

*Michigan Department
of Community Health*



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Administration**

**2013–2014 EXTERNAL QUALITY REVIEW
TECHNICAL REPORT**

for

Prepaid Inpatient Health Plans

December 2014



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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 10 PIHPs:

- ◆ Region 1—NorthCare Network (NorthCare)
- ◆ Region 2—Northern Michigan Regional Entity (Northern MI)
- ◆ Region 3—Lakeshore Regional Entity (Lakeshore)
- ◆ Region 4—Southwest Michigan Behavioral Health (Southwest MI)
- ◆ Region 5—Mid-State Health Network (Mid-State)
- ◆ Region 6—CMH Partnership of Southeastern Michigan (CMHPSM)
- ◆ Region 7—Detroit Wayne Mental Health Authority (Detroit)
- ◆ Region 8—Oakland County CMH Authority (Oakland)
- ◆ Region 9—Macomb County CMH Services (Macomb)
- ◆ Region 10 PIHP

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. MDCH selected one PIHP per region to manage the Medicaid specialty benefit for the entire region and to contract with Community Mental Health Service Providers (CMHSPs) and other providers within the region to deliver Medicaid funded mental health, substance use disorder, and developmental disabilities supports and services. MDCH stated in the AFP that “the new regional structure must consolidate authority and core functions, while simultaneously promoting local responsiveness.”¹⁻¹ The 10 new regional entities began operations on January 1, 2014.

¹⁻¹ Michigan Department of Community Health Behavioral Health & Developmental Disabilities Administration, *2013 Application for Participation for Specialty Prepaid Inpatient Health Plans*.

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 2013–2014 compliance monitoring review was designed to determine the PIHPs’ compliance with their contract and with State and federal regulations through review of performance of areas previously identified as opportunities for improvement. For the new PIHPs for which this was the first compliance review, HSAG determined the PIHPs’ readiness to demonstrate compliance with the requirements previously identified as an opportunity for improvement for any of the prior PIHPs in the region.
- ◆ **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. For the five PIHPs that were new regional entities, HSAG conducted a readiness review to prepare them for future performance measure reporting.
- ◆ **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 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.

¹⁻² 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 Related to Quality, Timeliness, and Access

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.

To draw conclusions and make recommendations about the **quality** and **timeliness** of and **access** to care and services 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.

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.

Overview

Table 1-1 shows HSAG’s assignment of the compliance review standards, performance measures, and PIPs to the domains of **quality**, **timeliness**, and **access**.

Table 1-1—Assignment of Activities to Performance Domains			
Compliance Review Standards	Quality	Timeliness	Access
Standard I—QAPIP Plan and Structure	✓		
Standard II—Performance Measurement and Improvement	✓	✓	
Standard III—Practice Guidelines	✓		
Standard IV—Staff Qualifications and Training	✓		
Standard V—Utilization Management		✓	✓
Standard VI—Customer Services	✓		✓
Standard VII—Enrollee Grievance Process	✓	✓	
Standard VIII—Enrollee Rights and Protections	✓		
Standard IX—Subcontracts and Delegation	✓		
Standard X—Provider Network	✓		✓
Standard XI—Credentialing	✓		
Standard XII—Access and Availability		✓	✓
Standard XIII—Coordination of Care	✓		✓
Standard XIV—Appeals	✓	✓	
Performance Measures	Quality	Timeliness	Access
Indicator 1—Preadmission Screening		✓	✓
Indicator 2—Face-to-Face Assessment		✓	✓
Indicator 3—First Service		✓	✓
Indicator 4a and 4b—Follow-Up Care After Discharge	✓	✓	✓
Indicator 5—Penetration Rate			✓
Indicator 6—Habilitation Supports Waiver (HSW) Rate	✓		
Indicator 8—Competitive Employment	✓		
Indicator 9—Earning Minimum Wage	✓		
Indicator 10—Readmission Rate	✓		
Indicator 13—Adults with DD living in a private residence	✓		
Indicator 14—Adults with MI living in a private residence	✓		
PIPs	Quality	Timeliness	Access
<i>Integration of Physical and Mental Health Care Topic</i>	✓	✓	✓

Compliance Monitoring Reviews

The PIHPs continued to show strong performance across the three domains of **quality**, **timeliness**, and **access**.

Twelve of the 14 standards addressed the **quality** domain. Two of these standards had been shown to be statewide strengths in the prior reviews, as all PIHPs had demonstrated full compliance with all requirements related to the Practice Guidelines and Staff Qualifications and Training standards. The PIHPs demonstrated full compliance with most requirements on the remaining standards in the **quality** domain.

Performance in the **timeliness** domain varied among the standards. The PIHPs met all requirements addressed in the 2013–2014 review cycle for the Performance Measurement and Improvement and Utilization Management standards. The 2013–2014 reviews resulted in a few recommendations for the Grievance Process and Appeals standards.

The PIHPs continued to show strong performance in the **access** domain, meeting all requirements included in the review for the Utilization Management, Customer Services, Provider Network, and Coordination of Care standards.

Validation of Performance Measures

The PIHPs continued to demonstrate strength in their validation results for performance measures related to **quality** and **timeliness** of, and **access** to, care and services. The five existing PIHPs achieved a validation designation of *Report* for all indicators across the **quality**, **timeliness**, and **access** domains, reflecting that the indicators were fully compliant with MDCH specifications. The five new PIHPs also achieved a validation designation of *Report* for all indicators across these three domains, demonstrating adequate system readiness and calculation processes for the next year of performance indicator reporting.

Due to the re-organization of the behavioral health system into 10 new regional entities, statewide rates for the performance measures could not be calculated, as the five new PIHPs were not required to report any rates for the 2013–2014 validation cycle.

MDCH defined a minimum performance standard for three of the eight performance indicators 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. These measures represented opportunities for improvement, as only one of the five PIHPs that reported rates met the standard for all sub-populations for indicators of timely follow-up care and readmissions. MDCH did not specify a minimum performance standard for the remaining indicators in this domain.

Performance indicators related to **timeliness** of and **access** to care and services reflected mixed performance. All five PIHPs reporting rates met the MDCH-defined minimum performance standard for timely preadmission screenings for psychiatric inpatient care and timely face-to-face assessments with a professional for all sub-populations. Timely access to needed ongoing services and timely follow-up care after discharge represented opportunities for improvement, as some of the PIHPs' rates fell below the minimum performance standard.

Validation of Performance Improvement Projects

For the 2013–2014 validation cycle, the PIHPs chose a topic related to the integration of physical and mental health care and provided their first-year submissions of the PIPs. MDCH selected this topic to focus on the many initiatives implemented by the PIHPs and CMHSPs to address the physical health care needs of the beneficiaries they serve.

The PIP topic of integration of physical and mental health care addressed **quality** and **timeliness** of, and **access** to, care and services. **Quality** of services can be improved through increased continuity of care and coordination of physical and behavioral health care services, resulting in a more holistic experience for beneficiaries. Ensuring that mental health care providers have knowledge of beneficiaries' physical health issues—and implementing actions to integrate care—can improve **access** to necessary screenings, tests, and other medical services. Monitoring that beneficiaries access physical health services in the recommended time frames will improve the **timeliness** of such care. As a result of these initiatives, the PIHPs will have information about beneficiaries' physical health care needs that can be used to make changes within their systems in order to affect the overall health of enrollees.

In this first year, the PIHPs completed the design phase of the PIPs. HSAG validated Activities I through VI, resulting in a validation status of *Met* for eight of the 10 studies. Overall, the PIHPs designed scientifically sound studies that enable the PIHPs to measure outcomes and allow for the successful progression to the next stage of the PIP process.

Findings for the Compliance Monitoring Reviews

The regulatory provisions addressed in the compliance monitoring reviews included Quality Assessment and Performance Improvement Program (438.240); Practice Guidelines (438.236); Quality Assessment and Performance Improvement—Access Standards, Coverage and Authorization of Services (438.210); Grievance System (438.228, 438.400–408, 438.414, and 438.416); Enrollee Rights and Information Requirements (42 CFR 438.100, 438.10, and 438.218); Subcontracts and Delegation (42 CFR 438.230); Provider Network (438.106, 438.12, 438.206, 438.207, and 438.214); Credentialing (438.12 and 438.214); Access and Availability (438.206); Coordination of Care (438.208); and Appeals (438.402, 438.406, 438.408, and 438.410). Two additional areas from the MDCH contract that were related but not specific to BBA regulations addressed Customer Services and Staff Qualifications and Training.

The 2013–2014 follow-up reviews evaluated the PIHPs' compliance with requirements that were not fully met in the prior reviews in 2011–2012 and 2012–2013. For regional entities that were composed of more than one of the previously contracted PIHPs, the 2013–2014 review assessed compliance with all requirements that were not fully met by any of the former PIHPs in the region. Appendix A presents a crosswalk between the previous 18 PIHPs and the 10 new regional entities.

Depending on prior performance, the review included any of the compliance standards reviewed in 2011–2012 and 2012–2013, with the exception of Standard XI—Access and Availability, as the Michigan Mission-Based Performance Indicator System data used for scoring most of the elements on this standard was not yet available for the new PIHPs. Due to the PIHPs' strong prior

performance, Standard III—Practice Guidelines and Standard IV—Staff Qualifications and Training were not included in any of the follow-up reviews as all PIHPs had previously demonstrated full compliance with all requirements in these areas.

For this review cycle, HSAG did not calculate any compliance scores for the standards or a total overall compliance score across all standards, as the results would not be comparable across the PIHPs due to the differences in the number of standards and elements evaluated during the follow-up review.

Four of the five PIHPs that did not have a change in their geographic service area demonstrated compliance with all requirements addressed in the follow-up review. One PIHP had a continued recommendation for the Appeals standard.

Performance of the five newly formed regional entities was mixed. While two of the new PIHPs demonstrated compliance with all requirements addressed in the 2013–2014 review, three of them had at least one and up to five recommendations for improvement.

The Performance Measurement and Improvement, Utilization Management, Customer Services, Enrollee Rights and Protections, Provider Network, and Coordination of Care standards represented statewide strengths, as all PIHPs demonstrated full compliance with the applicable requirements addressed in the 2013–2014 compliance reviews. Several PIHPs addressed prior recommendations or showed they were prepared to meet requirements related to the reporting of and follow-up on sentinel events; 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); written and timely notification of termination of a contracted provider to each enrollee who received his or her primary care from, or was seen on a regular basis by, the terminated provider; written notice of the decision to deny a provider participation in the network; and a written, functioning coordination agreement with each MHP serving any part of the PIHP's service area.

The compliance reviews identified opportunities for improvement for the Enrollee Grievance Process, Subcontracts and Delegation, Credentialing, and Appeals standards. Recommendations related to these standards addressed handling of grievances and appeals (e.g., acknowledgement of receipt, content of notices for disposition, information for beneficiaries); PIHP oversight of affiliates' provider network monitoring, grievance and appeals processes; PIHP-level policies for the credentialing, grievance, and appeals processes; and reporting requirements for improper conduct. These were areas for corrective actions primarily for the newly formed regional entities.

Section 3 (PIHP-specific findings) details 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 Codebook specifications. For PIHPs that were new regional entities, HSAG conducted a readiness review to prepare them for the State fiscal year (SFY) 2015 performance measure reporting. The readiness review assessed the data collection and reporting processes used by the PIHPs to determine their capability to report the MDCH-required performance indicators. The new PIHPs were not required to report rates for SFY 2014.

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 1-2 below presents the validation results for the individual indicators that were calculated by either the PIHPs or MDCH, as detailed in Section 2 of this report (Table 2-4).

Table 1-2—Overall Performance Indicator Compliance With MDCH Specifications Across All PIHPs	
Validation Finding	Percent
<i>Report (R)</i>	100%
<i>Not Reported (NR)</i>	0%
<i>No Benefit (NB)</i>	0%

Table 1-3 shows overall PIHP compliance with the MDCH codebook specifications for each of the 12 performance measures validated by HSAG.

Table 1-3—Performance Measure Results—Validation Designation				
Performance Measure		Percentage of PIHPs		
		<i>R</i>	<i>NR</i>	<i>NB</i>
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%

Table 1-3—Performance Measure Results—Validation Designation

Performance Measure		Percentage of PIHPs		
		R	NR	NB
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%
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.	100%	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%	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

HSAG validated the performance measures for each PIHP, including the newly formed regional entities. All 12 measures received a validation designation of *Report* for all five PIHPs reporting their rates, reflecting that the PIHPs demonstrated compliance with technical requirements and specifications for the collection and reporting of performance indicators. The five new PIHPs also achieved a validation designation of *Report* for all indicators, demonstrating adequate system readiness, data collection, and calculation processes for the next year of performance indicator reporting.

The PIHPs had adequate processes for data integration and data control, as well as sufficient and complete documentation of the performance indicator calculations. HSAG did not identify any opportunities for improvement in these areas. Statewide, the PIHPs demonstrated compliance with requirements for the collection, validation, and submission of quality improvement and encounter data to MDCH and—when applicable—provided adequate oversight of the affiliated community mental health centers and coordinating agencies. All PIHPs had sound processes for collecting, validating, and submitting quality improvement data and—when applicable—met the MDCH requirement for data completeness for first quarter SFY 2014.

Noted strengths included the use of region-wide information systems and electronic medical records to ensure standardized processes for the collection and reporting of performance indicator and quality improvement data. The PIHPs continued to enhance their analytical and reporting capabilities and strengthened data validation procedures. As a result of the transition to the new regional entities, several PIHPs developed comprehensive committee structures that included representatives from each CMHSP in the region to work collaboratively to resolve reporting process issues or concerns. Some of the new regional entities hired staff from the former PIHPs and CMHSPs in the region, using experienced staff to ensure continuity of performance indicator and quality improvement data reporting.

Several PIHPs should improve documentation in the electronic record system of exceptions and the reason for the exclusion. In cases when the PIHP opted to contract with or share employees with CMHSPs in the region, roles and PIHP oversight should be clearly defined and documented. Other opportunities for improvement addressed oversight of vendors, transition from manual to automated data validation processes, and continued efforts to improve rates that fall below the MDCH-defined minimum performance standard. As the merging of coordinating agency functions with the PIHP/CMHSP system is completed, the PIHPs should document the transition and any changes affecting performance indicator and quality improvement data reporting.

Across the five PIHPs that reported rates for the performance indicators, performance on Indicator 1—Timeliness of Inpatient Screenings and Indicator 2—Timeliness of Face-to-Face Assessments was strong, with all five PIHPs meeting the MDCH-established minimum performance standard of 95 percent for all sub-populations (adults and children with mental illness or developmental disability and Medicaid substance abuse beneficiaries). Indicator 3—Timeliness of First Service showed similar strong performance, with all five PIHPs' total rates meeting the performance standard of 95 percent; however, three PIHPs did not meet the standard for all sub-populations. Performance on Indicator 10—Readmission Rate was mixed. While all five PIHPs met the performance standard of 15 percent for readmissions of children, only three of the five PIHPs met the standard for adults. Indicator 4—Follow-Up Care represented the largest opportunity for improvement as only one PIHP met the performance standard of 95 percent for all three indicators for this measure (adults and children discharged from a psychiatric inpatient unit and beneficiaries discharged from a detox unit).

MDCH did not specify a minimum performance standard for the remaining indicators: penetration and habilitation supports (HSW) rates, and rates of adults who were employed competitively, earned minimum wage, or lived in a private residence.

Most indicators (Indicators 1 through 4b and Indicator 10) were reported and validated for first quarter SFY 2014. Indicators 5 through 9 and Indicators 13 and 14 were reported and validated for SFY 2013.

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 1-4 and Table 1-5 display the 2013–2014 results for the validated performance indicators for the five PIHPs that continued in their previous configuration. New regional entities (Regions 2, 3, 4, 5, and 10) were not required to report rates for this validation cycle. Therefore, statewide rates could not be calculated.

Table 1-4—PIHP Performance Measure Percentage Scores

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	Total	Follow-Up Care—Children	Follow-Up Care—Adults	Follow-Up Care—Detox
Region 1—NorthCare	100	100	97.60	98.86	100	100	96.97	97.99	96.26	94.59	94.12	100	95.67	93.75	100	100
Region 2—Northern MI																
Region 3—Lakeshore																
Region 4—Southwest MI																
Region 5—Mid-State																
Region 6—CMHPSM	100	99.67	99.32	100	100	100	95.71	99.04	99.00	98.89	100	97.67	98.81	95.00	96.97	78.95
Region 7—Detroit	100	95.65	95.94	96.77	98.97	97.10	98.95	97.55	99.15	96.59	100	100	98.12	99.66	98.24	92.19
Region 8—Oakland	97.30	95.03	100	98.06	100	100	98.82	98.84	100	99.68	94.44	100	99.62	96.55	99.12	100
Region 9—Macomb	99.75	100	98.39	97.98	95.65	100	97.64	97.82	98.15	100	96.55	92.00	98.28	93.94	92.43	100
Region 10 PIHP																
Statewide Rate																
MDCH Standard	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%

Notes: Rates in *blue* font indicate performance not meeting the MDCH minimum performance standard.

Table 1-5—PIHP Performance Measure Percentage Scores

PIHP	5.	6.	8. Competitive Employment			9. Minimum Wage			10. Inpatient Recidivism		13/14. Private Residence	
	Penetration Rate	HSW Rate	MI—Adults	DD—Adults	MI/DD Adults	MI—Adults	DD—Adults	MI/DD Adults	Children	Adults	DD—Adults	MI—Adults
Region 1—NorthCare	8.39	97.03	9.78	6.85	4.39	80.12	31.93	36.59	5.56	9.52	18.18	54.98
Region 2—Northern MI												
Region 3—Lakeshore												
Region 4—Southwest MI												
Region 5—Mid-State												
Region 6—CMHPSM	7.53	98.65	9.25	9.24	7.57	82.27	61.60	69.81	14.89	10.26	26.60	31.39
Region 7—Detroit	7.94	96.85	4.71	1.82	2.14	62.13	13.12	32.14	14.77	16.40	22.15	22.76
Region 8—Oakland	9.23	99.30	9.42	12.29	9.97	59.79	37.28	25.93	8.11	13.25	17.26	37.48
Region 9—Macomb	6.31	99.39	7.32	5.27	4.38	73.01	36.95	28.27	10.00	22.67	15.05	34.39
Region 10 PIHP												
Statewide Rate												
MDCH Standard	NA	NA	NA	NA	NA	NA	NA	NA	≤15%	≤15%	NA	NA

Notes: Rates in *blue* font 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 provided their first-year submissions on a new PIP topic. MDCH directed the PIHPs to develop a PIP on a topic of their choosing related to the integration of physical and mental health care. Table 1-6 presents a summary of the 2013–2014 PIP validation status results. For this first-year submission, 80 percent (8 of 10) of the PIPs received a *Met* validation status.

Table 1-6—PIP Validation Status	
Validation Status	Number of PIHPs
<i>Met</i>	8
<i>Partially Met</i>	2
<i>Not Met</i>	0

Table 1-7 presents a statewide summary of the PIHPs’ 2013–2014 validation results for each of the CMS PIP protocol activities. HSAG validated Activities I through VI for all 10 PIPs. 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 1-7—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	9/10	10/10
II.	Define the Study Question(s)	9/10	9/10
III.	Use a Representative and Generalizable Study Population	10/10	10/10
IV.	Select the Study Indicator(s)	9/10	9/10
V.	Use Sound Sampling Techniques*	NA	NA
VI.	Reliably Collect Data*	8/10	NA
VII.	Analyze Data and Interpret Study Results	Not Assessed	Not Assessed
VIII.	Implement Intervention and Improvement Strategies	Not Assessed	Not Assessed
IX.	Assess for Real Improvement	Not Assessed	Not Assessed
X.	Assess for Sustained Improvement	Not Assessed	No Critical Elements

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

The PIHPs selected new study topics related to the integration of physical and mental health care, focusing on improving the quality of care by identifying and documenting risk factors for co-morbid physical conditions and monitoring whether beneficiaries received care and services for the physical health condition. For the 2013–2014 validation cycle, the PIHPs completed the design phase of the PIPs, which included Activities 1–VI. Performance on the activities of the design phase of the new PIPs represented a statewide strength.

The first-year submissions for the new PIP topics met all applicable requirements related to the study population (Activity III). Requirements related to sound sampling techniques (Activity V) were not applicable to any of the PIPs.

Seven of the 10 PIHPs demonstrated high levels of compliance with CMS PIP protocol requirements for Activities I through VI and achieved scores of *Met* for all applicable evaluation and critical elements as well as for the validation status. One PIHP achieved a validation status of *Met*, but received a score of *Partially Met* for one of the evaluation elements in Activity VI—Reliably Collect Data. The two remaining PIHPs achieved a validation status of *Partially Met*, with scores of less than *Met* in Activity I—Select the Study Topic, Activity II—Define the Study Question, Activity IV—Select the Study Indicators, and Activity VI—Reliably Collect Data.

Opportunities for improvement addressed revisions to the study topic to ensure that it has the potential to affect integration of physical and mental health care, modification of the study question to address the potential impact of the interventions, corrections to the definition of the study indicator, improved descriptions of the data collection process, and documentation of the estimated degree of data completeness. None of these issues represented statewide opportunities for improvement.

Table 1-8 presents the results of the 2013–2014 PIP validation.

PIHP	% of All Elements <i>Met</i>	% of All Critical Elements <i>Met</i>	Validation Status
Region 1—NorthCare	100%	100%	<i>Met</i>
Region 2—Northern MI	100%	100%	<i>Met</i>
Region 3—Lakeshore	100%	100%	<i>Met</i>
Region 4—Southwest MI	100%	100%	<i>Met</i>
Region 5—Mid-State	73%	80%	<i>Partially Met</i>
Region 6—CMHPSM	100%	100%	<i>Met</i>
Region 7—Detroit	100%	100%	<i>Met</i>
Region 8—Oakland	73%	60%	<i>Partially Met</i>
Region 9—Macomb	100%	100%	<i>Met</i>
Region 10 PIHP	91%	100%	<i>Met</i>

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

Conclusions

Findings from the 2013–2014 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 standards included in the 2013–2014 review cycle. Four of the five PIHPs that had no change to their service area demonstrated full compliance with all requirements addressed in the follow-up review, indicating that they successfully implemented corrective actions to address areas for improvement identified in the previous review cycles. Two of the five new regional entities demonstrated compliance with all requirements included in the review. Opportunities for improvement identified in the 2013–2014 review cycle primarily related to the PIHP's policies and oversight role related to grievances, appeals, provider network monitoring, and credentialing.

Results from the validation of performance measures reflected continued compliance with technical requirements and specifications in the collection and reporting of performance indicators, resulting in all indicators being fully compliant with MDCH specifications across all PIHPs. The five PIHPs that reported rates for this validation cycle continued to demonstrate strong performance, with 88 percent of individual PIHP rates exceeding the respective MDCH benchmark for the indicator.

For the 2013–2014 validation cycle, HSAG validated Activities I–VI of the study design phase for all 10 PIPs. The studies demonstrated high levels of compliance with the requirements of the CMS PIP protocol for the validated activities, reflected in a validation status of *Met* for eight of the 10 PIPs. The validation did not identify any statewide opportunities for improvement. The results of the 2013–2014 validation suggest that overall, the PIHPs designed scientifically sound studies to measure outcomes for the integration of physical and mental health care and that the solid designs should allow for the successful progression to the next stage of the PIPs.

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 10 PIHPs with which the State contracts.

These reviews evaluated the PIHPs' progress in achieving compliance with federal and State regulations and contractual requirements related to those elements on the standards listed in Table 2-2 that scored less than *Met* in the previous review of the standard. None of the PIHPs required follow-up on Standard III—Practice Guidelines or Standard IV—Staff Qualifications and Training as all PIHPs had achieved 100 percent compliance during the previous compliance reviews. Standard XII—Access and Availability was excluded from the follow-up review, as the performance indicator data required for scoring the elements was not yet available for the newly formed PIHPs.

The 2013–2014 compliance monitoring reviews evaluated the PIHPs' compliance with selected federal and State regulations and contractual requirements related to the following standards:

- ◆ Standard I—QAPIP Plan and Structure
- ◆ Standard II—Performance Measurement and Improvement
- ◆ Standard V—Utilization Management
- ◆ Standard VI—Customer Services
- ◆ Standard VII—Enrollee Grievance Process
- ◆ Standard VIII—Enrollee Rights and Protections
- ◆ Standard IX—Subcontracts and Delegation
- ◆ Standard X—Provider Network

- ◆ Standard XI—Credentialing
- ◆ Standard XIII—Coordination of Care
- ◆ Standard XIV—Appeals

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

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

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.

The 2013 reorganization of the PIHPs into regional entities resulted in 10 PIHPs, five of which included service areas of two or more of the previous 18 PIHPs. To conduct the 2013–2014 follow-up reviews, HSAG assigned the elements for follow-up to the new regional entity that included the majority of the counties served by the previous PIHPs, as shown in Appendix A. For the 2013–2014 follow-up compliance reviews, the tools were customized for each PIHP, based on their performance in 2011–2012 and 2012–2013, to include only those standards for which the PIHP (or for the newly formed regional entities, any of the previous PIHPs in the region) had scored less than 100 percent and only those elements for which the PIHP had scored *Substantially Met*, *Partially Met*, or *Not Met*.

For each of the PIHP reviews in 2013–2014, 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 customized 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:** The 2013–2014 follow-up reviews did not include any record reviews for the utilization management, grievance process, and beneficiary appeals standards.

- ◆ **Compliance Monitoring Reviews:** The 2013–2014 compliance monitoring reviews were conducted either via telephone conference calls between key PIHP staff members and the HSAG review team or as a 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 interviews, HSAG prepared a report of the compliance monitoring review findings and—when applicable—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 these PIHPs with a template for their corrective action plans.

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.
- ◆ 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) 2013* to Date of Review
Information From Interviews Conducted	State Fiscal Year (SFY) 2013* to Date of Review
* Five of the regional entities began operations on January 1, 2014. For these PIHPs, the time period to which the data applied began on that date.	

Data Aggregation, Analysis, and How Conclusions Were Drawn

Reviewers used the compliance monitoring 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 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)*. One element on Standard I—QAPIP Plan and Structure was assessed for information only. Following discussions with MDCH, HSAG did not assign a score due to changing contractual requirements related to the content of that element. For this review cycle, HSAG did not calculate any compliance scores for the standards or a total overall compliance score across all standards, as the results would not be comparable across the PIHPs due to the differences in the number of standards and elements evaluated during the follow-up review.

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 2-1.

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

* Standard was not included in the follow-up review.

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. Six of these indicators were to be reported by the PIHPs quarterly, with MDCH calculating the remaining six. The majority of the performance indicators were reported and validated for the first quarter of the Michigan SFY 2014, as shown in Table 2-4.

For PIHPs that were new regional entities, HSAG conducted a readiness review to prepare them for SFY 2015 performance measure (indicator) reporting. The readiness review assessed the data collection and reporting processes used by the PIHPs to determine their capability of reporting the MDCH-required performance indicators. The new PIHPs were not required to report rates for SFY 2014.

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 V 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. A mini version of the

ISCAT was also received for each Coordinating Agency (CA). 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.
- Upon receiving the completed ISCATs/mini-ISCATs from the PIHPs/CAs, HSAG conducted a desk review of the tool and any supporting documentation submitted by the PIHPs. HSAG identified any potential issues, concerns, or items that required additional clarification. HSAG also conducted a line-by-line review of the source code submitted by the PIHPs/MDCH for the performance indicators.
- For the five PIHPs that continued in their previous configuration, HSAG reviewed the PIHP performance indicator reports provided by MDCH for the specified measurement period (i.e., first quarter SFY 2014). HSAG used previous reports to assess trending patterns and rate reasonability. For the newly formed PIHPs, HSAG used the rates calculated by the PIHPs for the second quarter SFY 2014 measurement period, which began January 1, 2014, and ended March 31, 2014, to assess calculation readiness.

◆ On-site Activities

- HSAG conducted on-site visits with each PIHP. HSAG collected information using several methods including interviews, system demonstration, review of data output files, primary source verification, observation of data processing, and review of data reports. The on-site visit activities are described as follows:
 - Opening session—The opening session included introductions of the validation team and key PIHP staff members involved in the performance measure validation activities. Discussion during the session covered the review purpose, the required documentation, basic meeting logistics, and queries to be performed.
 - Evaluation of system compliance—The evaluation included a review of the information systems, focusing on the processing of enrollment and disenrollment data. Additionally, HSAG evaluated the processes used to collect and calculate the performance indicators, including accurate numerator and denominator identification, and algorithmic compliance (which evaluated whether rate calculations were performed correctly, all data were combined appropriately, and numerator events were counted accurately). Based on the desk review of the ISCAT(s), HSAG conducted interviews with key PIHP staff members familiar with the processing, monitoring, and calculation of the performance indicators. HSAG used interviews to confirm findings from the documentation review, expand or clarify outstanding issues, and verify that written policies and procedures were used and followed in daily practice.
 - Overview of data integration and control procedures—The overview included discussion and observation of source code logic, a review of how all data sources were combined, and how the analytic file used for reporting the performance indicators was generated. HSAG also reviewed any supporting documentation provided for data integration. This session addressed data control and security procedures as well. For the five PIHPs that continued in their previous configuration, HSAG performed primary source verification

to further validate the output files. For those PIHPs that were contracted as new regional entities, HSAG focused on system readiness, data integration, and rate calculation and reporting process readiness review. Primary source verification and rate review were not performed with these PIHPs.

- Closing conference—The closing conference summarized preliminary findings based on the review of the ISCAT and the on-site visit, and reviewed the documentation requirements for any post-on-site 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 2013
Source Code/Programming Language for Performance Measures (From PIHPs and MDCH) or Description of the Performance Measure Calculation Process (From PIHPs)	SFY 2013
Previous Performance Measure Results Reports (From MDCH)	SFY 2013
Performance Measure Results (From PIHPs and MDCH)	First Quarter SFY 2014
Supporting Documentation (From PIHPs and MDCH)	SFY 2013
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 2014
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 2014
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 2014
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 2014
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 2014
5.	The percentage of Medicaid recipients having received PIHP managed services.	MDCH	First Quarter SFY 2014
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 2014
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 2013

Indicator	Calculation by:	Validation Review Period
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 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.	PIHP	First Quarter SFY 2014
13. The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	MDCH	SFY 2013
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 2013

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 *Report (R)*, *Not Reported (NR)*, or *No Benefit (NB)* for each performance measure. For the five PIHPs that continued in their previous configuration, the validation findings pertained to the rates reported based on the validation review period. For the PIHPs that were new regional entities, the validation findings were determined based on HSAG’s review of the PIHP’s calculation readiness of the indicators. 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 compliant based on the review findings. Consequently, it was possible that an error for a single element resulted in a designation of *NR* 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 *R*.

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 Medicaid beneficiaries 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 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.		✓	✓
3.	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.		✓	✓
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 (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 employment competitively.	✓		
9.	The percentage 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 employment activities.	✓		
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.	✓		
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 2013–2014 validation cycle, all PIHPs submitted a new statewide PIP on integrating behavioral health and physical health care. 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 2013–2014 validation cycle, HSAG provided technical assistance to all PIHPs 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 Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. 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
- ◆ Activity II. Define the Study Question(s)
- ◆ Activity III. Use a Representative and Generalizable Study Population
- ◆ Activity IV. Select the Study Indicator(s)
- ◆ Activity V. Use Sound Sampling Techniques
- ◆ Activity VI. Reliably Collect Data
- ◆ Activity VII. Analyze Data and Interpret Study Results
- ◆ Activity VIII. Implement Intervention and Improvement Strategies
- ◆ 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 2013

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 application 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 *Integrated Behavioral and Physical Health Care* PIP topic addressed CMS’ requirements related to quality outcomes—specifically, quality, timeliness of, and access to care and services. HSAG assigned the PIPs to the **quality, timeliness, and access** domains as depicted in Table 2-7.

Table 2-7—Assignment of PIPs to Performance Domains			
Topic	Quality	Timeliness	Access
<i>Integrated Behavioral and Physical Health Care</i>	✓	✓	✓

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

Introduction

This section of the report contains findings from the three 2013–2014 EQR activities—compliance monitoring, validation of performance measures, and validation of PIPs—for the 10 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 2013–2014 compliance monitoring follow-up reviews. These reviews evaluated the PIHPs’ progress toward—or for the new PIHPs their readiness to—achieving compliance with federal and State regulations and contractual requirements related to those elements on the standards listed in Table 3-1 that scored less than *Met* in the previous review of the standard. None of the PIHPs required follow-up on the Practice Guidelines or Staff Qualifications and Training standards as all PIHPs had achieved 100 percent compliance during the previous compliance reviews. Standard XII—Access and Availability was excluded from the follow-up review, as the performance indicator data required for scoring the elements was not yet available for the newly-formed PIHPs. HSAG assigned the compliance standards to the domains of **quality**, **timeliness**, and **access** to care as follows:

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

Region 1—NorthCare Network

Compliance Monitoring Results

Table 3-2 below presents the results of the 2013–2014 follow-up compliance review of **NorthCare Network**, 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 2013–2014 External Quality Review Compliance Monitoring Report for **NorthCare Network** contains a more detailed description of the results.

Table 3-2—Summary of 2013–2014 Compliance Review Results for NorthCare Network								
Standard		Total Elements	Total Applicable Elements	Number of Elements				
				<i>M</i>	<i>SM</i>	<i>PM</i>	<i>NM</i>	<i>NA</i>
I	<i>QAPIP Plan and Structure</i>	19		No follow-up required				
II	<i>Performance Measurement and Improvement</i>	21		No follow-up required				
III	<i>Practice Guidelines</i>	14		No follow-up required				
IV	<i>Staff Qualifications and Training</i>	6		No follow-up required				
V	<i>Utilization Management</i>	19	2	2	0	0	0	0
VI	<i>Customer Services</i>	10		No follow-up required				
VII	<i>Enrollee Grievance Process</i>	13		No follow-up required				
VIII	<i>Enrollee Rights and Protections</i>	32	2	2	0	0	0	0
IX	<i>Subcontracts and Delegation</i>	8		No follow-up required				
X	<i>Provider Network</i>	12		No follow-up required				
XI	<i>Credentialing</i>	25	1	1	0	0	0	0
XII	<i>Access and Availability</i>	Not included in the follow-up review						
XIII	<i>Coordination of Care</i>	4		No follow-up required				
XIV	<i>Appeals</i>	15		No follow-up required				
Total		198	5	5	0	0	0	0

Strengths

In the previous full review of the standards, the PIHP had achieved 100 percent compliance on the following standards: QAPIP Plan and Structure, Performance Measurement and Improvement, Practice Guidelines, Staff Qualifications and Training, Customer Services, Enrollee Grievance Process, Subcontracts and Delegation, Provider Network, Coordination of Care, and Appeals. Therefore, no follow-up review was required for these standards.

NorthCare Network demonstrated in the 2013–2014 follow-up compliance review that it had successfully addressed all recommendations for improvement for the Utilization Management, Enrollee Rights and Protections, and Credentialing standards.

Recommendations

The 2013–2014 review did not result in any recommendations for improvement as **NorthCare Network** demonstrated full compliance with all elements addressed in the follow-up review.

Summary Assessment Related to Quality, Timeliness, and Access

The standards included in **NorthCare Network**'s follow-up review addressed all three domains of **quality**, **timeliness**, and **access**. The previous full reviews of the standards determined full compliance with all requirements for 10 of the 12 standards in the **quality** domain, three of the four standards in the **timeliness** domain, and three of the four standards in the **access** domain. In the **quality** domain, **NorthCare Network** implemented corrective actions in the areas of Enrollee Rights and Protections as well as Credentialing. In the **timeliness** and **access** domains, **NorthCare Network** successfully addressed recommendations for the Utilization Management standard. The 2013–2014 follow-up compliance review did not result in any continued recommendations for improvement as the PIHP achieved full compliance with all requirements addressed in the follow-up review.

NorthCare Network demonstrated excellent performance across the three domains of **quality**, **timeliness**, and **access**.

Region 2—Northern Michigan Regional Entity

Compliance Monitoring Results

Table 3-3 below presents the results of the 2013–2014 follow-up compliance review of **Northern Michigan Regional Entity**, 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 2013–2014 External Quality Review Compliance Monitoring Report for **Northern Michigan Regional Entity** contains a more detailed description of the results.

Standard		Total Elements	Total Elements Assessed	Number of Elements				
				<i>M</i>	<i>SM</i>	<i>PM</i>	<i>NM</i>	<i>NA</i>
I	<i>QAPIP Plan and Structure</i>	19	1*	Reviewed for information only				
II	<i>Performance Measurement and Improvement</i>	21	No follow-up required					
III	<i>Practice Guidelines</i>	14	No follow-up required					
IV	<i>Staff Qualifications and Training</i>	6	No follow-up required					
V	<i>Utilization Management</i>	19	6	6	0	0	0	0
VI	<i>Customer Services</i>	10	No follow-up required					
VII	<i>Enrollee Grievance Process</i>	13	2	2	0	0	0	0
VIII	<i>Enrollee Rights and Protections</i>	32	1	1	0	0	0	0
IX	<i>Subcontracts and Delegation</i>	8	No follow-up required					
X	<i>Provider Network</i>	12	2	2	0	0	0	0
XI	<i>Credentialing</i>	25	No follow-up required					
XII	<i>Access and Availability</i>	Not included in the follow-up review						
XIII	<i>Coordination of Care</i>	4	No follow-up required					
XIV	<i>Appeals</i>	15	3	3	0	0	0	0
Total		198	15	14	0	0	0	0

* The element on Standard I—QAPIP Plan and Structure was assessed for information only, and no score was assigned.

Strengths

This was the first compliance monitoring review for **Northern Michigan Regional Entity**. The former PIHPs in Region 2 had achieved 100 percent compliance in the previous full review of the standards in the following areas: Performance Measurement and Improvement, Practice Guidelines,

Staff Qualifications and Training, Customer Services, Subcontracts and Delegation, Credentialing, and Coordination of Care. Therefore, no follow-up review was required for these standards.

Northern Michigan Regional Entity demonstrated in the 2013–2014 follow-up compliance review that it was prepared to comply with the requirements that had not been met by the previous PIHPs in the region for the following standards: QAPIP Plan and Structure, Utilization Management, Enrollee Grievance Process, Enrollee Rights and Protections, Provider Network, and Appeals.

Recommendations

The 2013–2014 review did not result in any recommendations for improvement as **Northern Michigan Regional Entity** demonstrated full compliance with all elements addressed in the follow-up review.

Summary Assessment Related to Quality, Timeliness, and Access

The standards included in **Northern Michigan Regional Entity**'s follow-up review addressed all three domains of **quality**, **timeliness**, and **access**. The previous full reviews of the standards determined full compliance with all requirements for seven of the 12 standards in the **quality** domain, one of the four standards in the **timeliness** domain, and two of the four standards in the **access** domain. In the **quality** domain, **Northern Michigan Regional Entity** demonstrated compliance with the requirements that were addressed for the QAPIP Plan and Structure, Grievance Process, Enrollee Rights and Protections, Provider Network, and Appeals standards. In the **timeliness** domain, **Northern Michigan Regional Entity** met the requirements assessed for the Utilization Management, Grievance Process, and Appeals standards. The PIHP's strong performance on the Utilization Management and Provider Network standards also addressed the **access** domain. The 2013–2014 follow-up compliance review did not result in any continued recommendations for improvement as the PIHP achieved full compliance with all requirements addressed in the follow-up review.

Northern Michigan Regional Entity demonstrated excellent performance across the three domains of **quality**, **timeliness**, and **access**.

Region 3—Lakeshore Regional Entity

Compliance Monitoring Results

Table 3-4 below presents the results of the 2013–2014 follow-up compliance review of **Lakeshore Regional Entity**, 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 2013–2014 External Quality Review Compliance Monitoring Report for **Lakeshore Regional Entity** contains a more detailed description of the results.

Standard		Total Elements	Total Elements Assessed	Number of Elements				
				<i>M</i>	<i>SM</i>	<i>PM</i>	<i>NM</i>	<i>NA</i>
I	<i>QAPIP Plan and Structure</i>	19		No follow-up required				
II	<i>Performance Measurement and Improvement</i>	21	2	2	0	0	0	0
III	<i>Practice Guidelines</i>	14		No follow-up required				
IV	<i>Staff Qualifications and Training</i>	6		No follow-up required				
V	<i>Utilization Management</i>	19	3	3	0	0	0	0
VI	<i>Customer Services</i>	10	3	3	0	0	0	0
VII	<i>Enrollee Grievance Process</i>	13	3	3	0	0	0	0
VIII	<i>Enrollee Rights and Protections</i>	32	3	3	0	0	0	0
IX	<i>Subcontracts and Delegation</i>	8	4	4	0	0	0	0
X	<i>Provider Network</i>	12	2	2	0	0	0	0
XI	<i>Credentialing</i>	25		No follow-up required				
XII	<i>Access and Availability</i>			Not included in the follow-up review				
XIII	<i>Coordination of Care</i>	4		No follow-up required				
XIV	<i>Appeals</i>	15	6	5	0	1	0	0
Total		198	26	25	0	1	0	0

Strengths

This was the first compliance monitoring review for **Lakeshore Regional Entity**. The former PIHPs in Region 3 had achieved 100 percent compliance in the previous full review of the standards in the following areas: QAPIP Plan and Structure, Practice Guidelines, Staff Qualifications and Training, Credentialing, and Coordination of Care. Therefore, no follow-up review was required for these standards.

Lakeshore Regional Entity demonstrated in the 2013–2014 follow-up compliance review that it was prepared to comply with the requirements that had not been met by the previous PIHPs in the region for the following standards: Performance Measurement and Improvement, Utilization Management, Customer Services, Enrollee Grievance Process, Enrollee Rights and Protections, Subcontracts and Delegation, Provider Network, and Appeals.

Recommendations

The 2013–2014 review resulted in a recommendation for improvement for the Appeals standard. **Lakeshore Regional Entity** should ensure that provisions in its contracts and information provided to beneficiaries correctly state the requirements and time frames for filing appeals.

Summary Assessment Related to Quality, Timeliness, and Access

The standards included in **Lakeshore Regional Entity**'s follow-up review addressed all three domains of **quality**, **timeliness**, and **access**. The previous full reviews of the standards determined full compliance with all requirements for five of the 12 standards in the **quality** domain, none of the four standards in the **timeliness** domain, and one of the four standards in the **access** domain. In the **quality** domain, **Lakeshore Regional Entity** demonstrated compliance with the requirements that were addressed for Performance Measurement and Improvement, Customer Services, Grievance Process, Enrollee Rights and Protections, Subcontracts and Delegation, and Provider Network. In the **timeliness** domain, **Lakeshore Regional Entity** met the requirements assessed for the Performance Measurement and Improvement, Utilization Management, and Grievance Process standards. The Utilization Management, Customer Services, and Provider Network standards also addressed the **access** domain. The 2013–2014 follow-up compliance review resulted in one continued recommendation for improvement for the Appeals standard, which addressed the domains of **quality** and **timeliness**.

Lakeshore Regional Entity demonstrated strong performance across the three domains of **quality**, **timeliness**, and **access**.

Region 4—Southwest Michigan Behavioral Health

Compliance Monitoring Results

Table 3-5 below presents the results of the 2013–2014 follow-up compliance review of **Southwest Michigan Behavioral Health**, 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 2013–2014 External Quality Review Compliance Monitoring Report for **Southwest Michigan Behavioral Health** contains a more detailed description of the results.

Standard		Total Elements	Total Elements Assessed	Number of Elements				
				<i>M</i>	<i>SM</i>	<i>PM</i>	<i>NM</i>	<i>NA</i>
I	<i>QAPIP Plan and Structure</i>	19		No follow-up required				
II	<i>Performance Measurement and Improvement</i>	21		No follow-up required				
III	<i>Practice Guidelines</i>	14		No follow-up required				
IV	<i>Staff Qualifications and Training</i>	6		No follow-up required				
V	<i>Utilization Management</i>	19	3	3	0	0	0	0
VI	<i>Customer Services</i>	10		No follow-up required				
VII	<i>Enrollee Grievance Process</i>	13	3	3	0	0	0	0
VIII	<i>Enrollee Rights and Protections</i>	32		No follow-up required				
IX	<i>Subcontracts and Delegation</i>	8		No follow-up required				
X	<i>Provider Network</i>	12		No follow-up required				
XI	<i>Credentialing</i>	25	1	1	0	0	0	0
XII	<i>Access and Availability</i>			Not included in the follow-up review				
XIII	<i>Coordination of Care</i>	4		No follow-up required				
XIV	<i>Appeals</i>	15	5	5	0	0	0	0
Total		198	12	12	0	0	0	0

Strengths

This was the first compliance monitoring review for **Southwest Michigan Behavioral Health**. The former PIHPs in Region 4 had achieved 100 percent compliance in the previous full review of the standards in the following areas: QAPIP Plan and Structure, Performance Measurement and Improvement, Practice Guidelines, Staff Qualifications and Training, Customer Services, Enrollee Rights and Protections, Subcontracts and Delegation, Provider Network, and Coordination of Care. Therefore, no follow-up review was required for these standards.

Southwest Michigan Behavioral Health demonstrated in the 2013–2014 follow-up compliance review that it was prepared to comply with the requirements that had not been met by the previous PIHPs in the region for the following standards: Utilization Management, Enrollee Grievance Process, Credentialing, and Appeals.

Recommendations

The 2013–2014 review did not result in any recommendations for improvement as **Southwest Michigan Behavioral Health** demonstrated full compliance with all elements addressed in the follow-up review.

Summary Assessment Related to Quality, Timeliness, and Access

The standards included in **Southwest Michigan Behavioral Health**'s follow-up review addressed all three domains of **quality**, **timeliness**, and **access**. The previous full reviews of the standards determined full compliance with all requirements for nine of the 12 standards in the **quality** domain, one of the four standards in the **timeliness** domain, and three of the four standards in the **access** domain. In the **quality** domain, **Southwest Michigan Behavioral Health** demonstrated compliance with the requirements that were addressed for the Grievance Process, Credentialing, and Appeals standards. In the **timeliness** domain, **Southwest Michigan Behavioral Health** met the requirements assessed for the Utilization Management, Grievance Process, and Appeals standards. The PIHP's strong performance on the Utilization Management standard also addressed the **access** domain. The 2013–2014 follow-up compliance review did not result in any continued recommendations for improvement as the PIHP achieved full compliance with all requirements addressed in the follow-up review.

Southwest Michigan Behavioral Health demonstrated excellent performance across the three domains of **quality**, **timeliness**, and **access**.

Region 5—Mid-State Health Network

Compliance Monitoring Results

Table 3-6 below presents the results of the 2013–2014 follow-up compliance review of **Mid-State Health Network**, 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 2013–2014 External Quality Review Compliance Monitoring Report for **Mid-State Health Network** contains a more detailed description of the results.

Standard		Total Elements	Total Elements Assessed	Number of Elements				
				<i>M</i>	<i>SM</i>	<i>PM</i>	<i>NM</i>	<i>NA</i>
I	<i>QAPIP Plan and Structure</i>	19	1*	Reviewed for information only				
II	<i>Performance Measurement and Improvement</i>	21	4	4	0	0	0	0
III	<i>Practice Guidelines</i>	14	No follow-up required					
IV	<i>Staff Qualifications and Training</i>	6	No follow-up required					
V	<i>Utilization Management</i>	19	3	3	0	0	0	0
VI	<i>Customer Services</i>	10	No follow-up required					
VII	<i>Enrollee Grievance Process</i>	13	5	5	0	0	0	0
VIII	<i>Enrollee Rights and Protections</i>	32	3	3	0	0	0	0
IX	<i>Subcontracts and Delegation</i>	8	1	0	0	1	0	0
X	<i>Provider Network</i>	12	No follow-up required					
XI	<i>Credentialing</i>	25	4	3	0	1	0	0
XII	<i>Access and Availability</i>	Not included in the follow-up review						
XIII	<i>Coordination of Care</i>	4	1	1	0	0	0	0
XIV	<i>Appeals</i>	15	4	4	0	0	0	0
Total		198	26*	23	0	2	0	0

*The element on Standard I—QAPIP Plan and Structure was assessed for information only, and no score was assigned.

Strengths

This was the first compliance monitoring review for **Mid-State Health Network**. The former PIHPs in Region 5 had achieved 100 percent compliance in the previous full review of the standards in the following areas: Practice Guidelines, Staff Qualifications and Training, Customer Services, and Provider Network. Therefore, no follow-up review was required for these standards.

Mid-State Health Network demonstrated in the 2013–2014 follow-up compliance review that it was prepared to comply with the requirements that had not been met by the previous PIHPs in the region for the following standards: QAPIP Plan and Structure, Performance Measurement and Improvement, Utilization Management, Enrollee Grievance Process, Enrollee Rights and Protections, Coordination of Care, and Appeals.

Recommendations

The 2013–2014 review resulted in recommendations for improvement for the Subcontracts and Delegation and Credentialing standards. **Mid-State Health Network** should finalize its formal process for review and follow-up on any provider monitoring of its subcontractors. The PIHP should develop a PIHP-level credentialing policy and ensure that it remains responsible for oversight regarding delegated credentialing or recredentialing decisions.

Summary Assessment Related to Quality, Timeliness, and Access

The standards included in **Mid-State Health Network**'s follow-up review addressed all three domains of **quality**, **timeliness**, and **access**. The previous full reviews of the standards determined full compliance with all requirements for four of the 12 standards in the **quality** domain, none of the four standards in the **timeliness** domain, and two of the four standards in the **access** domain. In the **quality** domain, **Mid-State Health Network** demonstrated compliance with the requirements that were addressed for the QAPIP Plan and Structure, Performance Measurement and Improvement, Grievance Process, Enrollee Rights and Protections, Coordination of Care, and Appeals standards. Review of elements for the Subcontracts and Delegation and Credentialing standards, which addressed the **quality** domain, resulted in continued recommendations for improvement. In the **timeliness** domain, **Mid-State Health Network** met the requirements assessed for the Performance Measurement and Improvement, Utilization Management, Grievance Process, and Appeals standards. The PIHP's strong performance on the Utilization Management and Coordination of Care standards also addressed the **access** domain.

Mid-State Health Network demonstrated strong performance across the three domains of **quality**, **timeliness**, and **access**.

Region 6—CMH Partnership of Southeast Michigan

Compliance Monitoring Results

Table 3-7 below presents the results of the 2013–2014 follow-up compliance review of **CMH Partnership of Southeast Michigan**, 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 2013–2014 External Quality Review Compliance Monitoring Report for **CMH Partnership of Southeast Michigan** contains a more detailed description of the results.

Standard		Total Elements	Total Elements Assessed	Number of Elements				
				<i>M</i>	<i>SM</i>	<i>PM</i>	<i>NM</i>	<i>NA</i>
I	<i>QAPIP Plan and Structure</i>	19		No follow-up required				
II	<i>Performance Measurement and Improvement</i>	21	1	1	0	0	0	0
III	<i>Practice Guidelines</i>	14		No follow-up required				
IV	<i>Staff Qualifications and Training</i>	6		No follow-up required				
V	<i>Utilization Management</i>	19		No follow-up required				
VI	<i>Customer Services</i>	10		No follow-up required				
VII	<i>Enrollee Grievance Process</i>	13	1	1	0	0	0	0
VIII	<i>Enrollee Rights and Protections</i>	32		No follow-up required				
IX	<i>Subcontracts and Delegation</i>	8	2	2	0	0	0	0
X	<i>Provider Network</i>	12		No follow-up required				
XI	<i>Credentialing</i>	25	4	4	0	0	0	0
XII	<i>Access and Availability</i>			Not included in the follow-up review				
XIII	<i>Coordination of Care</i>	4		No follow-up required				
XIV	<i>Appeals</i>	15	2	2	0	0	0	0
Total		198	10	10	0	0	0	0

Strengths

In the previous full review of the standards, **CMH Partnership of Southeast Michigan** had achieved 100 percent compliance on the following standards: QAPIP Plan and Structure, Practice Guidelines, Staff Qualifications and Training, Utilization Management, Customer Services, Enrollee Rights and Protections, Provider Network, and Coordination of Care. Therefore, no follow-up review was required for these standards.

CMH Partnership of Southeast Michigan demonstrated in the 2013–2014 follow-up compliance review that it had successfully addressed all recommendations for improvement for the Performance Measurement and Improvement, Enrollee Grievance Process, Subcontracts and Delegation, Credentialing, and Appeals standards.

Recommendations

The 2013–2014 review did not result in any recommendations for improvement as **CMH Partnership of Southeast Michigan** demonstrated full compliance with all elements addressed in the follow-up review.

Summary Assessment Related to Quality, Timeliness, and Access

The standards included in **CMH Partnership of Southeast Michigan**'s follow-up review addressed the domains of **quality** and **timeliness**. The previous full reviews of the standards determined full compliance with all requirements for seven of the 12 standards in the **quality** domain, one of the four standards in the **timeliness** domain, and all four standards in the **access** domain. In the **quality** domain, **CMH Partnership of Southeast Michigan** implemented corrective actions in the areas of Performance Measurement and Improvement, Enrollee Grievance Process, Subcontracts and Delegation, Credentialing, and Appeals. In the **timeliness** domain, **CMH Partnership of Southeast Michigan** successfully addressed recommendations for the Performance Measurement and Improvement, Enrollee Grievance Process, and Appeals standards. None of the standards addressing the **access** domain were included in the follow-up review. The 2013–2014 follow-up compliance review did not result in any continued recommendations for improvement as the PIHP achieved full compliance with all requirements addressed in the follow-up review.

CMH Partnership of Southeast Michigan demonstrated excellent performance across the three domains of **quality**, **timeliness**, and **access**.

Region 7—Detroit Wayne Mental Health Authority

Compliance Monitoring Results

Table 3-8 below presents the results of the 2013–2014 follow-up compliance review of **Detroit Wayne Mental Health Authority**, 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 2013–2014 External Quality Review Compliance Monitoring Report for **Detroit Wayne Mental Health Authority** contains a more detailed description of the results.

Standard		Total Elements	Total Elements Assessed	Number of Elements				
				<i>M</i>	<i>SM</i>	<i>PM</i>	<i>NM</i>	<i>NA</i>
I	<i>QAPIP Plan and Structure</i>	19	No follow-up required					
II	<i>Performance Measurement and Improvement</i>	21	No follow-up required					
III	<i>Practice Guidelines</i>	14	No follow-up required					
IV	<i>Staff Qualifications and Training</i>	6	No follow-up required					
V	<i>Utilization Management</i>	19	No follow-up required					
VI	<i>Customer Services</i>	10	No follow-up required					
VII	<i>Enrollee Grievance Process</i>	13	1	1	0	0	0	0
VIII	<i>Enrollee Rights and Protections</i>	32	No follow-up required					
IX	<i>Subcontracts and Delegation</i>	8	1	1	0	0	0	0
X	<i>Provider Network</i>	12	No follow-up required					
XI	<i>Credentialing</i>	25	No follow-up required					
XII	<i>Access and Availability</i>	Not included in the follow-up review						
XIII	<i>Coordination of Care</i>	4	No follow-up required					
XIV	<i>Appeals</i>	15	1	0	1	0	0	0
Total		198	3	2	1	0	0	0

Strengths

In the previous full review of the standards, **Detroit Wayne Mental Health Authority** had achieved 100 percent compliance on the following standards: QAPIP Plan and Structure, Performance Measurement and Improvement, Practice Guidelines, Staff Qualifications and Training, Utilization Management, Customer Services, Enrollee Rights and Protections, Provider Network, Credentialing, and Coordination of Care. Therefore, no follow-up review was required for these standards.

Detroit Wayne Mental Health Authority demonstrated in the 2013–2014 follow-up compliance review that it had successfully addressed all recommendations for improvement for the Enrollee Grievance Process, and Subcontracts and Delegation standards.

Recommendations

The 2013–2014 review resulted in one recommendation for improvement for the Appeals standard. **Detroit Wayne Mental Health Authority** should continue to provide training on the appeals process and complete the implementation of the electronic notice of disposition.

Summary Assessment Related to Quality, Timeliness, and Access

The standards included in **Detroit Wayne Mental Health Authority**'s follow-up review addressed all three domains of **quality** and **timeliness**. The previous full reviews of the standards determined full compliance with all requirements for nine of the 12 standards in the **quality** domain, two of the four standards in the **timeliness** domain, and all four standards in the **access** domain. In the **quality** domain, **Detroit Wayne Mental Health Authority** implemented corrective actions in the areas of Grievance Process and Subcontracts and Delegation. In the **timeliness** domain, **Detroit Wayne Mental Health Authority** successfully addressed the recommendation for the Grievance Process standard. The 2013–2014 follow-up compliance review resulted in one continued recommendation for improvement for the Appeals standard, which addressed the domains of **quality** and **timeliness**. None of the standards addressing the **access** domain were included in the follow-up review.

Detroit Wayne Mental Health Authority demonstrated strong performance across the three domains of **quality**, **timeliness**, and **access**.

Region 8—Oakland County CMH Authority

Compliance Monitoring Results

Table 3-9 below presents the results of the 2013–2014 follow-up compliance review of **Oakland County CMH Authority**, 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 2013–2014 External Quality Review Compliance Monitoring Report for **Oakland County CMH Authority** contains a more detailed description of the results.

Standard		Total Elements	Total Elements Assessed	Number of Elements				
				<i>M</i>	<i>SM</i>	<i>PM</i>	<i>NM</i>	<i>NA</i>
I	<i>QAPIP Plan and Structure</i>	19		No follow-up required				
II	<i>Performance Measurement and Improvement</i>	21		No follow-up required				
III	<i>Practice Guidelines</i>	14		No follow-up required				
IV	<i>Staff Qualifications and Training</i>	6		No follow-up required				
V	<i>Utilization Management</i>	19		No follow-up required				
VI	<i>Customer Services</i>	10		No follow-up required				
VII	<i>Enrollee Grievance Process</i>	13		No follow-up required				
VIII	<i>Enrollee Rights and Protections</i>	32	1	1	0	0	0	0
IX	<i>Subcontracts and Delegation</i>	8		No follow-up required				
X	<i>Provider Network</i>	12		No follow-up required				
XI	<i>Credentialing</i>	25		No follow-up required				
XII	<i>Access and Availability</i>			Not included in the follow-up review				
XIII	<i>Coordination of Care</i>	4		No follow-up required				
XIV	<i>Appeals</i>	15		No follow-up required				
Total		198	1	1	0	0	0	0

Strengths

In the previous full review of the standards, **Oakland County CMH Authority** had achieved 100 percent compliance on the following standards: QAPIP Plan and Structure, Performance Measurement and Improvement, Practice Guidelines, Staff Qualifications and Training, Utilization Management, Customer Services, Enrollee Grievance Process, Subcontracts and Delegation, Provider Network, Credentialing, Coordination of Care, and Appeals. Therefore, no follow-up review was required for these standards.

Oakland County CMH Authority demonstrated in the 2013–2014 follow-up compliance review that it had successfully addressed the recommendation for improvement for the Enrollee Rights and Protections standard.

Recommendations

The 2013–2014 review did not result in any recommendations for improvement as **Oakland County CMH Authority** demonstrated full compliance with the element addressed in the follow-up review.

Summary Assessment Related to Quality, Timeliness, and Access

The standards included in **Oakland County CMH Authority**'s follow-up review addressed the **quality** domain. The previous full reviews of the standards determined full compliance with all requirements for 11 of the 12 standards in the **quality** domain, all four standards in the **timeliness** domain, and all four standards in the **access** domain. In the **quality** domain, **Oakland County CMH Authority** implemented corrective actions in the area of Enrollee Rights and Protections. None of the standards addressing the **timeliness** or **access** domains were included in the follow-up review. The 2013–2014 follow-up compliance review did not result in any continued recommendations for improvement as the PIHP achieved full compliance with all requirements addressed in the follow-up review.

Oakland County CMH Authority demonstrated excellent performance across the three domains of **quality**, **timeliness**, and **access**.

Region 9—Macomb County CMH Services

Compliance Monitoring Results

Table 3-10 below presents the results of the 2013–2014 follow-up compliance review of **Macomb County CMH Services**, 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 2013–2014 External Quality Review Compliance Monitoring Report for **Macomb County CMH Services** contains a more detailed description of the results.

Table 3-10—Summary of 2013–2014 Compliance Review Results for Macomb County CMH Services								
Standard		Total Elements	Total Elements Assessed	Number of Elements				
				<i>M</i>	<i>SM</i>	<i>PM</i>	<i>NM</i>	<i>NA</i>
I	<i>QAPIP Plan and Structure</i>	19		No follow-up required				
II	<i>Performance Measurement and Improvement</i>	21	5	5	0	0	0	0
III	<i>Practice Guidelines</i>	14		No follow-up required				
IV	<i>Staff Qualifications and Training</i>	6		No follow-up required				
V	<i>Utilization Management</i>	19		No follow-up required				
VI	<i>Customer Services</i>	10		No follow-up required				
VII	<i>Enrollee Grievance Process</i>	13		No follow-up required				
VIII	<i>Enrollee Rights and Protections</i>	32		No follow-up required				
IX	<i>Subcontracts and Delegation</i>	8	1	1	0	0	0	0
X	<i>Provider Network</i>	12	1	1	0	0	0	0
XI	<i>Credentialing</i>	25	9	9	0	0	0	0
XII	<i>Access and Availability</i>			Not included in the follow-up review				
XIII	<i>Coordination of Care</i>	4		No follow-up required				
XIV	<i>Appeals</i>	15	1	1	0	0	0	0
Total		198	17	17	0	0	0	0

Strengths

In the previous full review of the standards, **Macomb County CMH Services** had achieved 100 percent compliance on the following standards: QAPIP Plan and Structure, Practice Guidelines, Staff Qualifications and Training, Utilization Management, Customer Services, Enrollee Grievance Process, Enrollee Rights and Protections, and Coordination of Care. Therefore, no follow-up review was required for these standards.

Macomb County CMH Services demonstrated in the 2013–2014 follow-up compliance review that it had successfully addressed all recommendations for improvement for the Performance Measurement and Improvement, Subcontracts and Delegation, Provider Network, Credentialing, and Appeals standards.

Recommendations

The 2013–2014 review did not result in any recommendations for improvement as **Macomb County CMH Services** demonstrated full compliance with all elements addressed in the follow-up review.

Summary Assessment Related to Quality, Timeliness, and Access

The standards included in **Macomb County CMH Services'** follow-up review addressed all three domains of **quality**, **timeliness**, and **access**. The previous full reviews of the standards determined full compliance with all requirements for seven of the 12 standards in the **quality** domain, two of the four standards in the **timeliness** domain, and three of the four standards in the **access** domain. In the **quality** domain, **Macomb County CMH Services** implemented corrective actions in the areas of Performance Measurement and Improvement, Subcontracts and Delegation, Provider Network, Credentialing, and Appeals. Improvements in the Performance Measurement and Improvement and Appeals standards also addressed the **timeliness** domains, while performance on the Provider Network standard also addressed the **access** domain. The 2013–2014 follow-up compliance review did not result in any continued recommendations for improvement as the PIHP achieved full compliance with all requirements addressed in the follow-up review.

Macomb County CMH Services demonstrated excellent performance across the three domains of **quality**, **timeliness**, and **access**.

Region 10 PIHP

Compliance Monitoring Results

Table 3-11 below presents the results of the 2013–2014 follow-up compliance review of Region 10 PIHP, 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 2013–2014 External Quality Review Compliance Monitoring Report for **Region 10 PIHP** contains a more detailed description of the results.

Table 3-11—Summary of 2013–2014 Compliance Review Results for Region 10 PIHP								
Standard		Total Elements	Total Elements Assessed	Number of Elements				
				<i>M</i>	<i>SM</i>	<i>PM</i>	<i>NM</i>	<i>NA</i>
I	<i>QAPIP Plan and Structure</i>	19	1*	Reviewed for information only				
II	<i>Performance Measurement and Improvement</i>	21	2	2	0	0	0	0
III	<i>Practice Guidelines</i>	14	No follow-up required					
IV	<i>Staff Qualifications and Training</i>	6	No follow-up required					
V	<i>Utilization Management</i>	19	No follow-up required					
VI	<i>Customer Services</i>	10	No follow-up required					
VII	<i>Enrollee Grievance Process</i>	13	2	1	0	1	0	0
VIII	<i>Enrollee Rights and Protections</i>	32	2	2	0	0	0	0
IX	<i>Subcontracts and Delegation</i>	8	1	0	0	1	0	0
X	<i>Provider Network</i>	12	1	1	0	0	0	0
XI	<i>Credentialing</i>	25	1	0	1	0	0	0
XII	<i>Access and Availability</i>	Not included in the follow-up review						
XIII	<i>Coordination of Care</i>	4	1	1	0	0	0	0
XIV	<i>Appeals</i>	15	3	1	1	1	0	0
Total		198	14	8	2	3	0	0

*The element on Standard I—QAPIP Plan and Structure was assessed for information only, and no score was assigned.

Strengths

This was the first compliance monitoring review for **Region 10 PIHP**. The former PIHPs in Region 10 had achieved 100 percent compliance in the previous full review of the standards in the following areas: Practice Guidelines, Staff Qualifications and Training, Utilization Management, and Customer Services. Therefore, no follow-up review was required for these standards.

Region 10 PIHP demonstrated in the 2013–2014 follow-up compliance review that it was prepared to comply with the requirements that had not been met by the previous PIHPs in the region for the following standards: QAPIP Plan and Structure, Performance Measurement and Improvement, Enrollee Rights and Protections, Provider Network, and Coordination of Care.

Recommendations

The 2013–2014 review resulted in recommendations for improvement for the following standards: Enrollee Grievance Process, Subcontracts and Delegation, Credentialing, and Appeals. **Region 10 PIHP** should finalize and implement PIHP-level policies on the grievance and appeals processes and develop and implement a monitoring process for the delegated grievance and appeals functions. The PIHP should finalize and implement its process for review and follow-up of provider monitoring of its subcontractors and revise its credentialing policy to address reporting responsibilities of the CMHSPs. **Region 10 PIHP** should ensure that notices of disposition for appeals include correct information related to the State fair hearing.

Summary Assessment Related to Quality, Timeliness, and Access

The standards included in **Region 10 PIHP**'s follow-up review addressed all three domains of **quality, timeliness, and access**. The previous full reviews of the standards determined full compliance with all requirements for three of the 12 standards in the **quality** domain, one of the four standards in the **timeliness** domain, and two of the four standards in the **access** domain. In the **quality** domain, **Region 10 PIHP** demonstrated compliance with the requirements that were addressed for the QAPIP Plan and Structure, Performance Measurement and Improvement, Enrollee Rights, Provider Network, and Coordination of Care standards. The review resulted in continued recommendations for the Grievance Process, Subcontracts and Delegation, Credentialing, and Appeals standards. In the **timeliness** domain, **Region 10 PIHP** met the requirements assessed for the Performance Measurement and Improvement standard, but received recommendations for Grievance Process and Appeals standards. In the **access** domain, the PIHP demonstrated compliance with all requirements that were addressed for the Provider Network and Coordination of Care standards. The 2013–2014 follow-up compliance review resulted in continued recommendations for improvement in the **quality** and **timeliness** domains.

Region 10 PIHP demonstrated strong performance across the three domains of **quality, timeliness, and access**.

Validation of Performance Measures

This section of the report presents the results for the validation of performance measures. For the PIHPs that were new regional entities (Regions 2, 3, 4, 5, and 10), HSAG conducted a readiness review. HSAG assessed the data collection and reporting processes used by the PIHPs to determine their capability to report the MDCH-required performance indicators. These new PIHPs were not required to report rates for this validation cycle. For the remaining five PIHPs (Regions 1, 6, 7, 8, and 9) HSAG conducted the validation of performance measures, including reported rates. The 2013–2014 validation of performance measures review included the same measures that were reported in 2012–2013.

The tables show validation findings and—when applicable—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 validation review periods for the indicators were as follows: first quarter SFY 2014 for Indicators 1 through 4b and Indicator 10; SFY 2013 for Indicators 5 through 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.

Region 1—NorthCare Network

Findings

Table 3-12 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2014 Validation of Performance Measures Report for **NorthCare Network** includes additional details of the validation results.

Table 3-12—Performance Measure Results for NorthCare Network				
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:	97.60%	R
		MI Adults:	98.86%	
		DD Children:	100%	
		DD Adults:	100%	
		Medicaid SA:	96.97%	
		Total:	97.99%	
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:	96.26%	R
		MI Adults:	94.59%	
		DD Children:	94.12%	
		DD Adults:	100%	
		Total:	95.67%	
4a.	The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days	Children:	93.75%	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.	8.39%		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.	97.03%		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:	9.78%	R
		DD Adults:	6.85%	
		MI/DD Adults:	4.39%	

**Table 3-12—Performance Measure Results
for NorthCare Network**

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:	80.12%	R
		DD Adults:	31.93%	
		MI/DD Adults:	36.59%	
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:	5.56%	R
		Adults:	9.52%	
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).	54.98%		R

Strengths

NorthCare Network used Peter Chang Enterprises’ (PCE’s) Electronic Medical Record throughout its region to gather, validate, and correct data efficiently and in real time. **NorthCare Network** also served as a Coordinating Agency (CA) for Medicaid members. Staff responsible for the CA data reported to the **NorthCare Network** chief executive officer (CEO) and attended routine meetings with the CEO and the PIHP staff. Such integration enabled **NorthCare Network** to seamlessly serve all members. Performance indicator rates for the PIHP have improved since last year, especially for readmissions within 30 days of discharge. The primary reason for the improvement on this indicator was a performance improvement project which included interventions (such as quarterly meetings) with the PIHP’s largest hospital provider.

Recommendations

The primary source verification for **NorthCare Network** identified an opportunity for improvement. It is recommended that decisions to exclude cases as exceptions be captured in the electronic record as an audit trail to ensure that all users receive the most complete and updated information about any case. HSAG identified an opportunity for improvement related to Indicator 3. During calculations for this indicator, the system incorrectly excluded cases. The PIHP should review the programming, as it could create inaccuracy in rates for Indicator 3 and may also impact other indicators.

Summary Assessment Related to Quality, Timeliness, and Access

NorthCare Network’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 benchmark for timely follow-up care for children discharged from a psychiatric inpatient unit. **NorthCare Network**’s total rates met six of the seven contractually

required performance standards related to **timeliness** of and **access** to services provided by the PIHP. However, in addition to the indicator for follow-up care for children, the PIHP failed to meet the 95 percent standard for timely access to ongoing services for mentally ill adults and developmentally disabled children.

NorthCare Network met the minimum performance standard for 15 of the 18 indicators and demonstrated strong performance with opportunities for improvement across the three domains of **quality, timeliness, and access**.

Region 2—Northern Michigan Regional Entity

Findings

Table 3-13 presents the results of the validation of performance measures. This was the first year that **Northern Michigan Regional Entity** underwent a formal information systems capabilities assessment. The PIHP was not required to report rates for this validation cycle. The State Fiscal Year 2014 Validation of Performance Measures Report for **Northern Michigan Regional Entity** includes additional details of the validation results.

Northern Michigan Regional Entity achieved a designation of *R (Report)* for demonstrating adequate system readiness, data collection, and calculation processes for the next year of performance indicator reporting.

	Indicator	Key Review Findings	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.	The calculation process was in accordance with MDCH Codebook specifications.	<i>R</i>
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.	The calculation process was in accordance with MDCH Codebook specifications.	<i>R</i>
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.	The calculation process was in accordance with MDCH Codebook specifications.	<i>R</i>
4a.	The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days	The calculation process was in accordance with MDCH Codebook specifications.	<i>R</i>
4b.	The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.	The calculation process was in accordance with MDCH Codebook specifications.	<i>R</i>
5.	The percent of Medicaid recipients having received PIHP managed services.	This indicator will be calculated by MDCH in compliance with MDCH Codebook specifications.	<i>R</i>
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.	This indicator will be calculated by MDCH in compliance with MDCH Codebook specifications.	<i>R</i>
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.	This indicator will be calculated by MDCH in compliance with MDCH Codebook specifications.	<i>R</i>

**Table 3-13—Performance Measure Results
for Northern Michigan Regional Entity**

	Indicator	Key Review Findings	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.	This indicator will be calculated by MDCH in compliance with MDCH Codebook specifications.	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	The calculation process was in accordance with MDCH Codebook specifications.	R
13.	The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	This indicator will be calculated by MDCH in compliance with MDCH Codebook specifications.	R
14.	The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	This indicator will be calculated by MDCH in compliance with MDCH Codebook specifications.	R

Strengths

The PIHP hired staff members who have prior experience with performance indicator and quality improvement data reporting requirements from a former PIHP in the region. **Northern Michigan Regional Entity** had adequate validation processes in place at each point where data are exchanged between various systems. All validation processes were appropriately documented. **Northern Michigan Regional Entity** adopted a comprehensive committee structure. These committees included representatives from each CMHSP who worked together to resolve reporting process issues or concerns. The PIHP demonstrated a strong commitment to performance indicator reporting. The rate calculation process was acceptable. **Northern Michigan Regional Entity** had adequate processes in place and demonstrated the ability to report rates for the next reporting year.

Recommendations

Northern Michigan Regional Entity had several quality improvement processes identified during the planning phase. The PIHP should proceed with the execution of these improvement processes and update and complete the information provided in the ISCAT. For the next performance measure validation audit, the PIHP should provide a flow chart describing each CMHSP’s claims/encounter data flow and performance indicator data processing. **Northern Michigan Regional Entity** should develop a verification process to monitor the processes that each CMHSP follows to gather data for reporting. The PIHP provided a flow chart describing the enrollment data process. The PIHP should also include a flow chart of the eligibility data process when submitting future ISCAT documentation.

Summary Assessment Related to Quality, Timeliness, and Access

Northern Michigan Regional Entity’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 can be reported.

Region 3—Lakeshore Regional Entity

Findings

Table 3-14 presents the results of the validation of performance measures. This was the first year that **Lakeshore Regional Entity** underwent a formal information systems capabilities assessment. The PIHP was not required to report rates for this validation cycle. The State Fiscal Year 2014 Validation of Performance Measures Report for **Lakeshore Regional Entity** includes additional details of the validation results.

Lakeshore Regional Entity achieved a designation of *R (Report)* for demonstrating adequate system readiness, data collection, and calculation processes for the next year of performance indicator reporting.

Table 3-14—Performance Measure Results for Lakeshore Regional Entity			
	Indicator	Key Review Findings	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.	Disposition start and end times are documented in order to determine if the disposition was completed within three hours.	R
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.	Request for service date and assessment date are noted in EMR to calculate if the assessment was within 14 days.	R
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.	Date of service with a professional is documented in EMR to calculate if the service start date was within 14 days.	R
4a.	The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days	Date of discharge and follow-up appointment are documented to calculate this rate for adults and children.	R
4b.	The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.	Date of discharge and follow-up appointment are documented to calculate this rate for substance abuse detox unit.	R
5.	The percent of Medicaid recipients having received PIHP managed services.	Calculated by MDCH from the demographic information sent by the PIHP.	R

Table 3-14—Performance Measure Results for Lakeshore Regional Entity			
	Indicator	Key Review Findings	Indicator Designation
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.	Calculated by MDCH from the demographic information sent by the PIHP.	<i>R</i>
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.	Employment information is gathered by the CMHSP, but the rate is calculated by MDCH.	<i>R</i>
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.	Minimum wage information is collected by the CMHSP, and the rate is calculated by MDCH.	<i>R</i>
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	Original date of discharge and readmission date are documented in the database to calculate the rate for this indicator.	<i>R</i>
13.	The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	Data are collected by the CMHSP, but the rate is calculated by MDCH.	<i>R</i>
14.	The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	Data are collected by the CMHSP, but the rate is calculated by MDCH.	<i>R</i>

Strengths

Lakeshore Regional Entity’s Regional Operations Advisory Team (ROAT) provided general oversight for Finance, Quality, Compliance, Utilization Management, and Information Technology to ensure uniformity among the CMHSP and CA processes. **Lakeshore Regional Entity** had access to experienced staff from various CMHSPs and CAs to work on PIHP processes such as performance improvement, quality improvement, and information technology. **Lakeshore Regional Entity** met with the performance improvement staff from all CMHSPs and CAs to agree on key definitions, such as exceptions versus exclusions for performance measure data, to ensure region-wide definitions and specifications to generate numerators and denominators for the State-mandated performance measures. **Lakeshore Regional Entity** used its own IT staff rather than a vendor to create queries and to manage the **Lakeshore Regional Entity** data warehouse.

Recommendations

Lakeshore Regional Entity engaged employees from some CMHSPs and CAs to work part-time for the PIHP to create new regional policies, structure, and processes. The PIHP should delineate the roles of employees shared with CMHSPs/CAs. **Lakeshore Regional Entity** should conduct primary source verification exercises during the PIHP’s annual site visits with the CMHSPs and

CAs to ensure that entities produce performance indicator data accurately. The PIHP should ensure that all CMHSPs follow the same criteria as to what is considered “start time” for the purposes of performance indicator calculations.

The PIHP should ensure access to case-specific documentation for any exceptions made by CMHSPs for any measure calculations and consider revising its criteria for requiring a corrective action plan for performance indicator rates falling below state-defined thresholds. **Lakeshore Regional Entity** should ensure complete documentation of any changes in systems, processes, and personnel when the CAs are incorporated into the PIHP.

Summary Assessment Related to Quality, Timeliness, and Access

Lakeshore Regional Entity’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 can be reported.

Region 4—Southwest Michigan Behavioral Health

Findings

Table 3-15 presents the results of the validation of performance measures. This was the first year that **Southwest Michigan Behavioral Health** underwent a formal information systems capabilities assessment. The PIHP was not required to report rates for this validation cycle. The State Fiscal Year 2014 Validation of Performance Measures Report for **Southwest Michigan Behavioral Health** includes additional details of the validation results.

Southwest Michigan Behavioral Health achieved a designation of *R (Report)* for demonstrating adequate system readiness, data collection, and calculation processes for the next year of performance indicator reporting.

Table 3-15—Performance Measure Results for Southwest Michigan Behavioral Health			
	Indicator	Key Review Findings	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.	Documents the start and end times in order to determine if the disposition was within three hours.	R
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.	The request for service is noted to calculate the rate for this measure.	R
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.	The date of service with a professional is documented.	R
4a.	The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days	The date of discharge and follow-up appointment are documented to calculate this rate for adults and children.	R
4b.	The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.	The date of discharge and follow-up appointment are documented to calculate this rate for the substance abuse detox unit.	R
5.	The percent of Medicaid recipients having received PIHP managed services.	Calculated by MDCH.	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.	Calculated by MDCH.	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.	Employment information is gathered by the CMHSP, but the rate is calculated by MDCH.	R

Table 3-15—Performance Measure Results for Southwest Michigan Behavioral Health			
Indicator		Key Review Findings	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.	Minimum wage information is collected by the CMHSP, and the rate is calculated by MDCH.	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	The original date of discharge and readmission date are documented in the database to calculate the rate for this indicator.	R
13.	The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	Data are collected by the CMHSP, but the rate is calculated by MDCH.	R
14.	The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	Data are collected by the CMHSP, but the rate is calculated by MDCH.	R

Strengths

Southwest Michigan Behavioral Health contracted with a vendor (Streamline) to calculate the PIHP’s performance measure rates. Since all CMHSPs use the SmartCare system, the PIHP was able to aggregate, clean, and transfer valid data and could efficiently implement a quality improvement process. The PIHP had multiple committees that included representatives from each CMHSP, the PIHP, and the vendor to address any concerns identified and share lessons learned.

Recommendations

Southwest Michigan Behavioral Health should define and document the data validation process and the PIHP’s oversight of the vendor for production of the performance measure rates. **Southwest Michigan Behavioral Health** should monitor the minimum wage field to determine whether it is left blank more often than the employment field. The PIHP should evaluate any differences between the CMHSPs in using exception codes to determine if there are any patterns.

Next year, the ISCAT should clarify the structure for **Southwest Michigan Behavioral Health** functioning as a PIHP/CA, and clarify and describe Streamline’s SmartCare and CareManagement systems and how they work together. The PIHP should submit rates in a format that clearly defines the columns with headings.

Summary Assessment Related to Quality, Timeliness, and Access

Southwest Michigan 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 can be reported.

Region 5—Mid-State Health Network

Findings

Table 3-16 presents the results of the validation of performance measures. This was the first year that **Mid-State Health Network** underwent a formal information systems capabilities assessment. The PIHP was not required to report rates for this validation cycle. The State Fiscal Year 2014 Validation of Performance Measures Report for **Mid-State Health Network** includes additional details of the validation results.

Mid-State Health Network achieved a designation of *R (Report)* for demonstrating adequate system readiness, data collection, and calculation processes for the next year of performance indicator reporting.

Table 3-16—Performance Measure Results for Mid-State Health Network			
	Indicator	Key Review Findings	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.	The calculation process was in accordance with MDCH Codebook specifications.	<i>R</i>
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.	The calculation process was in accordance with MDCH Codebook specifications.	<i>R</i>
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.	The calculation process was in accordance with MDCH Codebook specifications.	<i>R</i>
4a.	The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days	The calculation process was in accordance with MDCH Codebook specifications.	<i>R</i>
4b.	The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.	The calculation process was in accordance with MDCH Codebook specifications.	<i>R</i>
5.	The percent of Medicaid recipients having received PIHP managed services.	This indicator will be calculated by MDCH in compliance with MDCH Codebook specifications.	<i>R</i>
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.	This indicator will be calculated by MDCH in compliance with MDCH Codebook specifications.	<i>R</i>
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.	This indicator will be calculated by MDCH in compliance with MDCH Codebook specifications.	<i>R</i>

Table 3-16—Performance Measure Results for Mid-State Health Network			
Indicator		Key Review Findings	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.	This indicator will be calculated by MDCH in compliance with MDCH Codebook specifications.	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	The calculation process was in accordance with MDCH Codebook specifications.	R
13.	The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	This indicator will be calculated by MDCH in compliance with MDCH Codebook specifications.	R
14.	The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	This indicator will be calculated by MDCH in compliance with MDCH Codebook specifications.	R

Strengths

Mid-State Health Network hired staff members with prior experience with performance indicator and quality improvement data reporting requirements from the former regional PIHP. **Mid-State Health Network** also adopted a comprehensive committee structure. These committees had representatives from each CMHSP, who worked closely together to resolve any issues or concerns related to the reporting process. All processes were appropriately documented. The PIHP had a comprehensive plan in place to switch from manual to automated validation. **Mid-State Health Network** had adequate oversight for all vendors to whom it had delegated functions. The PIHP demonstrated a strong commitment to performance indicator reporting. The rate calculation process was acceptable. The PIHP had adequate processes in place and had rate reporting capabilities for the next reporting year.

Recommendations

Mid-State Health Network should continue to transition from manual to automated validation processes and use this opportunity for training and educating CMHSPs for possible improvement. It is recommended that the PIHP document each step of this process. Each CMHSP had a separate internal QI process; however, consolidating these processes under the PIHP’s centralized QI process would be beneficial. For next year’s audit, the PIHP should ensure that a mini-ISCAT is completed for each of its affiliates.

Summary Assessment Related to Quality, Timeliness, and Access

Mid-State Health Network’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 can be reported.

Region 6—CMH Partnership of Southeast Michigan

Findings

Table 3-17 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2014 Validation of Performance Measures Report for **CMH Partnership of Southeast Michigan** includes additional details of the validation results.

Table 3-17—Performance Measure Results for CMH Partnership of Southeast 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:	99.67%	
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:	99.32%	R
		MI Adults:	100%	
		DD Children:	100%	
		DD Adults:	100%	
		Medicaid SA:	95.71%	
		Total:	99.04%	
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:	99.00%	R
		MI Adults:	98.89%	
		DD Children:	100%	
		DD Adults:	97.67%	
		Total:	98.81%	
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:	96.97%	
4b.	The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.	78.95%		R
5.	The percent of Medicaid recipients having received PIHP managed services.	7.53%		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.	98.65%		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:	9.25%	R
		DD Adults:	9.24%	
		MI/DD Adults:	7.57%	

**Table 3-17—Performance Measure Results
for CMH Partnership of Southeast 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:	82.27%	R
		DD Adults:	61.60%	
		MI/DD Adults:	69.81%	
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:	14.89%	R
		Adults:	10.26%	
13.	The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	26.60%		R
14.	The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	31.39%		R

Strengths

As in prior years, using a uniform system continued to be a strength for **CMH Partnership of Southeast Michigan**. The PIHP, CMHSPs, and CAs use the same EII system. Using this single system eliminated the need for data migration and ensured that all data captured by each entity are available to the PIHP. The quantity of paper claims received by the PIHP was not significant; therefore, any concerns related to manual data entry errors were minimal.

Recommendations

CMH Partnership of Southeast Michigan should continue to work to improve its quality improvement data, specifically the minimum wage rate. With the implementation of several quality improvement projects, the PIHP is expected to produce better rates in the following measurement year. **CMH Partnership of Southeast Michigan** should improve its documentation to support audit findings and have documentation readily available to support exclusion of cases when calculating the rates. The PIHP is encouraged to track exclusions electronically to enable monitoring of the exclusions by county.

Summary Assessment Related to Quality, Timeliness, and Access

CMH Partnership of Southeast 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. **CMH Partnership of Southeast Michigan**'s total rates met six of the seven contractually required performance standards related to **timeliness** of and **access** to services provided by the PIHP. The PIHP's rate for timely follow-up care for beneficiaries discharged from a detox unit fell below the 95 percent threshold.

CMH Partnership of Southeast Michigan met the minimum performance standard for 17 of the 18 indicators and demonstrated strong performance across the three domains of **quality**, **timeliness**, and **access**.

Region 7—Detroit Wayne Mental Health Authority

Findings

Table 3-18 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 Mental Health Authority** includes additional details of the validation results.

Table 3-18—Performance Measure Results for Detroit Wayne Mental Health 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:	95.65%	
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:	95.94%	R
		MI Adults:	96.77%	
		DD Children:	98.97%	
		DD Adults:	97.10%	
		Medicaid SA:	98.95%	
		Total:	97.55%	
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:	99.15%	R
		MI Adults:	96.59%	
		DD Children:	100%	
		DD Adults:	100%	
		Total:	98.12%	
4a.	The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days	Children:	99.66%	R
		Adults:	98.24%	
4b.	The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.	92.19%		R
5.	The percent of Medicaid recipients having received PIHP managed services.	7.94%		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.	96.85%		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:	4.71%	R
		DD Adults:	1.82%	
		MI/DD Adults:	2.14%	

**Table 3-18—Performance Measure Results
for Detroit Wayne Mental Health 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:	62.13%	R
		DD Adults:	13.12%	
		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:	14.77%	R
		Adults:	16.40%	
13.	The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	22.15%		R
14.	The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	22.76%		R

Strengths

Detroit Wayne Mental Health Authority maintained a solid team with experienced professionals, who worked together to ensure consumer satisfaction and robust and accurate performance measure reporting. The PIHP had an outstanding readiness process in place for integrating physical health and behavioral health data. **Detroit Wayne Mental Health Authority** had a transition plan to integrate data from the CA into the same system as the mental health data. The PIHP—through its vendor, PCE—implemented access control mechanisms in the user interface to ensure that only authorized staff will have access to the CA’s data. The PIHP followed a multi-level monitoring process. **Detroit Wayne Mental Health Authority** audited the managers of comprehensive provider networks (MCPNs), which in turn were responsible to audit their providers. The MCPNs audited their own data prior to submission to the PIHP. All MCPN affiliates used the PCE system, ensuring the standardization of data used for performance indicator reporting across the PIHP.

Recommendations

Detroit Wayne Mental Health Authority should integrate the detailed data required for Performance Indicator 1 in the PCE system to monitor data accuracy for this indicator. The PIHP should continue efforts to strengthen discharge planning in an effort to improve the rate for hospital recidivism (Indicator 10). It is recommended that each MCPN affiliated with the PIHP complete a mini-ISCAT for the upcoming audit year. The PIHP should ensure that all sections of the ISCAT are completed with current information. **Detroit Wayne Mental Health Authority** should document all changes that occur when the CA merges with the PIHP.

Summary Assessment Related to Quality, Timeliness, and Access

Detroit Wayne Mental Health 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 three of the five contractually required performance standards related to the **quality** of services provided by the

PIHP. **Detroit Wayne Mental Health Authority**'s total rates met six of the seven contractually required performance standards related to **timeliness** of and **access** to services provided by the PIHP. The PIHP's rate for timely follow-up care for beneficiaries discharged from a detox unit fell below the 95 percent standard, while the rate for 30-day readmissions for adults exceeded the 15 percent threshold.

Detroit Wayne Mental Health Authority met the minimum performance standard for 16 of the 18 indicators and demonstrated strong performance across the three domains of **quality, timeliness, and access**.

Region 8—Oakland County CMH Authority

Findings

Table 3-19 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 3-19—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:	97.30%	R
		Adults:	95.03%	
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:	98.06%	
		DD Children:	100%	
		DD Adults:	100%	
		Medicaid SA:	98.82%	
		Total:	98.84%	
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:	99.68%	
		DD Children:	94.44%	
		DD Adults:	100%	
		Total:	99.62%	
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:	99.12%	
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.	9.23%		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.	99.30%		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:	9.42%	R
		DD Adults:	12.29%	
		MI/DD Adults:	9.97%	

**Table 3-19—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:	59.79%	R
		DD Adults:	37.28%	
		MI/DD Adults:	25.93%	
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:	8.11%	R
		Adults:	13.25%	
13.	The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	17.26%		R
14.	The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	37.48%		R

Strengths

Oakland County CMH Authority remained a single county PIHP, which allowed for swift decisions and rapid process implementation. Although there was a change in senior leadership, the organization continued to perform PIHP duties seamlessly. **Oakland County CMH Authority** contracted with PCE to create the Electronic Medical Record (EMR), Oakland Data and Information Network (ODIN). PCE was experienced in working with the PIHP and MDCH requirements. **Oakland County CMH Authority** had a collaborative relationship with PCE, resulting in timely completion of requested changes to ODIN and related processes. **Oakland County CMH Authority** used the iDashboards product and shared it with providers to monitor their data completeness status. **Oakland County CMH Authority** had a strong information technology department that created innovative tools for performance monitoring and ensuring data completeness.

Recommendations

Oakland County CMH Authority should revise the reports for Indicators 1, 2, and 3 to ensure they capture all relevant elements correctly. Performance indicator data received from the eight different providers were entered manually into an MS Excel spreadsheet. Due to the potential for data integrity issues, this process should be evaluated. Exceptions to the denominators for performance indicators should be documented in ODIN or another centrally accessible location. The reasons for the exception should be documented directly in the EMR. As recommended in the previous year, additional staff should be cross-trained to conduct all required steps of generating performance indicator data.

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 five

contractually required performance standards related to the **quality** of services provided by the PIHP. **Oakland County CMH Authority**'s total rates met all seven contractually required performance standards related to **timeliness** of and **access** to services provided by the PIHP. However, the PIHP's rate for timely access to ongoing services for developmentally disabled children fell below the 95 percent threshold.

Oakland County CMH Authority met the minimum performance standard for 17 of the 18 indicators and demonstrated strong performance across the three domains of **quality, timeliness, and access**.

Region 9—Macomb County CMH Services

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 **Macomb County CMH Services** includes additional details of the validation results.

Table 3-20—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:	99.75%	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:	98.39%	R
		MI Adults:	97.98%	
		DD Children:	95.65%	
		DD Adults:	100%	
		Medicaid SA:	97.64%	
		Total:	97.82%	
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:	98.15%	R
		MI Adults:	100%	
		DD Children:	96.55%	
		DD Adults:	92.00%	
		Total:	98.28%	
4a.	The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days	Children:	93.94%	R
		Adults:	92.43%	
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.	6.31%		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.	99.39%		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:	7.32%	R
		DD Adults:	5.27%	
		MI/DD Adults:	4.38%	

**Table 3-20—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:	73.01%	R
		DD Adults:	36.95%	
		MI/DD Adults:	28.27%	
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:	22.67%	
13.	The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	15.05%		R
14.	The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	34.39%		R

Strengths

Macomb County CMH Services maintained a solid team with experienced professionals who ensured robust and accurate performance measure reporting. The PIHP had an outstanding readiness process in place for integrating physical health and behavioral health data in the coming years. The PIHP was in the preparation phase to develop a report on demographic elements that would be useful to monitor providers’ compliance with collecting QI data information. The quantity of paper claims received by the PIHP was not significant; therefore, any concerns related to manual data entry errors were minimal. The PIHP had a training process that ensured cross-training for all functions to ensure a solid backup system.

Recommendations

As the data collection shifts from the CareNet claims processing system to the FOCUS claims processing system, **Macomb County CMH Services** should document the processes involved in this transition, including training and the overall impact of the transition. The PIHP should provide documentation showing how CareNet (used by its CA) obtained eligibility information. **Macomb County CMH Services** should track exclusions electronically and trend the provider’s reasoning for these exceptions.

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 two of the five contractually required performance standards related to the **quality** of services provided by the PIHP (timely follow-up care for beneficiaries discharged from a detox unit and 30-day readmissions for children). **Macomb County CMH Services’** total rates met five of the seven contractually required performance standards related to **timeliness** of and **access** to services provided by the PIHP. The PIHP’s rates for timely follow-up care for adults and children discharged from a

psychiatric inpatient unit fell below the 95 percent threshold. In addition, the rate for timely access to ongoing services for developmentally disabled adults fell below the minimum performance standard.

Macomb County CMH Services met the minimum performance standard for 14 of the 18 indicators and demonstrated strong performance with opportunities for improvement across the three domains of **quality, timeliness, and access**.

Region 10 PIHP

Findings

Table 3-21 presents the results of the validation of performance measures. This was the first year that **Region 10 PIHP** underwent a formal information systems capabilities assessment. The PIHP was not required to report rates for this validation cycle. The State Fiscal Year 2014 Validation of Performance Measures Report for **Region 10 PIHP** includes additional details of the validation results.

Region 10 PIHP achieved a designation of *R (Report)* for demonstrating adequate system readiness, data collection, and calculation processes for the next year of performance indicator reporting.

Table 3-21—Performance Measure Results for Region 10 PIHP			
	Indicator	Key Review Findings	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.	Disposition start and end times are documented in order to determine if the disposition was completed within three hours.	R
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.	Request for service date and assessment date noted in EMR to calculate if face-to-face assessment was within 14 days. The request for service was stated as date of visit to the clinic for Genesee CMH; perhaps it should be date of call from the member.	R
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.	Dates of service with a professional are documented.	R
4a.	The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days	Date of discharge and follow-up appointment are documented to calculate this rate for adults and children.	R
4b.	The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.	Date of discharge and follow-up appointment are documented to calculate this rate for substance abuse detox unit.	R
5.	The percent of Medicaid recipients having received PIHP managed services.	Calculated by MDCH from the demographic information sent by PIHP.	R

**Table 3-21—Performance Measure Results
for Region 10 PIHP**

Indicator	Key Review Findings	Indicator Designation
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.	Calculated by MDCH from the demographic information sent by PIHP. <i>R</i>
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.	Employment information is gathered by CMHSP, but the rate is calculated by MDCH. <i>R</i>
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.	Minimum wage information is collected by CMHSP, and the rate is calculated by MDCH. <i>R</i>
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	Original date of discharge and readmission date are documented in the database to calculate the rate for this indicator. <i>R</i>
13.	The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	Data are collected by CMHSP, but the rate is calculated by MDCH. <i>R</i>
14.	The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	Data are collected by CMHSP, but the rate is calculated by MDCH. <i>R</i>

Strengths

Region 10 PIHP was created by combining two former PIHPs. Processes that had proven to be successful for efficiency and production of quality data sets continued to be maintained by the new PIHP. Experienced staff members from the two former PIHPs were employed to ensure continuity in data completeness and quality. Region-wide use of PCE systems will facilitate future site visits and primary source verification for the PIHP.

Recommendations

Region 10 PIHP contracted with CMHSP employees to prepare and validate data for the PIHP. The PIHP should develop a clear process and procedure explaining the oversight role of the PIHP. It is recommended that documentation supporting the exceptions be made available at the PIHP as a hard copy or electronically. **Region 10 PIHP** should consider assigning the regional ID when entering a new member in the system—rather than checking for a duplicate later—and review region-wide practices for determining the service start date to ensure compliance with the MDCH Codebook. Pre-audit documents provided with the ISCAT should be labeled and named as documents representing and originating from the new PIHP. **Region 10 PIHP** should be

represented as one entity in the ISCAT. Attachments should be updated to ensure that the content reflects the new regional PIHP structure.

Summary Assessment Related to Quality, Timeliness, and Access

Region 10 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 can be reported.

Validation of Performance Improvement Projects

This section of the report presents the results of the validation of PIPs. For the 2013–2014 validation, the PIHPs selected a topic related to the integration of physical and mental health care and presented their first-year submissions. The PIP topics addressed CMS’ requirements related to the **quality** and **timeliness** of, and **access** to, care and services.

Region 1—NorthCare Network

Findings

For the 2013–2014 validation, **NorthCare Network** submitted its new PIP topic: *Improving Primary Health Services for Consumers with Self-Reported Obesity*.

Table 3-22 and Table 3-23 show **NorthCare Network**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2013–2014 PIP Validation Report for **NorthCare Network**.

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	2	2	0	0	0	1	1	0	0	0
II.	Define the Study Question(s)	1	1	0	0	0	1	1	0	0	0
III.	Use a Representative and Generalizable Study Population	1	1	0	0	0	1	1	0	0	0
IV.	Select the Study Indicator(s)	3	3	0	0	0	2	2	0	0	0
V.	Use Sound Sampling Techniques	6	0	0	0	6	1	0	0	0	1
VI.	Reliably Collect Data	6	4	0	0	2	1	0	0	0	1
VII.	Analyze Data and Interpret Study Results	9	Not Assessed				2	Not Assessed			
VIII.	Implement Intervention and Improvement Strategies	4	Not Assessed				1	Not Assessed			
IX.	Assess for Real Improvement	4	Not Assessed				1	Not Assessed			
X.	Assess for Sustained Improvement	1	Not Assessed				No Critical Elements				
Totals for All Activities		37	11	0	0	8	11	5	0	0	2

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

Strengths

HSAG's validation evaluated the technical methods of the PIP—the study design. Validation of Activities I through VI of **NorthCare Network's** PIP 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. The PIHP designed a scientifically sound study that was supported by the use of key research principles. The technical design of the PIP was sufficient to measure outcomes, and the PIP's solid design should allow for the successful progression to the next stage of the PIP process. The performance of this PIP suggests a thorough application of the PIP design.

Recommendations

HSAG identified one *Point of Clarification* as an opportunity for improvement in Activity III.

While **NorthCare Network** accurately and completely defined the study population and provided correct codes for the denominators, only codes for the entire study population/denominator should be documented in Activity III. The PIHP should move codes for the numerator to Activity VI.

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

NorthCare Network's new PIP topic, *Improving Primary Health Services for Consumers with Self-Reported Obesity*, addressed CMS' requirements related to quality outcomes—specifically, the **quality, timeliness, and accessibility** of care and services. The goal of the study is to increase the percentage of consumers with mental illness who self-report a diagnosis of obesity and receive primary health services to address obesity and/or nutrition. Adults with mental illness frequently have risk factors that can result in obesity. The risk factors associated with obesity can be alleviated with proper care and management.

For the 2013–2014 validation, **NorthCare Network** successfully completed the Study Design phase and demonstrated that it is well positioned to progress to the Study Implementation and Evaluation phase. The PIHP will submit baseline data for the next annual validation of the PIP. As **NorthCare Network** progresses in the study, assessment of the impact of the PIP on the **quality** and **timeliness** of, and **access** to, care and services will continue.

Region 2—Northern Michigan Regional Entity

Findings

For the 2013–2014 validation, **Northern Michigan Regional Entity** submitted its new PIP topic: *Increasing Diabetic Screenings for Consumers with SMI Prescribed and Antipsychotic Medication.*

Table 3-24 and Table 3-25 show **Northern Michigan Regional Entity**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2013–2014 PIP Validation Report for **Northern Michigan Regional Entity**.

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	2	2	0	0	0	1	1	0	0	0
II.	Define the Study Question(s)	1	1	0	0	0	1	1	0	0	0
III.	Use a Representative and Generalizable Study Population	1	1	0	0	0	1	1	0	0	0
IV.	Select the Study Indicator(s)	3	3	0	0	0	2	2	0	0	0
V.	Use Sound Sampling Techniques	6	0	0	0	6	1	0	0	0	1
VI.	Reliably Collect Data	6	3	0	0	3	1	0	0	0	1
VII.	Analyze Data and Interpret Study Results	9	Not Assessed				2	Not Assessed			
VIII.	Implement Intervention and Improvement Strategies	4	Not Assessed				1	Not Assessed			
IX.	Assess for Real Improvement	4	Not Assessed				1	Not Assessed			
X.	Assess for Sustained Improvement	1	Not Assessed				No Critical Elements				
Totals for All Activities		37	10	0	0	9	11	5	0	0	2

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

Strengths

HSAG's validation evaluated the technical methods of the PIP—the study design. Validation of Activities I through VI of **Northern Michigan Regional Entity's** PIP 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. The PIHP designed a scientifically sound study that was supported by the use of key research principles. The technical design of the PIP was sufficient to measure outcomes, and the PIP's solid design should allow for the successful progression to the next stage of the PIP process. The performance of this PIP suggests a thorough application of the PIP design.

Recommendations

HSAG identified *Points of Clarification* as opportunities for improvement in Activities III, IV, and VI.

Northern Michigan Regional Entity should delete Current Procedural Terminology (CPT) codes for the numerator from Activity III, as the PIHP only needs to include codes for the entire study population/denominator. In Activity IV, the PIHP should revise the study indicator title. **Northern Michigan Regional Entity** documented that it will identify a goal after collecting the baseline data. In Activity VI, the PIHP should include in the data analysis plan that it will compare the study indicator results to a goal.

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

Northern Michigan Regional Entity's new PIP topic, *Increasing Diabetic Screenings for Consumers with SMI Prescribed and Antipsychotic Medication*, addressed CMS' requirements related to quality outcomes—specifically, the **quality**, **timeliness**, and **accessibility** of care and services. The goal of the study is to increase diabetes screenings for consumers with SMI prescribed an antipsychotic medication. Individuals who are prescribed antipsychotic medication are at risk of metabolic side effects that can result in diabetes. Consumers can manage a healthier lifestyle with early detection. Following the diagnosis of pre-diabetes and diabetes, providers will focus on integrating care for the disease.

For the 2013–2014 validation, **Northern Michigan Regional Entity** successfully completed the Study Design phase and demonstrated that it is well positioned to progress to the Study Implementation and Evaluation phase. The PIHP will submit baseline data for the next annual validation of the PIP. As **Northern Michigan Regional Entity** progresses in the study, assessment of the impact of the PIP on the **quality** and **timeliness** of, and **access** to, care and services will continue.

Region 3—Lakeshore Regional Entity

Findings

For the 2013–2014 validation, **Lakeshore Regional Entity** submitted its new PIP topic: *Consumers Who Filled at Least One Prescription for a Second-Generation Antipsychotic Medication Who Receive an HbA1C, Lipid Panel, or Fasting Glucose.*

Table 3-26 and Table 3-27 show **Lakeshore Regional Entity**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2013–2014 PIP Validation Report for **Lakeshore Regional Entity**.

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	2	2	0	0	0	1	1	0	0	0
II.	Define the Study Question(s)	1	1	0	0	0	1	1	0	0	0
III.	Use a Representative and Generalizable Study Population	1	1	0	0	0	1	1	0	0	0
IV.	Select the Study Indicator(s)	3	3	0	0	0	2	2	0	0	0
V.	Use Sound Sampling Techniques	6	0	0	0	6	1	0	0	0	1
VI.	Reliably Collect Data	6	4	0	0	2	1	0	0	0	1
VII.	Analyze Data and Interpret Study Results	9	Not Assessed				2	Not Assessed			
VIII.	Implement Intervention and Improvement Strategies	4	Not Assessed				1	Not Assessed			
IX.	Assess for Real Improvement	4	Not Assessed				1	Not Assessed			
X.	Assess for Sustained Improvement	1	Not Assessed				No Critical Elements				
Totals for All Activities		37	11	0	0	8	11	5	0	0	2

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

Strengths

HSAG's validation evaluated the technical methods of the PIP—the study design. Validation of Activities I through VI of **Lakeshore Regional Entity**'s PIP 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. The PIHP designed a scientifically sound study that was supported by the use of key research principles. The technical design of the PIP was sufficient to measure outcomes, and the PIP's solid design should allow for the successful progression to the next stage of the PIP process. The performance of this PIP suggests a thorough application of the PIP design.

Recommendations

HSAG identified *Points of Clarification* as opportunities for improvement in Activities IV and VI.

In Activity IV, **Lakeshore Regional Entity** should revise the study indicator title and define the measurement periods in the recommended format. In Activity VI, the PIHP should set a percentage goal for Remeasurement 1 once it obtains baseline results and specify in the data analysis plan that it will compare these results to the goal.

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

Lakeshore Regional Entity's new PIP topic, *Consumers Who Filled at Least One Prescription for a Second-Generation Antipsychotic Medication Who Receive an HbA1C, Lipid Panel, or Fasting Glucose*, addressed CMS' requirements related to quality outcomes—specifically, the **quality**, **timeliness**, and **accessibility** of care and services. The goal of the study is to increase monitoring of consumers taking antipsychotic medications. Individuals prescribed antipsychotic medications are at risk for developing diabetes. Monitoring test results can assist in identifying those at risk for diabetes sooner, allowing for earlier health interventions.

For the 2013–2014 validation, **Lakeshore Regional Entity** successfully completed the Study Design phase and demonstrated that it is well positioned to progress to the Study Implementation and Evaluation phase. The PIHP will submit baseline data for the next annual validation of the PIP. As **Lakeshore Regional Entity** progresses in the study, assessment of the impact of the PIP on the **quality** and **timeliness** of, and **access** to, care and services will continue.

Region 4—Southwest Michigan Behavioral Health

Findings

For the 2013–2014 validation, **Southwest Michigan Behavioral Health** submitted its new PIP topic: *Improving Diabetes Treatment for Consumers with a Co-morbid Mental Health Condition*.

Table 3-28 and Table 3-29 show **Southwest Michigan Behavioral Health**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2013–2014 PIP Validation Report for **Southwest Michigan 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	2	2	0	0	0	1	1	0	0	0
II.	Define the Study Question(s)	1	1	0	0	0	1	1	0	0	0
III.	Use a Representative and Generalizable Study Population	1	1	0	0	0	1	1	0	0	0
IV.	Select the Study Indicator(s)	3	3	0	0	0	2	2	0	0	0
V.	Use Sound Sampling Techniques	6	0	0	0	6	1	0	0	0	1
VI.	Reliably Collect Data	6	3	0	0	3	1	0	0	0	1
VII.	Analyze Data and Interpret Study Results	9	Not Assessed				2	Not Assessed			
VIII.	Implement Intervention and Improvement Strategies	4	Not Assessed				1	Not Assessed			
IX.	Assess for Real Improvement	4	Not Assessed				1	Not Assessed			
X.	Assess for Sustained Improvement	1	Not Assessed				No Critical Elements				
Totals for All Activities		37	10	0	0	9	11	5	0	0	2

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

Strengths

HSAG's validation evaluated the technical methods of the PIP—the study design. Validation of Activities I through VI of **Southwest Michigan Behavioral Health's** PIP 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. The PIHP designed a scientifically sound study that was supported by the use of key research principles. The technical design of the PIP was sufficient to measure outcomes, and the PIP's solid design should allow for the successful progression to the next stage of the PIP process. The performance of this PIP suggests a thorough application of the PIP design.

Recommendations

HSAG identified *Points of Clarification* as opportunities for improvement in Activities IV and VI.

Southwest Michigan Behavioral Health should ensure that in Activity IV, it collects baseline data for the study indicator for the correct measurement period of nine months. In Activity VI, the PIHP should set a percentage goal for Remeasurement 1 once it obtains baseline results and specify in the data analysis plan that it will compare these results to the goal.

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

Southwest Michigan Behavioral Health's new PIP topic, *Improving Diabetes Treatment for Consumers with a Co-morbid Mental Health Condition*, addressed CMS' requirements related to quality outcomes—specifically, the **quality**, **timeliness**, and **accessibility** of care and services. The goal of the study is to increase the percentage of consumers with diabetes who receive treatment for the condition. Consumers with mental health issues are at increased risk for developing diabetes. Diabetes left untreated can result in serious health complications such as blindness, kidney disease, and amputations.

For the 2013–2014 validation, **Southwest Michigan Behavioral Health** successfully completed the Study Design phase and demonstrated that it is well positioned to progress to the Study Implementation and Evaluation phase. The PIHP will submit baseline data for the next annual validation of the PIP. As **Southwest Michigan Behavioral Health** progresses in the study, assessment of the impact of the PIP on the **quality** and **timeliness** of, and **access** to, care and services will continue.

Region 5—Mid-State Health Network

Findings

For the 2013–2014 validation, **Mid-State Health Network** submitted its new PIP topic: *Increasing Diabetes Screening for Consumers with Schizophrenia or Bipolar Disorder Prescribed Antipsychotic Medications*.

Table 3-30 and Table 3-31 show **Mid-State Health Network**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2013–2014 PIP Validation Report for **Mid-State Health Network**.

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	2	2	0	0	0	1	1	0	0	0
II.	Define the Study Question(s)	1	0	1	0	0	1	0	1	0	0
III.	Use a Representative and Generalizable Study Population	1	1	0	0	0	1	1	0	0	0
IV.	Select the Study Indicator(s)	3	3	0	0	0	2	2	0	0	0
V.	Use Sound Sampling Techniques	6	0	0	0	6	1	0	0	0	1
VI.	Reliably Collect Data	6	2	1	1	2	1	0	0	0	1
VII.	Analyze Data and Interpret Study Results	9	Not Assessed				2	Not Assessed			
VIII.	Implement Intervention and Improvement Strategies	4	Not Assessed				1	Not Assessed			
IX.	Assess for Real Improvement	4	Not Assessed				1	Not Assessed			
X.	Assess for Sustained Improvement	1	Not Assessed				No Critical Elements				
Totals for All Activities		37	8	2	1	8	11	4	1	0	2

Percentage Score of Evaluation Elements Met	73%
Percentage Score of Critical Elements Met	80%
Validation Status	Partially Met

Strengths

HSAG's validation evaluated the technical methods of the PIP—the study design. Validation of Activities I through VI of **Mid-State Health Network's** PIP resulted in a validation status of *Partially Met*, with an overall score of 73 percent and a score of 80 percent for critical elements. Based on the validation of this PIP, HSAG's assessment determined low confidence in the results. While the PIHP had opportunities for improvement with the documented study question and data collection process, other aspects of the study design were scientifically sound. **Mid-State Health Network** documented a relevant study topic, a well-defined study indicator, and a correctly defined study population. The PIHP appropriately defined the data elements to be collected and described the data analysis plan.

Recommendations

HSAG identified opportunities for improvement in Activities II and VI.

Mid-State Health Network should rephrase the study question in Activity II. In Activity VI, the PIHP should complete the definition of the data collection process, documenting details regarding the type of data collection used for the study and adding the estimated degree of administrative data completeness.

HSAG identified additional *Points of Clarification* to strengthen the study in Activities I, III, IV, and VI. These points addressed documentation of plan-specific historical data related to the study topic, CPT codes for the numerator, clarification of measurement periods and exclusion criteria for the study population, and documentation of the data collection method.

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

Mid-State Health Network's new PIP topic, *Increasing Diabetes Screening for Consumers with Schizophrenia or Bipolar Disorder Prescribed Antipsychotic Medications*, addressed CMS' requirements related to quality outcomes—specifically, the **quality, timeliness, and accessibility** of care and services. The goal of the study is to ensure that consumers with schizophrenia or bipolar disorder who are prescribed antipsychotic medication are receiving the necessary diabetes screenings because taking antipsychotic medications is associated with increased risk of developing diabetes.

For the 2013–2014 validation, **Mid-State Health Network** completed the Study Design phase and should make the recommended corrections before progressing to the Study Implementation and Evaluation phase. The PIHP will submit baseline data for the next annual validation of the PIP. As **Mid-State Health Network** progresses in the study, assessment of the impact of the PIP on the **quality and timeliness** of, and **access** to, care and services will continue.

Region 6—CMH Partnership of Southeast Michigan

For the 2013–2014 validation, **CMH Partnership of Southeastern Michigan** submitted its new PIP topic: *Medication Labs*.

Table 3-32 and Table 3-33 show **CMH Partnership of Southeastern Michigan**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2013–2014 PIP Validation Report for **CMH Partnership of Southeastern Michigan**.

Table 3-32—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	2	2	0	0	0	1	1	0	0	0
II.	Define the Study Question(s)	1	1	0	0	0	1	1	0	0	0
III.	Use a Representative and Generalizable Study Population	1	1	0	0	0	1	1	0	0	0
IV.	Select the Study Indicator(s)	3	3	0	0	0	2	2	0	0	0
V.	Use Sound Sampling Techniques	6	0	0	0	6	1	0	0	0	1
VI.	Reliably Collect Data	6	4	0	0	2	1	0	0	0	1
VII.	Analyze Data and Interpret Study Results	9	Not Assessed				2	Not Assessed			
VIII.	Implement Intervention and Improvement Strategies	4	Not Assessed				1	Not Assessed			
IX.	Assess for Real Improvement	4	Not Assessed				1	Not Assessed			
X.	Assess for Sustained Improvement	1	Not Assessed				No Critical Elements				
Totals for All Activities		37	11	0	0	8	11	5	0	0	2

Table 3-33—PIP Validation Status for CMH Partnership of Southeastern Michigan	
Percentage Score of Evaluation Elements <i>Met</i>	100%
Percentage Score of Critical Elements <i>Met</i>	100%
Validation Status	<i>Met</i>

Strengths

HSAG's validation evaluated the technical methods of the PIP—the study design. Validation of Activities I through VI of **CMH Partnership of Southeastern Michigan's** PIP 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. The PIHP designed a scientifically sound study that was supported by the use of key research principles. The technical design of the PIP was sufficient to measure outcomes, and the PIP's solid design should allow for the successful progression to the next stage of the PIP process. The performance of this PIP suggests a thorough application of the PIP design.

Recommendations

HSAG identified a *Point of Clarification* as an opportunity for improvement in Activity VI.

CMH Partnership of Southeastern Michigan should specify in the data analysis plan that the analysis will include a comparison of results to the goal.

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

CMH Partnership of Southeastern Michigan's new PIP topic, *Medication Labs*, addressed CMS' requirements related to quality outcomes—specifically, the **quality, timeliness, and accessibility** of care and services. The goal of the study is to increase the percentage of consumers who are taking antipsychotic medication and have lab values (including HbA1c or glucose, cholesterol, and triglycerides) entered in the electronic health record during the measurement year. These lab values are important to the PIHP because they indicate whether consumers need primary health services follow-up.

For the 2013–2014 validation, **CMH Partnership of Southeastern Michigan** successfully completed the Study Design phase and demonstrated that it is well positioned to progress to the Study Implementation and Evaluation phase. The PIHP will submit baseline data for the next annual validation of the PIP. As **CMH Partnership of Southeastern Michigan** progresses in the study, assessment of the impact of the PIP on the **quality and timeliness** of, and **access** to, care and services will continue.

Region 7—Detroit-Wayne Mental Health Authority

Findings

For the 2013–2014 validation, **Detroit Wayne Mental Health Authority** submitted its new PIP topic: *Improving Wellness Self-Management of SMI Consumers with Chronic Health Conditions*.

Table 3-34 and Table 3-35 show **Detroit-Wayne Mental Health Authority**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2013–2014 PIP Validation Report for **Detroit-Wayne Mental Health 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	2	2	0	0	0	1	1	0	0	0
II.	Define the Study Question(s)	1	1	0	0	0	1	1	0	0	0
III.	Use a Representative and Generalizable Study Population	1	1	0	0	0	1	1	0	0	0
IV.	Select the Study Indicator(s)	3	3	0	0	0	2	2	0	0	0
V.	Use Sound Sampling Techniques	6	0	0	0	6	1	0	0	0	1
VI.	Reliably Collect Data	6	4	0	0	2	1	0	0	0	1
VII.	Analyze Data and Interpret Study Results	9	Not Assessed				2	Not Assessed			
VIII.	Implement Intervention and Improvement Strategies	4	Not Assessed				1	Not Assessed			
IX.	Assess for Real Improvement	4	Not Assessed				1	Not Assessed			
X.	Assess for Sustained Improvement	1	Not Assessed				No Critical Elements				
Totals for All Activities		37	11	0	0	8	11	5	0	0	2

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

Strengths

HSAG's validation evaluated the technical methods of the PIP—the study design. Validation of Activities I through VI of **Detroit Wayne Mental Health Authority's** PIP 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. The PIHP designed a scientifically sound study that was supported by the use of key research principles. The technical design of the PIP was sufficient to measure outcomes, and the PIP's solid design should allow for the successful progression to the next stage of the PIP process. The performance of this PIP suggests a thorough application of the PIP design.

Recommendations

HSAG identified *Points of Clarification* as opportunities for improvement in Activity III and VI.

Detroit-Wayne Mental Health Authority should move the numerator CPT codes from Activity III to Activity VI. In future submissions, the PIHP should document the percentage of administrative data completeness in Activity VI and specify in the data analysis plan that it will compare annual study indicator results to the goal for the measurement period.

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

Detroit-Wayne Mental Health Authority's new PIP topic, *Improving Wellness Self-Management of SMI Consumers with Chronic Health Conditions*, addressed CMS' requirements related to quality outcomes—specifically, the **quality, timeliness, and accessibility** of care and services. The goal of the study is to increase the percentage of adult consumers with serious mental illness and at least one chronic health condition who completed a peer-led self-management workshop. The PIHP aims to empower SMI consumers to manage their health and wellness.

For the 2013–2014 validation, **Detroit-Wayne Mental Health Authority** successfully completed the Study Design phase and demonstrated that it is well positioned to progress to the Study Implementation and Evaluation phase. The PIHP will submit baseline data for the next annual validation of the PIP. As **Detroit-Wayne Mental Health Authority** progresses in the study, assessment of the impact of the PIP on the **quality and timeliness** of, and **access** to, care and services will continue.

Region 8—Oakland County CMH Authority

Findings

For the 2013–2014 validation, **Oakland County CMH Authority** submitted its new PIP topic: *Increasing the Proportion of Medicaid Eligible Adults with Mental Illness and Diabetes Whose Diabetes Diagnosis Is Identified on Axis III in Their EMR.*

Table 3-36 and Table 3-37 show **Oakland County CMH Authority**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2013–2014 PIP Validation Report 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	2	1	0	1	0	1	1	0	0	0
II.	Define the Study Question(s)	1	1	0	0	0	1	1	0	0	0
III.	Use a Representative and Generalizable Study Population	1	1	0	0	0	1	1	0	0	0
IV.	Select the Study Indicator(s)	3	1	2	0	0	2	0	2	0	0
V.	Use Sound Sampling Techniques	6	0	0	0	6	1	0	0	0	1
VI.	Reliably Collect Data	6	4	0	0	2	1	0	0	0	1
VII.	Analyze Data and Interpret Study Results	9	Not Assessed				2	Not Assessed			
VIII.	Implement Intervention and Improvement Strategies	4	Not Assessed				1	Not Assessed			
IX.	Assess for Real Improvement	4	Not Assessed				1	Not Assessed			
X.	Assess for Sustained Improvement	1	Not Assessed				No Critical Elements				
Totals for All Activities		37	8	2	1	8	11	3	2	0	2

Percentage Score of Evaluation Elements Met	73%
Percentage Score of Critical Elements Met	60%
Validation Status	Partially Met

Strengths

HSAG's validation evaluated the technical methods of the PIP—the study design. Validation of Activities I through VI of **Oakland County CMH Authority's** PIP resulted in a validation status of *Partially Met*, with an overall score of 73 percent and a score of 60 percent for critical elements. Based on the validation of this PIP, HSAG's assessment determined low confidence in the results. The PIHP received *Met* scores for all applicable evaluation elements in Activities II, III, and VI. The study question, study population, and data collection activities were appropriately documented.

Recommendations

HSAG identified opportunities for improvement in Activities I and IV.

Oakland County CMH Authority should refocus the study topic in Activity I; improving documentation of consumers' co-occurring medical conditions on Axis III alone does not meet MDCH's requirement for an integrated physical and behavioral health care PIP. In Activity IV, the PIHP should recalculate the goal for Remeasurement 2 and ensure that the study indicator denominator is defined correctly.

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

Oakland County CMH Authority's new PIP topic, *Increasing the Proportion of Medicaid Eligible Adults with Mental Illness and Diabetes Whose Diabetes Diagnosis Is Identified on Axis III in Their EMR*, addressed CMS' requirements related to quality outcomes—specifically, the **quality**, **timeliness**, and **accessibility** of care and services. However, the topic does not fully address MDCH's integrated physical and behavioral health care requirement for the PIP. To meet this requirement, the PIHP should take the study a step further and measure, for example, whether consumers with diabetes received the recommended screenings.

For the 2013–2014 validation, **Oakland County CMH Authority** completed the Study Design phase and should make the recommended corrections before progressing to the Study Implementation and Evaluation phase. The PIHP will submit baseline data for the next annual validation of the PIP. As **Oakland County CMH Authority** progresses in the study, assessment of the impact of the PIP on the **quality** and **timeliness** of, and **access** to, care and services will continue.

Region 9—Macomb County CMH Services

Findings

For the 2013–2014 validation, **Macomb County CMH Services** submitted its new PIP topic: *Increasing Metabolic Syndrome Screening for Adults with Severe Mental Illness*.

Table 3-38 and Table 3-39 show **Macomb County CMH Services**' scores based on HSAG's PIP evaluation. For additional details, refer to the 2013–2014 PIP Validation Report for **Macomb County CMH Services**.

Table 3-38—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	2	2	0	0	0	1	1	0	0	0
II.	Define the Study Question(s)	1	1	0	0	0	1	1	0	0	0
III.	Use a Representative and Generalizable Study Population	1	1	0	0	0	1	1	0	0	0
IV.	Select the Study Indicator(s)	3	3	0	0	0	2	2	0	0	0
V.	Use Sound Sampling Techniques	6	0	0	0	6	1	0	0	0	1
VI.	Reliably Collect Data	6	4	0	0	2	1	0	0	0	1
VII.	Analyze Data and Interpret Study Results	9	Not Assessed				2	Not Assessed			
VIII.	Implement Intervention and Improvement Strategies	4	Not Assessed				1	Not Assessed			
IX.	Assess for Real Improvement	4	Not Assessed				1	Not Assessed			
X.	Assess for Sustained Improvement	1	Not Assessed				No Critical Elements				
Totals for All Activities		37	11	0	0	8	11	5	0	0	2

Table 3-39—PIP Validation Status for Macomb County CMH Services	
Percentage Score of Evaluation Elements <i>Met</i>	100%
Percentage Score of Critical Elements <i>Met</i>	100%
Validation Status	<i>Met</i>

Strengths

HSAG's validation evaluated the technical methods of the PIP—the study design. Validation of Activities I through VI of **Macomb County CMH Services'** PIP 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. The PIHP designed a scientifically sound study that was supported by the use of key research principles. The technical design of the PIP was sufficient to measure outcomes, and the PIP's solid design should allow for the successful progression to the next stage of the PIP process. The performance of this PIP suggests a thorough application of the PIP design.

Recommendations

HSAG identified *Points of Clarification* as opportunities for improvement in Activity I and VI.

Macomb County CMH Services should correct the measurement period for baseline data in Activity I. In Activity VI, the PIHP should explain how the Adult Treatment Panel III measures completed for consumers will be identified and provide treatment or billing codes, if used. Once the report to extract all data needed for this study has been created, the PIHP should include a description of the steps to collect data using this report.

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

Macomb County CMH Services' new PIP topic, *Increasing Metabolic Syndrome Screening for Adults with Severe Mental Illness*, addressed CMS' requirements related to quality outcomes—specifically, the **quality, timeliness, and accessibility** of care and services. The goal of the study is to increase the percentage of consumers who are prescribed atypical antipsychotic medication and also receive screening for metabolic syndrome. The PIHP aims to improve the process and outcomes of health care delivery by early identification of indicators of metabolic risk, which can lead to diabetes.

For the 2013–2014 validation, **Macomb County CMH Services** successfully completed the Study Design phase and demonstrated that it is well positioned to progress to the Study Implementation and Evaluation phase. The PIHP will submit baseline data for the next annual validation of the PIP. As **Macomb County CMH Services** progresses in the study, assessment of the impact of the PIP on the **quality and timeliness** of, and **access** to, care and services will continue.

Region 10 PIHP

Findings

For the 2013–2014 validation, **Region 10 PIHP** submitted its new PIP topic: *Behavioral and Physical Health Care Integration*.

Table 3-40 and Table 3-41 show **Region 10 PIHP**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2013–2014 PIP Validation Report for **Region 10 PIHP**.

**Table 3-40—PIP Validation Scores
for Region 10 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	2	2	0	0	0	1	1	0	0	0
II.	Define the Study Question(s)	1	1	0	0	0	1	1	0	0	0
III.	Use a Representative and Generalizable Study Population	1	1	0	0	0	1	1	0	0	0
IV.	Select the Study Indicator(s)	3	3	0	0	0	2	2	0	0	0
V.	Use Sound Sampling Techniques	6	0	0	0	6	1	0	0	0	1
VI.	Reliably Collect Data	6	3	1	0	2	1	0	0	0	1
VII.	Analyze Data and Interpret Study Results	9	Not Assessed				2	Not Assessed			
VIII.	Implement Intervention and Improvement Strategies	4	Not Assessed				1	Not Assessed			
IX.	Assess for Real Improvement	4	Not Assessed				1	Not Assessed			
X.	Assess for Sustained Improvement	1	Not Assessed				No Critical Elements				
Totals for All Activities		37	10	1	0	8	11	5	0	0	2

**Table 3-41—PIP Validation Status
for Region 10 PIHP**

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

Strengths

HSAG's validation evaluated the technical methods of the PIP—the study design. Validation of Activities I through VI of **Region 10 PIHP**'s PIP 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. While **Region 10 PIHP** had an opportunity for improvement in the data collection process, all other aspects of the study were determined to be scientifically sound.

Recommendations

HSAG identified opportunities for improvement in Activity VI. **Region 10 PIHP** should clearly document all steps in the administrative data collection process used to generate the study indicator results.

HSAG identified additional *Points of Clarification* to strengthen the study in Activities III and VI. These points addressed CPT codes for the numerator, documenting a percentage goal for Remeasurement 1, and including in the data analysis plan that results will be compared to the goal.

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

Region 10 PIHP's new PIP topic, *Behavioral and Physical Health Care Integration*, addressed CMS' requirements related to quality outcomes—specifically, the **quality**, **timeliness**, and **accessibility** of care and services. The goal of the study is to increase the percentage of consumers who were identified with cardiovascular risk factors and had an encounter for a medical service to treat the condition. Review of consumers' health conditions and referral to primary care can result in improved health outcomes.

For the 2013–2014 validation, **Region 10 PIHP** completed the Study Design phase and should make the recommended corrections before progressing to the Study Implementation and Evaluation phase. The PIHP will submit baseline data for the next annual validation of the PIP. As **Region 10 PIHP** progresses in the study, assessment of the impact of the PIP on the **quality** and **timeliness** of, and **access** to, care and services will continue.

4. Assessment of PIHP Follow-Up on Prior Recommendations

Introduction

This section of the report presents an assessment of the PIHPs' follow-up on prior recommendations for the EQR activities.

The 2013–2014 compliance monitoring reviews addressed the PIHPs' compliance with requirements that had received scores of less than Met in the previous review of the standard. This section presents a summary of the PIHPs' progress in addressing recommendations identified in the 2011–2012 and 2012–2013 reviews of the 14 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 2012–2013 validation cycle.

For the 2013–2014 validation, the PIHPs selected a new PIP topic related to the integration of physical and mental health care. This section will not present any findings related to the PIHPs' follow-up on recommendations from the 2012–2013 validation of the projects on the previous topic. Follow-up on any current-year recommendations related to the PIPs will be addressed in the next technical report.

Region 1—NorthCare Network

Compliance Monitoring

Table 4-1 shows the results for **NorthCare Network** from the 2011–2012 and 2012–2013 compliance monitoring reviews and the 2013–2014 assessment of the PIHP’s follow-up on HSAG’s recommendations.

Standard	Full Compliance		One or More Remaining Corrective Action(s)
	Achieved at Initial Review	Achieved After Follow-Up	
I	QAPIP Plan and Structure	✓	
II	Performance Measurement and Improvement	✓	
III	Practice Guidelines	✓	
IV	Staff Qualifications	✓	
V	Utilization Management		✓
VI	Customer Services	✓	
VII	Enrollee Grievance Process	✓	
VIII	Enrollee Rights and Protections		✓
IX	Subcontracts and Delegation	✓	
X	Provider Network	✓	
XI	Credentialing		✓
XII	Access and Availability	Not included in the follow-up review	
XIII	Coordination of Care	✓	
XIV	Appeals	✓	

The 2011–2012 and 2012–2013 compliance monitoring reviews resulted in recommendations for improvement for the following standards: Utilization Management, Enrollee Rights and Protections, and Credentialing. The PIHP addressed recommendations through corrective action plans and implemented improvements. As determined in the 2013–2014 review, **NorthCare Network** successfully addressed all recommendations.

Validation of Performance Measures

NorthCare Network followed the previous year’s recommendation to document any changes to its systems and processes that occurred during the transition to the new regional entity. The only changes that occurred were in the formation of the PIHP board and hiring of new staff, and no significant changes were made to systems or processes. **NorthCare Network** ensured that the PIHP staff members were detached from the CMHSP staff to ensure appropriate access to data. **NorthCare Network** continued to monitor performance indicator rates for the PIHP, most of which improved to exceed the MDCH-established threshold.

Region 2—Northern Michigan Regional Entity

Compliance Monitoring

The 2013–2014 compliance monitoring review was the first for the newly-formed **Northern Michigan Regional Entity**. Therefore, this PIHP had not received any prior recommendations for improvement.

Validation of Performance Measures

No previous recommendations were available because **Northern Michigan Regional Entity** became a new PIHP as of January 1, 2014.

Region 3—Lakeshore Regional Entity

Compliance Monitoring

The 2013–2014 compliance monitoring review was the first for the newly-formed **Lakeshore Regional Entity**. Therefore, the PIHP had not received any prior recommendations for improvement.

Validation of Performance Measures

No previous recommendations were available because **Lakeshore Regional Entity** became a new PIHP as of January 1, 2014.

Region 4—Southwest Michigan Behavioral Health

Compliance Monitoring

The 2013–2014 compliance monitoring review was the first for the newly-formed **Southwest Michigan Behavioral Health**. Therefore, the PIHP had not received any prior recommendations for improvement.

Validation of Performance Measures

No previous recommendations were available because **Southwest Michigan Behavioral Health** became a new PIHP as of January 1, 2014

Region 5—Mid-State Health Network

Compliance Monitoring

The 2013–2014 compliance monitoring review was the first for the newly-formed **Mid-State Health Network**. Therefore, the PIHP had not received any prior recommendations for improvement.

Validation of Performance Measures

No previous recommendations were available because **Mid-State Health Network** became a new PIHP as of January 1, 2014

Region 6—CMH Partnership of Southeast Michigan

Compliance Monitoring

Table 4-2 shows the results for **CMH Partnership of Southeast Michigan** from the 2011–2012 and 2012–2013 compliance monitoring reviews and the 2013–2014 assessment of the PIHP’s follow-up on HSAG’s recommendations.

Table 4-2—Compliance Following Initial and Follow-Up Reviews for CMH Partnership of Southeast Michigan				
Standard		Full Compliance		One or More Remaining Corrective Action(s)
		Achieved at Initial Review	Achieved After Follow-Up	
I	QAPIP Plan and Structure	✓		
II	Performance Measurement and Improvement		✓	
III	Practice Guidelines	✓		
IV	Staff Qualifications	✓		
V	Utilization Management	✓		
VI	Customer Services	✓		
VII	Enrollee Grievance Process		✓	
VIII	Enrollee Rights and Protections	✓		
IX	Subcontracts and Delegation		✓	
X	Provider Network	✓		
XI	Credentialing		✓	
XII	Access and Availability	Not included in the follow-up review		
XIII	Coordination of Care	✓		
XIV	Appeals		✓	

The 2011–2012 and 2012–2013 compliance monitoring reviews resulted in recommendations for improvement for the following standards: Performance Measurement and Improvement, Enrollee Grievance Process, Subcontracts and Delegation, Credentialing, and Appeals. **CMH Partnership of Southeast Michigan** addressed recommendations through corrective actions and implemented improvements. As determined in the 2013–2014 review, the PIHP successfully addressed all recommendations.

Validation of Performance Measures

CMH Partnership of Southeastern Michigan took action to address the previous year’s recommendations. The PIHP was encouraged to work on improving the minimum wage rate. Several quality improvement projects were implemented, and the rate continued to show improvement. In addition, based on last year’s recommendation to address data reporting challenges associated with the Recovery-Oriented System of Care (ROSC), the PIHP added several front-end validation processes to improve data quality and data completeness.

Region 7—Detroit Wayne Mental Health Authority

Compliance Monitoring

Table 4-3 shows the results for **Detroit Wayne Mental Health Authority** from the 2011–2012 and 2012–2013 compliance monitoring reviews and the 2013–2014 assessment of the PIHP’s follow-up on HSAG’s recommendations.

Table 4-3—Compliance Following Initial and Follow-Up Reviews for Detroit Wayne Mental Health Authority				
Standard		Full Compliance		One or More Remaining Corrective Action(s)
		Achieved at Initial Review	Achieved After Follow-Up	
I	QAPIP Plan and Structure	✓		
II	Performance Measurement and Improvement	✓		
III	Practice Guidelines	✓		
IV	Staff Qualifications	✓		
V	Utilization Management	✓		
VI	Customer Services	✓		
VII	Enrollee Grievance Process		✓	
VIII	Enrollee Rights and Protections	✓		
IX	Subcontracts and Delegation		✓	
X	Provider Network	✓		
XI	Credentialing	✓		
XII	Access and Availability	Not included in the follow-up review		
XIII	Coordination of Care	✓		
XIV	Appeals			✓

The 2011–2012 and 2012–2013 compliance monitoring reviews resulted in recommendations for improvement for the following standards: Enrollee Grievance Process, Subcontracts and Delegation, and Appeals. **Detroit Wayne Mental Health Authority** addressed recommendations through corrective actions and implemented improvements. As determined in the 2013–2014 review, the PIHP successfully addressed the recommendations for the Enrollee Grievance and Subcontracts and Delegation standards, but received a continued recommendation for the Appeals standard related to the content of the notice of disposition.

Validation of Performance Measures

Detroit Wayne Mental Health Authority took action to address the recommendations from the previous year’s audit. The PIHP continued its effort to improve the rates which had fallen below MDCH’s expected thresholds. The PIHP achieved rates above the State’s 95 percent threshold for all QI data elements. The PIHP also implemented processes for its providers in an effort to improve quality and timeliness of data submitted by them.

Region 8—Oakland County CMH Authority

Compliance Monitoring

Table 4-4 shows the results for **Oakland County CMH Authority** from the 2011–2012 and 2012–2013 compliance monitoring reviews and the 2013–2014 assessment of the PIHP’s follow-up on HSAG’s recommendations.

Table 4-4—Compliance Following Initial and Follow-Up Reviews for Oakland County CMH Authority				
Standard		Full Compliance		One or More Remaining Corrective Action(s)
		Achieved at Initial Review	Achieved After Follow-Up	
I	QAPIP Plan and Structure	✓		
II	Performance Measurement and Improvement	✓		
III	Practice Guidelines	✓		
IV	Staff Qualifications	✓		
V	Utilization Management	✓		
VI	Customer Services	✓		
VII	Enrollee Grievance Process	✓		
VIII	Enrollee Rights and Protections		✓	
IX	Subcontracts and Delegation	✓		
X	Provider Network	✓		
XI	Credentialing	✓		
XII	Access and Availability	Not included in the follow-up review		
XIII	Coordination of Care	✓		
XIV	Appeals	✓		

The 2011–2012 and 2012–2013 compliance monitoring reviews resulted in a recommendation for improvement for the Enrollee Rights and Protections standard. **Oakland County CMH Authority** addressed the recommendation through corrective actions and implemented improvements. As determined in the 2013–2014 review, the PIHP successfully addressed the recommendation.

Validation of Performance Measures

Oakland County CMH Authority addressed the recommendations from the previous year’s audit. The PIHP implemented use of internal reports (iDashboards) to monitor data completeness and created a folder containing documentation of the processes followed for performance indicator rates production. **Oakland County CMH Authority** continued to document changes to the process and system as recommended last year.

Region 9—Macomb County CMH Services

Compliance Monitoring

Table 4-5 shows the results for **Macomb County CMH Services** from the 2011–2012 and 2012–2013 compliance monitoring reviews and the 2013–2014 assessment of the PIHP’s follow-up on HSAG’s recommendations.

Table 4-5—Compliance Following Initial and Follow-Up Reviews for Macomb County CMH Services				
Standard	Full Compliance		One or More Remaining Corrective Action(s)	
	Achieved at Initial Review	Achieved After Follow-Up		
I	QAPIP Plan and Structure	✓		
II	Performance Measurement and Improvement		✓	
III	Practice Guidelines	✓		
IV	Staff Qualifications	✓		
V	Utilization Management	✓		
VI	Customer Services	✓		
VII	Enrollee Grievance Process	✓		
VIII	Enrollee Rights and Protections	✓		
IX	Subcontracts and Delegation		✓	
X	Provider Network		✓	
XI	Credentialing		✓	
XII	Access and Availability	Not included in the follow-up review		
XIII	Coordination of Care	✓		
XIV	Appeals		✓	

The 2011–2012 and 2012–2013 compliance monitoring reviews resulted in recommendations for improvement for the following standards: Performance Measurement and Improvement, Subcontracts and Delegation, Provider Network, Credentialing, and Appeals. **Macomb County CMH Services** addressed the recommendations through corrective actions and implemented improvements. As determined in the 2013–2014 review, the PIHP successfully addressed all recommendations.

Validation of Performance Measures

Macomb County CMH Services followed through on recommendations from the previous year. The PIHP collected and reported National Provider Identifier (NPI) data to MDCH. The PIHP also implemented several reports to monitor its agencies and identified additional training needs that could improve data accuracy in the reports.

Region 10 PIHP

Compliance Monitoring

The 2013–2014 compliance monitoring review was the first for the newly-formed **Region 10 PIHP**. Therefore, the PIHP had not received any prior recommendations for improvement.

Validation of Performance Measures

No previous recommendations were available because **Region 10 PIHP** became a new PIHP as of January 1, 2014.

Appendix A. Summary Tables of External Quality Review Activity Results

Introduction

This section of the report addresses the compliance monitoring reviews and presents two-year comparison tables for scores for the validation of performance measures and the validation of PIPs.

Compliance Monitoring

The 2013–2014 compliance monitoring reviews did not result in any compliance scores for the standards reviewed or overall. Therefore, this technical report does not present PIHP or statewide performance trends.

The 2013–2014 compliance monitoring reviews addressed all elements that had received a score of less than *Met* during the prior review of the standard in the 2011–2012 and 2012–2013 compliance review cycles.

The 2013 reorganization of the PIHPs into regional entities resulted in 10 PIHPs, five of which included service areas of two or more of the previous 18 PIHPs. To conduct the 2013–2014 follow-up reviews, HSAG assigned the elements for follow-up to the new regional entity that included the majority of the counties served by the previous PIHPs, as shown in Table A-1 below.

Table A-1—Assignment of PIHPs to Regional Entities for Follow-Up Compliance Reviews	
New Regional Entity	Previous PIHPs
Region 1—NorthCare Network	NorthCare
Region 2—Northern Michigan Regional Entity	Northern Affiliation, Northwest CMH Affiliation
Region 3—Lakeshore Regional Entity	Lakeshore Behavioral Health Alliance, network180
Region 4—Southwest Michigan Behavioral Health	Southwest Affiliation, Venture Behavioral Health
Region 5—Mid-State Health Network	Access Alliance of Michigan, CMH Affiliation of Mid-Michigan, CMH for Central Michigan, LifeWays, Saginaw County CMH Authority
Region 6—CMH Partnership of Southeast Michigan	CMH Partnership of Southeastern Michigan
Region 7—Detroit Wayne Mental Health Authority	Detroit-Wayne County CMH Agency
Region 8—Oakland County CMH Authority	Oakland County CMH Authority
Region 9—Macomb County CMH Services	Macomb County CMH Services
Region 10 PIHP	Genesee County CMH, Thumb Alliance PIHP

Results for Validation of Performance Measures

Table A-2 shows the overall statewide PIHP compliance with the MDCH code book specifications. For the 2013–2014 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.

Please note that the number of PIHPs changed from 18 for the 2012–2013 validation to 10 PIHPs for the 2013–2014 validation. Since the five new PIHPs were not required to report rates for SFY 2014, the *Report* validation designation was assigned based on HSAG’s system readiness review. This designation indicates adequate system readiness, data collection, and calculation processes for the next year of performance indicator reporting.

Table A-2—Degree of Compliance for Performance Measures

Indicator		Percentage of PIHPs					
		Report		Not Reported		No Benefit	
		2012 – 2013	2013 – 2014	2012 – 2013	2013 – 2014	2012 – 2013	2013 – 2014
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.	100%	100%	0%	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.	100%	100%	0%	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.	100%	100%	0%	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.	100%	100%	0%	0%	0%	0%
5.	The percent of Medicaid recipients having received PIHP managed services.	100%	100%	0%	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.	100%	100%	0%	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.	83%	100%	17%	0%	0%	0%

Table A-2—Degree of Compliance for Performance Measures

Indicator		Percentage of PIHPs					
		Report		Not Reported		No Benefit	
		2012 – 2013	2013 – 2014	2012 – 2013	2013 – 2014	2012 – 2013	2013 – 2014
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 and Table A-4 present a two-year comparison of the PIHP-specific results for the validated performance indicators for regional entities that continued with their previous service area (Regions 1, 6, 7, 8, and 9). Newly-formed PIHPs (Regions 2, 3, 4, 5, and 10) were not required to report performance measure rates for this validation cycle.

**Table A-3—PIHP Performance Measure Results (Percentage Scores)
Comparison of Prior-Year (2012–2013) and Current-Year (2013–2014) 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	Total	Follow-Up Care— Children	Follow-Up Care— Adults	Follow-Up Care— Detox
Region 1—NorthCare	P	100	99.34	97.94	98.99	100	100	99.09	98.81	98.67	98.77	100	100	99.31	87.50	97.14	100
	C	100	100	97.60	98.86	100	100	96.97	97.99	96.26	94.59	94.12	100	95.67	93.75	100	100
Region 2—Northern MI	P																
	C																
Region 3—Lakeshore	P																
	C																
Region 4—Southwest MI	P																
	C																
Region 5—Mid-State	P																
	C																
Region 6—CMHPSM	P	100	100	99.36	100	100	100	95.12	98.81	100	95.71	100	96.30	97.82	100	99.01	50.00
	C	100	99.67	99.32	100	100	100	95.71	99.04	99.00	98.89	100	97.67	98.81	95.00	96.97	78.95

**Table A-3—PIHP Performance Measure Results (Percentage Scores)
Comparison of Prior-Year (2012–2013) and Current-Year (2013–2014) 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	Total	Follow-Up Care— Children	Follow-Up Care— Adults	Follow-Up Care— Detox	
Region 7—Detroit	P	100	97.49	97.18	95.36	98.04	97.73	99.89	97.94	99.10	96.74	97.26	96.34	98.58	99.19	99.22	100
	C	100	95.65	95.94	96.77	98.97	97.10	98.95	97.55	99.15	96.59	100	100	98.12	99.66	98.24	92.19
Region 8—Oakland	P	90.16	89.06	98.58	100	100	100	99.63	99.57	98.65	100	100	100	99.26	100	97.03	100
	C	97.30	95.03	100	98.06	100	100	98.82	98.84	100	99.68	94.44	100	99.62	96.55	99.12	100
Region 9—Macomb	P	98.66	99.48	98.18	99.32	85.71	95.24	100	98.62	98.80	99.35	95.45	100	99.39	98.73	93.85	100
	C	99.75	100	98.39	97.98	95.65	100	97.64	97.82	98.15	100	96.55	92.00	98.28	93.94	92.43	100
Region 10 PIHP	P																
	C																

**Table A-4—PIHP Performance Measure Results (Percentage Scores)
Comparison of Prior-Year (2012–2013) and Current-Year (2013–2014) 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	MI—Adults	DD—Adults	MI/DD Adults	MI—Adults	DD—Adults	MI/DD Adults	Children	Adults	DD—Adults	MI—Adults
Region 1—NorthCare	P	8.03	98.90	10.45	7.33	3.51	76.65	32.39	35.53	7.69	15.79	18.18	54.70
	C	8.39	97.03	9.78	6.85	4.39	80.12	31.93	36.59	5.56	9.52	18.18	54.98
Region 2—Northern MI	P												
	C												
Region 3—Lakeshore	P												
	C												
Region 4—Southwest MI	P												
	C												
Region 5—Mid-State	P												
	C												
Region 6—CMHPSM	P	6.93	98.06	9.14	9.29	6.76	87.35	72.43	77.50	9.52	11.11	24.90	32.59
	C	7.53	98.65	9.25	9.24	7.57	82.27	61.60	69.81	14.89	10.26	26.60	31.39
Region 7—Detroit	P	7.41	99.67	4.18	2.45	3.61	58.33	11.81	32.14	10.62	17.78	21.84	21.16
	C	7.94	96.85	4.71	1.82	2.14	62.13	13.12	32.14	14.77	16.40	22.15	22.76
Region 8—Oakland	P	8.48	99.77	8.35	11.68	9.07	57.14	34.67	24.93	3.03	11.90	16.68	34.93
	C	9.23	99.30	9.42	12.29	9.97	59.79	37.28	25.93	8.11	13.25	17.26	37.48
Region 9—Macomb	P	5.97	99.59	6.86	6.20	4.32	58.33	38.50	29.09	11.63	18.88	15.94	34.80
	C	6.31	99.39	7.32	5.27	4.38	73.01	36.95	28.27	10.00	22.67	15.05	34.39
Region 10 PIHP	P												
	C												

Results for Validation of Performance Improvement Projects

Table A-5 presents a two-year comparison of the PIHPs' validation status. However, for 2012–2013 validation, the 18 PIHPs submitted PIPs on *Increasing the Proportion of Medicaid Eligible Adults With a Mental Illness Who Receive Peer-Delivered Services or Supports*; for the 2013–2014 validation, the 10 Regional Entities (PIHPs) submitted a new PIP on a topic related to the integration of physical and mental health care. Therefore, validation results are not fully comparable across the two validation cycles.

Validation Status	Number of PIPs	
	2012–2013	2013–2014
<i>Met</i>	17	8
<i>Partially Met</i>	1	2
<i>Not Met</i>	0	0

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

Validation Activity	Number of PIPs Meeting All Evaluation Elements/ Number Reviewed		Number of PIPs Meeting All Critical Elements/ Number Reviewed	
	2012–2013	2013–2014	2012–2013	2013–2014
I. Select the Study Topic	18/18	9/10	18/18	10/10
II. Define the Study Question(s)	18/18	9/10	18/18	9/10
III. Use a Representative and Generalizable Study Population	18/18	10/10	18/18	10/10
IV. Select the Study Indicator(s)	18/18	9/10	18/18	9/10
V. Use Sound Sampling Techniques*	NA	NA	NA	NA
VI. Reliably Collect Data*	17/18	8/10	NA	NA
VII. Analyze Data and Interpret Study Results	6/18	Not Assessed	18/18	Not Assessed
VIII. Implement Intervention and Improvement Strategies	14/18	Not Assessed	18/18	Not Assessed
IX. Assess for Real Improvement	5/18	Not Assessed	<i>No Critical Elements</i>	Not Assessed
X. Assess for Sustained Improvement	12/12	Not Assessed	<i>No Critical Elements</i>	<i>No Critical Elements</i>

*In 2012–2013 and 2013–2014, HSAG scored all elements for Activity V and the critical element in Activity VI *Not Applicable* for all PIPs.

Table A-7 presents a two-year comparison of PIP scores for each PIHP. Please note that 2012–2013 scores are not available for the newly-configured PIHPs (Regions 2, 3, 4, 5, and 10) and that the number of activities validated decreased from 10 activities in 2012–2013 to six activities for the 2013–2014 first-year submissions on the new study topics.

PIHP	% of All Evaluation Elements <i>Met</i>		% of All Critical Elements <i>Met</i>		Validation Status	
	2012–2013	2013–2014	2012–2013	2013–2014	2012–2013	2013–2014
	Activities I–X	Activities I–VI	Activities I–X	Activities I–VI	Activities I–X	Activities I–VI
Region 1—NorthCare	97%	100%	100%	100%	<i>Met</i>	<i>Met</i>
Region 2—Northern MI		100%		100%		<i>Met</i>
Region 3—Lakeshore		100%		100%		<i>Met</i>
Region 4—Southwest MI		100%		100%		<i>Met</i>
Region 5—Mid-State		73%		80%		<i>Partially Met</i>
Region 6—CMHPSM	91%	100%	100%	100%	<i>Met</i>	<i>Met</i>
Region 7—Detroit	100%	100%	100%	100%	<i>Met</i>	<i>Met</i>
Region 8—Oakland	88%	73%	100%	60%	<i>Met</i>	<i>Partially Met</i>
Region 9—Macomb	91%	100%	100%	100%	<i>Met</i>	<i>Met</i>
Region 10 PIHP		91%		100%		<i>Met</i>

The compliance monitoring tool appendix follows this cover page.

HSAG customized the 2013–2014 compliance monitoring tool for each PIHP to include only those elements that scored less than *Met* in the 2011–2012 and 2012–2013 reviews.

The following section presents a complete set of elements for the 14 standards addressed in the 2013–2014 follow-up compliance review.



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

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 <div style="text-align: right;">42 CFR 438.240 Attachment P 6.7.1.1 PIHP Contract 6.1</div>		
a. There is a written quality assessment performance improvement program (QAPIP) description.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
b. The QAPIP description specifies an adequate organizational structure that allows for clear and appropriate administration and evaluation of the QAPIP.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
2. Role of Beneficiaries The written QAPIP description includes a description of the role for beneficiaries. <div style="text-align: right;">Attachment P 6.7.1.1</div>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings



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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 <u>adopting</u> process and outcome improvements.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
b. The written QAPIP description includes the mechanisms or procedures used or to be used for <u>communicating</u> process and outcome improvements.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings



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Requirement	Evidence/Documentation as Submitted by the PIHP	Score
4. Accountability to the Governing Body Attachment P 6.7.1.1		
a. The QAPIP is accountable to the Governing Body.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> 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 <u>QAPIP Plan</u> .		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
c. There is documentation that the Governing Body has approved an annual <u>QI Plan</u> .		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
d. The Governing Body routinely receives written reports from the QAPIP.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



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<p>e. The written reports from the QAPIP describe <u>performance improvement projects</u> undertaken.</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p>f. The written reports from the QAPIP describe <u>actions taken</u>.</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p>g. The written reports from the QAPIP describe the <u>results</u> of those actions.</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p>h. The Governing Body formally reviews on a periodic basis (but no less than annually) a written report on the operation of the QAPIP.</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

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Requirement	Evidence/Documentation as Submitted by the PIHP	Score
5. Designated Senior Official There is a designated senior official responsible for the QAPIP implementation. <div style="text-align: right;">Attachment P 6.7.1.1</div>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
6. Active Participation <div style="text-align: right;">Attachment P 6.7.1.1</div>		
a. There is active participation of <u>providers</u> in the QAPIP.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
b. There is active participation of <u>consumers</u> in the QAPIP.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

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Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>7. 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.</p> <p align="right">Attachment P 6.7.1.1</p>		
<p>a. The PIHP must submit to the State for approval of its methodology for verification.</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p>b. The PIHP must annually submit its findings from this process and provide any follow up actions that were taken as a result of the findings.</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
Findings		



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Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>8. 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.</p> <p align="right">Attachment P 6.7.1.1</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings

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 =					



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Standard II—Performance Measurement and Improvement

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
1. Performance Measures The PIHP utilizes standardized performance measures established by the department, which, at a minimum, address: <div style="text-align: right; margin-right: 50px;">42 CFR 438.240(c) MDCH Contract Attachment P6.7.1.1</div>		
a. Access		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
b. Efficiency		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
c. Outcome		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings



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Standard II—Performance Measurement and Improvement

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

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
3. Performance Improvement Projects The PIHP’s QAPIP includes at least two affiliation-wide performance improvement projects (PIPs) during the waiver renewal period. 42 CFR 438.240(d) MDCH Contract Attachment P6.7.1.1		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

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

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
5. Appropriate Credentials PIHP has a process to ensure that persons involved in the review of sentinel events must have the appropriate credentials to review the scope of care. MDCH Contract Attachment P6.7.1.1		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

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



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



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k. The organization evaluates the effects of the above activities.

- Met
- Substantially Met
- Partially Met
- Not Met
- Not Applicable

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
7. Consumer Inclusion The organization ensures the incorporation of consumers receiving long-term supports or services (persons receiving case management or supports coordination) into the review and analysis of the information obtained from quantitative and qualitative methods. MDCH Contract Attachment P6.7.1.1		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings

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



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Standard III—Practice Guidelines		
Requirement	Evidence/Documentation as Submitted by the PIHP	Score
1. Relevant Practice Guidelines The QAPIP describes the process for the use of practice guidelines, including the following: <div style="text-align: right; margin-right: 100px;">MDCH Contract Attachment P6.7.1.1 42 CFR 438.236</div>		
a. Adoption process		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
b. Development process		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
c. Implementation		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
d. Continuous monitoring		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
e. Evaluation		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



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Standard III—Practice Guidelines

Findings

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



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Standard III—Practice Guidelines

Findings

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

Findings



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Standard III—Practice Guidelines

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

Findings



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



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Standard IV—Staff Qualifications and Training

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
1. Employed and Contracted Staff Qualifications <div style="text-align: right; font-size: small;">Attachment P 6.7.1.1 PIHP Contract 6.4.3</div>		
a. The QAPIP contains written procedures to determine whether <u>physicians</u> are qualified to perform their services.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
b. The QAPIP contains written procedures to determine whether <u>other licensed health care professionals</u> are qualified to perform their services.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
c. The QAPIP contains written procedures to ensure <u>non-licensed providers</u> of care or support are qualified to perform their jobs.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings



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Standard 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: <div style="text-align: right; font-size: small;">Attachment P 6.7.1.1</div>		
a. Training for new personnel with regard to their responsibilities, program policy, and operating procedures		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
b. Methods for identifying staff training needs		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
c. In-service training, continuing education, and staff development activities.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

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Results—Standard 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					=	



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Standard V—Utilization Management

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
1. Written Program Description <div style="text-align: right; font-size: small;">42 CFR 438.210(a)(4) Attachment P 6.7.1.1</div>		
a. The PIHP has a written utilization program description that includes <u>procedures</u> to evaluate medical necessity.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
b. The PIHP has a written utilization program description that includes the <u>criteria</u> used in making decisions.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
c. The PIHP has a written utilization program description that includes the process used to <u>review and approve</u> the provision of medical services.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

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Standard V—Utilization Management

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
2. Scope <div style="text-align: right;">42 CFR 438.240(b)(3) Attachment P 6.7.1.1</div>		
a. The program has mechanisms to identify and correct <u>under</u> -utilization.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
b. The program has mechanisms to identify and correct <u>over</u> -utilization.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

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Standard V—Utilization Management

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
3. Procedures Prospective (preauthorization), concurrent, and retrospective procedures are established and include: <div style="text-align: right; margin-right: 50px;"> 42 CFR 438.210(b) Attachment P 6.7.1.1 </div>		
a. Review decisions are supervised by qualified medical professionals.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
b. Decisions to deny or reduce services are made by health care professionals who have the appropriate clinical expertise to treat the conditions.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
c. Efforts are made to obtain all necessary information including pertinent clinical information and consult with treating physician as appropriate.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
d. The reasons for decisions are <u>clearly documented</u> .		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
e. The reasons for decisions <u>are available to the beneficiary</u> .		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



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Standard V—Utilization Management

<p>f. There are well-publicized and readily available appeals mechanisms for <u>providers</u>.</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p>g. There are well-publicized and readily available appeals mechanisms for <u>beneficiaries</u>.</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p>h. Notification of the denial is sent to the <u>beneficiary</u>.</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p>i. Notification of the denial is sent to the <u>provider</u>.</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p>j. Notification of a denial includes a description of how to file an appeal.</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p>k. <u>UM Decisions</u> are made in a timely manner as required by the exigencies of the situation.</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



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<p>l. <u>Decisions on appeals</u> are made in a timely manner as required by the exigencies of the situation.</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p>m. There are mechanisms to evaluate the effects of the program using data on beneficiary satisfaction, provider satisfaction, or other appropriate measures.</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p>n. If the organization delegates responsibility for utilization management, it has mechanisms to ensure that these standards are met by the delegate.</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings

Results—Standard 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 =					



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Standard VI—Customer Services

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>1. Designated Unit The PIHP has a designated unit called “Customer Services”, with a minimum of one full-time equivalent (FTE) performing the customer services function, within the customer services unit or elsewhere within the PIHP.</p> <p style="text-align: right;">MDCH Contract Attachment P6.3.1.1</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>2. Phone Access</p> <p style="text-align: right;">MDCH Contract Attachment P6.3.1.1</p>		
<p>a. Toll-Free Telephone Line The PIHP has a designated toll-free customer services telephone line and access to a TTY number. The telephone numbers are displayed in agency brochures and public information material.</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p>b. Live Voice The PIHP ensures that the customer services telephone line is answered by a live voice during business hours. The PIHP uses methods other than telephone menus to triage high volumes of calls and ensures that that there is a response to each call within one business day.</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings



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Standard VI—Customer Services

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>3. Hours of Operation The PIHP publishes the hours of customer services unit operation and the process for accessing information from customer services outside those hours. The customer services unit or function will operate minimally eight hours daily, Monday through Friday, except for Holidays.</p> <p style="text-align: right;">MDCH Contract Attachment P6.3.1.1</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>4. Customer Handbook The customer handbook includes:</p> <ul style="list-style-type: none"> ◆ All state-required topics as specified in the contract attachment. ◆ The date of the publication and revision(s). ◆ Names, addresses, phone numbers, TTYs, e-mails, and web addresses for affiliate CMHSPs, substance abuse coordinating agency, or network providers. ◆ Information about how to contact the Medicaid Health Plans or Medicaid fee-for-service programs in the PIHP service area (actual phone numbers and addresses may be omitted and held at the customer services office due to frequent turnover of plans and providers). <p style="text-align: right;">MDCH Contract Attachment P6.3.1.1</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

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Standard VI—Customer Services

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>5. Provider Listing The customer services unit maintains a current listing of all providers, both organizations and practitioners, with whom the PIHP contracts, the services they provide, languages they speak, and any specialty for which they are known. The list includes independent PCP facilitators and identification of providers that are not accepting new patients.</p> <p style="text-align: right;">MDCH Contract Attachment P6.3.1.1</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>6. Access to Information The customer services unit has access to information about the PIHP, including CMHSP affiliate annual report; current organizational chart; CMHSP board member list, meeting schedule, and minutes, that are available to be provided in a timely manner to the beneficiary upon request.</p> <p style="text-align: right;">MDCH Contract Attachment P6.3.1.1</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

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Standard VI—Customer Services

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>7. Assistance with Grievances and Appeals Upon request, the customer services unit assists beneficiaries with the grievance, appeals, and local dispute resolution processes and coordinates, as appropriate, with the Fair Hearing Officer and the local Office of Recipient Rights.</p> <p align="right">MDCH Contract Attachment P6.3.1.1</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>8. Training Customer services staff receives training to welcome people to the public mental health system and to possess current working knowledge, or know where in the organization detailed information can be obtained, in at least the following areas:</p> <p align="right">MDCH Contract Attachment P6.3.1.1</p>		
<p>a. Working Knowledge About:</p> <ul style="list-style-type: none"> ◆ The populations served (serious mental illness, serious emotional disturbance, developmental disability, and substance abuse disorder) and eligibility criteria for various benefit plans (e.g., Medicaid, Adult Benefit Waiver, MICHild) ◆ Service array (including substance abuse treatment services), medical necessity requirements, and eligibility for and referral to specialty services ◆ Grievance and appeals, fair hearings, local dispute resolution processes, and recipient rights ◆ Information about and referral for Medicaid-covered services within the PIHP as well as outside to Medicaid health plans, fee-for-service practitioners, and the Department of Human Services 		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



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Standard VI—Customer Services

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

- Met
- Substantially Met
- Partially Met
- Not Met
- Not Applicable

Findings

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



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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. <div style="text-align: right;">42 CFR 438.402</div>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
2. Information to Enrollees The PIHP provides enrollees with information about the grievances, procedures, and timeframes that include: <ul style="list-style-type: none"> ◆ 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. <div style="text-align: right;">42 CFR 438.10(g)(1) PIHP Contract 6.3.3</div>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings



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Standard VII—Enrollee Grievance Process

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>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:</p> <ul style="list-style-type: none"> ◆ 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. <p align="right">42 CFR 438.414 42 CFR 438.10(g)(1)</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>4. Method for Filing Grievance procedures allow the enrollee to file a grievance either orally or in writing.</p> <p align="right">42 CFR 438.402(b)(3)(1)</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

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Standard VII—Enrollee Grievance Process

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>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.</p> <p align="right">42 CFR 438.406(a)(7)</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>6. Process for Handling Grievances Customer Services or the Recipient Rights Office performs the following functions:</p> <p align="right">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</p>		
<p>a. Logs the receipt of the verbal or written grievance for reporting to the PIHP QI Program.</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p>b. 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.</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



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Standard VII—Enrollee Grievance Process

<p>c. Acknowledges to the beneficiary the receipt of the grievance.</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p>d. 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.</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p>e. 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.</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p>f. 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.</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p>g. 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.</p> <p>The content of the notice of disposition includes:</p> <ul style="list-style-type: none"> ◆ The results of the grievance process; ◆ The date the grievance process was conducted; ◆ The beneficiary’s right to request a fair hearing if the notice is more than 60 calendar days from the date of the request for a grievance; and ◆ How to access the fair hearing process. 		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



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Standard VII—Enrollee Grievance Process

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
7. Recordkeeping The PIHP maintains records of grievances. <div align="right">42 CFR 438.416 PIHP Contract 6.3.2</div>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings

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 =						



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Standard VIII—Enrollee Rights and Protections

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
1. Written Policies		
<p style="text-align: right;">42 CFR 438.100 (a)(1) 42 CFR 438.100(a)(2)</p>		
a. The PIHP has written policies regarding enrollee rights.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
b. The PIHP has processes to ensure that its staff and affiliated providers take those rights into account when furnishing services to enrollees.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

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



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



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Findings

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



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<p>c. Grievance, appeal, and fair hearing procedures and timeframes that include:</p> <ul style="list-style-type: none"> ◆ The right to a state fair hearing; ◆ The method for obtaining a hearing; ◆ The rules that govern representation at the hearing; ◆ The right to file grievances and appeals; ◆ The requirements and timeframes for filing a grievance or appeal; ◆ The availability of assistance in the filing process; ◆ The toll-free numbers that the beneficiary can use to file a grievance or an appeal by phone; ◆ The fact that when requested by the beneficiary, benefits will continue if the beneficiary files an appeal or a request for State fair hearing within the timeframes specified and that the beneficiary may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the beneficiary; and ◆ Any appeal rights that the State chooses to make available to providers to challenge the failure to cover a service. <p style="text-align: right;">42 CFR 438.10(g)(1)(vi)(A) MDCH Contract 6.3.3</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p>d. The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled.</p> <p style="text-align: right;">42 CFR 438.10(f)(6)(v) MDCH Contract 6.3.3</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



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<p>e. Procedures for obtaining benefits, including authorization requirements.</p> <p align="right">42 CFR 438.10(f)(6)(vi) MDCH Contract 6.3.3</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p>f. The extent to which, and how, enrollees may obtain benefits from out-of-network providers.</p> <p align="right">42 CFR 438.10(f)(6)(vii) MDCH Contract 6.3.3</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p>g. The extent to which, and how, after-hours and emergency coverage is provided, including:</p> <ul style="list-style-type: none"> ◆ What constitutes emergency medical condition, emergency services, and post-stabilization services; ◆ The fact that prior authorization is not required for emergency services; ◆ The process and procedures for obtaining emergency services, including use of the 911 telephone system or its local equivalent; ◆ The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered under the contract; and ◆ The fact that, subject to these provisions, the enrollee has the right to use any hospital or other setting for emergency care. <p align="right">42 CFR 438.10(f)(6)(viii) MDCH Contract 6.3.3</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



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<p>h. Cost sharing, if any.</p> <p align="right">42 CFR 438.10(f)(6)(xi)</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p>i. How and where to access any benefits that are available under the State plan but are not covered under the contract, including any cost sharing and how transportation is provided.</p> <p align="right">42 CFR 438.10 (e)(2)(ii)(E)</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p>j. The PIHP provides adult enrollees with written information on advance directives policies, and include a description of applicable State law. The information reflects changes in State law as soon as possible, but not later than 90 days after the effective date of the change.</p> <p align="right">42 CFR 438.10(g)(2), 42 CFR 438.6(i) MDCH Contract 6.8.6</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p>k. The PIHP provides to the beneficiary annually (e.g., at the time of person-centered planning) the estimated cost to the PIHP of each covered support and service he or she is receiving.</p> <p align="right">MDCH Contract 6.3.3</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p>l. Additional information that is available upon request, including information on the structure and operation of the PIHP and physician incentive plans in use by the PIHP or network providers.</p> <p align="right">42 CFR 438.10(g)(3)(i) 42 CFR 438.6(h) MDCH Contract 6.3.3</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

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Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>4. Written Notice of Significant Change The PIHP gives each enrollee written notice of any significant change, as defined by the State, in any of the general information (3 a–l), including change in its provider network (e.g., addition of new providers and planned termination of existing providers).</p> <p style="text-align: right;">42 CFR 438.10(f)(4) MDCH Contract 6.3.3</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>5. Notice of Termination of Providers</p> <p style="text-align: right;">42 CFR 438.10(f)(5) MDCH Contract 6.3.3</p>		
<p>a. The PIHP makes a good faith effort to give <u>written notice</u> of termination of a contracted provider to each enrollee who received his or her primary care from, or was seen on a regular basis by, the terminated provider.</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p>b. The PIHP makes a good faith effort to give written notice of termination of a contracted provider <u>within 15 days</u> after receipt or issuance of the termination notice.</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

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Requirement	Evidence/Documentation as Submitted by the PIHP	Score
6. Right to Request and Obtain Information 42 CFR 438.10(f)(2)		
a. The PIHP (or State) notifies all enrollees of their right to, at least once a year request and obtain information about enrollee rights and protections.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
b. This information includes the information described in 3 a-1 on the previous pages.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings

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

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

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>9. Provider-Enrollee Communication The PIHP does not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a enrollee who is his or her patient, for the following:</p> <ul style="list-style-type: none"> ◆ The enrollee’s health status, medical care, or treatment options, including any alternative treatment that may be self-administered; ◆ Any information the enrollee needs in order to decide among all relevant treatment options; ◆ The risks, benefits, and consequences of treatment or nontreatment; and ◆ The enrollee’s right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. <p align="right">42 CFR 438.102(a)</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

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Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>10. Services Not Covered on Moral/Religious Basis A PIHP not electing to provide, reimburse for, or provide coverage of, a counseling or referral service based on objections to the service on moral or religious grounds must furnish information about the services it does not cover as follows:</p> <ul style="list-style-type: none"> ◆ To the State, with its application for a Medicaid contract, and whenever it adopts the policy during the term of the contract; ◆ To potential enrollees, before and during enrollment; and ◆ To enrollees, within 90 days after adopting the policy with respect to any particular service, with the overriding rule to furnish the information at least 30 days before the effective date of the policy. (The PIHP does not have to include how and where to obtain the services.) <p align="right">42 CFR 438.102(a)(2)(b)(1)</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings

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

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

Findings

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



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Standard IX—Subcontracts and Delegation

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
1. Predelegation Assessment Prior to entering into delegation subcontracts or agreements, the PIHP evaluates the proposed subcontractor’s ability to perform the activities to be delegated. <div align="right">438.230(b)</div>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
2. Written Agreements The PIHP has a written agreement with each delegated subcontractor. <div align="right">438.230(b)(2)</div>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

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Standard IX—Subcontracts and Delegation

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
3. Content of Agreement—Activities The written agreement specifies the activities delegated to the subcontractor. <div align="right">438.230(b)(2)(i) MDCH Contract 6.4.2</div>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
4. Content of Agreement—Reports The written agreement specifies the report responsibilities delegated to the subcontractor. <div align="right">438.230(b)(2)(i) MDCH Contract 6.4.2</div>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
5. Content of Agreement—Revocation/Sanctions The written agreement includes provisions for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate. <div align="right">438.230(b)(2)(ii)</div>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

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Standard IX—Subcontracts and Delegation

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>6. Monitoring of Delegates The PIHP annually monitors affiliates, as applicable, and provider networks who perform delegated functions to assure quality and performance with the standards in the Quality Assessment and Performance Improvement Technical Requirement (PIHP Contract Attachment P6.7.1.1).</p> <p align="right">438.230(b)(3) MDCH Contract 6.4(J)</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>7. Corrective Action If the PIHP identifies deficiencies or areas for improvement, the PIHP and the subcontractor take corrective action.</p> <p align="right">438.230(b)(4)</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>8. PIHP Oversight The PIHP must review and follow up on any provider network monitoring of its subcontractors.</p> <p align="right">MDCH Contract 6.4(J) MDCH Contract Attachment P6.7.1.1</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

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



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Standard X—Provider Network

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
1. Provider Written Agreements The PIHP maintains a network of providers supported by written agreements. <div style="text-align: right;">438.206(b)(1)</div>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
2. Sufficiency of Agreements Written agreements provide adequate access to all services covered under the contract. <div style="text-align: right;">438.206(b)(1)</div>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
3. Content of Agreements Written agreements ensure that beneficiaries are not held liable when the PIHP does not pay the health care provider furnishing services under the contract. <div style="text-align: right;">438.106(b)(2)</div>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

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Standard X—Provider Network

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>4. Content of Agreements Written agreements ensure that beneficiaries are not held liable for payment of covered services furnished under the contract if those payments are in excess of the amount that the beneficiary would owe if the PIHP provided the service directly.</p> <p style="text-align: right;">438.106(c)</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>5. Delivery Network In establishing and maintaining the network, the PIHP considers: anticipated Medicaid enrollment, expected utilization, numbers and types of providers required, number of network providers who are not accepting new beneficiaries, geographic location of providers and beneficiaries, distance, travel time, and transportation availability, including physical access for beneficiaries with disabilities.</p> <p style="text-align: right;">438.206(b)(1)(i-v)</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings



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

Standard X—Provider Network

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>6. Geographic Access for Mental Health and Substance Abuse Services The PIHP ensures geographic access to covered, alternative, and allowable supports and services in accordance with the following standards: For office or site-based services, the PIHP's primary service providers (e.g., case managers, psychiatrists, primary therapists) must be:</p> <ul style="list-style-type: none"> ◆ Within 30 miles or 30 minutes of the recipient's residence in urban areas. ◆ Within 60 miles or 60 minutes in rural areas. <p style="text-align: right; margin-top: 10px;">MDCH Contract 3.1</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>7. Excluded Providers The PIHP does not employ or contract with providers excluded from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act.</p> <p style="text-align: right; margin-top: 10px;">438.214(d)</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings



Appendix B: Documentation Request and Evaluation Tool
Michigan Department of Community Health (MDCH)
Prepaid Inpatient Health Plans (PIHPs)
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Standard X—Provider Network		
Requirement	Evidence/Documentation as Submitted by the PIHP	Score
8. Reason For Decision To Decline If the PIHP declines to include individual providers or groups of providers in its network, it gives the affected providers written notice of the reason for its decision. <div style="text-align: right;">438.12 MDCH Contract 6.4.1</div>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
Findings		
Requirement	Evidence/Documentation as Submitted by the PIHP	Score
9. Network Changes The PIHP notifies MDCH within seven days of any significant changes to the provider network composition that affect adequate capacity and services. <div style="text-align: right;">438.207(c)(2) MDCH Contract 6.4(F)</div>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
Findings		
Requirement	Evidence/Documentation as Submitted by the PIHP	Score
10. Out-Of-Network Services If a necessary service covered under the contract is unavailable within the network, the PIHP adequately and timely covers the service out of network for as long as the PIHP is unable to provide it. <div style="text-align: right;">438.206(b)(4) MDCH Contract 3.4.7</div>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
Findings		



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Michigan Department of Community Health (MDCH)
Prepaid Inpatient Health Plans (PIHPs)
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Standard X—Provider Network

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
11. Requirements Related to Payment The PIHP requires out-of-network providers to coordinate with the PIHP regarding payment and ensures that any cost to the beneficiary is no greater than it would be if the services were furnished within the network. <div style="text-align: right;">438.206(b)(5)</div>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
12. Second Opinion The PIHP provides for a second opinion from a qualified health care professional within the network or arranges for the beneficiary to obtain one outside the network at no cost to the beneficiary. <div style="text-align: right;">438.206(b)(3) MDCH Contract 3.4.6</div>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings

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



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

Standard XI—Credentialing

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>1. Credentialing The PIHP follows a documented process consistent with State policy for credentialing and recredentialing of providers who are employed by or have signed contracts or participation agreements with the PIHP.</p> <p align="right">438.214(b)(2) MDCH Contract 6.4.3</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>2. Health Care Professionals The PIHP's processes for credentialing and recredentialing are conducted and documented for at least the following health care professionals:</p> <ul style="list-style-type: none"> ◆ Physicians (MDs or DOs) ◆ Physician assistants ◆ Psychologists (licensed, limited license, or temporary license) ◆ Social workers (licensed master's, licensed bachelor's, limited license, or registered social service technicians) ◆ Licensed professional counselors ◆ Nurse practitioners, registered nurses, or licensed practical nurses ◆ Occupational therapists or occupational therapist assistants ◆ Physical therapists or physical therapist assistants ◆ Speech pathologists <p align="right">MDCH Contract Attachment P6.4.3.1</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings



Appendix B: Documentation Request and Evaluation Tool
Michigan Department of Community Health (MDCH)
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Standard XI—Credentialing

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
3. Written Policy—Criteria, Scope, Timeline, and Process The credentialing policy reflects the scope, criteria, timeliness, and process for credentialing and recredentialing providers. <div style="text-align: right;">MDCH Contract Attachment P6.4.3.1</div>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
4. Provider Discrimination The PIHP has processes to ensure: <ul style="list-style-type: none"> ◆ That the credentialing and recredentialing processes do not discriminate against: <ul style="list-style-type: none"> ▪ A health care professional solely on the basis of license, registration, or certification. ▪ A health care professional who serves high-risk populations or who specializes in the treatment of conditions that require costly treatment. ◆ Compliance with Federal Requirements that prohibit employment or contracts with providers excluded from participation under either Medicare or Medicaid. <div style="text-align: right;"> 438.12 and 438.214(c) MDCH Contract 6.4.1 MDCH Contract Attachment P6.4.3.1 </div>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings



Appendix B: Documentation Request and Evaluation Tool
Michigan Department of Community Health (MDCH)
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Standard XI—Credentialing		
Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>5. Written Policy—Authorities The PIHP’s credentialing policy was approved by the PIHP’s governing body and identifies the PIHP administrative staff member responsible for oversight of the process.</p> <p style="text-align: right; margin-top: 10px;">MDCH Contract Attachment P6.4.3.1</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
Findings		
Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>6. Written Policy—Responsibility The PIHP’s policy identifies the administrative staff member and entity (e.g., credentialing committee) responsible for oversight and implementation of the process and delineates their role.</p> <p style="text-align: right; margin-top: 10px;">MDCH Contract Attachment P6.4.3.1</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
Findings		
Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>7. Written Policy—Documentation The policy describes the methodology to document that each credentialing or recredentialing file was complete and reviewed prior to presentation to the credentialing committee for evaluation.</p> <p style="text-align: right; margin-top: 10px;">MDCH Contract Attachment P6.4.3.1</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
Findings		



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Standard XI—Credentialing		
Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>8. Written Policy—Integration With QAPIP The credentialing policy describes how findings of the PIHP’s Quality Assessment and Performance Improvement Program (QAPIP) are incorporated into the recredentialing process.</p> <p align="right">MDCH Contract Attachment P6.4.3.1</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
Findings		
Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>9. Written Policy—Provider Role The policy describes any use of participating providers in making credentialing decisions.</p> <p align="right">MDCH Contract Attachment P6.4.3.1</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
Findings		
Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>10. Credentialing Files The PIHP’s processes require that an individual file be maintained for each credentialed provider and that each file include:</p> <ul style="list-style-type: none"> ◆ The initial credentialing and all subsequent recredentialing applications. ◆ Information gained through primary source verification. ◆ Any other pertinent information used in determining whether or not the provider met the PIHP’s credentialing standards. <p align="right">MDCH Contract Attachment P6.4.3.1</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



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Standard XI—Credentialing

Findings

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Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>11. Initial Credentialing—Application</p> <p>The PIHP’s policy and procedures require that the written application is completed, signed, and dated by the applicant and attests to the following elements:</p> <ul style="list-style-type: none"> ◆ Lack of present illegal drug use ◆ Any history of loss of license and/or felony convictions ◆ Any history of loss or limitation of privileges or disciplinary action ◆ Attestation by the applicant of the correctness and completeness of the application <p align="right">MDCH Contract Attachment P6.4.3.1</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings

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Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>12. Initial Credentialing—Requirements</p> <p>The PIHP’s policy and procedures require that the initial credentialing of an applicant include:</p> <ul style="list-style-type: none"> ◆ An evaluation of the applicant’s work history for the past five years. ◆ Primary source verification of licensure or certification. ◆ Primary source verification of board certification or highest level of credentials attained, if applicable, or completion of any required internships/residency programs or other postgraduate training. ◆ Documentation of graduation from an accredited school. ◆ A National Practitioner Data Bank (NPDB) query, or, in lieu of an NPDB query, verification of all of the following: <ul style="list-style-type: none"> ▪ A minimum five-year history of professional liability claims 		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



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Standard XI—Credentialing

<p>resulting in a judgment or settlement</p> <ul style="list-style-type: none"> ▪ Disciplinary status with a regulatory board or agency ▪ A Medicare/Medicaid sanctions query <p>If the individual practitioner undergoing credentialing is a physician, then the physician profile information obtained from the American Medical Association may be used to satisfy the primary source verification of the first three items above.</p> <p style="text-align: right;">MDCH Contract Attachment P6.4.3.1</p>		
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Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>13. Temporary/Provisional Credentialing of Individual Practitioners</p> <p style="text-align: right;">MDCH Contract Attachment P6.4.3.1</p>		
<p>a. Policies and Limitations</p> <p>The PIHP has a policy and procedures to address granting of temporary or provisional credentials and the policy and procedures require that the temporary or provisional credentials are not granted for more than 150 days.</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p>b. Application</p> <p>The PIHP’s policy and procedures require that, at a minimum, a provider must complete a signed application that includes the following items:</p> <ul style="list-style-type: none"> ◆ Lack of present illegal drug use ◆ History of loss of license, registration, or certification and/or felony convictions ◆ History of loss or limitation of privileges or disciplinary action ◆ A summary of the provider's work history for the prior five years 		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



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<ul style="list-style-type: none"> ◆ Attestation by the applicant of the correctness and completeness of the application 		
<p>c. Review and Primary Source Verification The PIHP’s designee reviews the information obtained and determines whether to grant provisional credentials. If approved, the PIHP conducts primary source verification of the following:</p> <ul style="list-style-type: none"> ◆ Licensure or certification ◆ Board certification, if applicable, or the highest level of credential attained ◆ Medicare/Medicaid sanctions 		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p>d. Timeliness of the PIHP Decision The PIHP’s policy and procedures require that the PIHP has up to 31 days from the receipt of a complete application and the minimum required documents within which to render a decision regarding temporary or provisional credentialing.</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>14. Recredentialing—Timelines The PIHP’s policy requires recredentialing of physicians and other licensed, registered, or certified health care providers at least every two years.</p> <p align="right">MDCH Contract Attachment P6.4.3.1</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings



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Standard XI—Credentialing

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

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>16. Delegation of PIHP Responsibilities for Credentialing/ Recredentialing If responsibilities for credentialing/recredentialing are delegated by the PIHP, the PIHP:</p> <ul style="list-style-type: none"> ◆ Retains the right to approve, suspend, or terminate providers selected by the entity. ◆ Must meet all requirements associated with the delegation. ◆ Specifies in the delegation agreement/subcontract the functions that are delegated and those that are retained. <p>Is responsible for oversight of delegated credentialing or recredentialing decisions.</p> <p align="right">MDCH Contract Attachment P6.4.3.1</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



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

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>17. Credentialing Organizational Providers The PIHP must validate, and revalidate at least every two years, that an organizational provider is licensed as necessary to operate within the State and has not been excluded from Medicaid or Medicare.</p> <p align="right">MDCH Contract Attachment P6.4.3.1</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>18. Organizational Providers—Credentialing for Individuals Employed by, or Contracted with, an Organizational Provider The PIHP must ensure that the contract between the PIHP and any organizational provider requires the organizational provider to credential and recredential their directly employed and subcontracted direct service providers in accordance with the PIHP’s credentialing/recredentialing policies and procedures (which must conform to MDCH’s credentialing process).</p> <p align="right">MDCH Contract Attachment P6.4.3.1</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings



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Standard XI—Credentialing

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>19. Deeming If the PIHP accepts the credentialing decision of another PIHP for an individual or organizational provider, it maintains copies of the current credentialing PIHP's decision in its administrative records.</p> <p style="text-align: right;">MDCH Contract Attachment P6.4.3.1</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>20. Notification of Adverse Credentialing Decision The PIHP's policy and procedures address the requirement for the PIHP to inform an individual or organizational provider in writing of the reasons for the PIHP's adverse credentialing decisions.</p> <p style="text-align: right;">MDCH Contract Attachment P6.4.3.1</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>21. Provider Appeals The PIHP's policy and procedures address the PIHP's appeal process (consistent with State and federal regulations) that is available to providers for instances when the PIHP denies, suspends, or terminates a provider for any reason other than lack of need.</p> <p style="text-align: right;">MDCH Contract Attachment P6.4.3.1</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings



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Michigan Department of Community Health (MDCH)
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Standard XI—Credentialing		
Requirement	Evidence/Documentation as Submitted by the PIHP	Score
22. Reporting Requirements The PIHP has procedures for reporting, to appropriate authorities (i.e., MDCH, the provider’s regulatory board or agency, the Attorney General, etc.), improper known organizational provider or individual practitioner conduct which results in suspension or termination from the PIHP’s provider network. The procedures are consistent with current federal and State requirements, including those specified in the MDCH Medicaid Managed Specialty Supports and Services Contract. MDCH Contract Attachment P6.4.3.1		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
Findings		

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



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Michigan Department of Community Health (MDCH)
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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
<p>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.</p> <p style="text-align: right;">MDCH 3.1 P6.5.1.1</p>		
<p>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.</p>		
<p>a. Children</p>		<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met
<p>b. Adult</p>		<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met

Findings



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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		<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met
b. Adult		<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met
c. Developmentally Disabled—Children		<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met
d. Developmentally Disabled—Adult		<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met
e. Substance Abuse		<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met

Findings



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Michigan Department of Community Health (MDCH)
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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		<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met
b. Mentally Ill—Adult		<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met
c. Developmentally Disabled—Children		<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met
d. Developmentally Disabled—Adult		<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met
e. Substance Abuse		<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met

Findings



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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		<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met
b. Adults		<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> 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.		<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met

Findings



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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. <div style="text-align: right;">438.206(c)</div>		<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> 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		=		



Appendix B: Documentation Request and Evaluation Tool
Michigan Department of Community Health (MDCH)
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Standard XIII—Coordination of Care

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
1. Coordination Procedures/Primary Care Providers The PIHP has procedures to ensure that coordination occurs between primary care physicians and the PIHP and/or its network. MDCH Contract 6.4.4 and 6.8.3		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
2. Coordination With Other MCOs and PIHPs PIHP procedures ensure that the services the PIHP furnishes to the beneficiary are coordinated with the services the beneficiary receives from other MCOs and PIHPs. 438.208(b)(2)		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
3. Results of Assessments Shared With MCOs and PIHPs PIHP procedures ensure that results of beneficiary assessments performed by the PIHP are shared with other MCOs and PIHPs serving the beneficiary in order to prevent duplication of services. 438.208(b)(3)		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings



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

Standard XIII—Coordination of Care

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

Findings

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



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

Standard XIV—Appeals

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
1. Appeals The PIHP has internal appeals procedures that address: <div style="text-align: right;">438.402 MDCH 6.4(B) Attachment P6.3.2.1</div>		
a. The beneficiary’s right to a State fair hearing.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
b. The method for a beneficiary to obtain a hearing.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
c. The beneficiary’s right to file appeals.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
d. The requirements and time frames for filing appeals.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings



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

Standard XIV—Appeals

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

Findings



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

Standard XIV—Appeals

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>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.</p> <p style="text-align: right;">438.410(a) Attachment P6.3.2.1</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>4. 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.</p> <p style="text-align: right;">438.406(a)(3)(i) Attachment P6.3.2.1</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings



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

Standard XIV—Appeals

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>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:</p> <ul style="list-style-type: none"> ◆ An appeal of a denial that is based on lack of medical necessity ◆ An appeal that involves clinical issues <p align="right">438.406(a)(3)(ii) Attachment P6.3.2.1</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>6. 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.</p> <p align="right">438.406(b)(3)(ii)</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings



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

Standard XIV—Appeals

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>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.</p> <p style="text-align: right;">438.408(b) Attachment P6.3.2.1</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>8. Notice of Disposition The notice of disposition includes an explanation of the results of the resolution and the date it was completed.</p> <p style="text-align: right;">438.408(e) Attachment P6.3.2.1</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings



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

Standard XIV—Appeals

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>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:</p> <ul style="list-style-type: none"> ◆ 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. <p style="text-align: right;">438.408(e)(2) Attachment P6.3.2.1</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>10. Denial of a Request for Expedited Resolution of an Appeal If a request for expedited resolution of an appeal is denied, the PIHP:</p> <ul style="list-style-type: none"> ◆ 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. <p style="text-align: right;">438.410(c) Attachment P6.3.2.1</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings



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

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 Tools

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. For the 2013–2014 validation cycle, HSAG prepared two version of these tools: one version (Appendices C1 and C2) for the continuing PIHPs (Regions 1, 6, 7, 8, and 9) and another version (Appendices C3 and C4) for the new PIHPs (Regions 2, 3, 4, 5, and 10).

**Appendix C1: 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 2012	_____	June 2013	_____
November 2012	_____	July 2013	_____
December 2012	_____	August 2013	_____
January 2013	_____	September 2013	_____
February 2013	_____	October 2013	_____
March 2013	_____	November 2013	_____
April 2013	_____	December 2013	_____
May 2013	_____		

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

III. DATA ACQUISITION CAPABILITIES

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

Please fill in the following table with the appropriate percentages:

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

Comments: _____

III. DATA ACQUISITION CAPABILITIES

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

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

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

III. DATA ACQUISITION CAPABILITIES

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

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

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

CLAIM—Institutional Data		ENCOUNTER—Institutional Data	
Diagnoses: ____	Procedures: ____	Diagnoses: ____	Procedures: ____
CLAIM—Professional Data		ENCOUNTER—Professional Data	
Diagnoses: ____	Procedures: ____	Diagnoses: ____	Procedures: ____

5. Principal and Secondary Diagnoses

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

- Yes
- No

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

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

Institutional Data: _____

Professional Data: _____

III. DATA ACQUISITION CAPABILITIES

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

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

9. Medicaid Claims/Encounters

9a. How are Medicaid claims/encounters received?

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

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

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

III. DATA ACQUISITION CAPABILITIES

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

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

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

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

III. DATA ACQUISITION CAPABILITIES

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

New system purchased and installed to replace old system.

Description/implementation dates _____

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

Description/implementation dates _____

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

Description/implementation dates _____

New product line adjudicated (processed) on old system.

Description/implementation dates _____

Conversion of a product line from one system to another.

Description/implementation dates _____

Comments: _____

III. DATA ACQUISITION CAPABILITIES

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

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

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

If batch, how often is it run? _____

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

How is completeness estimated? How is completeness defined?

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

Are Medicaid encounters audited regularly? Randomly?

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

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 pending 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. (1 st Quarter SFY 2014)	_____
#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. (1 st Quarter SFY 2014)	_____
#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. (1 st Quarter SFY 2014)	_____
#4a	The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days. (1 st Quarter SFY 2014)	_____
#4b	The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days. (1 st Quarter SFY 2014)	_____
#5	The percent of Medicaid recipients having received PIHP managed services. (1 st Quarter SFY 2014)	_____
#6	The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination. (1 st Quarter SFY 2014)	_____
#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 2013)	_____
#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 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. (1 st Quarter SFY 2014)	_____
#13	The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s). (SFY 2013)	_____
#14	The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s). (SFY 2013)	_____

III. DATA ACQUISITION CAPABILITIES

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

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

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

5. Do you evaluate the quality of this information?

If so, how?

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

III. DATA ACQUISITION CAPABILITIES

D. Integration and Control of Data for Performance Measure Reporting

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

File Consolidation

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

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

- By querying the processing systems online (claims/encounter, eligibility, etc.)?

Yes

No

- By using extract files created for analytical purposes (i.e., extracting or “freezing” the necessary data into a separate database for analysis)?

Yes

No

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

- By using a separate relational database or data warehouse (i.e., a performance measure repository)?

Yes

No

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

III. DATA ACQUISITION CAPABILITIES

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

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

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

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

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

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

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

III. DATA ACQUISITION CAPABILITIES

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

Yes

No

If yes, please describe: _____

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

Yes

No

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

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

Yes

No

III. DATA ACQUISITION CAPABILITIES

Subcontractor Data Integration

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

Type of Delegated Service	Always Receive Member-Level Data From This Subcontractor? (Yes or No)	Integrate Subcontractor Data With PIHP Administrative Data? (Yes or No)	Completeness of Data (A, B, or C)	Quality of Data (A, B, or C)	Rationale for Rating/ Concerns With Data Collection
<i>EXAMPLE: CMHSP #1—All mental health services for blank population</i>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> A <input checked="" type="checkbox"/> B <input type="checkbox"/> C	<input checked="" type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<i>Volumes of encounters not consistent from month to month.</i>
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	_____

III. DATA ACQUISITION CAPABILITIES

Performance Measure Repository Structure

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

If your 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 repository.

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

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

Yes No

If so, please answer the following questions.

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

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

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

IV. Outsourced or Delegated Functions

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

Vendor Oversight

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

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

Yes No

If so, please answer the following questions.

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

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

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

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 C2: 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 ISCAT, 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.

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? _____

II. INFORMATION SYSTEMS: DATA PROCESSING PROCEDURES AND PERSONNEL

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?

10c. Describe the controls used to assure all Medicaid claims data entered into the system are fully accounted for (e.g., batch control sheets). This question is asking how you ensure that for each service that is provided, an encounter is generated within your system.

10d. Describe the provisions in place for physical security of the computer system and manual files:

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

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

- Consumers
- Providers

10f. Describe their access and the security that is maintained restricting or controlling such access.

III. DATA ACQUISITION CAPABILITIES

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

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

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

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

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

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

DATA SOURCE	No	Yes	Please specify the type of form used
Direct CMH Programs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sub-Panel/Contract Agency	<input type="checkbox"/>	<input type="checkbox"/>	_____
Off-Panel/COFR Providers	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hospitals	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other:	<input type="checkbox"/>	<input type="checkbox"/>	_____

III. DATA ACQUISITION CAPABILITIES

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

Please fill in the following table with the appropriate percentages:

MEDIUM	Direct CMH Programs	Sub-Panel/ Contract Agency	Off-Panel/COFR Providers	Hospital	Other
Claims/Encounters Submitted Electronically	___%	___%	___%	___%	___%
Claims/Encounters Submitted on Paper	___%	___%	___	___%	___%
Services Not Submitted as Claims or Encounters	___%	___%	___%	___%	___%
TOTAL	100%	100%	100%	100%	100%

Comments: _____

III. DATA ACQUISITION CAPABILITIES

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

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

DATA ELEMENTS	Direct CMH Programs	Sub-Panel/ Contract Agency	Off-Panel/COFR Providers	Hospital	Other
Consumer DOB/Age	_____	_____	_____	_____	_____
Diagnosis	_____	_____	_____	_____	_____
Procedure	_____	_____	_____	_____	_____
First Date of Service	_____	_____	_____	_____	_____
Last Date of Service	_____	_____	_____	_____	_____
# of Units	_____	_____	_____	_____	_____
Revenue Code	_____	_____	_____	_____	_____
Provider ID	_____	_____	_____	_____	_____
Place of Service	_____	_____	_____	_____	_____

III. DATA ACQUISITION CAPABILITIES

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

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

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

CLAIM—Institutional Data		ENCOUNTER—Institutional Data	
Diagnoses: ____	Procedures: ____	Diagnoses: ____	Procedures: ____
CLAIM—Professional Data		ENCOUNTER—Professional Data	
Diagnoses: ____	Procedures: ____	Diagnoses: ____	Procedures: ____

5. Principal and Secondary Diagnoses

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

Yes

No

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

6. Please explain what happens if a Medicaid claims/encounter is submitted and one or more required fields are missing, incomplete, or invalid. For example, if diagnosis is not coded, is the claims examiner required by the system to use an online software product like AutoCoder to determine the correct ICD-9 code?

Institutional Data: _____

Professional Data: _____

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	<input type="checkbox"/>	<input type="checkbox"/>
Sub-Panel/Contract Agency	<input type="checkbox"/>	<input type="checkbox"/>
Off-Panel/COFR Providers	<input type="checkbox"/>	<input type="checkbox"/>
Hospital:	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>

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

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

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

III. DATA ACQUISITION CAPABILITIES

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.
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?

III. DATA ACQUISITION CAPABILITIES

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.

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			

III. DATA ACQUISITION CAPABILITIES

21. Describe the Medicaid claims/encounter suspend (“pend”) process, including timeliness of reconciling pending services.

For example, indicate how the pend happens, how it is communicated to providers, and how long something can be pending before it is rejected.

22. Describe how Medicaid claims are suspended/pending for review, for non-approval due to missing authorization code(s), or for other reasons.

What triggers a processor to follow up on “pending” 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?

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.

III. DATA ACQUISITION CAPABILITIES

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.

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? _____

III. DATA ACQUISITION CAPABILITIES

- 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.

- 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.

III. DATA ACQUISITION CAPABILITIES

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:

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:

III. DATA ACQUISITION CAPABILITIES

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. (1 st Quarter SFY 2014)	_____
#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. (1 st Quarter SFY 2014)	_____
#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. (1 st Quarter SFY 2014)	_____
#4a	The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days. (1 st Quarter SFY 2014)	_____
#4b	The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days. (1 st Quarter SFY 2014)	_____
#5	The percent of Medicaid recipients having received PIHP managed services. (1 st Quarter SFY 2014)	_____
#6	The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination. (1 st Quarter SFY 2014)	_____
#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 2013)	_____
#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 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. (1 st Quarter SFY 2014)	_____
#13	The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s). (SFY 2013)	_____
#14	The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s). (SFY 2013)	_____

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
<i>EXAMPLE: Large provider group #1</i>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> A <input checked="" type="checkbox"/> B <input type="checkbox"/> C	<input checked="" type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<i>Volumes of encounters not consistent from month to month.</i>
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	

III. DATA ACQUISITION CAPABILITIES

Performance Measure Repository Structure

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

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

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

- Yes
 No

Report Production

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

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

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

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

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

III. DATA ACQUISITION CAPABILITIES

E. Provider Data

Compensation Structure

The purpose of this section is to evaluate the Medicaid provider compensation structure, as this may influence the quality and completeness of data. Please identify the percentage of physicians, other licensed professionals, and non-licensed services staff who are compensated by each payment mechanism listed in the first column. Each column should total 100%.

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

III. DATA ACQUISITION CAPABILITIES

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

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

Summary of Requested Documentation

The documentation requested in the previous questions is summarized in the table below. Please label all attached documentation as described in the table, and by the item number in the far right column. Remember—you are not limited to providing only the documentation listed below; you are encouraged to provide any additional documentation that helps clarify an answer or eliminates the need for a lengthy response.

Requested Document	Details	Label Number
Previous Medicaid Performance Measure Reports	Please attach final documentation from any previous Medicaid performance measure reporting calculated by your organization for the last 4 quarters.	1
Organizational Chart	Please attach an organizational chart for your organization. The chart should make clear the relationship among key individuals/departments responsible for information management, including performance measure reporting.	2
Data Integration Flow Chart	Please provide a flowchart that gives an overview of the structure of your management IS. Be sure to show how all claims, encounter, membership, provider, vendor, and other data are integrated for performance measure reporting.	3
Performance Measure Repository File Structure (if applicable)	Provide a complete file structure, file format, and field definitions for the performance measure repository.	4
Program/Query Language for Performance Measure Repository Reporting (if applicable)	Provide full documentation on the software programs or codes used to convert performance measure repository data to performance measures.	5
Medicaid Claims Edits	List of specific edits performed on claims/encounters as they are adjudicated with notation of performance timing (pre- or post-payment) and whether they are manual or automated functions.	6
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 C3: 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:

January 2014	_____
February 2014	_____
March 2014	_____

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

III. DATA ACQUISITION CAPABILITIES

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

Please fill in the following table with the appropriate percentages:

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

Comments: _____

III. DATA ACQUISITION CAPABILITIES

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

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

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

III. DATA ACQUISITION CAPABILITIES

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

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

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

CLAIM—Institutional Data		ENCOUNTER—Institutional Data	
Diagnoses: ____	Procedures: ____	Diagnoses: ____	Procedures: ____
CLAIM—Professional Data		ENCOUNTER—Professional Data	
Diagnoses: ____	Procedures: ____	Diagnoses: ____	Procedures: ____

5. Principal and Secondary Diagnoses

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

- Yes
- No

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

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

Institutional Data: _____

Professional Data: _____

III. DATA ACQUISITION CAPABILITIES

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

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

9. Medicaid Claims/Encounters

9a. How are Medicaid claims/encounters received?

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

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

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

III. DATA ACQUISITION CAPABILITIES

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

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

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

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

III. DATA ACQUISITION CAPABILITIES

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

New system purchased and installed to replace old system.

Description/implementation dates _____

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

Description/implementation dates _____

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

Description/implementation dates _____

New product line adjudicated (processed) on old system.

Description/implementation dates _____

Conversion of a product line from one system to another.

Description/implementation dates _____

Comments: _____

III. DATA ACQUISITION CAPABILITIES

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

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

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

If batch, how often is it run? _____

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

How is completeness estimated? How is completeness defined?

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

Are Medicaid encounters audited regularly? Randomly?

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

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 pending 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.	_____
#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.	_____
#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.	_____
#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 percent of Medicaid recipients having received PIHP managed services.	_____
#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.	_____
#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.	_____
#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.	_____
#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.	_____
#13	The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	_____
#14	The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	_____

III. DATA ACQUISITION CAPABILITIES

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

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

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

5. Do you evaluate the quality of this information?

If so, how?

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

III. DATA ACQUISITION CAPABILITIES

D. Integration and Control of Data for Performance Measure Reporting

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

File Consolidation

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

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

- By querying the processing systems online (claims/encounter, eligibility, etc.)?

Yes

No

- By using extract files created for analytical purposes (i.e., extracting or “freezing” the necessary data into a separate database for analysis)?

Yes

No

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

- By using a separate relational database or data warehouse (i.e., a performance measure repository)?

Yes

No

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

III. DATA ACQUISITION CAPABILITIES

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

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

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

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

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

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

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

III. DATA ACQUISITION CAPABILITIES

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

Yes

No

If yes, please describe: _____

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

Yes

No

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

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

Yes

No

III. DATA ACQUISITION CAPABILITIES

Subcontractor Data Integration

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

Type of Delegated Service	Always Receive Member-Level Data From This Subcontractor? (Yes or No)	Integrate Subcontractor Data With PIHP Administrative Data? (Yes or No)	Completeness of Data (A, B, or C)	Quality of Data (A, B, or C)	Rationale for Rating/ Concerns With Data Collection
<i>EXAMPLE: CMHSP #1—All mental health services for blank population</i>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> A <input checked="" type="checkbox"/> B <input type="checkbox"/> C	<input checked="" type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<i>Volumes of encounters not consistent from month to month.</i>
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	_____

III. DATA ACQUISITION CAPABILITIES

Performance Measure Repository Structure

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

If your 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 repository.

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

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

Yes No

If so, please answer the following questions.

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

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

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

IV. Outsourced or Delegated Functions

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

Vendor Oversight

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

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

Yes No

If so, please answer the following questions.

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

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

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

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 C4: 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 ISCAT, 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.

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? _____

II. INFORMATION SYSTEMS: DATA PROCESSING PROCEDURES AND PERSONNEL

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?

10c. Describe the controls used to assure all Medicaid claims data entered into the system are fully accounted for (e.g., batch control sheets). This question is asking how you ensure that for each service that is provided, an encounter is generated within your system.

10d. Describe the provisions in place for physical security of the computer system and manual files:

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

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

Consumers

Providers

10f. Describe their access and the security that is maintained restricting or controlling such access.

III. DATA ACQUISITION CAPABILITIES

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

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

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

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

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

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

DATA SOURCE	No	Yes	Please specify the type of form used
Direct CMH Programs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sub-Panel/Contract Agency	<input type="checkbox"/>	<input type="checkbox"/>	_____
Off-Panel/COFR Providers	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hospitals	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other:	<input type="checkbox"/>	<input type="checkbox"/>	_____

III. DATA ACQUISITION CAPABILITIES

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

Please fill in the following table with the appropriate percentages:

MEDIUM	Direct CMH Programs	Sub-Panel/ Contract Agency	Off-Panel/COFR Providers	Hospital	Other
Claims/Encounters Submitted Electronically	___%	___%	___%	___%	___%
Claims/Encounters Submitted on Paper	___%	___%	___	___%	___%
Services Not Submitted as Claims or Encounters	___%	___%	___%	___%	___%
TOTAL	100%	100%	100%	100%	100%

Comments: _____

III. DATA ACQUISITION CAPABILITIES

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

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

DATA ELEMENTS	Direct CMH Programs	Sub-Panel/ Contract Agency	Off-Panel/COFR Providers	Hospital	Other
Consumer DOB/Age	_____	_____	_____	_____	_____
Diagnosis	_____	_____	_____	_____	_____
Procedure	_____	_____	_____	_____	_____
First Date of Service	_____	_____	_____	_____	_____
Last Date of Service	_____	_____	_____	_____	_____
# of Units	_____	_____	_____	_____	_____
Revenue Code	_____	_____	_____	_____	_____
Provider ID	_____	_____	_____	_____	_____
Place of Service	_____	_____	_____	_____	_____

III. DATA ACQUISITION CAPABILITIES

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

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

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

CLAIM—Institutional Data		ENCOUNTER—Institutional Data	
Diagnoses: ____	Procedures: ____	Diagnoses: ____	Procedures: ____
CLAIM—Professional Data		ENCOUNTER—Professional Data	
Diagnoses: ____	Procedures: ____	Diagnoses: ____	Procedures: ____

5. Principal and Secondary Diagnoses

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

Yes

No

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

6. Please explain what happens if a Medicaid claims/encounter is submitted and one or more required fields are missing, incomplete, or invalid. For example, if diagnosis is not coded, is the claims examiner required by the system to use an online software product like AutoCoder to determine the correct ICD-9 code?

Institutional Data: _____

Professional Data: _____

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	<input type="checkbox"/>	<input type="checkbox"/>
Sub-Panel/Contract Agency	<input type="checkbox"/>	<input type="checkbox"/>
Off-Panel/COFR Providers	<input type="checkbox"/>	<input type="checkbox"/>
Hospital:	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>

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

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

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

III. DATA ACQUISITION CAPABILITIES

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.
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?

III. DATA ACQUISITION CAPABILITIES

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.

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			

III. DATA ACQUISITION CAPABILITIES

21. Describe the Medicaid claims/encounter suspend (“pend”) process, including timeliness of reconciling pending services.

For example, indicate how the pend happens, how it is communicated to providers, and how long something can be pending before it is rejected.

22. Describe how Medicaid claims are suspended/pending for review, for non-approval due to missing authorization code(s), or for other reasons.

What triggers a processor to follow up on “pending” 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?

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.

III. DATA ACQUISITION CAPABILITIES

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.

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? _____

III. DATA ACQUISITION CAPABILITIES

- 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.

- 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.

III. DATA ACQUISITION CAPABILITIES

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:

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:

III. DATA ACQUISITION CAPABILITIES

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.	_____
#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.	_____
#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.	_____
#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 percent of Medicaid recipients having received PIHP managed services.	_____
#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.	_____
#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.	_____
#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 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.	_____
#13	The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	_____
#14	The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	_____

III. DATA ACQUISITION CAPABILITIES

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

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

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

5. Do you evaluate the quality of this information?

If so, how?

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

III. DATA ACQUISITION CAPABILITIES

D. Integration and Control of Data for Performance Measure Reporting

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

File Consolidation

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

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

- By querying the processing systems online (claims/encounter, eligibility, etc.)?
 Yes No
- By using extract files created for analytical purposes (i.e., extracting or “freezing” the necessary data into a separate database for analysis)?
 Yes No

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

By using a separate relational database or data warehouse (i.e., a performance measure repository)?

Yes No

If so, is this the same system from which all other reporting is produced? 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
<i>EXAMPLE: Large provider group #1</i>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> A <input checked="" type="checkbox"/> B <input type="checkbox"/> C	<input checked="" type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<i>Volumes of encounters not consistent from month to month.</i>
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	

III. DATA ACQUISITION CAPABILITIES

Performance Measure Repository Structure

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

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

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

- Yes
- No

Report Production

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

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

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

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

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

III. DATA ACQUISITION CAPABILITIES

E. Provider Data

Compensation Structure

The purpose of this section is to evaluate the Medicaid provider compensation structure, as this may influence the quality and completeness of data. Please identify the percentage of physicians, other licensed professionals, and non-licensed services staff who are compensated by each payment mechanism listed in the first column. Each column should total 100%.

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

III. DATA ACQUISITION CAPABILITIES

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

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

Summary of Requested Documentation

The documentation requested in the previous questions is summarized in the table below. Please label all attached documentation as described in the table, and by the item number in the far right column. Remember—you are not limited to providing only the documentation listed below; you are encouraged to provide any additional documentation that helps clarify an answer or eliminates the need for a lengthy response.

Requested Document	Details	Label Number
Previous Medicaid Performance Measure Reports	Please attach final documentation from any previous Medicaid performance measure reporting calculated by your organization for the last 4 quarters.	1
Organizational Chart	Please attach an organizational chart for your organization. The chart should make clear the relationship among key individuals/departments responsible for information management, including performance measure reporting.	2
Data Integration Flow Chart	Please provide a flowchart that gives an overview of the structure of your management IS. Be sure to show how all claims, encounter, membership, provider, vendor, and other data are integrated for performance measure reporting.	3
Performance Measure Repository File Structure (if applicable)	Provide a complete file structure, file format, and field definitions for the performance measure repository.	4
Program/Query Language for Performance Measure Repository Reporting (if applicable)	Provide full documentation on the software programs or codes used to convert performance measure repository data to performance measures.	5
Medicaid Claims Edits	List of specific edits performed on claims/encounters as they are adjudicated with notation of performance timing (pre- or post-payment) and whether they are manual or automated functions.	6
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 2013–2014 PIP Validation Tool:
<PIP Topic>
for <PIHP Full Name>

DEMOGRAPHIC INFORMATION

Health Plan Name: <PIHP Full Name>

Project Leader Name: _____ Title: _____

Telephone Number: _____ E-Mail Address: _____

Name of Project: <PIP Topic>

Section to be completed by HSAG

Type of Project: Clinical Nonclinical
 Collaborative HEDIS

_____ Year 1 Validation	Year 1 validated through Activity _____	_____ Baseline	_____ Remeasurement 1
_____ Year 2 Validation	Year 2 validated through Activity _____	_____ Remeasurement 2	_____ Remeasurement 3
_____ Year 3 Validation	Year 3 validated through Activity _____		

Submission Date: _____

Appendix D: Michigan 2013–2014 PIP Validation Tool:
<PIP Topic>
for <PIHP Full Name>

EVALUATION ELEMENTS		SCORING	COMMENTS
Performance Improvement Project Evaluation			
I.	Select the Study Topic: 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*	1. Is selected following collection and analysis of data. NA is not applicable to this element for scoring.	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA	
	2. Has the potential to improve consumer health, functional status, or satisfaction. The scoring for this element will be Met or Not Met .	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA	

Results for Activity I

Total Evaluation Elements					Critical Elements				
Total Evaluation Elements**	Met	Partially Met	Not Met	NA	Critical Elements***	Met	Partially Met	Not Met	NA
2	0	0	0	0	1	0	0	0	0

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

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

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

Appendix D: Michigan 2013–2014 PIP Validation Tool:
<PIP Topic>
for <PIHP Full Name>

EVALUATION ELEMENTS	SCORING	COMMENTS
Performance Improvement Project 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(s):	
C*	1. States the problem to be studied in simple terms and is in the recommended X/Y format. <i>NA is not applicable to this element for scoring.</i>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA

Results for Activity II

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

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

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

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

Appendix D: Michigan 2013–2014 PIP Validation Tool:
<PIP Topic>
for <PIHP Full Name>

EVALUATION ELEMENTS		SCORING	COMMENTS
Performance Improvement Project Evaluation			
III.	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 indicator(s) apply. The study population:		
C*	1. <i>Is accurately and completely defined and captures all beneficiaries to whom the study question(s) apply.</i> <i>NA is not applicable to this element for scoring.</i>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA	

Results for Activity III

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

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

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

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

Appendix D: Michigan 2013–2014 PIP Validation Tool:
<PIP Topic>
for <PIHP Full Name>

EVALUATION ELEMENTS		SCORING	COMMENTS
Performance Improvement Project Evaluation			
IV.	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 consumer's blood pressure is or is not below a specified level) that is to be measured. The selected indicator(s) should track performance or improvement over time. The indicator(s) should be objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research. The study indicator(s):		
C*	1. Are well-defined, objective, and measure changes in health or functional status, consumer satisfaction, or valid process alternatives. <i>NA is not applicable to this element for scoring.</i>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA	
	2. Include the basis on which the indicator(s) were adopted, if internally developed.	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA	
C*	3. Allow for the study question(s) to be answered. <i>NA is not applicable to this element for scoring.</i>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA	

Results for Activity IV

Total Evaluation Elements					Critical Elements				
Total Evaluation Elements**	Met	Partially Met	Not Met	NA	Critical Elements***	Met	Partially Met	Not Met	NA
3	0	0	0	0	2	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 2013–2014 PIP Validation Tool:
<PIP Topic>
for <PIHP Full Name>

EVALUATION ELEMENTS		SCORING	COMMENTS
Performance Improvement Project Evaluation			
V.	Use Sound Sampling Techniques: (This activity is scored only if sampling is used.) If sampling is used to select beneficiaries of the study, proper sampling techniques are necessary to provide valid and reliable information on the quality of care provided. Sampling methods should:		
	1. Include the measurement period for the sampling methods used (e.g., baseline, Remeasurement 1, etc.)	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA	
	2. Include the title of the applicable study indicator(s).	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA	
	3. Identify the population size.	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA	
C*	4. Identify the sample size.	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA	
	5. Specify the margin of error and confidence level.	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA	
	6. Describe in detail the methods used to select the sample.	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA	

Results for Activity V

Total Evaluation Elements					Critical Elements				
Total Evaluation Elements**	Met	Partially Met	Not Met	NA	Critical Elements***	Met	Partially Met	Not Met	NA
6	0	0	0	0	1	0	0	0	0

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

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

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

Appendix D: Michigan 2013–2014 PIP Validation Tool:
<PIP Topic>
for <PIHP Full Name>

EVALUATION ELEMENTS		SCORING	COMMENTS
Performance Improvement Project Evaluation			
VI.	Reliably Collect Data: Data collection must ensure that the data collected on the study indicator(s) 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 should include:		
	1. Clearly defined data elements to be collected. <i>NA is not applicable to this element for scoring.</i>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA	
	2. A clearly defined and systematic process for collecting baseline and remeasurement data.	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA	
	3. Qualifications of staff beneficiaries collecting manual data.	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA	
C*	4. A manual data collection tool that ensures consistent and accurate collection of data according to indicator specifications.	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA	
	5. An estimated degree of administrative data completeness. <i>Met = 80–100 percent complete</i> <i>Partially Met = 50–79 percent complete</i> <i>Not Met = <50 percent complete or not provided</i>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA	
	6. A description of the data analysis plan.	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA	

Results for Activity VI

Total Evaluation Elements					Critical Elements				
Total Evaluation Elements**	Met	Partially Met	Not Met	NA	Critical Elements***	Met	Partially Met	Not Met	NA
6	0	0	0	0	1	0	0	0	0

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

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

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

Appendix D: Michigan 2013–2014 PIP Validation Tool:
<PIP Topic>
for <PIHP Full Name>

EVALUATION ELEMENTS		SCORING	COMMENTS
Performance Improvement Project Evaluation			
VII.	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:		
	1. Are conducted according to the data analysis plan in the study design. <i>NA is not applicable to this element for scoring.</i>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA	
C*	2. Allow for the generalization of results to the study population if a sample was selected. <i>If sampling was not used, this score will be NA.</i>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA	
	3. Identify factors that threaten internal or external validity of findings. <i>NA is not applicable to this element for scoring.</i>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA	
	4. Include an interpretation of findings. <i>NA is not applicable to this element for scoring.</i>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA	
C*	5. Are presented in a way that provides accurate, clear, and easily understood information. <i>NA is not applicable to this element for scoring.</i>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA	
	6. Identify the initial measurement and the remeasurement of study indicators.	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA	
	7. Identify statistical differences between the initial measurement and the remeasurement.	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA	
	8. Identify factors that affect the ability to compare the initial measurement with the remeasurement.	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA	



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EVALUATION ELEMENTS	SCORING	COMMENTS
Performance Improvement Project Evaluation		
VII.	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. <i>Include an interpretation of the extent to which the study was successful.</i>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA	

Results for Activity VII

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

* "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.



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EVALUATION ELEMENTS		SCORING	COMMENTS
Performance Improvement Project Evaluation			
VIII.	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 consumer 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.	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA	
	2. System changes that are likely to induce permanent change.	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA	
	3. Revised if the original interventions are not successful.	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA	
	4. Evaluated for effectiveness.	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> 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
4	0	0	0	0	1	0	0	0	0

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

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

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

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EVALUATION ELEMENTS		SCORING	COMMENTS
Performance Improvement Project 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 baseline methodology.	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA	
	2. There is documented improvement in processes or outcomes of care.	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA	
C*	3. There is statistical evidence that observed improvement is true improvement over baseline.	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA	
	4. The improvement appears to be the result of planned intervention(s).	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA	

Results for Activity IX

Total Evaluation Elements					Critical Elements				
Total Evaluation Elements**	Met	Partially Met	Not Met	NA	Critical Elements***	Met	Partially Met	Not Met	NA
4	0	0	0	0	1	0	0	0	0

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

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

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



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EVALUATION ELEMENTS	SCORING	COMMENTS
Performance Improvement Project Evaluation		
X.	Assess for Sustained Improvement: Assess for demonstrated improvement through repeated measurements over comparable time periods.	
C*	1. Repeated measurements over comparable time periods demonstrate sustained improvement or that a decline in improvement is not statistically significant.	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA

Results for Activity X

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

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

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

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

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Table 1—2013–2014 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	2					1				
II. Define the Study Question(s)	1					1				
III. Use a Representative and Generalizable Study Population	1					1				
IV. Select the Study Indicator(s)	3					2				
V. Use Sound Sampling Techniques	6					1				
VI. Reliably Collect Data	6					1				
VII. Analyze Data and Interpret Study Results	9					2				
VIII. Implement Intervention and Improvement Strategies	4					1				
IX. Assess for Real Improvement	4					1				
X. Assess for Sustained Improvement	1					1				
Totals for All Activities	37					12				

Table 2—2013–2014 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.



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EVALUATION OF THE OVERALL VALIDITY AND RELIABILITY OF PIP RESULTS

HSAG assessed the implications of the study's findings on the likely validity and reliability of the results based on the CMS protocol for validating PIPs. HSAG also assessed whether the State should have confidence in the reported PIP findings.

Met = High confidence/confidence in reported PIP results

Partially Met = Low confidence in reported PIP results

Not Met = Reported PIP results not credible

Summary of Aggregate Validation Findings

Met

Partially Met

Not Met

Summary statement on the validation findings:

Activities xx through xx were assessed for this PIP Validation Report. Based on the validation of this PIP, HSAG's assessment determined xx confidence in the results.



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DEMOGRAPHIC INFORMATION

Plan Name: <PIHP Full Name>

Project Leader Name: _____

Title: _____

Telephone Number: _____

E-Mail Address: _____

Name of Project: <PIP Topic>

Section to be completed by HSAG

Type of Project:

Date of Project: From _____ to _____

Clinical

Nonclinical

Submission Date: _____

Collaborative

HEDIS

Validation Date: _____

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Activity I: Select the Study Topic. PIP topics should target improvement in relevant areas of care/services and reflect the population in terms of demographic characteristics, prevalence of disease, and the potential consequences (risks) of disease. The goal of the project should be to improve processes and/or outcomes of health care or services.

The study topic should:

- ◆ Be selected following the collection and analysis of plan-specific data.
- ◆ Have the potential to improve beneficiary health, functional status, or satisfaction.
- ◆ Be based on a high-volume, high-risk, or problem-prone area for which improvement is needed.

Study Topic:

Provide PIHP-specific data:

Describe how the study topic has the potential to improve beneficiary health, functional status, or satisfaction:

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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.

The Study Question(s) should:

- ◆ Be structured in the recommended X/Y format: “Does doing X result in Y?”
- ◆ State the problem in clear and simple terms.
- ◆ Be answerable based on the data collection methodology and study indicator(s) provided.

Study Question(s):

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Activity III. Use a Representative and Generalizable Study Population. The study population should be clearly defined to represent the population to which the study question and indicators apply, without excluding beneficiaries with special health care needs.

The study population definition should:

- ◆ Include the requirements for the length of enrollment, defining continuous enrollment, new enrollment, and allowable gaps in enrollment.
- ◆ Include the complete age range of the study population and the anchor dates used to identify age criteria, if applicable.
- ◆ Clearly define the inclusion, exclusion, and diagnosis criteria.
- ◆ Include a list of diagnosis/procedure/pharmacy/billing codes used to identify beneficiaries, if applicable.
- ◆ Capture all beneficiaries to whom the study question(s) applies.
- ◆ Include how race/ethnicity will be identified, if applicable.

Study Population:

Beneficiary enrollment requirements:

Beneficiary age criteria (if applicable):

Inclusion, exclusion, and diagnosis criteria:

Diagnosis/procedure/pharmacy/billing codes (if applicable):

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Activity IV: Select the Study Indicator(s). The selected indicator(s) should track performance or improvement over time. The study indicator(s) should be objective, completely and clearly defined, measurable, and based on current clinical knowledge or health services research.

There is a minimum requirement of one study indicator. The plan may submit additional indicators based on the focus of the PIP.

The description of the study Indicator(s) should:

- ◆ Include the complete title of the study indicator.
- ◆ Include complete descriptions of the numerators and denominators, defining the terms used.
- ◆ Include the rationale for selecting the study indicator(s).
- ◆ If indicators are based on nationally recognized measures (e.g., HEDIS), include the year of the HEDIS technical specifications used for the applicable measurement year and update the year annually, as appropriate.
- ◆ Include complete dates for all measurement periods (with the day, month, and year).
- ◆ Include plan-specific goals for the remeasurement periods and the State-designated goal, if applicable.

Study Indicator 1: Enter title of study indicator	Provide a narrative description and the rationale for selecting the study indicator: Describe the basis on which the indicators were adopted, if internally developed.
Numerator (no numeric value)	
Denominator (no numeric value)	
Baseline Measurement Period (include date range) MM/DD/YYYY to MM/DD/YYYY	
Remeasurement 1 Period (include date range) MM/DD/YYYY to MM/DD/YYYY	
PIHP-Specific Remeasurement 1 Goal	
Remeasurement 2 Period (include date range) MM/DD/YYYY to MM/DD/YYYY	
PIHP-Specific Remeasurement 2 Goal	
State-Designated Goal (if applicable)	

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Activity IV: Select the Study Indicator(s). The selected indicator(s) should track performance or improvement over time. The study indicator(s) should be objective, completely and clearly defined, measurable, and based on current clinical knowledge or health services research.

There is a minimum requirement of one study indicator. The plan may submit additional indicators based on the focus of the PIP.

The description of the study Indicator(s) should:

- ◆ Include the complete title of the study indicator.
- ◆ Include complete descriptions of the numerators and denominators, defining the terms used.
- ◆ Include the rationale for selecting the study indicator(s).
- ◆ If indicators are based on nationally recognized measures (e.g., HEDIS), include the year of the HEDIS technical specifications used for the applicable measurement year and update the year annually, as appropriate.
- ◆ Include complete dates for all measurement periods (with the day, month, and year).
- ◆ Include plan-specific goals for the remeasurement periods and the State-designated goal, if applicable.

Study Indicator 2: Enter title of study indicator	Provide a narrative description and the rationale for selecting the study indicator: Describe the basis on which the indicators were adopted, if internally developed.
Numerator (no numeric value)	
Denominator (no numeric value)	
Baseline Measurement Period (include date range) MM/DD/YYYY to MM/DD/YYYY	
Remeasurement 1 Period (include date range) MM/DD/YYYY to MM/DD/YYYY	
PIHP-Specific Remeasurement 1 Goal	
Remeasurement 2 Period (include date range) MM/DD/YYYY to MM/DD/YYYY	
PIHP-Specific Remeasurement 2 Goal	
State-Designated Goal (if applicable)	

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Activity IV: Select the Study Indicator(s). The selected indicator(s) should track performance or improvement over time. The study indicator(s) should be objective, completely and clearly defined, measurable, and based on current clinical knowledge or health services research.

There is a minimum requirement of one study indicator. The plan may submit additional indicators based on the focus of the PIP.

The description of the study Indicator(s) should:

- ◆ Include the complete title of the study indicator.
- ◆ Include complete descriptions of the numerators and denominators, defining the terms used.
- ◆ Include the rationale for selecting the study indicator(s).
- ◆ If indicators are based on nationally recognized measures (e.g., HEDIS), include the year of the HEDIS technical specifications used for the applicable measurement year and update the year annually, as appropriate.
- ◆ Include complete dates for all measurement periods (with the day, month, and year).
- ◆ Include plan-specific goals for the remeasurement periods and the State-designated goal, if applicable.

Study Indicator 3: Enter title of study indicator	Provide a narrative description and the rationale for selecting the study indicator: Describe the basis on which the indicators were adopted, if internally developed.
Numerator (no numeric value)	
Denominator (no numeric value)	
Baseline Measurement Period (include date range) MM/DD/YYYY to MM/DD/YYYY	
Remeasurement 1 Period (include date range) MM/DD/YYYY to MM/DD/YYYY	
PIHP-Specific Remeasurement 1 Goal	
Remeasurement 2 Period (include date range) MM/DD/YYYY to MM/DD/YYYY	
PIHP-Specific Remeasurement 2 Goal	
State-Designated Goal (if applicable)	
Additional information about the study indicators:	

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Activity V: Use Sound Sampling Techniques. If sampling is to be used to select beneficiaries of the study, proper sampling techniques are necessary to provide valid and reliable information on the quality of care provided. Sampling techniques should be in accordance with generally accepted principles of research design and statistical analysis. Representative sampling techniques should be used to ensure generalizable information.

The description of the sampling methods should:

- ◆ Include components identified in the table below.
- ◆ Be updated annually for each measurement period and for each study indicator.
- ◆ Include a detailed narrative description of the methods used to select the sample.

Measurement Period	Study Indicator	Population Size	Sample Size	Margin of Error and Confidence Level
MM/DD/YYYY–MM/DD/YYYY				

Describe in detail the methods used to select the sample:

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Activity VI: Reliably Collect Data. The data collection methods must ensure that data collected on the study indicators are valid and reliable.

Data collection methodology should include the following:

- ◆ Identification of data elements and data sources.
- ◆ When and how data are collected.
- ◆ How data are used to calculate the study indicators.
- ◆ How data are analyzed.

Data Sources (Select all that apply)

Hybrid—Both medical/treatment records (manual data collection) and administrative data collection processes are used

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 manual data collection staff, including 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

Codes used to identify data elements (e.g., ICD-9, CPT codes) _____

Data completeness assessment attached

Coding verification process attached

Quality control process attached

Estimated percentage of administrative data completeness: _____ percent.

Describe the process used to determine data completeness:

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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Activity VI: Reliably Collect Data. The data collection methods must ensure that data collected on the study indicators are valid and reliable.

Data collection methodology should include the following:

- ◆ Identification of data elements and data sources.
- ◆ When and how data are collected.
- ◆ How data are used to calculate the study indicators.
- ◆ How data are analyzed.

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):

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Data analysis plan and other pertinent methodological features.

- ◆ Include how the rates or means are calculated, the type of statistical testing to be used to compare study indicator results between baseline and the most remeasurement period and between each remeasurement period, details of how data will be analyzed, and how the rates compare to the stated goal/benchmark.
- ◆ Documentation should include clear definitions of the data elements to be collected.
- ◆ Documentation should include a systematic process with an ordered sequence of steps. Each step depends on the outcome of the previous step. This can be defined in a narrative or with algorithms/flow charts.

Describe the data analysis plan:

Describe the data collection process:

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Activity VII: Data Analysis and Interpretation of Results. Clearly present the results of the study indicator(s). For HEDIS-based PIPs, the data entered in the table below should align with the data reported in the PIHP's IDSS.

Enter results for each study indicator—including the goals, statistical testing with complete *p* values, and the statistical significance—in the table provided.

Study Indicator 1 Title: Enter title of study indicator

Time Period Measurement Covers	Indicator Measurement	Numerator	Denominator	Rate or Results	Goal	Statistical Test, Statistical Significance, and <i>p</i> value
MM/DD/YYYY– MM/DD/YYYY	<i>Baseline</i>					
	Remeasurement 1					
	Remeasurement 2					
	Remeasurement 3					

Study Indicator 2 Title: Enter title of study indicator

Time Period Measurement Covers	Indicator Measurement	Numerator	Denominator	Rate or Results	Goal	Statistical Test, Statistical Significance, and <i>p</i> value
MM/DD/YYYY– MM/DD/YYYY	<i>Baseline</i>					
	Remeasurement 1					
	Remeasurement 2					
	Remeasurement 3					

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Activity VII: Data Analysis and Interpretation of Results. Clearly present the results for each of the study indicator(s). Describe the data analysis performed and the results of the statistical analysis, and interpret the findings. Through data analysis and interpretation, real improvement as well as sustained improvement can be determined.

The data analysis and interpretation of study indicator results should include the following for each measurement period:

- ◆ A description of the data analysis process conducted on the selected study indicators, including the statistical testing performed and the p values calculated to four decimal places (i.e., 0.0235).
- ◆ A description of the results for the statistical analysis, an interpretation of the findings, and a comparison of the results/changes from measurement period to measurement period, including a comparison to the goal.
- ◆ Identification of any factors that could influence the comparability of measurement periods or the validity of the findings for each measurement period.
- ◆ Discussion of any random, year-to-year variations, population changes, sampling errors, or statistically significant increases or decreases that may have occurred during the remeasurement process.
- ◆ A discussion of the extent to which the PIP was successful and any follow-up activities planned.

Describe the data analysis process and provide an interpretation of the results for each measurement period.

Baseline Measurement:

Remeasurement 1:

Remeasurement 2:

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Activity VIII: Improvement Strategies (interventions for improvement as a result of analysis). Interventions are developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis. Describe the barriers/interventions and provide quantitative details on the processes used to identify the barriers/interventions and to evaluate the effectiveness of the interventions. Do not include intervention planning activities.

This activity will include the following:

- ◆ Pre-baseline interventions.
- ◆ Baseline and remeasurement barriers/interventions.
- ◆ The processes used to identify barriers/interventions and to evaluate the effectiveness of the interventions.

Pre-Baseline Interventions: If interventions were implemented prior to the start of the baseline period, please enter each intervention in the table below. If not, please enter “not applicable” in the first row of the Pre-Baseline table.

Use the table below to list Pre-Baseline interventions.

Date Implemented (MM/YY)	Pre-Baseline Interventions

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Activity VIII: Improvement Strategies (interventions for improvement as a result of analysis). Interventions are developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis. Describe the barriers/interventions and provide quantitative details on the processes used to identify the barriers/interventions and to evaluate the effectiveness of the interventions. Do not include intervention planning activities.

This activity will include the following:

- ◆ Pre-baseline interventions.
- ◆ Baseline and remeasurement barriers/interventions.
- ◆ The processes used to identify barriers/interventions and to evaluate the effectiveness of the interventions.

Baseline Interventions: If interventions were implemented during the baseline period, please describe the process used to identify barriers and the process to develop the corresponding interventions for the baseline measurement period. Please include the team/committee/group that conducted the causal/barrier analysis and any QI tools that were used to identify barriers such as data mining, fishbone diagram, process level data, etc. Describe the process used to prioritize the barriers. Lastly, describe the process that will be used to evaluate the effectiveness of each intervention. If interventions were not implemented during the baseline period, please enter “not applicable” in the first row of the baseline table below.

Use the table below to list barriers and corresponding interventions for the baseline measurement period. For each remeasurement period, copy the ongoing interventions from the previous measurement period to the current remeasurement table and select whether the intervention was (1) new, continued, or revised, and (2) beneficiary, provider, or system.

Date Implemented (MM/YY)	Check if Beneficiary, Provider, or System Intervention	Baseline Barriers	Baseline Intervention That Addresses the Barrier Listed in the Previous Column
	Click to select status		
	Click to select status		
	Click to select status		
	Click to select status		

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Activity VIII: Improvement Strategies (interventions for improvement as a result of analysis). Interventions are developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis. Describe the barriers/interventions and provide quantitative details on the processes used to identify the barriers/interventions and to evaluate the effectiveness of the interventions. Do not include intervention planning activities.

This activity will include the following:

- ◆ Pre-baseline interventions.
- ◆ Baseline and remeasurement barriers/interventions.
- ◆ The processes used to identify barriers/interventions and to evaluate the effectiveness of the interventions.

Remeasurement 1 Interventions: In the space below, please describe the process used to identify barriers and the process to develop the corresponding interventions for the Remeasurement 1 period. Please include the team/committee/group that conducted the causal/barrier analysis and any QI tools that were used to identify barriers such as data mining, fishbone diagram, process level data, etc. Describe the process used to prioritize the barriers. In addition, describe the process used to determine if existing interventions were continued, revised, or discontinued. Lastly, describe the process that will be used to evaluate the effectiveness of each intervention.

Use the table below to list barriers and corresponding interventions for the baseline measurement period. For each remeasurement period, copy the ongoing interventions from the previous measurement period to the current remeasurement table and select if the intervention was (1) new, continued, or revised, and (2) beneficiary, provider, or system.

Date Implemented (MM/YY)	Check if Continued, New, or Revised	Check if Beneficiary, Provider, or System Intervention	Remeasurement 1 Barriers	Remeasurement 1 Intervention That Addresses the Barrier Listed in the Previous Column
	Click to select status	Click to select status		
	Click to select status	Click to select status		
	Click to select status	Click to select status		
	Click to select status	Click to select status		

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Activity VIII: Improvement Strategies (interventions for improvement as a result of analysis). Interventions are developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis. Describe the barriers/interventions and provide quantitative details on the processes used to identify the barriers/interventions and to evaluate the effectiveness of the interventions. Do not include intervention planning activities.

This activity will include the following:

- ◆ Pre-baseline interventions.
- ◆ Baseline and remeasurement barriers/interventions.
- ◆ The processes used to identify barriers/interventions and to evaluate the effectiveness of the interventions.

Remeasurement 2 Interventions: In the space below, please describe the process used to identify barriers and the process to develop the corresponding interventions for the Remeasurement 2 period. Please include the team/committee/group that conducted the causal/barrier analysis and any QI tools that were used to identify barriers such as data mining, fishbone diagram, process level data, etc. Describe the process used to prioritize the barriers. In addition, describe the process used to determine if existing interventions were continued, revised, or discontinued. Lastly, describe the process that will be used to evaluate the effectiveness of each intervention.

Use the table below to list barriers and corresponding interventions for the baseline measurement period. For each remeasurement period, copy the previous measurement period ongoing interventions to the current remeasurement table and select if the intervention was (1) new, continued, or revised, and (2) beneficiary, provider, or system.

Date Implemented (MM/YY)	Check if Continued, New, or Revised	Check if Beneficiary, Provider, or System Intervention	Remeasurement 2 Barriers	Remeasurement 2 Intervention That Addresses the Barrier Listed in the Previous Column
	Click to select status	Click to select status		
	Click to select status	Click to select status		
	Click to select status	Click to select status		
	Click to select status	Click to select status		

Appendix D: Michigan 2013–2014 PIP Summary Form:
<PIP Topic>
for <PIHP Full Name>

Activity VIII: Improvement Strategies (interventions for improvement as a result of analysis). Interventions are developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis. Describe the barriers/interventions and provide quantitative details on the processes used to identify the barriers/interventions and to evaluate the effectiveness of the interventions. Do not include intervention planning activities.

This activity will include the following:

- ◆ Pre-baseline interventions.
- ◆ Baseline and remeasurement barriers/interventions.
- ◆ The processes used to identify barriers/interventions and to evaluate the effectiveness of the interventions.

Remeasurement 3 Interventions: In the space below, please describe the process used to identify barriers and the process to develop the corresponding interventions for the Remeasurement 3 period. Please include the team/committee/group that conducted the causal/barrier analysis and any QI tools that were used to identify barriers such as data mining, fishbone diagram, process level data, etc. Describe the process used to prioritize the barriers. In addition, describe the process used to determine if existing interventions were continued, revised, or discontinued. Lastly, describe the process that will be used to evaluate the effectiveness of each intervention.

Use the table below to list barriers and corresponding interventions for the baseline measurement period. For each remeasurement period, copy the previous measurement period ongoing interventions to the current remeasurement table and select if the intervention was (1) new, continued, or revised, and (2) beneficiary, provider, or system.

Date Implemented (MM/YY)	Check if Continued, New, or Revised	Check if Beneficiary, Provider, or System Intervention	Remeasurement 3 Barriers	Remeasurement 3 Intervention That Addresses the Barrier Listed in the Previous Column
	Click to select status	Click to select status		
	Click to select status	Click to select status		
	Click to select status	Click to select status		
	Click to select status	Click to select status		