**	**3**

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

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

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 VII, indicating the PIP was appropriately designed to measure outcomes and improvement. The interventions were designed to change behavior at a system, provider, or beneficiary level. **Genesee County CMH** demonstrated sustained improvement in Activity X. The PIHP continued existing interventions and implemented the following intervention during Remeasurement 2: **Genesee County CMH** researched peer support specialist training and certification requirements to determine if requirements are creating a barrier to peer support specialist recruiting and certification efforts.

Recommendations

HSAG identified one *Point of Clarification*, two *Partially Met* scores, and one *Not Met* score as opportunities for improvement in Activities VIII and IX. In the Activity VIII *Point of Clarification*, HSAG again recommended that **Genesee County CMH** address the incorrectly documented rate increase from 2010 to 2011. **Genesee County CMH** received two *Partially Met* scores in Activity VIII. The PIHP included a partial interpretation of the findings for the study indicator but did not compare the Remeasurement 1 results to the Remeasurement 2 results. The interpretation of the findings should include a comparison of the outcomes and a discussion of the statistical test results between measurement periods. **Genesee County CMH** received one *Not Met* score in Activity IX. The rate increase for the study indicator was not statistically significant and did not offer statistical evidence that observed improvement was true improvement. The PIHP should begin the causal/barrier analysis process anew to determine if the original barriers are still applicable. Implemented interventions should be clearly linked to the identified barriers to ensure a positive impact on the outcomes. **Genesee County CMH** should regularly evaluate the efficacy of its implemented interventions to determine if the interventions are successfully impacting the outcomes. Interventions that the PIHP determines are not successful should be modified or discontinued.

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

During this measurement period, **Genesee County CMH** reported a rate increase from 10.6 percent to 11.6 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, and the PIP did not achieve true improvement during this measurement period. **Genesee County CMH** did not meet its Remeasurement 2 goal but demonstrated sustained improvement in Activity X. The PIHP increased the rate of peer-delivered services or supports for adults with a mental illness from a baseline rate of 9.4 percent to a Remeasurement 2 rate of 11.6 percent. From baseline to Remeasurement 2, the **Genesee County CMH** peer-delivered services PIP showed a measured 23.4 percent improvement in the outcomes, and demonstrated the potential to positively affect consumer health, functional status, or satisfaction and impact the **quality** of care and services.

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 2012–2013 PIP Validation Tool for **Lakeshore Behavioral Health Alliance**. Validation of Activities I through X resulted in a validation status of *Met*, with an overall score of 85 percent and a score of 100 percent for critical elements. Based on the validation of this PIP, HSAG's assessment determined confidence in the results.

Table 3-50—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	6	2	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	1	0	0	0	No Critical Elements				
Totals for All Activities		**53**	**29**	**2**	**3**	**19**	**13**	**10**	**0**	**0**	**3**

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

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

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 VII, indicating the PIP was appropriately designed and implemented to measure outcomes and improvement. The interventions were designed to change behavior at a system, provider, or beneficiary level. The PIP demonstrated sustained improvement in Activity X. **Lakeshore Behavioral Health Alliance** implemented the following interventions during Remeasurement 2: The PIHP hired additional peer support specialists and started three groups facilitated by peer support specialists.

Recommendations

HSAG identified two *Partially Met* scores in Activity VIII and three *Not Met* scores in Activity IX of the PIP as opportunities for improvement. In Activity VIII, HSAG noted that the rate in the PIP narrative did not match the rate in the Activity IX table as recommended in the previous validation. **Lakeshore Behavioral Health Alliance** reported statistical test results and conclusions that HSAG was unable to replicate. The PIHP should recalculate the statistical test results and correct all discrepancies to ensure that the PIP narrative is consistent with the statistical test results as well as the data reported in the Activity IX table. The study indicators did not improve, and **Lakeshore Behavioral Health Alliance** did not demonstrate statistical evidence of true improvement, which resulted in *Not Met* scores in Activity IX.

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

During Remeasurement 2, **Lakeshore Behavioral Health Alliance** reported a rate decrease from 15.3 percent to 14.2 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 rate decrease was not statistically significant. The PIP did not demonstrate true improvement during this measurement period. **Lakeshore Behavioral Health Alliance** did not meet its Remeasurement 2 goal of 20 percent; however, the PIP demonstrated sustained improvement over comparable time periods without a statistically significant decline in performance. **Lakeshore Behavioral Health Alliance** increased the rate of peer-delivered services or supports for adults with a mental illness from a baseline rate of 9.6 percent to a Remeasurement 2 rate of 14.2 percent. From baseline to Remeasurement 2, the **Lakeshore Behavioral Health Alliance** peer-delivered services PIP showed a measured 47.9 percent improvement in the outcomes and demonstrated the potential to positively affect consumer health, functional status, or satisfaction and impact the **quality** of care and services. **Lakeshore Behavioral Health Alliance** should conduct regular causal/barrier analyses to ensure the appropriate barriers are being addressed and evaluate all implemented interventions to determine their efficacy.

LifeWays

Findings

Table 3-52 and Table 3-53 show **LifeWays**' scores based on HSAG's PIP evaluation. For additional details, refer to the 2012–2013 PIP Validation Tool for **LifeWays**. 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 3-52—PIP Validation Scores *for* LifeWays

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	1	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**	**29**	**1**	**3**	**19**	**13**	**10**	**0**	**0**	**3**

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

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

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 the PIP was appropriately designed to measure outcomes and improvement. The interventions were designed to change behavior at a system, provider, or beneficiary level. The PIHP implemented the following interventions during Remeasurement 2: **LifeWays** published peer support specialists recovery stories, promoted available peer support services at community forums, hosted new support groups facilitated by peer support specialists, provided new skills trainings at local drop-in centers, and created a recovery newsletter.

Recommendations

HSAG identified one *Partially Met* score in Activity VIII and three *Not Met* scores in Activity IX as opportunities for improvement. In Activity VIII, the PIHP reported *z* scores and *p* values for Remeasurements 1 and 2 that HSAG was unable to replicate. **LifeWays** should consider seeking technical assistance regarding *z* score and *p* value calculation. In Activity IX, the PIP rate demonstrated a decline in Remeasurement 2. The rate had steadily declined since the baseline measurement and could not be assessed for sustained improvement. **LifeWays** documented that the implemented interventions did not have the desired effect on the rate and that the PIHP will focus on ensuring the appropriate procedure codes and modifiers are used during the FY 2013 measurement period. The PIHP should begin the causal/barrier analysis process anew to determine if the original barriers are still applicable. Implemented interventions should be clearly linked to the identified barriers to ensure a positive impact on the outcomes. **LifeWays** should regularly evaluate the efficacy of its implemented interventions to determine if the interventions are successfully impacting the outcomes. Interventions that the PIHP determines are not successful should be modified or discontinued.

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

During this measurement period, **LifeWays** reported a rate decrease from 6.5 percent to 5.5 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. The Remeasurement 2 rate was lower than the baseline rate. The rate decrease from Remeasurement 1 to Remeasurement 2 was not statistically significant, and the PIP did not demonstrate real improvement. The PIP could not be assessed for sustained improvement in Activity X because the rate has steadily declined since the baseline measurement period, from a baseline rate of 6.7 percent to a Remeasurement 2 rate of 5.5 percent. **LifeWays** did not meet its Remeasurement 1 goal of 13.38 percent. The decrease from baseline to Remeasurement 2 demonstrated a 17.9 percent decline in the outcomes. **LifeWays** did not demonstrate that the implemented interventions had the potential to effectively improve the outcomes or impact the **quality** of care and services. **LifeWays** should revisit its causal/barrier analysis, prioritize barriers, and ensure that implemented interventions address the identified barriers.

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 2012–2013 PIP Validation Tool for **Macomb County CMH Services**. Validation of Activities I through X 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 3-54—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	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	1	0	0	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	1	0	0	0	No Critical Elements				
Totals for All Activities		**53**	**32**	**2**	**1**	**18**	**13**	**10**	**0**	**0**	**3**

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

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

Strengths

Macomb County CMH 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 I through VI, indicating that the PIP was appropriately designed. The PIP demonstrated sustained improvement in Activity X. **Macomb County CMH Services** implemented the following interventions during Remeasurement 2: The PIHP scheduled recovery-oriented trainings for providers, helped existing peer support staff members obtain peer support certifications, and hired an additional peer support specialist. The interventions were designed to change behavior at a system, provider, or beneficiary level.

Recommendations

HSAG identified two *Points of Clarification*, two *Partially Met* scores, and one *Not Met* score as opportunities for improvement in Activities I, VII, VIII, and IX. HSAG noted in the *Point of Clarification* in Activity I that the historical rate of peer-delivered services documented in Activity III should be moved to Activity I. In the *Point of Clarification* in Activity VII, HSAG recommended that **Macomb County CMH Services** revisit its causal/barrier analysis, establish barriers, and develop interventions specific to the identified barriers. In Activity VII, **Macomb County CMH Services** received one *Partially Met* score because it did not document if continuing interventions would be standardized and monitored. The PIHP should regularly evaluate the efficacy of implemented interventions and determine which interventions are successful. Successful interventions should be standardized and monitored to ensure their continued success. In Activity VIII, HSAG was unable to replicate the Chi-square and *p* values reported by **Macomb County CMH Services** for Remeasurements 1 and 2. The PIHP should consider seeking technical assistance with the statistical testing and ensure that all *p* value results are reported to four decimal places. **Macomb County CMH Services** did not demonstrate statistical evidence of true improvement, which resulted in a *Not Met* score in Activity IX.

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

During this measurement period, **Macomb County CMH Services** reported a rate increase from 1.0 percent to 1.1 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 rate increase from Remeasurement 1 to Remeasurement 2 was not statistically significant, and the PIP did not demonstrate true improvement during this measurement period. **Macomb County CMH Services** did not meet its documented Remeasurement 2 goal of 1.25 percent, but the PIP demonstrated sustained improvement over comparable time periods. **Macomb County CMH Services** significantly increased the rate of peer-delivered services or supports for adults with a mental illness, from a baseline rate of 0.7 percent to a Remeasurement 2 rate of 1.1 percent. From baseline to Remeasurement 2, the **Macomb County CMH Services** peer-delivered services PIP showed a measured 57.1 percent improvement in the outcomes, and demonstrated the potential to positively affect consumer health, functional status, or satisfaction and impact the **quality** of care and services. **Macomb County CMH Services** should conduct regular causal/barrier analyses to ensure that the appropriate barriers are being addressed.

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 2012–2013 PIP Validation Tool for **network180**. 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.

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	1	0	0	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	2	1	1	0	No Critical Elements				
X.	Assess for Sustained Improvement	1	Not Assessed				No Critical Elements				
Totals for All Activities		**53**	**28**	**5**	**1**	**18**	**13**	**10**	**0**	**0**	**3**

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

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

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 VI, indicating that the PIP was appropriately designed. **network180** implemented the following interventions during Remeasurement 2: The PIHP offered incentives to providers, updated billing codes for services delivered by peer support specialists, and assisted peer support specialists with completion of the certification process. **network180** initiated efforts to increase the number of peer support specialist applicants, educated network providers about the role of peer support specialists, and revised a monthly monitoring tool for encounter data to capture more peer-related activities than had been reported previously. The interventions were designed to change behavior at a system, provider, or beneficiary level.

Recommendations

HSAG identified five *Partially Met* scores and one *Not Met* score as opportunities for improvement in Activities VII through IX. In Activity VII, **network180** documented that it would continue its implemented interventions but did not discuss standardizing and monitoring successful interventions. The PIHP changed the denominators and rates for the baseline and Remeasurement 1 periods, but it did not document the reason for the change in Activities VIII or IX. In Activity VIII, **network180** reported statistical test results that HSAG was unable to replicate. The PIHP should consider seeking technical assistance regarding the statistical testing and document if there were any factors that affected the ability to compare the Remeasurement 1 results to the Remeasurement 2 results. In Activity IX, **network180** did not demonstrate statistical evidence of true improvement, which resulted in a *Not Met* score.

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

All of **network180**'s previously reported rates changed based on the PIHPs revised denominators for the baseline and Remeasurement 1 periods. The updated Remeasurement 1 rate was the same as the updated baseline rate of 8.8 percent. During Remeasurement 2, the PIHP documented a rate of 9.4 percent. The rate increase documented for Remeasurement 2 was not a statistically significant increase over either the baseline or the Remeasurement 1 rate. Therefore, the PIP did not demonstrate evidence of true improvement. As **network180** reported only one measurement period (Remeasurement 2) with a rate above the baseline rate, another measurement period is needed to determine if the reported improvement can be sustained. **network180** increased the rate of peer-delivered services or supports for adults with a mental illness from a baseline rate of 8.8 percent to a Remeasurement 2 rate of 9.4 percent. From baseline to Remeasurement 2, the **network180** peer-delivered services PIP showed a measured 6.8 percent improvement in the outcomes and demonstrated the potential to positively affect consumer health, functional status, or satisfaction and impact the **quality** of care and services. **network180** should conduct regular causal/barrier analyses to ensure the appropriate barriers are being addressed and evaluate its implemented interventions to determine if the interventions are having the desired effect on the outcomes.

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 2012–2013 PIP Validation Tool for **NorthCare**. Validation of Activities I through X resulted in a validation status of *Met*, with an overall score of 97 percent and a score of 100 percent for critical elements. Based on the validation of this PIP, HSAG's assessment determined high confidence in the results.

Table 3-58—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	4	0	0	0	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	3	0	1	0	No Critical Elements				
X.	Assess for Sustained Improvement	1	1	0	0	0	No Critical Elements				
Totals for All Activities		**53**	**34**	**0**	**1**	**18**	**13**	**10**	**0**	**0**	**3**

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

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

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 VIII, indicating the PIP was appropriately designed to measure outcomes and improvement. The interventions were designed to change behavior at a system, provider, or beneficiary level. The PIHP appropriately analyzed and interpreted the data and demonstrated sustained improvement in Activity X. **NorthCare** implemented the following interventions during Remeasurement 2: The PIHP continued to support peer support specialist training and education efforts, investigated and identified a data reporting issue that may be causing the underreporting of peer support specialist services, and assigned staff to be responsible for running a report to identify and correct inaccurate encounter data.

Recommendations

HSAG identified one *Point of Clarification* and one *Not Met* score as opportunities for improvement in Activities VIII and IX. In Activity VIII, HSAG recommended that **NorthCare** provide the statistical testing results for each measurement period in the last column of the Activity IX table. In Activity IX, the PIHP received the *Not Met* score because the rate increase between Remeasurement 1 and Remeasurement 2 did not provide statistical evidence that observed improvement was true improvement. **NorthCare** should regularly monitor interventions to determine if the interventions are having the desired effect. For interventions not having the desired effect, the PIHP should decide if current interventions might need to be modified or discontinued.

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

During this measurement period, **NorthCare** reported a rate increase from 10.1 percent to 10.6 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 rate increase was not statistically significant. Therefore, the PIP did not show statistical evidence that observed improvement is true improvement. **NorthCare** did not meet its documented Remeasurement 2 goal of 12 percent, but it did achieve sustained improvement over comparable time periods without a statistically significant decline in performance. **NorthCare** increased the rate of peer-delivered services or supports for adults with a mental illness from a baseline rate of 9.8 percent to a Remeasurement 2 rate of 10.6 percent. From baseline to Remeasurement 2, the **NorthCare** peer-delivered services PIP showed a measured 8.2 percent improvement in the outcomes and demonstrated the potential to positively affect consumer health, functional status, or satisfaction and impact the **quality** of care and services.

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 2012–2013 PIP Validation Tool for **Northern Affiliation**. Validation of Activities I through X resulted in a validation status of *Met*, with an overall score of 100 percent and a score of 100 percent for critical elements. 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	4	0	0	0	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	1	0	0	0	No Critical Elements				
Totals for All Activities		**53**	**35**	**0**	**0**	**18**	**13**	**10**	**0**	**0**	**3**

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

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

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 X, indicating the PIP was appropriately designed to measure outcomes and improvement and the interventions were designed to change behavior at a system, provider, or beneficiary level. The PIHP appropriately analyzed data and interpreted study results and demonstrated true improvement in Activity IX. **Northern Affiliation** achieved sustained improvement over comparable time periods without a statistically significant decline in performance. The PIHP implemented the following interventions during Remeasurement 2: **Northern Affiliation** implemented the illness management and recovery model, which allowed peer support specialists to co-facilitate groups, and assisted a peer support specialist with the completion of the certification process.

Recommendations

HSAG identified two *Points of Clarification* as opportunities for improvement in Activity VIII. **Northern Affiliation** reported the Remeasurement 2 goal as 4.18 percent in Activity VIII and as 4.12 percent in Activity IX. **Northern Affiliation** should ensure that its goal is documented consistently throughout the PIP. The PIHP also reported that the goal for Remeasurement 3 is to maintain the Remeasurement 2 rate of 5.1 percent, which would not reflect an improvement in outcomes. The PIHP should revise its Remeasurement 3 goal to reflect an improvement in the rate.

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

During this measurement period, **Northern Affiliation** reported a rate increase from 3.3 percent to 5.1 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 rate increase was statistically significant; therefore, the PIP demonstrated true improvement. **Northern Affiliation** met its documented Remeasurement 2 goal of 4.18 percent. During Remeasurement 2, the PIHP achieved sustained improvement over comparable time periods without a statistically significant decline in performance. **Northern Affiliation** significantly increased the rate of peer-delivered services or supports for adults with a mental illness from a baseline rate of 2.1 percent to a Remeasurement 2 rate of 5.1 percent. From baseline to Remeasurement 2, the **Northern Affiliation** peer-delivered services PIP showed a measured 142.9 percent improvement in the outcomes and demonstrated the potential to positively affect consumer health, functional status, or satisfaction and impact the **quality** of care and services.

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 2012–2013 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 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 3-62—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	1	0	0	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**	**1**	**1**	**18**	**13**	**10**	**0**	**0**	**3**

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

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

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 VI, indicating that the PIP was appropriately designed. The PIHP also demonstrated true improvement in Activity IX. **Northwest CMH Affiliation** implemented the following interventions during Remeasurement 2: The PIHP integrated peer support specialists into the case management team, hired a peer support specialist supervisor, conducted additional analysis to determine how many consumers were receiving services from an uncertified peer support specialist, and continued the ongoing review of peer services data.

Recommendations

HSAG identified one *Point of Clarification*, one *Partially Met*, and one *Not Met* score as opportunities for improvement in Activities VII and VIII. In Activity VII, **Northwest CMH Affiliation** received a *Partially Met* score related to the standardization and monitoring of successful interventions. The PIHP did not discuss how successful interventions would be standardized and monitored to ensure their continued success. The PIHP should discuss how it would standardize and monitor successful interventions. The *Point of Clarification* in Activity VIII recommended that the *p* value be recorded to four decimal places. The PIHP received a *Not Met* score in Activity VIII because it did not document if there were any factors that may have affected the ability to compare the results between measurement periods. The PIHP should document if there were any factors that may have affected the ability to compare the results between measurement periods, or include a statement that there were no such factors.

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

During this measurement period, **Northwest CMH Affiliation** reported a rate increase from 5.4 percent to 10.8 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 rate increase was statistically significant, and the PIP demonstrated real improvement during Remeasurement 2. The PIP could not be assessed for sustained improvement in Activity X because only one remeasurement period demonstrated results above the baseline rate. **Northwest CMH Affiliation** exceeded its Remeasurement 2 goal of increasing the rate by 20 percent. The PIHP significantly increased the rate of peer-delivered services or supports for adults with a mental illness from a baseline rate of 6.4 percent to a Remeasurement 2 rate of 10.8 percent. From baseline to Remeasurement 2, the **Northwest CMH Affiliation** peer-delivered services PIP showed a measured 68.8 percent improvement in the outcomes and demonstrated the potential to positively affect consumer health, functional status, or satisfaction and impact the **quality** of care and services. To ensure continued improvement, **Northwest CMH Affiliation** should revisit its causal/barrier analysis process as the barriers identified at the start of this PIP may have changed. The PIHP should regularly evaluate the efficacy of interventions, determine which interventions are most successful, and standardize successful interventions systemwide. **Northwest CMH Affiliation** should and monitor all standardized interventions to ensure continued success.

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 2012–2013 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 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 3-64—PIP Validation Scores *for* Oakland County CMH Authority

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	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**	**29**	**1**	**3**	**19**	**13**	**10**	**0**	**0**	**3**

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

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

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 VI, indicating that the PIP was appropriately designed to measure outcomes and improvement. The PIHP also appropriately analyzed data and interpreted study results in Activity VIII. **Oakland County CMH Authority** implemented the following interventions during Remeasurement 2: The PIHP assigned a peer support specialist to the Adult Services Recovery Resource Center to be responsible for calling all newly enrolled consumers about available services and informed consumers who chronically missed appointments about the availability of a treatment motivation group led by peer support specialists.

Recommendations

HSAG identified opportunities for improvement in Activity VII—Implement Intervention and Improvement Strategies and 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. The PIHP should revise or discontinue existing interventions and implement new interventions that specifically address the identified issues. **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

During this measurement period, **Oakland County CMH Authority** reported a rate decrease from 19.8 percent to 19.4 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. The rate decrease was not statistically significant. **Oakland County CMH Authority** did not meet its documented Remeasurement 2 goal of 29.3 percent or demonstrate real improvement. The PIP could not be assessed for sustained improvement in Activity X because both remeasurement periods had outcomes below the baseline rate. The rate of peer-delivered services or supports for adults with a mental illness continuously declined from a baseline rate of 27.6 percent to a Remeasurement 2 rate of 19.4 percent, resulting in a measured 29.7 percent decline in the outcomes. The PIHP did not demonstrate that implemented interventions effectively improved the outcomes or positively affected consumer health, functional status, satisfaction, or the **quality** of care and services. **Oakland County CMH Authority** should revisit its causal/barrier analysis process to determine if the correct barriers are being addressed. The PIHP should develop problem-solving techniques to identify the reasons for the continuing decline in outcomes.

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 2012–2013 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 79 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 3-66—PIP Validation Scores *for* Saginaw County CMH Authority

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	0	1	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	1	0	3	0	No Critical Elements				
X.	Assess for Sustained Improvement	1	Not Assessed				No Critical Elements				
Totals for All Activities		**53**	**26**	**2**	**5**	**19**	**13**	**10**	**0**	**0**	**3**

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

Percentage Score of Evaluation Elements *Met*	**79%**
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. **Saginaw County CMH Authority** implemented a new intervention during Remeasurement 2 and provided training to practitioners regarding the appropriate use of the HE modifier in encounter data.

Recommendations

HSAG identified one *Point of Clarification*, two *Partially Met* scores, and five *Not Met* scores as opportunities for improvement in Activities VI, VIII, and IX. In Activity VI, the PIHP received a *Not Met* score because it did not include remeasurement period timelines in Activity VI. **Saginaw County CMH Authority** should provide timelines in Activity VI that match the timelines provided in Activities III and IX. In Activity VIII, the data included in the PIP narrative did not match the data in the Activity IX results table, resulting in a *Partially Met* score. **Saginaw County CMH Authority** received a *Partially Met* score in Activity VIII because the statistical results did not agree with the numerators and denominators reported in the narrative or the Activity IX results table. The PIHP should recalculate the Chi-square and *p* value results and ensure that the correct numerators and denominators are documented consistently throughout the PIP. **Saginaw County CMH Authority** received a *Not Met* score in Activity VIII because the PIHP did not document if there are any factors that affected the ability to compare measurement period. If no such factors exist, the PIHP should document that fact. In Activity IX, the PIHP received three *Not Met* scores because the study indicator did not demonstrate improvement. The PIHP should begin the problem-solving process anew for unsuccessful interventions, evaluate interventions to determine if they demonstrate the desired effect, and modify or discontinue ineffective interventions.

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

Using the correct numerators and denominators, HSAG calculated that for Remeasurement 2, **Saginaw County CMH Authority** had a rate decrease from 13.2 percent to 11.1 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 rate decrease was statistically significant, and the PIP did not demonstrate real improvement or meet the documented Remeasurement 1 goal of a 1.0 percent rate increase. The PIP could not be assessed for sustained improvement in Activity X because both remeasurement periods had outcomes below the baseline rate. The rate of peer-delivered services or supports for adults with a mental illness continuously declined from a baseline rate of 17.6 percent to a Remeasurement 2 rate of 11.1 percent, resulting in a measured 36.9 percent decline in the outcomes. **Saginaw County CMH Authority** did not demonstrate that implemented interventions effectively improved the outcomes or positively affected consumer health, functional status, satisfaction, or the **quality** of care and services. **Saginaw County CMH Authority** should revisit its causal/barrier analysis process to determine if the correct barriers are being addressed.

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 2012–2013 PIP Validation Tool for **Southwest Affiliation**. Validation of Activities I through X 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 3-68—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	4	0	0	0	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	1	0	0	0	No Critical Elements				
Totals for All Activities		**53**	**33**	**1**	**1**	**18**	**13**	**10**	**0**	**0**	**3**

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

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

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 VII, indicating the PIP was appropriately designed to measure outcomes and improvement. The PIHP interventions were designed to change behavior at an institutional, practitioner, or beneficiary level. The PIP demonstrated sustained improvement in Activity X. The PIHP implemented the following interventions during Remeasurement 2: **Southwest Affiliation** received approval from MDCH to allow some of its certified peer support specialists to become trainers. Seven certified peer support specialists were granted trainer status, and 10 peer support specialists were certified by **Southwest Affiliation** trainers. The PIHP encouraged providers to participate in a recovery self-assessment.

Recommendations

HSAG identified one *Point of Clarification*, one *Partially Met* score, and one *Not Met* score as opportunities for improvement in Activities VIII and IX. In Activity VIII, **Southwest Affiliation** documented a 34 percent increase in the number of peer support specialists. In the *Point of Clarification*, HSAG calculated that the increase from 38 to 52 peer support specialists was a 37 percent increase. The PIHP should correct the discrepancy. **Southwest Affiliation** received a *Partially Met* score in Activity VIII because the Remeasurement 2 denominator was not documented consistently throughout the PIP. The improvement demonstrated during this measurement period was not statistically significant and resulted in a *Not Met* score in Activity IX.

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

During this measurement period, **Southwest Affiliation** reported a rate increase from 24.8 percent to 26.4 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. The rate increase was not statistically significant. The PIHP did not demonstrate true improvement in Activity IX during this measurement period; however, **Southwest Affiliation** demonstrated sustained improvement in Activity X. **Southwest Affiliation** exceeded its Remeasurement 2 goal. The PIHP increased the rate of peer-delivered services or supports for adults with a mental illness from a baseline rate of 19.8 percent to a Remeasurement 2 rate of 26.4 percent. From baseline to Remeasurement 2, the **Southwest Affiliation** peer-delivered services PIP showed a measured 33.3 percent improvement in the outcomes and demonstrated the potential to positively affect consumer health, functional status, or satisfaction and impact the **quality** of care and services. **Southwest Affiliation** should standardize successful interventions systemwide and monitor all standardized interventions to ensure continued success.

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 2012–2013 PIP Validation Tool for **Thumb Alliance PIHP**. Validation of Activities I through X resulted in a validation status of *Met*, with an overall score of 100 percent and a score of 100 percent for critical elements. Based on the validation of this PIP, HSAG's assessment determined high confidence in the results.

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

Review 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	4	0	0	0	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	1	0	0	0	No Critical Elements				
Totals for All Activities		**53**	**35**	**0**	**0**	**18**	**13**	**10**	**0**	**0**	**3**

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

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

Strengths

Thumb Alliance PIHP 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 X, 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. **Thumb Alliance PIHP** 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, and showed sustained improvement in Activity X. The PIHP continued several successful interventions and implemented the following interventions during Remeasurement 2: **Thumb Alliance PIHP** developed criteria for assigning consumers to peer support specialists, expanded peer support specialist duties to include group therapy, pursued additional training opportunities for peer support specialist certification, and offered stress management support to peer support specialists for role-related stressors.

Recommendations

HSAG identified two *Points of Clarification* as opportunities for improvement in Activities IV and VIII. In Activity IV, HSAG recommended that **Thumb Alliance PIHP** revise the enrollment periods to correspond to the current measurement period. In Activity VIII, **Thumb Alliance PIHP** should document the actual *p* value for each measurement period as opposed to documenting *p* <.05. HSAG also recommended that the PIHP document the *p* value to four decimal places.

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

During this measurement period, **Thumb Alliance PIHP** reported a rate increase from 20.1 percent to 23.3 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 rate increase was statistically significant, and the PIHP demonstrated true improvement in Activity IX. **Thumb Alliance PIHP** achieved sustained improvement in Activity X as repeated measurements over comparable time periods demonstrated sustained improvement without a statistically significant decline in performance. The PIHP increased the rate of peer-delivered services or supports for adults with a mental illness from a baseline rate of 16.1 percent to a Remeasurement 2 rate of 23.3 percent. From baseline to Remeasurement 2, the **Thumb Alliance PIHP** peer-delivered services PIP showed a measured 44.7 percent improvement in the outcomes and demonstrated the potential to positively affect consumer health, functional status, or satisfaction and impact the **quality** of care and services. **Thumb Alliance** should regularly evaluate standardized systemwide interventions to ensure continued success.

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 2012–2013 PIP Validation Tool for **Venture Behavioral Health**. Validation of Activities I through X 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 3-72—PIP Validation Scores *for* Venture Behavioral Health

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	4	0	0	0	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	1	0	0	0	No Critical Elements				
Totals for All Activities		**53**	**33**	**1**	**1**	**18**	**13**	**10**	**0**	**0**	**3**

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

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

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. The PIP demonstrated sustained improvement in Activity X. **Venture Behavioral Health** implemented the following interventions during Remeasurement 2: The PIHP hired additional peer support specialists, provided training focused on defining peer support specialist services and the related documentation, and transitioned peer support specialists to adult groups. **Venture Behavioral Health** initiated a peer review process, expanded the availability of peer support specialist services, and researched additional options for peer support specialist certifications.

Recommendations

HSAG identified one *Point of Clarification*, one *Partially Met* score, and one *Not Met* score as opportunities for improvement in Activities III, VIII, and IX. **Venture Behavioral Health** received a *Point of Clarification* in Activity III related to the omission of a Remeasurement 2 goal in Activity III. **Venture Behavioral Health** should document a goal in Activity III and ensure that it is consistent with the goal documented in Activity VIII. The PIHP received a *Partially Met* score in Activity VIII because the *p* value documented in the narrative did not match the *p* value documented in the Activity IX table. **Venture Behavioral Health** should ensure that all *p* values are documented consistently throughout the PIP. The PIHP should correct the noted Chi-square value discrepancies and report all *p* values to four decimal places. In Activity IX, the PIHP received a *Not Met* score because the PIP did not demonstrate statistically significant improvement during this measurement period.

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

During this measurement period, **Venture Behavioral Health** reported a rate increase from 6.9 percent to 7.6 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 rate increase was not statistically significant. Although the PIP did not demonstrate true improvement in Activity IX during this measurement period, it demonstrated sustained improvement in Activity X. **Venture Behavioral Health** significantly increased the rate of peer-delivered services or supports for adults with a mental illness from a baseline rate of 4.7 percent to a Remeasurement 2 rate of 7.6 percent. From baseline to Remeasurement 2, the **Venture Behavioral Health** peer-delivered services PIP showed a measured 61.7 percent improvement in the outcomes and demonstrated the potential to positively affect consumer health, functional status, or satisfaction and impact the **quality** of care and services. **Venture Behavioral Health** should continue to conduct regular causal/barrier analyses to ensure that the appropriate barriers are being addressed and evaluate all implemented interventions to determine their efficacy.

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 2012–2013 compliance monitoring reviews addressed the PIHPs' compliance with requirements related to six 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 2011–2012 validation cycle.

For the 2012–2013 validation, the PIHPs continued their PIPs 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 2011–2012 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 six standards included in the 2012–2013 review cycle. There were no continued recommendations for improvement.

Validation of Performance Measures

Access Alliance of Michigan took action as a result of the previous year's recommendation to increase oversight of CA encounter data and began performing a line-by-line reconciliation with CA encounter submission to ensure all billed encounters were submitted to the State.

Validation of Performance Improvement Projects

The 2011–2012 validation of performance improvement projects for **Access Alliance of Michigan** identified opportunities for improvement for Activity VII—Implement Intervention and Improvement Strategies, Activity VIII—Analyze Data and Interpret Study Results, and Activity IX—Assess for Real Improvement. In its 2012–2013 PIP submission, the PIHP reported that it revised existing and implemented new interventions to address identified barriers. The PIHP addressed the recommendations related to the data analysis and presented the study results in a clear, accurate, and easy-to-understand format. The data analysis included an interpretation of the extent to which the PIP was successful. Study results submitted for the 2012–2013 PIP validation showed improvement in the study indicator that was consistent with the planned interventions. However, the improvement was not statistically significant. **Access Alliance of Michigan** should continue its efforts to achieve and sustain statistically significant improvement in the study indicator.

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 six standards included in the 2012–2013 review cycle. There were no continued recommendations for improvement.

Validation of Performance Measures

HSAG cited no specific areas for improvement during last year's audit. **CMH Affiliation of Mid-Michigan** continued its efforts to monitor encounter data submissions and ensure all data were transferred to CHAMPS as suggested by the auditor. However, this challenge is ongoing, and this year's requirement to provide the National Provider Identifier (NPI) number for the rendering provider has presented new challenges. The PIHP is proactively working on meeting this new requirement which necessitated retooling its processes and building infrastructure.

Validation of Performance Improvement Projects

The 2011–2012 validation of performance improvement projects for **CMH Affiliation of Mid-Michigan** identified opportunities for improvement in Activities VIII—Analyze Data and Interpret Study Results and IX—Assess for Real Improvement. In its 2012–2013 PIP submission, the PIHP presented results in a clear, accurate, and easy-to-understand format but did not correct discrepancies in the data reported for the first remeasurement period. **CMH Affiliation of Mid-Michigan** achieved statistically significant improvement in the study indicator.

CMH for Central Michigan

Compliance Monitoring

The previous compliance monitoring review for **CMH for Central Michigan** determined that the PIHP achieved full compliance on all six standards included in the 2012–2013 review cycle. There were no continued recommendations for improvement.

Validation of Performance Measures

CMH for Central Michigan took action as a result of the previous year's recommendations. The PIHP is now able to transfer CA encounter data into a separate database to evaluate volume prior to submission to MDCH. The challenge the PIHP faced the previous year with the minimum wage data element completeness was resolved by thorough monitoring and system edits available in the PIHP's Web-based electronic health record system, CIGMMO.

Validation of Performance Improvement Projects

The 2011–2012 validation of performance improvement projects for **CMH for Central Michigan** identified opportunities for improvement in Activity VIII—Analyze Data and Interpret Study Results. In its 2012–2013 PIP submission, the PIHP presented results in a clear, accurate, and easy-to-understand format and corrected discrepancies in the data reported for the first remeasurement period.

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 four of the six standards included in the 2012–2013 review cycle. The PIHP implemented corrective actions and successfully addressed the continued recommendations for improvement for Standard I—QAPIP Plan and Structure, and Standard XIV—Appeals. **CMH Partnership of Southeastern Michigan** demonstrated that Behavior Treatment Committee data were routinely reviewed and analyzed by the PIHP and developed a template letter for the notice of disposition to ensure that all required information was included in the notice of disposition for appeals that were not resolved fully in favor of the beneficiary.

Validation of Performance Measures

CMH Partnership of Southeastern Michigan took action as a result of the previous year's recommendations. The PIHP was encouraged last year to work with its vendor and MDCH to resolve gaps in data affecting QI data element completeness. Although this issue was investigated last year, the monitoring reports reflected a resolution to the issue with QI data elements reflecting near 100 percent completeness, so the PIHP presumed the issue was resolved. The PIHP will continue to work to resolve this issue per auditor recommendations. **CMH Partnership of Southeastern Michigan** was able to resolve the challenges with the HSW rate, which now reflects high performance. The PIHP was advised to monitor substance abuse data, as the ROSC was more widely implemented in 2012. The PIHP has been monitoring the data and challenges in data capture for reporting purposes. The PIHP feels the rates do not reflect true performance, as the ROSC is a true continuum of care, and there is really no gap between discharge and follow-up services. **CMH Partnership of Southeastern Michigan** is continuing to work on this issue.

Validation of Performance Improvement Projects

The 2011–2012 validation of performance improvement projects for **CMH Partnership of Southeastern Michigan** identified opportunities for improvement in Activity VIII—Analyze Data and Interpret Study Results. In its 2012–2013 PIP submission, the PIHP addressed factors that affected the ability to compare results between measurement periods and included an interpretation of the extent to which the PIP was successful.

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 two of the six standards included in the 2012–2013 review cycle. The PIHP implemented corrective actions and successfully addressed six of the eight continued recommendations for improvement. For Standard I—QAPIP Plan and Structure, **Detroit-Wayne County CMH Agency** demonstrated compliance with the requirement for quarterly review of analyses of data from the Behavior Treatment Review Committee, including the numbers of interventions and length of time the interventions were used per person. For Standard VII—Enrollee Grievance Process, the PIHP demonstrated timely resolution of grievances but should ensure that written notices of disposition include an accurate date for the resolution of the grievance. **Detroit-Wayne County CMH Agency** improved its performance on the Michigan Mission-Based Performance Indicator System (MMBPIS) rates reported for Standard XII—Access and Availability. The PIHP met or exceeded the minimum performance standard for timely face-to-face assessments for children with a developmental disability, as well as for access to ongoing services for adults and children with a mental illness. The PIHP should continue efforts to meet the 95 percent standard for timely access to ongoing services for children with a developmental disability. For Standard XIV—Appeals, **Detroit-Wayne County CMH Agency** demonstrated compliance with the requirements related to providing notices of disposition for beneficiary appeals.

Validation of Performance Measures

Detroit-Wayne County CMH Agency continued its efforts to centralize and standardize processes across the MCPNs. As of October 2013, all MCPNs used their own custom Peter Chang Enterprises (PCE) systems. The PIHP actively monitored its performance using the performance indicators and analyzed the root cause when rates fell below the minimum performance standard to determine a plan of action.

Validation of Performance Improvement Projects

The 2011–2012 validation of performance improvement projects for **Detroit-Wayne County CMH Agency** identified one *Point of Clarification* in Activity VII. In its 2012–2013 PIP submission, the PIHP included a narrative discussion about the success of quality improvement actions and how the interventions were standardized and monitored as a result of those actions.

Genesee County CMH

Compliance Monitoring

The previous compliance monitoring review for **Genesee County CMH** determined that the PIHP achieved full compliance on all six standards included in the 2012–2013 review cycle. There were no continued recommendations for improvement.

Validation of Performance Measures

Genesee County CMH was encouraged to continue to work with MDCH regarding challenges with CHAMPS and encounter reconciliation processes. The PIHP continued this effort, and although the issues have not been resolved, the PIHP continued to be persistent in raising awareness regarding its challenges with CHAMPS, and requested more frequent, automated reports in order to perform ongoing encounter data evaluation/reconciliation.

Validation of Performance Improvement Projects

The 2011–2012 validation of performance improvement projects for **Genesee County CMH** 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. In its 2012–2013 PIP submission, the PIHP included a narrative discussion about the success of quality improvement actions and how the interventions were standardized and monitored as a result of those actions, but it provided only a partial interpretation of the findings for the study indicator. While the study indicator demonstrated improvement, **Genesee County CMH** continued to achieve only improvement that was not statistically significant.

Lakeshore Behavioral Health Alliance

Compliance Monitoring

The previous compliance monitoring review for **Lakeshore Behavioral Health Alliance** determined that the PIHP achieved full compliance on two of the six standards included in the 2012–2013 review cycle. The PIHP implemented corrective actions and successfully addressed four of the eight continued recommendations for improvement. For Standard I—QAPIP Plan and Structure, the PIHP provided documentation that the governing body approved an annual QI Plan. For Standard V—Utilization Management, **Lakeshore Behavioral Health Alliance** demonstrated that reasons for denial decisions were made available to the beneficiary, that beneficiaries received notifications of denials, and that the PIHP monitored affiliates' performance on the delegated utilization management function. The PIHP should continue efforts to ensure that the reason for the denial is clearly documented and that decisions to deny or reduce services are made by health care professionals who have the appropriate clinical expertise to treat the beneficiary's condition. For Standard VII—Enrollee Grievance Process and Standard XIV—Appeals, **Lakeshore Behavioral Health Alliance** should continue efforts to comply with all requirements for providing a notice of disposition of the grievance or appeal.

Validation of Performance Measures

Lakeshore Behavioral Health Alliance acted on the recommendation to investigate the cause of the drop in the penetration rate during the previous review period and found that it was due to incomplete encounter submissions. **Lakeshore Behavioral Health Alliance** has mitigated the gap, and the penetration rate has returned to a more reasonable level. The PIHP did not explore options with its vendor, Avatar, to incorporate increased automation into its software because the PIHP is exploring moving to another vendor.

Validation of Performance Improvement Projects

The 2011–2012 validation of performance improvement projects for **Lakeshore Behavioral Health Alliance** identified a *Point of Clarification* in Activity VIII— Analyze Data and Interpret Study Results as an opportunity for improvement. In its 2012–2013 PIP submission, the PIHP did not address the *Point of Clarification* from the prior year. The data reported in the PIP narrative did not match the data reported in the Activity IX table.

LifeWays

Compliance Monitoring

The previous compliance monitoring review for **LifeWays** determined that the PIHP achieved full compliance on four of the six standards included in the 2012–2013 review cycle. The PIHP implemented corrective actions and successfully addressed the continued recommendations for improvement for Standard VII—Enrollee Grievance Process and Standard XIV—Appeals. **LifeWays** demonstrated compliance with the requirements for handling grievances and documented internal appeals procedures that addressed the beneficiary's right to a State fair hearing.

Validation of Performance Measures

LifeWays took action as a result of previous recommendations to evaluate and improve performance indicator data due to low performance. **LifeWays** evaluated and streamlined processes and has already seen some improvements in a short period of time. Another recommendation was for the PIHP to formally monitor CA encounter data completeness, which was considered, but due to the transition from one CA to another and the issues that resulted from that change, this monitoring was not accomplished.

Validation of Performance Improvement Projects

The 2011–2012 validation of performance improvement projects for **LifeWays** identified opportunities for improvement in Activity VIII—Analyze Data and Interpret Study Results and Activity IX—Assess for Real Improvement. **LifeWays** presented results in a clear, accurate, and easy-to-understand format and included a statement that the PIP had no factors that affected the ability to compare results between the first and second Remeasurement periods. HSAG again could not replicate the statistical testing results reported by **LifeWays**. The PIHP did not achieve improvement in the study indicator as the rate showed a decline from Remeasurement 1 to Remeasurement 2.

Macomb County CMH Services

Compliance Monitoring

The previous compliance monitoring review for **Macomb County CMH Services** determined that the PIHP achieved full compliance on five of the six standards included in the 2012–2013 review cycle. The PIHP implemented corrective actions and successfully addressed the continued recommendation for improvement for Standard XIV—Appeals. **Macomb County CMH Services** demonstrated compliance with the requirement for acknowledging receipt of appeals.

Validation of Performance Measures

Macomb County CMH Services took appropriate actions to address the previous year's recommendations. The PIHP compiled extensive documentation, worked closely with its vendor, and conducted careful and thorough planning related to its major upgrade to FOCUS, which was successful. **Macomb County CMH Services** made concerted efforts to employ system edits and staff education to improve QI data completeness, which were also successful.

Validation of Performance Improvement Projects

The 2011–2012 validation of performance improvement projects for **Macomb County CMH Services** 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. In its 2012–2013 PIP submission, **Macomb County CMH Services** documented the historical rate of peer-delivered services; included timelines for the collection of baseline and remeasurement data; provided an interpretation of findings; presented results in a clear, accurate, and easy-to-understand format; reported that the PIP had no factors that affected the ability to compare results between measurement periods; and included an interpretation of the extent to which the PIP was successful. **Macomb County CMH Services** should continue its efforts to address standardization and monitoring of interventions going forward, ensure accurate statistical testing results for Remeasurements 1 and 2, and achieve statistically significant improvement in the study indicator.

network180

Compliance Monitoring

The previous compliance monitoring review for **network180** determined that the PIHP achieved full compliance on three of the six standards included in the 2012–2013 review cycle. The PIHP implemented corrective actions and successfully addressed two of the four continued recommendations for improvement. For Standard VII—Enrollee Grievance Process and Standard XIV—Appeals, **network180** demonstrated compliance with the requirements related to having a grievance process in place for enrollees and ensuring that decisions on appeals are made by individuals who had no prior involvement in any previous level of review or decision-making. For Standard XII—Access and Availability, **network180** should continue efforts to meet the minimum performance standard for timely access to ongoing services for children with a mental illness and adults with a developmental disability.

Validation of Performance Measures

network180 acted on the recommendation to improve QI data completeness. The efforts clearly were effective, resulting in required QI data elements meeting the State's threshold of 95 percent completeness for first quarter SFY 2013. Other recommendations related to automation or electronic capture of exceptions and outliers, and expanded data capture for performance indicator reporting were not addressed, as the PIHP was preparing for transitioning to a new clinical system. These improvements will be addressed once the new system goes live in the next year.

Validation of Performance Improvement Projects

The 2011–2012 validation of performance improvement projects for **network180** identified opportunities for improvement in Activity IX—Assess for Real Improvement. In its 2012–2013 PIP submission, the PIHP demonstrated improvement in the study indicator that was consistent with the planned and implemented interventions. However, **network180** did not achieve improvement that was statistically significant.

NorthCare

Compliance Monitoring

The previous compliance monitoring review for **NorthCare** determined that the PIHP achieved full compliance on four of the six standards included in the 2012–2013 review cycle. The PIHP implemented corrective actions and successfully addressed the three continued recommendations for improvement for Standard VII—Enrollee Grievance Process and Standard XIV—Appeals. **NorthCare** demonstrated compliance with the requirements for notices of disposition for grievances and appeals.

Validation of Performance Measures

NorthCare took action related to the previous year's recommendations. **NorthCare** continued its efforts to improve rates; for example, the PIHP's recidivism rate improved greatly over the previous year, with fewer consumers being readmitted within 30 days of discharge. The PIHP monitored all rates on an ongoing basis, and any outliers over two consecutive quarters required affiliates to submit a corrective action plan.

Validation of Performance Improvement Projects

The 2011–2012 validation of performance improvement projects for **NorthCare** identified opportunities for improvement in Activity VIII—Analyze Data and Interpret Study Results and Activity IX—Assess for Real Improvement. In its 2012–2013 PIP submission, the PIHP presented results in a clear, accurate, and easy-to-understand format; included documentation of statistical testing between measurement periods; and reported that the PIP had no factors that affected the ability to compare results between measurement periods. However, **NorthCare** reported improvement for this measurement period that was not statistically significant.

Northern Affiliation

Compliance Monitoring

The previous compliance monitoring review for **Northern Affiliation** determined that the PIHP achieved full compliance on five of the six standards included in the 2012–2013 review cycle. The PIHP implemented corrective actions and successfully addressed the continued recommendation for improvement for Standard XII—Access and Availability. **Northern Affiliation** improved its performance and exceeded the minimum performance standard for timely access to ongoing services for adults with a developmental disability.

Validation of Performance Measures

Northern Affiliation acted on recommendations made as part of last year's audit. The PIHP successfully worked through the issues it faced with CHAMPS and encounter data submission, and penetration rates reflected an improvement in encounter data completeness. **Northern Affiliation** continued to monitor QI and HSW data, with performance at or above MDCH thresholds.

Validation of Performance Improvement Projects

The 2011–2012 validation of performance improvement projects for **Northern Affiliation** identified one *Point of Clarification* for Activity VIII—Analyze Data and Interpret Study Results as an opportunity for improvement. In its 2012–2013 PIP submission, the PIHP correctly reported the rate increase between measurement periods as a percentage point increase.

Northwest CMH Affiliation

Compliance Monitoring

The previous compliance monitoring review for **Northwest CMH Affiliation** determined that the PIHP achieved full compliance on four of the six standards included in the 2012–2013 review cycle. The PIHP implemented corrective actions and successfully addressed one of the two continued recommendations for improvement. For Standard V—Utilization Management, **Northwest CMH Affiliation** should continue efforts to ensure that beneficiaries are being provided with written notification of a utilization management denial. For Standard VII—Enrollee Grievance Process, **Northwest CMH Affiliation** demonstrated compliance with the requirements related to the notice of disposition.

Validation of Performance Measures

Northwest CMH Affiliation continued its close monitoring of data and considered the recommendation to automate indicators 2 and 3. However, due to system challenges and the need to manually review and validate each exclusion or outlier, the PIHP deemed this recommendation impractical. From a data quality perspective, the need for manual validation will likely always exist.

Validation of Performance Improvement Projects

The 2011–2012 validation of performance improvement projects for **Northwest CMH Affiliation** identified opportunities for improvement in Activity IX—Assess for Real Improvement. In its 2012–2013 PIP submission, the PIHP documented improvement in the study indicator, demonstrated that the improvement was consistent with the planned and implemented interventions, and provided statistical evidence that the reported improvement was statistically significant.

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 six standards included in the 2012–2013 review cycle. 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 transitioned the final core provider onto its electronic medical record and transactional system, ODIN, in October 2012. The one remaining provider not using ODIN, may decide not to make the transition. While the PIHP continued its efforts to explore ways to fully automate performance indicator rates for reporting, there may always be a manual verification component to exception review. Lastly, the auditor recommended that the PIHP closely monitor rates that did not meet expected performance levels. **Oakland County CMH Authority** closely monitored rates that did not meet expected performance levels. The corrective action plan had good results, with performance improving within a short period of time.

Validation of Performance Improvement Projects

The 2011–2012 validation of performance improvement projects for **Oakland County CMH Authority** identified opportunities for improvement in Activity IX—Assess for Real Improvement. In its 2012–2013 PIP submission, the PIHP did not demonstrate improvement in the study indicator and should continue efforts to achieve improvement in processes or outcomes of care that appears to be the result of planned interventions and is statistically significant.

Saginaw County CMH Authority

Compliance Monitoring

The previous compliance monitoring review for **Saginaw County CMH Authority** determined that the PIHP achieved full compliance on three of the six standards included in the 2012–2013 review cycle. The PIHP implemented corrective actions and successfully addressed four of the eight continued recommendations for improvement. For Standard I—QAPIP Plan and Structure, **Saginaw County CMH Authority** demonstrated that data from the Behavior Treatment Committee were routinely reviewed and analyzed by the PIHP. For Standard VII—Enrollee Grievance Process, **Saginaw County CMH Authority** ensured that beneficiaries received the required information about grievances but should continue efforts to ensure that the PIHP resolves all grievances within 60 days of receipt of the grievance. **Saginaw County CMH Authority** improved its performance on the Michigan Mission-Based Performance Indicator System (MMBPIS) rates reported for Standard XII—Access and Availability. The PIHP exceeded the minimum performance standard for access to ongoing services for adults with a mental illness and timely follow-up care after discharge from a detox unit. The PIHP should continue efforts to meet the 95 percent standard for timely access to ongoing services for children with a mental illness and adults with a developmental disability as well as for timely follow-up care after discharge from a psychiatric inpatient unit for children with a mental illness.

Validation of Performance Measures

Saginaw County CMH Authority reviewed the recommendation to evaluate the default date assigned in its data system, Sentri, when providers entered service data, and to determine if edits in the system were necessary to prohibit the default date from automatically populating. After reviewing the system, provider documentation practices, and other edits, it was determined that staff training would be implemented to reinforce the need to ensure the correct date of service was entered, as opposed to allowing the default of "today's date" to remain.

Validation of Performance Improvement Projects

The 2011–2012 validation of performance improvement projects for **Saginaw County CMH Authority** identified opportunities for improvement in Activities VI—Reliably Collect Data, VIII—Analyze Data and Interpret Study Results, and IX—Assess for Real Improvement. In its 2012–2013 PIP submission, the PIHP included an interpretation of the findings for the study indicator. **Saginaw County CMH Authority** should continue its efforts to address the remaining recommendations to include timelines for the remeasurement periods, ensure that data reported are accurate and consistent between the narrative and tables, document any factors that may have affected the ability to compare data between measurement periods, and achieve statistically significant improvement in processes or outcomes of care that appears to be the result of planned interventions.

Southwest Affiliation

Compliance Monitoring

The previous compliance monitoring review for **Southwest Affiliation** determined that the PIHP achieved full compliance on the five of the six standards included in the 2012–2013 review cycle. The PIHP implemented corrective actions and successfully addressed the continued recommendation for improvement for Standard XII—Access and Availability. **Southwest Affiliation** improved its performance and exceeded the minimum performance standard for access to ongoing services for adults with a developmental disability.

Validation of Performance Measures

Southwest Affiliation took appropriate actions related to previous recommendations. The prior year's recommendations were related to low QI data completeness issues. The recommendation was for **Southwest Affiliation** to consider all options available, including incentives, in order to obtain complete QI data (instead of depending on the new system alone to mitigate the gap). The PIHP found that as the PIHP's new health information system Streamline was implemented, there were numerous ways to ensure QI data were captured, including reports and system flags, as well as supervisory review and reinforcement. **Southwest Affiliation** discovered it misunderstood how MDCH calculates QI data completeness and took action to correct this issue.

Validation of Performance Improvement Projects

The 2011–2012 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 five of the six standards included in the 2012–2013 review cycle. The PIHP should continue efforts to address the continued recommendation for improvement for Standard XIV—Appeals and ensure that for appeals not resolved fully in favor of the beneficiary, the notice of disposition includes all required information.

Validation of Performance Measures

Thumb Alliance PIHP continued to actively work with and provide feedback to MDCH related to challenges with reporting requirements. The PIHP raised questions or concerns as they presented, reflecting an active, collaborative relationship benefiting both parties. **Thumb Alliance PIHP** continued to monitor its QI data completeness, and all required QI data elements met required thresholds.

Validation of Performance Improvement Projects

The 2011–2012 validation of performance improvement projects for **Thumb Alliance PIHP** 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. In its 2012–2013 PIP submission, the PIHP successfully addressed all recommendations by reporting accurate denominators for each measurement period throughout the PIP documentation and data analysis and demonstrating statistically significant improvement in the study indicator that was consistent with the planned and implemented interventions.

Venture Behavioral Health

Compliance Monitoring

The previous compliance monitoring review for **Venture Behavioral Health** determined that the PIHP achieved full compliance on five of the six standards included in the 2012–2013 review cycle. The PIHP implemented corrective actions and successfully addressed the continued recommendation for improvement on Standard V—Utilization Management. **Venture Behavioral Health** conducted site visits of the affiliates and monitored delegates' performance to ensure compliance with standards related to service authorizations.

Validation of Performance Measures

Venture Behavioral Health implemented consumer-level data validation as part of the ongoing reporting process for the performance indicators by using its standing practice of generating reports. The PIHP provided the reports to the affiliates and made them responsible for the consumer-level data validation.

Validation of Performance Improvement Projects

The 2011–2012 validation of performance improvement projects for **Venture Behavioral Health** identified an opportunity for improvement in Activity VIII—Analyze Data and Interpret Study Results. In its 2012–2013 PIP submission, the PIHP reported that the PIP had no factors that affected the ability to compare results between measurement periods.

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 2012–2013 compliance monitoring reviews compared to the results of previous reviews to provide an overview of the PIHP and statewide performance trends on the six compliance monitoring standards addressed in the 2012–2013 review cycle.

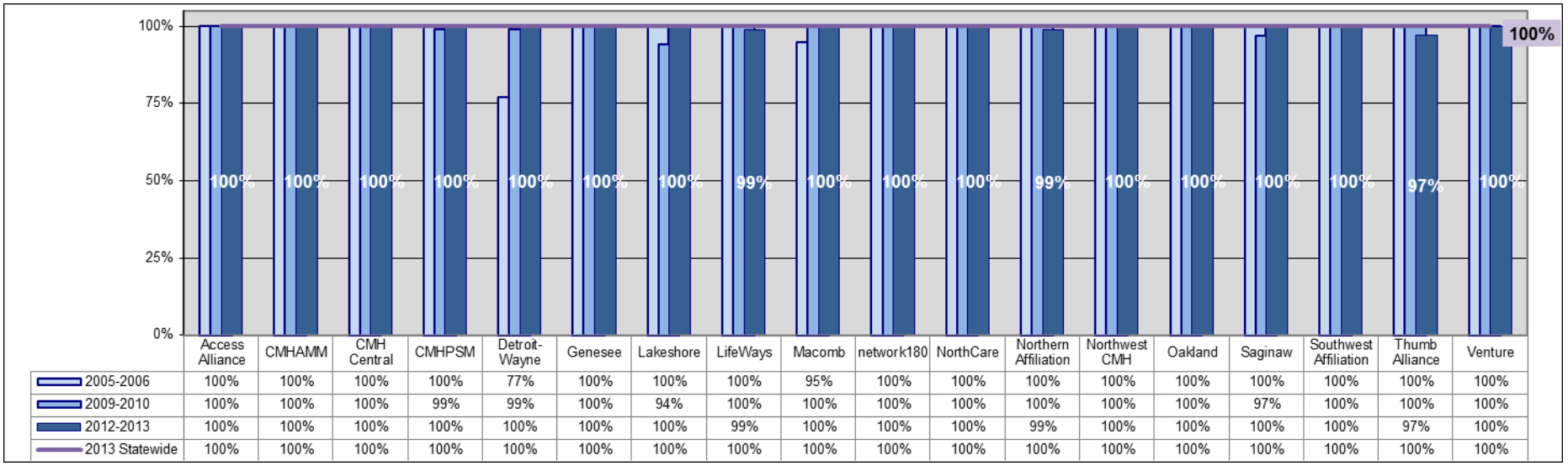
Compliance Monitoring Standards

Figure A-1 through Figure A-6 present compliance scores for each of the 18 PIHPs for the following standards:

- Standard I—QAPIP Program and Structure
- Standard IV—Staff Training and Qualifications
- Standard V—Utilization Management
- Standard VII—Enrollee Grievance Process
- Standard XII—Access and Availability
- Standard XIV—Appeals

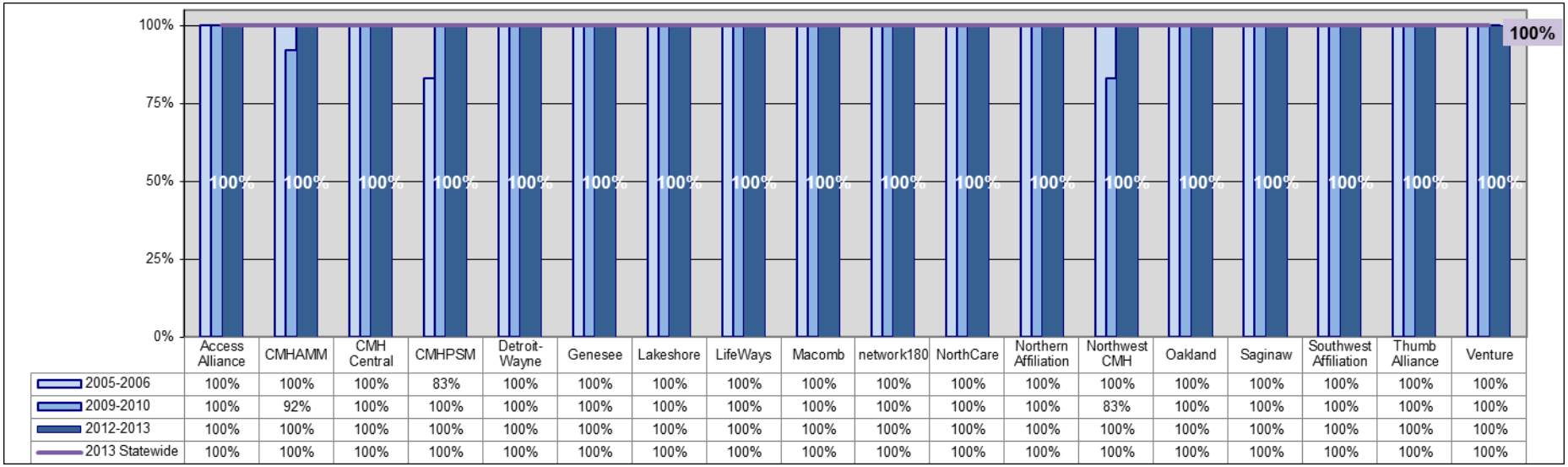
The figures present the PIHPs' performance for the prior review cycles, showing combined scores after each follow-up review. Standards I through VIII were reviewed in 2004–2005, with a follow-up review in 2005–2006. Standards IX through XIV were reviewed in 2006–2007, with a follow-up review in 2007–2008. 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 2012–2013 reviews, as well as the statewide score for each of the six compliance monitoring standards included in the 2012–2013 review.

Figure A-1—Standard I: QAPIP Plan and Structure



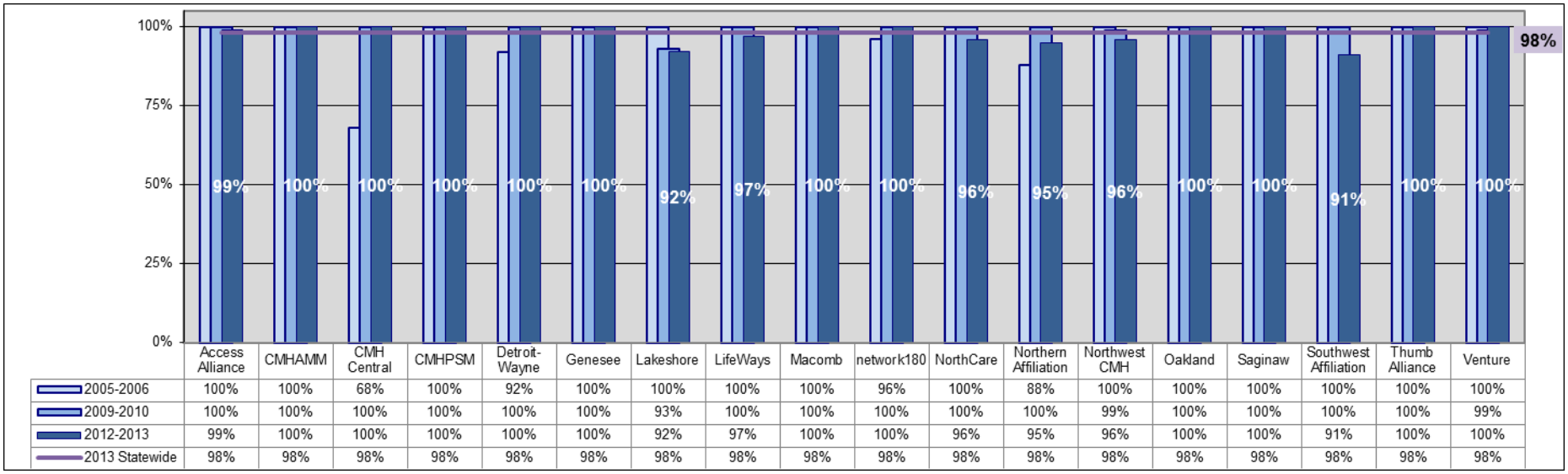
	Access Alliance	CMHAMM	CMH Central	CMHPSM	Detroit-Wayne	Genesee	Lakeshore	LifeWays	Macomb	network180	NorthCare	Northern Affiliation	Northwest CMH	Oakland	Saginaw	Southwest Affiliation	Thumb Alliance	Venture
2005-2006	100%	100%	100%	100%	77%	100%	100%	100%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%
2009-2010	100%	100%	100%	99%	99%	100%	94%	100%	100%	100%	100%	100%	100%	100%	97%	100%	100%	100%
2012-2013	100%	100%	100%	100%	100%	100%	100%	99%	100%	100%	100%	99%	100%	100%	100%	100%	97%	100%
2013 Statewide	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Figure A-2—Standard IV: Staff Qualifications and Training



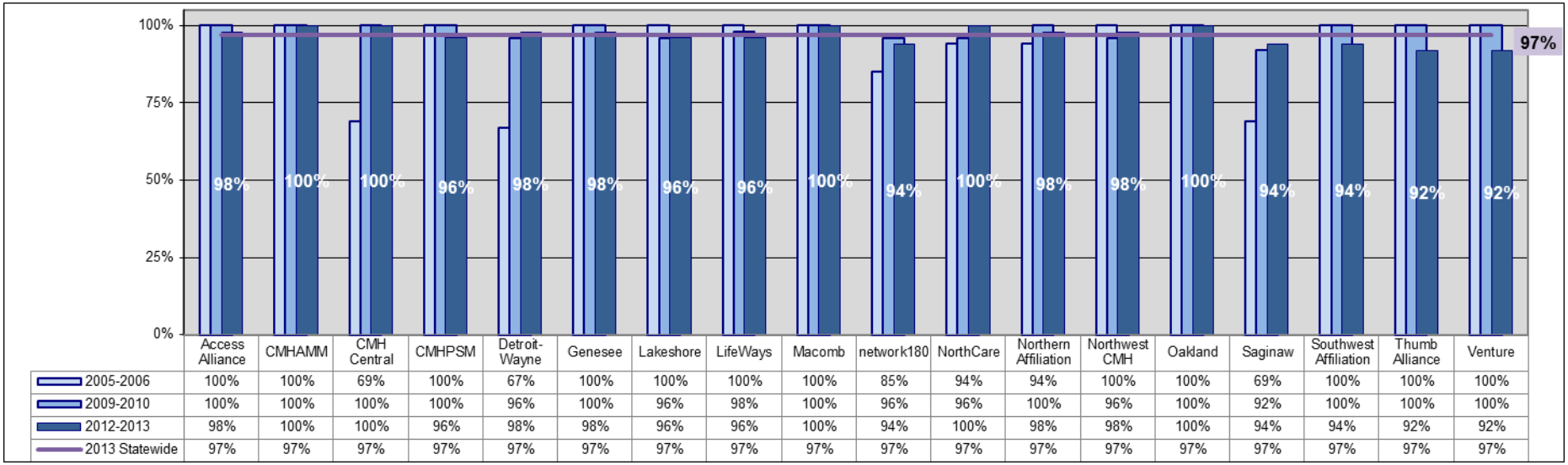
	Access Alliance	CMHAMM	CMH Central	CMHPSM	Detroit-Wayne	Genesee	Lakeshore	LifeWays	Macomb	network180	NorthCare	Northern Affiliation	Northwest CMH	Oakland	Saginaw	Southwest Affiliation	Thumb Alliance	Venture
2005-2006	100%	100%	100%	83%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
2009-2010	100%	92%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	83%	100%	100%	100%	100%	100%
2012-2013	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
2013 Statewide	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Figure A-3—Standard V: Utilization Management



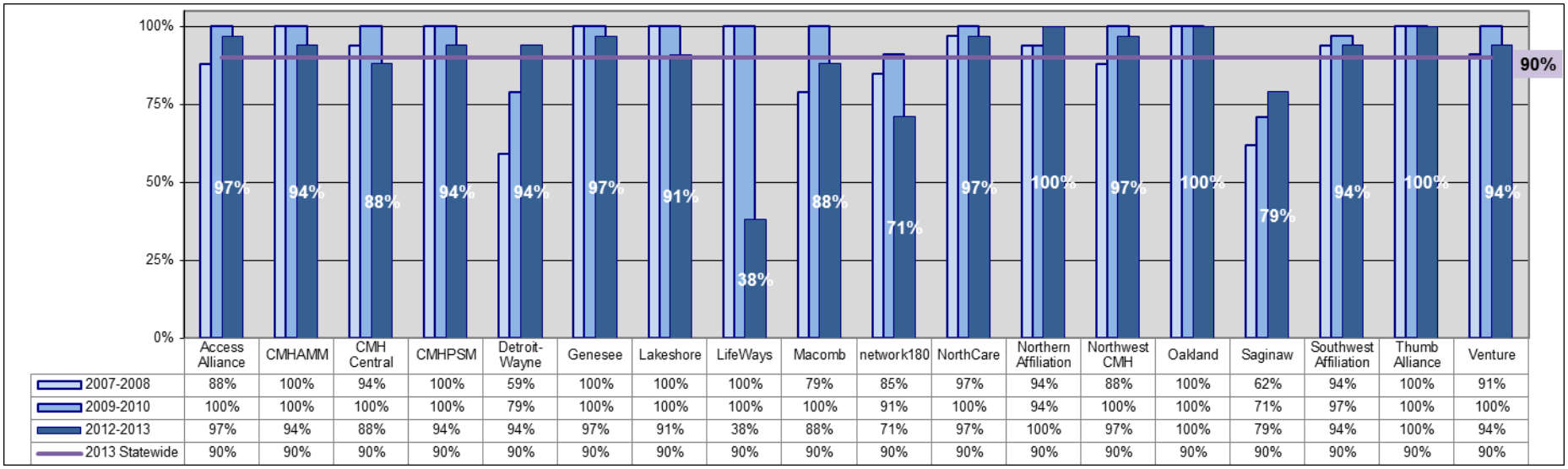
	Access Alliance	CMHAMM	CMH Central	CMHPSM	Detroit-Wayne	Genesee	Lakeshore	LifeWays	Macomb	network180	NorthCare	Northern Affiliation	Northwest CMH	Oakland	Saginaw	Southwest Affiliation	Thumb Alliance	Venture
2005-2006	100%	100%	68%	100%	92%	100%	100%	100%	100%	96%	100%	88%	100%	100%	100%	100%	100%	100%
2009-2010	100%	100%	100%	100%	100%	100%	93%	100%	100%	100%	100%	100%	99%	100%	100%	100%	100%	99%
2012-2013	99%	100%	100%	100%	100%	100%	92%	97%	100%	100%	96%	95%	96%	100%	100%	91%	100%	100%
2013 Statewide	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%

Figure A-4—Standard VII: Enrollee Grievance Process



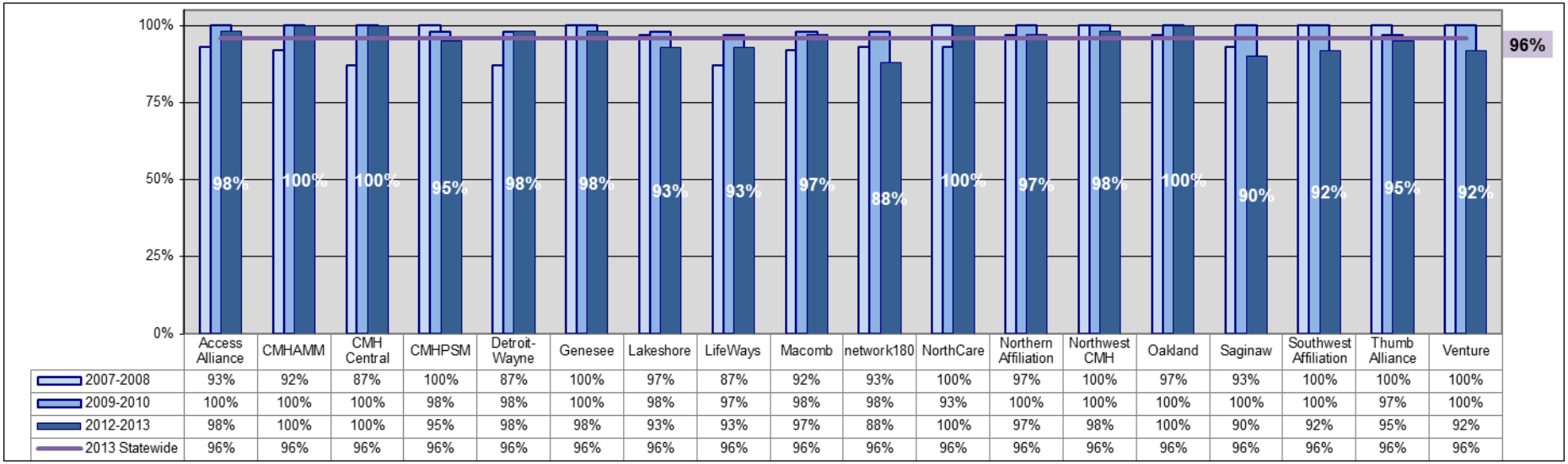
	Access Alliance	CMHAMM	CMH Central	CMHPSM	Detroit-Wayne	Genesee	Lakeshore	LifeWays	Macomb	network180	NorthCare	Northern Affiliation	Northwest CMH	Oakland	Saginaw	Southwest Affiliation	Thumb Alliance	Venture
2005-2006	100%	100%	69%	100%	67%	100%	100%	100%	100%	85%	94%	94%	100%	100%	69%	100%	100%	100%
2009-2010	100%	100%	100%	100%	96%	100%	96%	98%	100%	96%	96%	100%	96%	100%	92%	100%	100%	100%
2012-2013	98%	100%	100%	96%	98%	98%	96%	96%	100%	94%	100%	98%	98%	100%	94%	94%	92%	92%
2013 Statewide	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%

Figure A-5—Standard XII: Access and Availability



	Access Alliance	CMHAMM	CMH Central	CMHPSM	Detroit-Wayne	Genesee	Lakeshore	LifeWays	Macomb	network180	NorthCare	Northern Affiliation	Northwest CMH	Oakland	Saginaw	Southwest Affiliation	Thumb Alliance	Venture
2007-2008	88%	100%	94%	100%	59%	100%	100%	100%	79%	85%	97%	94%	88%	100%	62%	94%	100%	91%
2009-2010	100%	100%	100%	100%	79%	100%	100%	100%	100%	91%	100%	94%	100%	100%	71%	97%	100%	100%
2012-2013	97%	94%	88%	94%	94%	97%	91%	38%	88%	71%	97%	100%	97%	100%	79%	94%	100%	94%
2013 Statewide	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%

Figure A-6—Standard XIV: Appeals



	Access Alliance	CMHAMM	CMH Central	CMHPSM	Detroit-Wayne	Genesee	Lakeshore	LifeWays	Macomb	network180	NorthCare	Northern Affiliation	Northwest CMH	Oakland	Saginaw	Southwest Affiliation	Thumb Alliance	Venture
2007-2008	93%	92%	87%	100%	87%	100%	97%	87%	92%	93%	100%	97%	100%	97%	93%	100%	100%	100%
2009-2010	100%	100%	100%	98%	98%	100%	98%	97%	98%	98%	93%	100%	100%	100%	100%	100%	97%	100%
2012-2013	98%	100%	100%	95%	98%	98%	93%	93%	97%	88%	100%	97%	98%	100%	90%	92%	95%	92%
2013 Statewide	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%

PIHP Compliance

Table A-1 presents the compliance scores for all 18 PIHPs on the six compliance monitoring standards reviewed in 2012–2013 (Standards I, IV, V, VII, XII, and XIV). The remaining standards were addressed in the previous compliance review cycle.

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

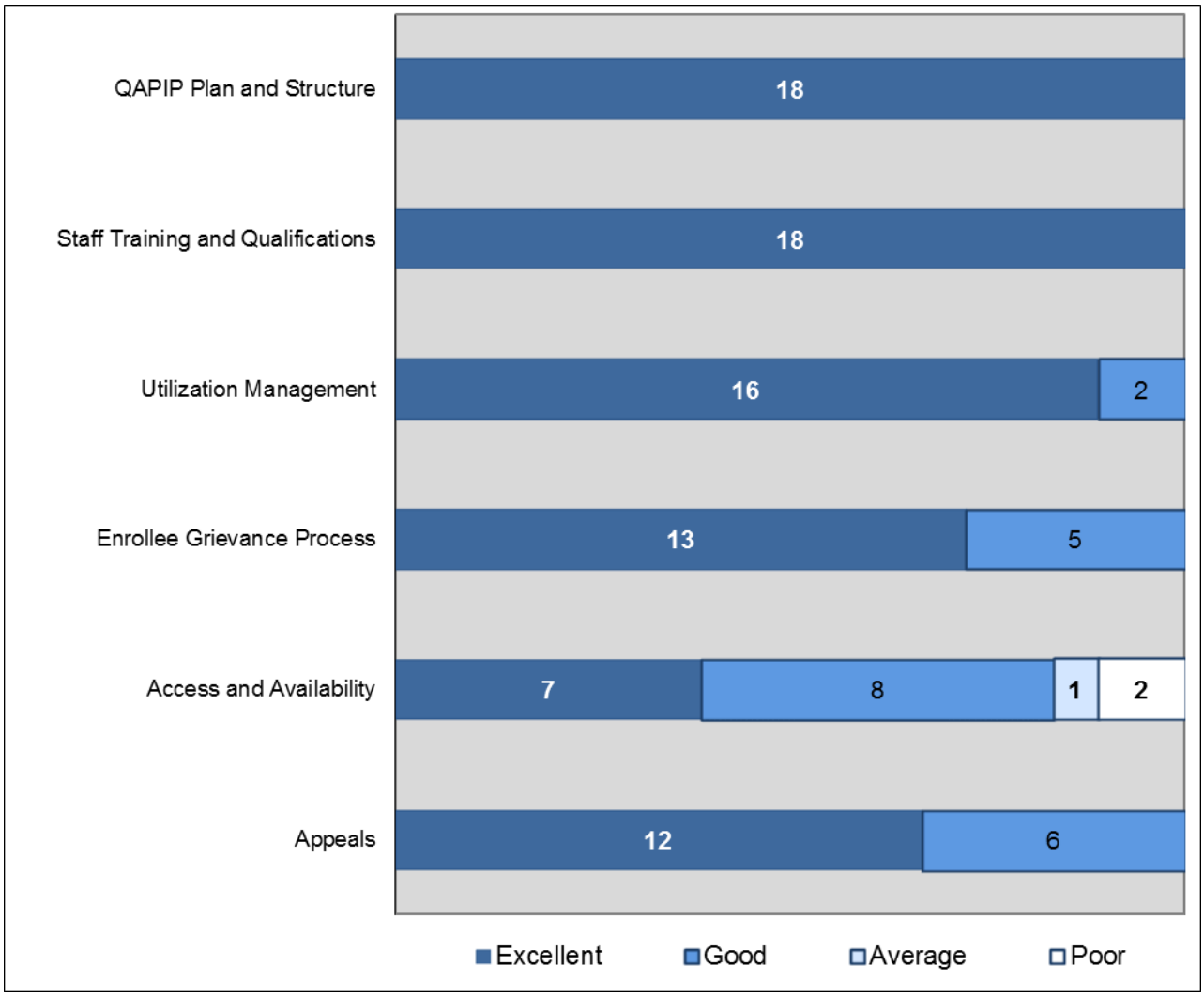
PIHP	I. QAPIP Plan and Structure	IV. Staff Qualifications and Training	V. Utilization Management	VII. Enrollee Grievance Process	XII. Access and Availability	XIV. Appeals
Access Alliance	100%	100%	99%	98%	97%	98%
CMHAMM	100%	100%	100%	100%	94%	100%
CMH Central	100%	100%	100%	100%	88%	100%
CMHPSM	100%	100%	100%	96%	94%	95%
Detroit-Wayne	100%	100%	100%	98%	94%	98%
Genesee	100%	100%	100%	98%	97%	98%
Lakeshore	100%	100%	92%	96%	91%	93%
LifeWays	99%	100%	97%	96%	38%	93%
Macomb	100%	100%	100%	100%	88%	97%
network180	100%	100%	100%	94%	71%	88%
NorthCare	100%	100%	96%	100%	97%	100%
Northern Affiliation	99%	100%	95%	98%	100%	97%
Northwest CMH	100%	100%	96%	98%	97%	98%
Oakland	100%	100%	100%	100%	100%	100%
Saginaw	100%	100%	100%	94%	79%	90%
Southwest Affiliation	100%	100%	91%	94%	94%	92%
Thumb Alliance	97%	100%	100%	92%	100%	95%
Venture	100%	100%	100%	92%	94%	92%
Statewide Score	100%	100%	98%	97%	90%	96%

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-7 presents the number of PIHPs receiving *Excellent/Good/Average/Poor* compliance scores for the 2012–2013 review for each of the six standards.

Figure A-7—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 2012–2013 validation, HSAG assigned each performance measure a validation finding designation of *Report*, *Not Reported*, or *No Benefit*. More detailed explanations of these designations can be found in Section 2 of this report.

Table A-2—Degree of Compliance for Performance Measures

Indicator		Percentage of PIHPs					
		Fully Compliant / Report		*Substantially Compliant / Not Reported*		*Not Valid / No Benefit*	
		2011 – 2012	2012 – 2013	2011 – 2012	2012 – 2013	2011 – 2012	2012 – 2013
1.	The percentage of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	100%	100%	0%	0%	0%	0%
2.	The percentage of new Medicaid beneficiaries during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service.	94%	100%	6%	0%	0%	0%
3.	The percentage of new Medicaid beneficiaries during the quarter starting any needed ongoing service within 14 days of a non-emergent face-to-face assessment with a professional.	94%	100%	6%	0%	0%	0%
4a.	The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.	94%	100%	6%	0%	0%	0%
4b.	The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.	94%	100%	6%	0%	0%	0%
5.	The percent of Medicaid recipients having received PIHP managed services.	94%	100%	6%	0%	0%	0%
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.	100%	100%	0%	0%	0%	0%
8.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who are employed competitively.	89%	100%	11%	0%	0%	0%
9.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.	61%	83%	39%	17%	0%	0%
10.	The percentage of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.	100%	100%	0%	0%	0%	0%
13.	The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	100%	100%	0%	0%	0%	0%
14.	The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	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	
			2011–2012	2012–2013
1.	The percentage of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children	99.09%	98.61%
		Adults	98.86%	98.38%
2.	The percentage of new Medicaid beneficiaries 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	97.81%	97.84%
		MI Adults	97.78%	98.64%
		DD Children	98.45%	97.60%
		DD Adults	98.75%	98.75%
		Medicaid SA	97.06%	98.47%
		Total	97.62%	98.30%
3.	The percentage of new Medicaid beneficiaries during the quarter starting any needed ongoing service within 14 days of a non-emergent face-to-face assessment with a professional.	MI Children	96.30%	95.07%
		MI Adults	97.59%	97.25%
		DD Children	97.18%	97.01%
		DD Adults	92.65%	97.30%
		Medicaid SA	98.45%	98.50%
		Total	97.22%	97.03%
4a.	The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.	Children	97.49%	97.33%
		Adults	97.58%	97.06%
4b.	The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.		99.19%	98.08%
5.	The percent of Medicaid recipients having received PIHP managed services.		6.95%	7.34%
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.		88.81%	99.39%
8.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who are employed competitively.	MI Adults	7.30%	7.39%
		DD Adults	7.65%	6.96%
		MI/DD Adults	7.74%	6.90%
9.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.	Adults with MI	71.30%	71.35%
		Adults with DD	28.81%	28.20%
		Adults With MI/DD	38.43%	36.22%

Table A-3—Statewide Performance Measure Rates				
Indicator			Reported Rate	
			2011–2012	2012–2013
10.	The percentage of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.	Children	9.93%	9.62%
		Adults	12.05%	14.86%
13.	The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).		18.63%	18.47%
14.	The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).		41.32%	39.42%

Table A-4 and Table A-5 present a two-year comparison of the PIHP-specific results for the validated performance indicators.

Table A-4—PIHP Performance Measure Results—Percentage Scores *for* Access
Comparison of Prior-Year (2011–2012) and Current-Year (2012–2013) Rates

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	P	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
	C	98.00	97.81	99.33	100	100	100	100	99.83	96.27	98.27	100	100	100	98.35	96.55	100	100
CMHAMM	P	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
	C	100	97.78	99.20	99.45	100	100	96.67	98.72	99.47	98.50	100	92.86	100	99.22	100	91.36	100
CMH Central	P	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
	C	100	97.12	96.73	98.45	100	100	100	97.94	95.98	99.47	100	100	100	98.10	100	96.77	100
CMHPSM	P	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
	C	100	100	99.36	100	100	100	95.12	98.81	100	95.71	100	96.30	97.06	97.82	100	99.01	50.00
Detroit-Wayne	P	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
	C	100	97.49	97.18	95.36	98.04	97.73	99.89	97.94	99.10	96.74	97.26	96.34	99.87	98.58	99.19	99.22	100
Genesee	P	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
	C	98.60	99.78	99.29	100	100	100	95.51	98.65	98.94	97.79	100	100	95.62	97.34	95.65	95.88	96.34
Lakeshore	P	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
	C	100	100	98.51	100	100	100	96.48	98.12	97.47	98.33	100	100	97.94	97.98	100	100	100
LifeWays	P	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
	C	94.12	96.77	73.13	82.43	92.86	88.89	100	84.36	74.65	96.05	57.14	81.82	100	87.79	93.33	95.12	100
Macomb	P	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
	C	98.66	99.48	98.18	99.32	85.71	95.24	100	98.62	98.80	99.35	95.45	100	100	99.39	98.73	93.85	100

Table A-4—PIHP Performance Measure Results—Percentage Scores *for* Access
Comparison of Prior-Year (2011–2012) and Current-Year (2012–2013) Rates

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
network180	P	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
	C	98.68	95.88	98.44	98.71	100	100	99.48	98.72	81.91	87.01	100	100	85.09	84.17	85.37	85.71	92.59
NorthCare	P	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
	C	100	99.34	97.94	98.99	100	100	99.09	98.81	98.67	98.77	100	100	100	99.31	87.50	97.14	100
Northern Affiliation	P	100	98.96	100	100	100	100	100	100	100	95.24	100	100	100	98.60	100	100	100
	C	100	100	99.34	98.86	100	91.67	100	99.05	98.85	97.56	100	100	100	98.82	100	100	100
Northwest CMH	P	94.12	100	98.82	96.47	100	100	100	98.14	97.14	100	100	100	100	99.06	100	100	100
	C	96.30	100	99.29	99.35	100	100	100	99.47	97.92	91.59	100	71.43	100	95.32	93.10	90.20	100
Oakland	P	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
	C	90.16	89.06	98.58	100	100	100	99.63	99.57	98.65	100	100	100	98.76	99.26	100	97.03	100
Saginaw	P	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
	C	100	100	100	100	100	100	100	100	95.00	96.55	100	100	98.02	97.27	91.67	100	100
Southwest Affiliation	P	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
	C	100	100	99.30	99.21	90.91	100	77.55	96.00	98.98	100	85.71	100	98.28	98.90	95.00	98.72	100
Thumb Alliance	P	100	100	99.16	99.29	100	100	100	99.55	100	100	100	100	100	100	100	100	100
	C	100	100	100	100	100	100	100	100	94.29	95.15	100	100	99.13	96.85	95.65	100	100
Venture	P	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*
	C	95.77	99.27	96.81	99.82	96.15	100	95.17	98.03	96.09	98.78	100	100	98.59	98.16	100	96.67	100

Note: * The PIHP reported no applicable discharges during the 2011–2012 reporting period.

Table A-5—PIHP Performance Measure Results—Percentage Scores *for* Penetration Rate, HSW Rate, and Outcomes Comparison of Prior-Year (2011–2012) and Current-Year (2012–2013) Rates													
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	P	9.08	94.13	10.67	9.22	12.41	79.72	36.29	38.84	5.71	10.58	21.04	66.89
	C	8.99	99.46	10.18	9.63	9.66	82.71	38.12	41.91	8.82	7.62	20.65	61.30
CMHAMM	P	6.45	97.01	8.96	9.03	10.37	77.93	58.27	55.28	6.25	7.69	13.73	49.75
	C	6.88	99.73	9.91	9.81	8.31	82.16	60.54	56.69	10.00	13.83	13.87	47.80
CMH Central	P	9.35	95.39	10.42	9.45	5.60	82.00	21.55	23.19	18.18	9.38	30.10	62.71
	C	10.09	99.81	10.13	8.21	4.57	79.14	15.80	13.85	0.00	12.12	28.57	56.10
CMHPSM	P	6.08	44.89	8.22	9.82	9.90	89.62	72.31	88.64	5.26	7.78	24.27	35.89
	C	6.93	98.06	9.14	9.29	6.76	87.35	72.43	77.50	9.52	11.11	24.90	32.59
Detroit-Wayne	P	7.16	96.77	4.26	2.89	3.90	58.72	12.87	31.37	11.78	12.61	22.86	21.56
	C	7.41	99.67	4.18	2.45	3.61	58.33	11.81	32.14	10.62	17.78	21.84	21.16
Genesee	P	7.08	97.60	4.73	6.65	4.89	64.23	16.00	20.93	10.20	11.28	7.58	46.83
	C	7.11	98.92	4.25	6.10	4.23	60.75	13.56	20.93	1.89	14.77	6.53	43.24
Lakeshore	P	3.60	98.74	8.04	9.32	8.42	77.33	28.92	28.13	0.00	5.71	10.96	60.31
	C	5.71	98.74	8.29	8.94	8.24	74.36	29.44	28.03	10.34	14.06	9.68	55.67
LifeWays	P	7.17	92.69	4.69	8.70	4.61	80.39	91.67	66.67	15.38	16.67	12.63	39.91
	C	7.02	100	5.98	5.06	5.18	72.13	63.64	64.29	13.33	13.79	16.03	41.02
Macomb	P	5.85	98.77	7.08	5.86	4.40	51.55	37.42	37.70	11.34	18.42	18.15	36.32
	C	5.97	99.59	6.86	6.20	4.32	58.33	38.50	29.09	11.63	18.88	15.94	34.80

Table A-5—PIHP Performance Measure Results—Percentage Scores *for* Penetration Rate, HSW Rate, and Outcomes
Comparison of Prior-Year (2011–2012) and Current-Year (2012–2013) Rates

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
network180	P	6.63	99.40	8.68	8.25	10.17	75.87	21.02	25.21	4.08	20.30	11.61	51.46
	C	7.12	99.40	9.76	6.48	9.27	81.31	18.91	27.98	4.65	17.14	10.41	49.85
NorthCare	P	7.51	97.75	10.19	5.95	5.86	73.27	31.23	41.11	17.39	20.45	17.83	58.11
	C	8.03	98.90	10.45	7.33	3.51	76.65	32.39	35.53	7.69	15.79	18.18	54.70
Northern Affiliation.	P	6.69	95.36	7.71	15.48	17.35	57.32	43.98	62.79	8.33	7.41	23.80	57.20
	C	7.52	99.08	9.14	13.25	18.40	58.41	38.07	60.92	2.78	2.13	24.11	55.89
Northwest CMH	P	7.66	95.05	9.58	9.50	8.43	94.55	52.27	78.40	17.65	12.73	7.39	58.80
	C	7.99	98.92	9.04	6.95	6.93	91.07	50.91	72.95	12.50	12.33	6.95	55.34
Oakland	P	7.78	98.94	8.10	12.70	8.92	61.76	34.68	23.39	8.00	10.80	17.66	34.18
	C	8.48	99.77	8.35	11.68	9.07	57.14	34.67	24.93	3.03	11.90	16.68	34.93
Saginaw	P	5.59	97.48	6.01	11.65	6.78	84.31	21.43	30.77	11.11	3.03	9.87	34.85
	C	5.17	100	5.58	8.09	2.65	77.19	25.45	31.58	13.64	14.29	9.29	31.56
Southwest Affiliation	P	7.15	40.26	9.09	11.45	9.56	82.89	42.57	58.18	10.87	6.19	19.47	59.31
	C	6.64	99.78	8.28	10.15	10.64	80.69	40.52	60.94	8.33	7.53	27.45	59.53
Thumb Alliance	P	8.02	98.95	8.19	3.93	3.72	35.38	9.69	12.23	8.33	12.05	15.84	56.65
	C	8.23	99.64	7.33	4.15	4.12	52.61	11.85	10.69	25.71	13.33	15.63	52.43
Venture	P	6.92	96.28	11.03	9.29	6.27	81.29	42.16	47.62	0.00	6.90	13.59	50.64
	C	7.80	99.69	10.37	8.22	5.23	71.43	52.54	48.60	9.52	6.02	14.19	47.08

Results for Validation of Performance Improvement Projects

Table A-6 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.*

Table A-6—Comparison of PIHPs' PIP Validation Status

Validation Status	Number of PIPs	
	2011–2012	2012–2013
Met	15	17
Partially Met	2	1
Not Met	1	0

Table A-7 presents a two-year comparison of statewide PIP validation results, showing how many of the PIPs reviewed for each activity received *Met* scores for all evaluation or critical elements.

Table A-7—Summary of Data From Validation of Performance Improvement Projects

Validation Activity		Number of PIPs Meeting All Evaluation Elements/ Number Reviewed		Number of PIPs Meeting All Critical Elements/ Number Reviewed	
		2011–2012	2012–2013	2011–2012	2012–2013
I.	Select the Study Topic(s)	17/18	18/18	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	17/18	18/18	17/18	18/18
V.	Use Sound Sampling Techniques*	*NA*	*NA*	*NA*	*NA*
VI.	Reliably Collect Data*	16/18	17/18	*NA*	*NA*
VII.	Implement Intervention and Improvement Strategies	15/18	14/18	18/18	18/18
VIII.	Analyze Data and Interpret Study Results	7/18	6/18	18/18	18/18
IX.	Assess for Real Improvement	7/18	5/18	*No critical elements*	
X.	Assess for Sustained Improvement	0/0	12/12	*No critical elements*	

*HSAG scored all elements for Activity V and the critical element in Activity VI *Not Applicable* for all PIPs.

Table A-8 presents a two-year comparison of PIP scores for each PIHP.

Table A-8—Comparison of PIHP PIP Validation Scores						
PIHP	% of All Evaluation Elements *Met*		% of All Critical Elements *Met*		Validation Status	
	2011–2012	2012–2013	2011–2012	2012–2013	2011–2012	2012–2013
Access Alliance	82%	91%	100%	100%	*Met*	*Met*
CMHAMM	91%	97%	100%	100%	*Met*	*Met*
CMH Central	94%	94%	100%	100%	*Met*	*Met*
CMHPSM	94%	91%	100%	100%	*Met*	*Met*
Detroit-Wayne	100%	100%	100%	100%	*Met*	*Met*
Genesee	91%	91%	100%	100%	*Met*	*Met*
Lakeshore	100%	85%	100%	100%	*Met*	*Met*
LifeWays	82%	88%	100%	100%	*Met*	*Met*
Macomb	73%	91%	100%	100%	*Partially Met*	*Met*
network180	91%	82%	100%	100%	*Met*	*Met*
NorthCare	88%	97%	100%	100%	*Met*	*Met*
Northern Affiliation	100%	100%	100%	100%	*Met*	*Met*
Northwest CMH	91%	94%	100%	100%	*Met*	*Met*
Oakland	91%	88%	100%	100%	*Met*	*Met*
Saginaw	76%	79%	100%	100%	*Partially Met*	*Partially Met*
Southwest Affiliation	100%	94%	100%	100%	*Met*	*Met*
Thumb Alliance	73%	100%	90%	100%	*Not Met*	*Met*
Venture	97%	94%	100%	100%	*Met*	*Met*

Appendix B. Compliance Monitoring Tool

The compliance monitoring tool appendix follows this cover page.

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

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

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

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

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

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

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

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

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

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

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

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

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
7. Verification of Services The written description of the PIHP's QAPIP addresses how it will verify whether services reimbursed by Medicaid were actually furnished to beneficiaries by affiliates (as applicable), providers, and subcontractors. Attachment P 6.7.1.1		
a. The PIHP must submit to the State for approval of its methodology for verification.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
b. The PIHP must annually submit its findings from this process and provide any follow up actions that were taken as a result of the findings.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

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

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

Findings

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

Standard IV—Staff Qualifications and Training

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

Standard IV—Staff Qualifications and Training

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

Findings

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

Standard V—Utilization Management

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

Standard V—Utilization Management

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

Findings

Standard V—Utilization Management

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
3. Procedures Prospective (preauthorization), concurrent, and retrospective procedures are established and include: 42 CFR 438.210(b) Attachment P 6.7.1.1		
a. Review decisions are supervised by qualified medical professionals.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
b. Decisions to deny or reduce services are made by health care professionals who have the appropriate clinical expertise to treat the conditions.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
c. Efforts are made to obtain all necessary information including pertinent clinical information and consult with treating physician as appropriate.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
d. The reasons for decisions are clearly documented.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
e. The reasons for decisions are available to the beneficiary.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met**

Standard V—Utilization Management		
		☐ **Not Applicable**
f. There are well-publicized and readily available appeals mechanisms for providers.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
g. There are well-publicized and readily available appeals mechanisms for beneficiaries.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
h. Notification of the denial is sent to the beneficiary.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
i. Notification of the denial is sent to the provider.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
j. Notification of a denial includes a description of how to file an appeal.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Standard V—Utilization Management		
k. UM Decisions are made in a timely manner as required by the exigencies of the situation.		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
l. Decisions on appeals are made in a timely manner as required by the exigencies of the situation.		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
m. There are mechanisms to evaluate the effects of the program using data on beneficiary satisfaction, provider satisfaction, or other appropriate measures.		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
n. If the organization delegates responsibility for utilization management, it has mechanisms to ensure that these standards are met by the delegate.		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings		

Results—Standard V						
Met	=		X	1.0	=	
Substantially Met	=		X	.75	=	
Partially Met	=		X	.50	=	

Not Met	=		X .00	=	
Not Applicable	=				
Total Applicable	=		**Total Score**	=	
Total Score ÷ Total Applicable				=	

Standard VII—Enrollee Grievance Process

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

Findings

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

Findings

Standard VII—Enrollee Grievance Process

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

Findings

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

Findings

Standard VII—Enrollee Grievance Process

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

Findings

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

Standard VII—Enrollee Grievance Process		
c. Acknowledges to the beneficiary the receipt of the grievance.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
d. Submits the written grievance to appropriate staff, including a PIHP administrator with the authority to require corrective action and none of whom shall have been involved in the initial determination.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
e. For grievances regarding denial of expedited resolution of an appeal and for a grievance that involves clinical issues, the grievance is reviewed by health care professionals who have the appropriate clinical expertise in treating the enrollee's condition or disease.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
f. Facilitates resolution of the grievance as expeditiously as the enrollee's health condition requires, but no later than 60 calendar days of receipt of the grievance.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
g. Provides a written disposition within 60 calendar days of the PIHP's receipt of the grievance to the customer, guardian, or parent of a minor child. The content of the notice of disposition includes: ◆ The results of the grievance process; ◆ The date the grievance process was conducted; ◆ The beneficiary's right to request a fair hearing if the notice is more than 60 calendar days from the date of the request for a grievance; and		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Standard VII—Enrollee Grievance Process

◆ How to access the fair hearing process.		

Findings

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

Findings

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

Standard XII—Access And Availability

Findings were derived from the Michigan Mission-Based Performance Indicator System—Access Domain, Indicators 1 through 4.b.

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

Standard XII—Access And Availability

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
2. Access Standards—Face-to-Face Assessment The PIHP ensures that 95 percent of new beneficiaries receive a face-to-face assessment with a professional within 14 days of a nonemergency request for service.		
a. Children		☐ **Met** ☐ **Partially Met** ☐ **Not Met**
b. Adults		☐ **Met** ☐ **Partially Met** ☐ **Not Met**
c. Developmentally Disabled—Children		☐ **Met** ☐ **Partially Met** ☐ **Not Met**
d. Developmentally Disabled—Adults		☐ **Met** ☐ **Partially Met** ☐ **Not Met**
e. Substance Abuse		☐ **Met** ☐ **Partially Met** ☐ **Not Met**
Findings		

Standard XII—Access And Availability

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
3. Access Standards—Ongoing Services The PIHP ensures that 95 percent of new beneficiaries start needed, ongoing service within 14 days of a nonemergent assessment with a professional.		
a. Mentally Ill—Children		☐ **Met** ☐ **Partially Met** ☐ **Not Met**
b. Mentally Ill—Adults		☐ **Met** ☐ **Partially Met** ☐ **Not Met**
c. Developmentally Disabled—Children		☐ **Met** ☐ **Partially Met** ☐ **Not Met**
d. Developmentally Disabled—Adults		☐ **Met** ☐ **Partially Met** ☐ **Not Met**
e. Substance Abuse		☐ **Met** ☐ **Partially Met** ☐ **Not Met**
Findings		

Standard XII—Access And Availability

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
4. Access Standards—Follow-up Care After Discharge/Inpatient The PIHP ensures that 95 percent of beneficiaries discharged from a psychiatric inpatient unit are seen for follow-up care within seven days.		
a. Children		☐ **Met** ☐ **Partially Met** ☐ **Not Met**
b. Adults		☐ **Met** ☐ **Partially Met** ☐ **Not Met**
Findings		

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
5. Access Standards—Follow-up After Discharge/Detox The PIHP ensures that 95 percent of beneficiaries discharged from a substance abuse detoxification unit are seen for follow-up care within seven days.		☐ **Met** ☐ **Partially Met** ☐ **Not Met**
Findings		

Standard XII—Access And Availability

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
6. Providers Required to Meet Access Standards The PIHP requires its providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services. 438.206(c)		☐ **Met** ☐ **Partially Met** ☐ **Not Met**

Findings

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

Standard XIV—Appeals

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
1. Appeals The PIHP has internal appeals procedures that address: 438.402 MDCH 6.4(B) Attachment P6.3.2.1		
a. The beneficiary's right to a State fair hearing.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
b. The method for a beneficiary to obtain a hearing.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
c. The beneficiary's right to file appeals.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
d. The requirements and time frames for filing appeals.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Standard XIV—Appeals

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
2. Local Appeals Process In handling appeals, the PIHP meets the following requirements:		
a. Acknowledges receipt of each appeal, in writing, unless the beneficiary or provider requests expedited resolution. 438.406(a)(2), (c)(1) Attachment P6.3.2.1		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
b. Ensures that oral inquiries seeking to appeal an action are treated as appeals in order to establish the earliest possible filing date. 438.406(b)(1) Attachment P6.3.2.1		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
c. Maintains a log of all requests for appeals and reports data to the PIHP quality assessment/performance improvement program. Attachment P6.3.2.1		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Standard XIV—Appeals

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
3. Expedited Process The PIHP has an expedited review process for appeals when the PIHP determines (from a request from the beneficiary) or the provider indicates (in making the request on the beneficiary's behalf or supporting the beneficiary's request) that taking the time for a standard resolution could seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function. 438.410(a) Attachment P6.3.2.1		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
4. Individuals Making Decisions—Not Previously Involved The PIHP ensures that individuals who make decisions on appeals are individuals who were not involved in any previous level of review or decision-making. 438.406(a)(3)(i) Attachment P6.3.2.1		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Findings

Standard XIV—Appeals

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
5. Individuals Making Decisions—Clinical Expertise The PIHP ensures that individuals who make decisions on appeals have the appropriate clinical expertise in treating the beneficiary's condition or disease when deciding any of the following: ◆ An appeal of a denial that is based on lack of medical necessity ◆ An appeal that involves clinical issues 438.406(a)(3)(ii) Attachment P6.3.2.1		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
6. Right to Examine Records The appeals process provides the beneficiary and his or her representative the opportunity, before and during the appeals process, to examine the beneficiary's case file, including medical records and any other documents and records considered during the appeals process. 438.406(b)(3)(ii)		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Standard XIV—Appeals

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
7. Notice of Disposition The PIHP provides written notice of the results of a standard resolution as expeditiously as the beneficiary's health condition requires, but no later than 45 calendar days from the day the PIHP received the request for a standard appeal and no later than three working days after the PIHP received a request for an expedited resolution of the appeal. 438.408(b) Attachment P6.3.2.1		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
8. Notice of Disposition The notice of disposition includes an explanation of the results of the resolution and the date it was completed. 438.408(e) Attachment P6.3.2.1		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Standard XIV—Appeals

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
9. Appeals Not Resolved in Favor of Beneficiary When the appeal is not resolved wholly in favor of the beneficiary, the notice of disposition includes: ◆ The right to request a State fair hearing. ◆ How to request a State fair hearing. ◆ The right to request to receive benefits while the State fair hearing is pending, if requested within 12 days of the PIHP mailing the notice of disposition, and how to make the request. ◆ The fact that the beneficiary may be held liable for the cost of those benefits if the hearing decision upholds the PIHP's action. 438.408(e)(2) Attachment P6.3.2.1		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
10. Denial of a Request for Expedited Resolution of an Appeal If a request for expedited resolution of an appeal is denied, the PIHP: ◆ Transfers the appeal to the time frame for standard resolution (i.e., no longer than 45 days from the date the PIHP received the appeal). ◆ Makes reasonable efforts to give the beneficiary prompt oral notice of the denial. ◆ Gives the beneficiary follow-up written notice within two calendar days. 438.410(c) Attachment P6.3.2.1		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Standard XIV—Appeals

Findings

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

Appendix C. Performance Measure Validation Tool

The performance measure validation 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 TOOL (ISCAT) FOR PREPAID INPATIENT HEALTH PLANS (PIHPS)

I. GENERAL INFORMATION

Please provide the following general information:

Note: When completing this ISCAT, 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: _____
Mailing Address: _____
PMV Contact Name and Title: _____
PMV Contact E-Mail Address: _____
PMV Contact Phone Number: _____
PMV Contact Fax Number: _____
Chief Information Officer (CIO) Name and Title: _____
CIO Phone Number: _____
CIO 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:

October 2011	_____		June 2012	_____
November 2011	_____		July 2012	_____
December 2011	_____		August 2012	_____
January 2012	_____		September 2012	_____
February 2012	_____		October 2012	_____
March 2012	_____		November 2012	_____
April 2012	_____		December 2012	_____
May 2012	_____			

E. Has your organization ever undergone a formal IS capabilities assessment (other than the performance measure validation activity performed by the EQRO)? A formal IS capabilities assessment must have been performed by an external reviewer.
Note: CARF/JCHO reviews would not apply as they do not get to the level of detail necessary to meet CMS protocols.

☐ Yes ☐ No

If *yes*, who performed the assessment? _____When was the assessment completed? _____

I. GENERAL INFORMATION

F. In an attachment to the ISCAT, 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.

_____

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.

_____

II. INFORMATION SYSTEMS: DATA PROCESSING PROCEDURES AND PERSONNEL

10. Who is responsible for your organization meeting the State Medicaid reporting requirements, as certified on file with MDCH? *(Check all that apply)*

- ☐ CEO/Executive Director
- ☐ CFO/Director of Administrative Services/Finance
- ☐ COO
- ☐ Other: _____

11. Staffing

11a. Describe the Medicaid claims and/or service/encounter data processing organization in terms of staffing and their expected productivity goals. What is the overall daily, monthly, and annual productivity of the department and of each processor? Productivity is defined as the volume of claims/encounters that are processed during a pre-established interval (i.e., per day or per week).

_____

11b. Describe claims and/or service/encounter data processor training from new hire to refresher courses for seasoned processors:

_____

11c. What is the average tenure of the staff? _____

11d. What is the annual turnover? _____

II. INFORMATION SYSTEMS: DATA PROCESSING PROCEDURES AND PERSONNEL

12. Security (Note: The intent of this section is to ensure that your PIHP has adequate systems and protocols in place to ensure data are secure. Voluminous documentation is not necessary. Simply identify the type of security products that are used and have backup documentation available for review.)

12a. How is the loss of Medicaid claim and service/encounter data prevented in the event of system failure?

_____

How frequently are system back-ups performed? _____

Where are back-up data stored? _____

12b. What is done to minimize the corruption of Medicaid data due to system failure or program error?

_____

12c. Describe the controls used to assure all Medicaid claims data entered into the system are fully accounted for (e.g., batch control sheets). This question is asking how you ensure that for each service that is provided, an encounter is generated within your system.

_____

12d. Describe the provisions in place for physical security of the computer system and manual files:

_____

- Premises/Computer Facilities _____
- Documents (Any documents that contain PHI) _____
- Database access and levels of security _____

12e. What other individuals have access to your computer system that contains performance indicator data?

☐ Consumers

☐ Providers

Describe their access and the security that is maintained restricting or controlling such access.

_____

III. DATA ACQUISITION CAPABILITIES

The purpose of this section is to obtain a high-level understanding of how you collect and maintain claims/encounters, enrollment information, and data on ancillary services.

A. Administrative Data (Claims and Encounter Data, and other Administrative Data Sources)

For the purposes of this ISCA, a *claim* is defined as a service for which direct reimbursement is made (FFS). An *encounter* is defined as a capitated service, in which no direct reimbursement for the service is provided—rather, the provider receives a capitation payment based on member panels. The intent of these questions is to provide the reviewers with an understanding of the data elements and data flow for the two different payment arrangements. If your PIHP does not utilize one or the other, enter N/A anywhere that claims and encounters are broken out for the non-applicable payment arrangement. **Consider daily appointments/service data as encounter data when responding to the following questions.**

This section requests information on input data sources (e.g., paper and electronic claims) and on the transaction system(s) you use.

1. Do you use standard claims or encounter forms (either paper or electronic format) for the following?

Please specify the type of form used (e.g., CMS1500, UB 92, or service activity log) in the table below.

DATA SOURCE	No	Yes	Please specify the type of form used
CMH/MCPN (for direct-run providers)	☐	☐	_____
Sub-Panel Provider (for a CMH contract agency)	☐	☐	_____
Off-Panel Provider (for out-of-network providers, incl. COFR	☐	☐	_____
Hospital	☐	☐	_____
Other: _____	☐	☐	_____
Other: _____	☐	☐	_____

III. DATA ACQUISITION CAPABILITIES

2. We would like to understand how claims or service/encounter data are submitted to your plan. We are also interested in an estimate of what percentage (if any) of services provided to your consumers by all providers serving your Medicaid enrollees are NOT submitted as claims or encounters and therefore are not represented in your administrative data. For example, your PIHP may collect encounter data from a system where service activity is gathered, but the data are never formatted for submission (a UB-92/CMS-1500 or 837 P format).

Please fill in the following table with the appropriate percentages:

MEDIUM	CMH/MCPN (for direct-run providers)	Sub-Panel Provider (for a CMH contract agency)	Off-Panel Provider (for out-of-network providers, incl. COFR)	Hospital	Other
Claims/Encounters Submitted Electronically	___%	___%	___%	___%	___%
Claims/Encounters Submitted on Paper	___%	___%	___%	___%	___%
Services Not Submitted as Claims or Encounters	___%	___%	___%	___%	___%
TOTAL	**100%**	**100%**	**100%**	**100%**	**100%**

Comments:_____

III. DATA ACQUISITION CAPABILITIES

3. Please document whether the following data elements (data fields) are required by you for providers, and/or delegated entities, for each of the types of Medicaid claims/encounters identified below.

If required, enter an "R" in the appropriate box. Where the requirements differ, please indicate by entering an "R/P" for paper required elements, or an "R/E" for electronic required elements. For professional submissions (non-institutional), "First Date of Service" means "Date of Service," and "Last Date of Service" should be entered as "N/A."

DATA ELEMENTS	CMH/MCPN (for direct-run providers)	Sub-Panel Provider (for a CMH contract agency)	Off-Panel Provider (for out-of-network providers, incl. COFR)	Hospital	Other
Consumer DOB/Age	_____	_____	_____	_____	_____
Diagnosis	_____	_____	_____	_____	_____
Procedure	_____	_____	_____	_____	_____
First Date of Service	_____	_____	_____	_____	_____
Last Date of Service	_____	_____	_____	_____	_____
# of Units	_____	_____	_____	_____	_____
Revenue Code	_____	_____	_____	_____	_____
Provider ID	_____	_____	_____	_____	_____
Place of Service	_____	_____	_____	_____	_____

III. DATA ACQUISITION CAPABILITIES

4. Please describe how each new consumer is assigned a diagnosis, the maximum number of diagnoses maintained per consumer within the master client file, and how often the diagnoses are updated within the system. _____

4a. How many diagnoses and procedures are captured on each claim? On each encounter?

This question is asking how many diagnoses or procedure codes the claims processing system is capable of capturing. For example, if four diagnosis codes can be submitted on a claim, can the system capture all four, or more?

CLAIM—Institutional Data		**ENCOUNTER—Institutional Data**	
Diagnoses: ___	Procedures: ___	Diagnoses: ___	Procedures: ___
CLAIM—Professional Data		**ENCOUNTER—Professional Data**	
Diagnoses: ___	Procedures: ___	Diagnoses: ___	Procedures: ___

5. Principal and Secondary Diagnoses

5a. Can your system distinguish between principal (primary) and secondary diagnoses?

☐ Yes

☐ No

5b. If *yes* to 5a, above, how do you distinguish between principal (primary) and secondary diagnoses?

_____

6. Please explain what happens if a Medicaid claims/encounter is submitted and one or more required fields are missing, incomplete, or invalid. For example, if the procedure is not coded, is the claims examiner required by the system to use an online software product like AutoCoder to determine the correct CPT code?

Institutional Data: _____

Professional Data: _____

III. DATA ACQUISITION CAPABILITIES

7. Under what circumstances can claims processors change Medicaid claims/encounter or service information?

_____

8. Identify any instance where the content of a field is intentionally different from the description or intended use of the field. For example, if the dependent's Social Security Number (SSN) is unknown, do you enter the consumer's SSN instead?

_____

9. Medicaid Claims/Encounters

9a. How are Medicaid claims/encounters received?

Note: An *intermediary* is defined as an entity that accepts service data (claims/encounter) and converts or aggregates the data into a standard submission format. These are sometimes referred to as *data clearinghouses*.

SOURCE	Received Directly	Submitted Through an Intermediary
CMH/MCPN (for direct-run providers)	☐	☐
Sub-Panel Provider (for a CMH contract agency)	☐	☐
Off-Panel Provider (for out-of-network providers, incl. COFR)	☐	☐
Hospital	☐	☐
Other: _____	☐	☐

9b. If the data are received through an intermediary, what changes, if any, are made to the data?

_____

III. DATA ACQUISITION CAPABILITIES

10. Please estimate the percentage of coding types provided by setting (institutional/inpatient or professional/outpatient) using the following coding schemes (When more than one coding scheme is used, the total may be more than 100 percent.)

	INSTITUTIONAL		PROFESSIONAL	
CODING SCHEME	**Inpatient Diagnosis**	**Inpatient Procedure**	**Ambulatory/ Outpatient Diagnosis**	**Ambulatory/ Outpatient Procedure**
ICD-9-CM	___%	___%	___%	___%
CPT-4		___%		___%
HCPCS		___%		___%
DSM-IV	___%		___%	
Internally Developed	___%	___%	___%	___%
Other (Specify)	___%	___%	___%	___%
Not Required	___%	___%	___%	___%
TOTAL	**100%**	**100%**	**100%**	**100%**

11. Please identify all information systems through which service and utilization data for the Medicaid population are processed. Describe the flow of a claim/encounter or service data from the point of service, through any external vendors, to the point it reaches your PIHP.

Your response should start with the systems used by those who handle data after a service is performed, through the point where your PIHP receives the data (or the performance indicator results). Use the "mini-ISCAT" and have your subcontractors complete their sections; then you will only need to respond with regard to your PIHP.

III. DATA ACQUISITION CAPABILITIES

12. Please check the appropriate box(es) to indicate any major systems changes/updates that have taken place in the last three years in your Medicaid claims or encounter system. If you check a box, please provide a description of the change and the specific dates on which changes were implemented.

☐ New system purchased and installed to replace old system.

Description/implementation dates _____

☐ New system purchased and installed to replace most of old system; old system still used.

Description/implementation dates _____

☐ Major enhancements made to old system. (If *yes*: Please describe the enhancements.)

Description/implementation dates _____

☐ New product line adjudicated (processed) on old system.

Description/implementation dates _____

☐ Conversion of a product line from one system to another.

Description/implementation dates _____

Comments: _____

III. DATA ACQUISITION CAPABILITIES

13. Have any of these changes influenced, even temporarily, the quality and/or completeness of the Medicaid data that are collected? If so, how and when?

_____

14. How many years of Medicaid data are retained online? How are historical Medicaid data accessed when needed?

_____

15. How much volume of Medicaid data is processed online versus batch? Batch processing refers to collecting claims/encounters/service data and processing them in bulk on a pre-determined schedule. _____

If batch, how often is it run? _____

16. How complete are the Medicaid data three months after the close of a reporting period (i.e. a quarter)?

_____

How is completeness estimated? How is completeness defined?

_____

17. What is your policy regarding Medicaid claims/encounter audits? Are any audits performed evaluating the data submitted compared with the consumer record?

_____

Are Medicaid encounters audited regularly? Randomly?

_____

18. What are the standards regarding timeliness of processing? Within what timeframe must claims/encounters or service data be entered?

_____

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.

_____

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 percentage of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. (1st Quarter SFY 2013)	_____
#2	The percentage of new Medicaid beneficiaries during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service. (1st Quarter SFY 2013)	_____
#3	The percentage of new Medicaid beneficiaries during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional. (1st Quarter SFY 2013)	_____
#4a	The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days. (1st Quarter SFY 2013)	_____
#4b	The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days. (1st Quarter SFY 2013)	_____
#5	The percent of Medicaid recipients having received PIHP managed services. (1st Quarter SFY 2013)	_____
#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. (1st Quarter SFY 2013)	_____
#8	The percent of (a) adults with mental illness, and the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disability served by the CMHSPs and PIHPs who are employed competitively. (SFY 2012)	_____
#9	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disability served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities. (SFY 2012)	_____
#10	The percentage of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge. (1st Quarter SFY 2013)	_____
#13	The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s). (SFY 2012)	_____
#14	The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s). (SFY 2012)	_____

III. DATA ACQUISITION CAPABILITIES

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

_____

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

_____

4. Describe the kinds of information sources available to the PIHP from the subcontractor (e.g., monthly hard copy reports, full claims data).

_____

5. Do you evaluate the quality of this information?

If so, how?

_____

6. Did you incorporate these subcontractor data into the creation of Medicaid-related studies or performance indicator reporting? If not, why not?

_____

III. DATA ACQUISITION CAPABILITIES

D. Integration and Control of Data for Performance Measure Reporting

This section requests information on how your PIHP integrates Medicaid claims, encounter/service, membership, provider, vendor, and other data to calculate performance rates. All questions relate to your current systems and processes, unless indicated otherwise.

File Consolidation

1. Provide a written description of the process used to calculate each performance indicator, including all data sources. This may be included as Attachment 5.

_____

2. In consolidating data for Medicaid performance measurement, how are the data sets for each measure collected:

- By querying the processing systems online (claims/encounter, eligibility, etc.)?
  - ☐ Yes
  - ☐ No

- By using extract files created for analytical purposes (i.e., extracting or "freezing" the necessary data into a separate database for analysis)?
  - ☐ Yes
  - ☐ No

  If so, how frequently are the files updated? How do they account for claim and encounter submission and processing lags? How is the file creation process checked for accuracy?

  _____

- By using a separate relational database or data warehouse (i.e., a performance measure repository)?
  - ☐ Yes
  - ☐ No

  If so, is this the same system from which all other reporting is produced?

  _____

III. DATA ACQUISITION CAPABILITIES

3. Describe the procedure for consolidating Medicaid claims/encounter, member, provider, and other data for performance measure reporting (whether it be into a relational database or file extracts on a measure-by-measure basis).

3a. How many different types of data are merged together to create reports?

_____

3b. What control processes are in place to ensure data merges are accurate and complete? In other words, how do you ensure that the merges were done correctly?

_____

3c. What control processes are in place to ensure that no extraneous data are captured (e.g., lack of specificity in consumer identifiers may lead to inclusion of non-eligible members or to double-counting)?

_____

3d. Do you compare samples of data in the repository to raw data in transaction sets (such as the 837) to verify if all the required data are captured (e.g., were any members, providers, or services lost in the process)?

_____

3e. Describe your process(es) to monitor that the required level of coding detail is maintained (e.g., all significant digits and primary and secondary diagnoses remain) after data have been merged?

_____

4. Describe both the files accessed to create Medicaid performance measures and the fields from those files used for linking or analysis. Use either a schematic or text to respond.

_____

III. DATA ACQUISITION CAPABILITIES

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

☐ Yes

☐ No

If yes, please describe: _____

6. Are Medicaid reports created from a vendor software product?

☐ Yes

☐ No

If so, how frequently are the files updated? How are reports checked for accuracy?

_____

7. Are data files used to report Medicaid performance measures archived and labeled with the performance period in question?

☐ Yes

☐ No

III. DATA ACQUISITION CAPABILITIES

Subcontractor Data Integration

8. Information on several types of external encounter sources is requested. In the table on the following page, for each type of delegated service, please indicate the following:

- First column: Indicate the number of entities contracted (or subcontracted) to provide the mental health services. Include subcontractors that offer all or some of the services.
- Second column: Indicate whether your PIHP receives member-level data for any Medicaid performance measure reporting from the subcontractors. Answer "Yes" only if all data received from contracted entities are at the member level. If *any* encounter-related data are received in aggregate form, you should answer "No." If type of service is not a covered benefit, indicate "N/A."
- Third column: Indicate whether all data needed for Medicaid performance measure reporting are integrated, at the member-level, with PIHP administrative data.
- Fourth and fifth columns: Rank the completeness and quality of the Medicaid data provided by the subcontractors. Consider data received from all sources when using the following data quality grades:
  - A. Data are complete or of high quality.
  - B. Data are generally complete or of good quality.
  - C. Data are incomplete or of poor quality.
- In the sixth column, describe any concerns you have in ensuring completeness and quality of Medicaid data received from contracted entities. If measure is not being calculated because of no eligible members, please indicate "N/A."

Type of Delegated Service	**Always Receive Member-Level Data From This Subcontractor? (Yes or No)**	**Integrate Subcontractor Data With PIHP Administrative Data? (Yes or No)**	**Completeness of Data (A, B, or C)**	**Quality of Data (A, B, or C)**	**Rationale for Rating/ Concerns With Data Collection**
EXAMPLE: CMHSP #1—All mental health services for blank population	☒ Yes ☐ No	☒ Yes ☐ No	☐ A ☒ B ☐ C	☒ A ☐ B ☐ C	*Volumes of encounters not consistent from month to month.*
______	☐ Yes ☐ No	☐ Yes ☐ No	☐ A ☐ B ☐ C	☐ A ☐ B ☐ C	______
______	☐ Yes ☐ No	☐ Yes ☐ No	☐ A ☐ B ☐ C	☐ A ☐ B ☐ C	______
______	☐ Yes ☐ No	☐ Yes ☐ No	☐ A ☐ B ☐ C	☐ A ☐ B ☐ C	______
______	☐ Yes ☐ No	☐ Yes ☐ No	☐ A ☐ B ☐ C	☐ A ☐ B ☐ C	______
______	☐ Yes ☐ No	☐ Yes ☐ No	☐ A ☐ B ☐ C	☐ A ☐ B ☐ C	______
______	☐ Yes ☐ No	☐ Yes ☐ No	☐ A ☐ B ☐ C	☐ A ☐ B ☐ C	______
______	☐ Yes ☐ No	☐ Yes ☐ No	☐ A ☐ B ☐ C	☐ A ☐ B ☐ C	______

III. DATA ACQUISITION CAPABILITIES

Performance Measure Repository Structure

A *performance measure repository structure* is defined as a database that contains consumer-level data used to report performance indicators.

If your PIHP uses a performance measure repository, please answer the following question. Otherwise, skip to the Report Production section.

9. If your PIHP uses a performance measure repository for Medicaid performance measures, review the repository structure. Does it contain all the key information necessary for Medicaid performance measure reporting?

☐ Yes

☐ No

Report Production

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

_____

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

_____

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

_____

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

_____

14. Do you have internal back-ups for performance measure programmers (i.e., do others know the programming language and the structure of the actual programs)? Is there documentation?

_____

III. DATA ACQUISITION CAPABILITIES

E. Provider Data

Compensation Structure

The purpose of this section is to evaluate the Medicaid provider compensation structure, as this may influence the quality and completeness of data. Please identify the percentage for each category level listed. Each column should total 100%.

Payment Mechanism	CMH/MCPN (for direct run providers)	Sub-panel provider (for a CMH contract agency)	Off Panel Provider (for out of network providers, incl CORF)	Hospital
1. Fee-for-Service—no withhold or bonus	___%	___%	___%	___%
2. Fee-for-Service, with withhold. Please specify % withhold:	___%	___%	___%	___%
3. Fee-for-Service with bonus. Bonus range:	___%	___%	___%	___%
4. Capitated—no withhold or bonus	___%	___%	___%	___%
5. Capitated with withhold. Please specify % withhold:	___%	___%	___%	___%
6. Capitated with bonus. Bonus range:	___%	___%	___%	___%
7. Case Rate—with withhold or bonus	___%	___%	___%	___%
8. Case Rate—no withhold or bonus	___%	___%	___%	___%
9. Salaried – mental health center staff	___%	___%	___%	___%
10. Other	___%	___%	___%	___%
TOTAL	100%	100%	100%	100%

1. **How are Medicaid fee schedules and provider compensation rules maintained? Who has updating authority?**

   _____

2. **Are Medicaid fee schedules and contractual payment terms automated? Is payment against the schedules automated for all types of participating providers?**

   _____

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 respository.

   _____

   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?

_____

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**
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 TOOL (ISCAT) 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-ISCAT. When completing this ISCAT, 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: _____
Mailing Address: _____
Contact Name and Title: _____
Contact E-Mail Address: _____
Contact Phone Number: _____
Contact Fax Number: _____
Chief Information Officer (CIO) Name and Title: _____
CIO Phone Number: _____
CIO 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.

II. INFORMATION SYSTEMS: DATA PROCESSING PROCEDURES AND PERSONNEL

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.

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?

_____

10b. 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

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	☐	☐	_____
Sub-Panel/Contract Agency	☐	☐	_____
Off-Panel/COFR Providers	☐	☐	_____
Hospitals	☐	☐	_____
Other:	☐	☐	_____

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 Serv ce	_____	_____	_____	_____	_____
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: _____

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?

_____

III. DATA ACQUISITION CAPABILITIES

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	☐	☐
Sub-Panel/Contract Agency	☐	☐
Off-Panel/COFR Providers	☐	☐
Hospital:	☐	☐
Other:	☐	☐

9b. If the data are received through an intermediary, what changes, if any, are made to the data?

_____

III. DATA ACQUISITION CAPABILITIES

10. Please estimate the percentage of coding types provided by setting (institutional/inpatient or professional/outpatient) using the following coding schemes (When more than one coding scheme is used, the total may be more than 100 percent.)

	INSTITUTIONAL		PROFESSIONAL	
CODING SCHEME	**Inpatient Diagnosis**	**Inpatient Procedure**	**Ambulatory/ Outpatient Diagnosis**	**Ambulatory/ Outpatient Procedure**
ICD-9-CM	___%	___%	___%	___%
CPT-4		___%		___%
HCPCS		___%		___%
DSM-IV	___%		___%	
Internally Developed	___%	___%	___%	___%
Other (Specify)	___%	___%	___%	___%
Not Required	___%	___%	___%	___%
TOTAL	**100%**	**100%**	**100%**	**100%**

11. Please identify all information systems through which service and utilization data for the Medicaid population are processed. Describe the flow of a claim/encounter or service data from the point of service, through any external vendors, to the point it reaches 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.

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.

III. DATA ACQUISITION CAPABILITIES

Description/implementation dates

Comments:

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?

_____

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?

_____

23. 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?

III. DATA ACQUISITION CAPABILITIES

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

25. Claims/Encounters Systems

25a. 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.

_____

25b. 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) _____

25c. 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

25d. 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? _____

25e. 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.

_____

25f. 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.)?

_____

25g. Describe how your systems and procedures handle validation and payment of Medicaid claims and encounters (service data) when procedure codes are not provided.

_____

III. DATA ACQUISITION CAPABILITIES

25h. 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?

_____

26. 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.

_____

27. 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.

_____

28. Other Administrative Data Used for Performance Indicator Reporting

28a**. 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:

III. DATA ACQUISITION CAPABILITIES

28b. 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.

_____

28c. 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:

_____

28d. For each data source identified above, describe the validation activities performed by your organization to ensure the data in the administrative database are accurate.

_____

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 percentage of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. (1st Quarter SFY 2013)	_____
#2	The percentage of new Medicaid beneficiaries during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service. (1st Quarter SFY 2013)	_____
#3	The percentage of new Medicaid beneficiaries during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional. (1st Quarter SFY 2013)	_____
#4a	The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days. (1st Quarter SFY 2013)	_____
#4b	The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days. (1st Quarter SFY 2013)	_____
#5	The percent of Medicaid recipients having received PIHP managed services. (1st Quarter SFY 2013)	_____
#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. (1st Quarter SFY 2013)	_____
#8	The percent of (a) adults with mental illness, and the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disability served by the CMHSPs and PIHPs who are employed competitively. (SFY 2012)	_____
#9	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disability served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities. (SFY 2012)	_____
#10	The percentage of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge. (1st Quarter SFY 2013)	_____
#13	The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s). (SFY 2012)	_____
#14	The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s). (SFY 2012)	_____

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? ☐ Yes ☐ No

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?

_____

III. DATA ACQUISITION CAPABILITIES

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.

_____

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
EXAMPLE: Large provider group #1	☒ Yes ☐ No	☒ Yes ☐ No	☐ A ☒ B ☐ C	☒ A ☐ B ☐ C	*Volumes of encounters not consistent from month to month.*
	☐ Yes ☐ No	☐ Yes ☐ No	☐ A ☐ B ☐ C	☐ A ☐ B ☐ C	
	☐ Yes ☐ No	☐ Yes ☐ No	☐ A ☐ B ☐ C	☐ A ☐ B ☐ C	
	☐ Yes ☐ No	☐ Yes ☐ No	☐ A ☐ B ☐ C	☐ A ☐ B ☐ C	
	☐ Yes ☐ No	☐ Yes ☐ No	☐ A ☐ B ☐ C	☐ A ☐ B ☐ C	
	☐ Yes ☐ No	☐ Yes ☐ No	☐ A ☐ B ☐ C	☐ A ☐ B ☐ C	
	☐ Yes ☐ No	☐ Yes ☐ No	☐ A ☐ B ☐ C	☐ A ☐ B ☐ C	
	☐ Yes ☐ No	☐ Yes ☐ No	☐ A ☐ B ☐ C	☐ A ☐ B ☐ C	

III. DATA ACQUISITION CAPABILITIES

Performance Measure Repository Structure

A *performance measure repository structure* is defined as a database that contains consumer-level data used to report performance indicators.

If your 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**
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**
Other: _____	_____	**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 2012–2013 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	**Section to be completed by HSAG**	
Date of Study:	_____ to _____	_____ Year 1 Validation	_____ Initial Submission _____ Resubmission
Type of Delivery System :	PIHP	_____ Year 2 Validation	_____ Initial Submission _____ Resubmission
		_____ Year 3 Validation	_____ Initial Submission _____ Resubmission
Number of Medicaid Beneficiaries in PIHP: _____		_____ Baseline Assessment	_____ Remeasurement 1
Number of Medicaid Beneficiaries in Study: _____		_____ Remeasurement 2	_____ Remeasurement 3
Submission Date: _____		Year 1 validated through Activity _____	
		Year 2 validated through Activity _____	
		Year 3 validated through Activity _____	

Appendix D: Michigan 2012–2013 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	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
—	2. Is selected following collection and analysis of data. ***NA*** is not applicable to this element for scoring.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
—	3. Addresses a broad spectrum of care and services The score for this element will be ***Met*** **or** ***Not Met*****.**	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
—	4. Includes all eligible populations that meet the study criteria. ***NA*** is not applicable to this element for scoring.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
—	5. Does not exclude beneficiaries with special health care needs. The score for this element will be ***Met*** **or** ***Not Met*****.**	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	

Appendix D: Michigan 2012–2013 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*.**	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	

Results for Activity I

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

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

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

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

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

Appendix D: Michigan 2012–2013 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. ***NA*** is not applicable to this element for scoring.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
C	2. Is answerable. ***NA*** is not applicable to this element for scoring.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	

Results for Activity II

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

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

Appendix D: Michigan 2012–2013 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.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
—	2. Are based on current, evidence-based practice guidelines, pertinent peer-reviewed literature, or consensus expert panels.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
C	3. Allow for the study question to be answered. ***NA*** is not applicable to this element for scoring.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
—	4. Measure changes (outcomes) in health or functional status, satisfaction, or valid process alternatives. ***NA*** is not applicable to this element for scoring.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
C	5. Have available data that can be collected on each indicator. ***NA*** is not applicable to this element for scoring.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
—	6. Are nationally recognized measures such as HEDIS technical specifications, when appropriate. The scoring for this element will be ***Met*** or ***NA*****.**	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	

Appendix D: Michigan 2012–2013 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.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	

Results for Activity III

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

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

Appendix D: Michigan 2012–2013 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. ***NA*** is not applicable to this element for scoring.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
—	2. Includes requirements for the length of a beneficiary's enrollment in the PIHP.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
C	3. Captures all beneficiaries to whom the study question applies. ***NA*** is not applicable to this element for scoring.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	

Results for Activity IV

Total Evaluation Elements

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

Critical Elements

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

Appendix D: Michigan 2012–2013 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.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
—	2. Identify the sample size.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
—	3. Specify the confidence level.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
—	4. Specify the acceptable margin of error.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
C	5. Ensure a representative sample of the eligible population.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
—	6. Are in accordance with generally accepted principles of research design and statistical analysis.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	

Results for Activity V

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

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

Appendix D: Michigan 2012–2013 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. ***NA*** is not applicable to this element for scoring.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
—	2. The identification of specified sources of data. ***NA*** is not applicable to this element for scoring.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
—	3. A defined and systematic process for collecting Baseline and remeasurement data.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
—	4. A timeline for the collection of Baseline and remeasurement data. ***NA*** is not applicable to this element for scoring.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
—	5. Qualified staff and personnel to abstract manual data.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
C	6. A manual data collection tool that ensures consistent and accurate collection of data according to indicator specifications.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
—	7. A manual data collection tool that supports interrater reliability.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
—	8. Clear and concise written instructions for completing the manual data collection tool.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
—	9. An overview of the study in written instructions.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
—	10. Administrative data collection algorithms/ flow charts that show activities in the production of indicators.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	

Appendix D: Michigan 2012–2013 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:**		
—	11. An estimated degree of administrative data completeness. Met = 80–100 percent Partially Met = 50–79 percent Not Met = <50percent or not provided	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	

Results for Activity VI

Total Evaluation Elements				
Total Evaluation Elements	*Met*	*Partially Met*	*Not Met*	*NA*
11	0	0	0	0

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

Appendix D: Michigan 2012–2013 PIP Validation Tool: <PIP Topic> *for* <PIHP Full Name>

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. ***NA*** is not applicable to this element for scoring.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
__	2. System changes that are likely to induce permanent change.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
__	3. Revised if the original interventions are not successful.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
__	4. Standardized and monitored if interventions are successful.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	

Results for Activities VII

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

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

Appendix D: Michigan 2012–2013 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. ***NA*** is not applicable to this element for scoring.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
C	2. Allow for the generalization of results to the study population if a sample was selected. If sampling was not used, this score will be ***NA*.**	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
—	3. Identify factors that threaten internal or external validity of findings. ***NA*** is not applicable to this element for scoring.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
—	4. Include an interpretation of findings. ***NA*** is not applicable to this element for scoring.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
—	5. Are presented in a way that provides accurate, clear, and easily understood information. ***NA*** is not applicable to this element for scoring.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
—	6. Identify the initial measurement and the remeasurement of the study indicators.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
—	7. Identify statistical differences between the initial measurement and the remeasurement.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
—	8. Identify factors that affect the ability to compare the initial measurement with the remeasurement.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	

Appendix D: Michigan 2012–2013 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:**		
—	9. Include an interpretation of the extent to which the study was successful.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	

Results for Activity VIII

Total Evaluation Elements					Critical Elements				
Total Evaluation Elements	*Met*	*Partially Met*	*Not Met*	*NA*	Critical Elements	*Met*	*Partially Met*	*Not Met*	*NA*
9	0	0	0	0	2	0	0	0	0

Appendix D: Michigan 2012–2013 PIP Validation Tool: <PIP Topic> *for* <PIHP Full Name>

EVALUATION ELEMENTS		SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation			
IX.	**Assess for Real Improvement: Through repeated measurement of the quality indicators selected for the project, meaningful change in performance relative to the performance observed during baseline measurement must be demonstrated. Assess for any random, year-to-year variations, population changes, or sampling errors that may have occurred during the measurement process.**		
—	1. The remeasurement methodology is the same as the Baseline methodology.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
—	2. There is documented improvement in processes or outcomes of care.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
—	3. The improvement appears to be the result of planned intervention(s).	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
—	4. There is statistical evidence that observed improvement is true improvement.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	

Results for Activity IX

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

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

Appendix D: Michigan 2012–2013 PIP Validation Tool: <PIP Topic> *for* <PIHP Full Name>

EVALUATION ELEMENTS		SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation			
X.	**Assess for Sustained Improvement: Assess for any demonstrated improvement through repeated measurements over comparable time periods. Assess for any random, year-to-year variations, population changes, or sampling errors that may have occurred during the remeasurement process.**		
—	1. Repeated measurements over comparable time periods demonstrate sustained improvement or that a decline in improvement is not statistically significant.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	

Results for Activity X

Total Evaluation Elements

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

Critical Elements

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

Appendix D: Michigan 2012–2013 PIP Validation Tool: <PIP Topic> *for* <PIHP Full Name>

Table 1—2012–2013 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—2012–2013 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 2012–2013 PIP Validation Tool: <PIP Topic> *for* <PIHP Full Name>

EVALUATION OF THE OVERALL VALIDITY AND RELIABILITY OF PIP RESULTS
HSAG assessed the implications of the study's findings on the likely validity and reliability of the results based on the CMS 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 2012–2013 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	**Section to be completed by HSAG** _____ Year 1 Validation _____ Initial Submission _____ Resubmission _____ Year 2 Validation _____ Initial Submission _____ Resubmission _____ Year 3 Validation _____ Initial Submission _____ Resubmission
Type of Delivery System: PIHP	_____ Baseline Assessment _____ Remeasurement 1 _____Remeasurement 2 _____ Remeasurement 3
Date of Study: _____ to _____	
Number of Medicaid Beneficiaries Served by PIHP _____ Number of Medicaid Beneficiaries in Project/Study _____	Year 1 validated through Activity _____ Year 2 validated through Activity _____ Year 3 validated through Activity _____
Submission Date: _____	

Appendix D: Michigan 2012–2013 PIP Summary Form: Peer Delivered Services *for* <PIHP Full Name>

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:

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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	
Remeasurement 1 Period	

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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 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.

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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 (*Describe*)	Sampling Method (*Describe*)

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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.
[ ] Once a year [ ] Twice a year [ ] Once a season [ ] Once a quarter [ ] Once a month [ ] Once a week [ ] Once a day [ ] Continuous [ ] Other (list and describe):	[ ] Once a year [ ] Once a season [ ] Once a quarter [ ] Once a month [ ] Continuous [ ] Other (list and describe):

F. Activity VIc: Data analysis plan and other pertinent methodological features.

Estimated percentage degree of administrative data completeness: _____ percent.

Describe the process used to determine data completeness and accuracy:

Supporting documentation:

Appendix D: Michigan 2012–2013 PIP Summary Form: Peer Delivered Services *for* <PIHP Full Name>

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
Describe the process used for the casual/barrier analyses that led to the development of the interventions:			

Appendix D: Michigan 2012–2013 PIP Summary Form: Peer Delivered Services *for* <PIHP Full Name>

G. Activity VIIb: Implement intervention and improvement strategies. Real, sustained improvements in care result from a continuous cycle of measuring and analyzing performance, as well as, developing and implementing systemwide improvements in care. Describe interventions designed to change behavior at an institutional, practitioner, or beneficiary level.
Describe interventions: **Baseline to Remeasurement 1:** **Remeasurement 1 to Remeasurement 2:** **Remeasurement 2 to Remeasurement 3:**

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:

H. Activity VIIIb: Interpretation of study results. Describe the results of the statistical analysis, interpret the findings, and compare and discuss results/changes from measurement period to measurement period. Discuss the successfulness of the study and indicate follow-up activities. Identify any factors that could influence the measurement or validity of the findings.
Interpretation of study results (address factors that threaten the internal or external validity of the findings for each measurement period): **Baseline Measurement:** **Baseline to Remeasurement 1:** **Remeasurement 1 to Remeasurement 2:** **Remeasurement 2 to Remeasurement 3:**

Appendix D: Michigan 2012–2013 PIP Summary Form: Peer Delivered Services *for* <PIHP Full Name>

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 *p* value
	Baseline:					
	Remeasurement 1					
	Remeasurement 2					
	Remeasurement 3					
	Remeasurement 4					
	Remeasurement 5					

Describe any demonstration of meaningful change in performance observed from baseline and each measurement period (e.g., baseline to Remeasurement 1, Remeasurement 1 to Remeasurement 2, or baseline to final remeasurement):

Quantifiable Measure 2: Enter title of study indicator

Time Period Measurement Covers	Baseline Project Indicator Measurement	Numerator	Denominator	Rate or Results	Industry Benchmark	Statistical Test Significance and *p* value
	Baseline:					
	Remeasurement 1					
	Remeasurement 2					
	Remeasurement 3					
	Remeasurement 4					
	Remeasurement 5					

Describe any demonstration of meaningful change in performance observed from baseline and each measurement period (e.g., baseline to Remeasurement 1, Remeasurement 1 to Remeasurement 2, or baseline to final remeasurement):

Appendix D: Michigan 2012–2013 PIP Summary Form: Peer Delivered Services *for* <PIHP Full Name>

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 *p* value
	Baseline:					
	Remeasurement 1					
	Remeasurement 2					
	Remeasurement 3					
	Remeasurement 4					
	Remeasurement 5					

Describe any demonstration of meaningful change in performance observed from baseline and each measurement period (e.g., baseline to Remeasurement 1, Remeasurement 1 to Remeasurement 2, or baseline to final remeasurement):

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: