State of Michigan

Department of Community Health

Mental Health and Substance Abuse Administration

2006–2007 External Quality Review Technical Report

for

Prepaid Inpatient Health Plans

September 2007

HSAG Health Services Advisory Group

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Purpose of Report

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

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

Scope of EQR Activities Conducted

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

- **Compliance monitoring.** This evaluation was designed to determine the PIHPs' compliance with their contract and with State and federal regulations through review of performance in the seven compliance areas (i.e., Standards IX through XV) of Subcontracts and Delegation, Provider Network, Credentialing, Access and Availability, Coordination of Care, Appeals, and Advance Directives. Prior years' compliance monitoring activities evaluated the PIHPs' performance on Standards I through VIII (QAPI Plan and Structure, Performance Measurement and Improvement, Practice Guidelines, Staff Qualifications and Training, Utilization Management, Customer Service, Recipient Grievance Process, and Enrollee Rights and Protections).
- **Validation of performance measures.** HSAG validated each of the performance measures identified by MDCH to evaluate the accuracy of the performance measures reported by or on behalf of a PIHP. The validation also determined the extent to which Medicaid-specific performance measures calculated by a PIHP followed specifications established by MDCH.
- **Validation of performance improvement projects (PIPs).** For each PIHP, one PIP was reviewed to ensure that the projects were designed, conducted, and reported in a methodologically sound manner, allowing real improvements in care to be achieved and giving confidence in the reported improvements.

The results of these three EQR activities performed by HSAG were reported to MDCH and the PIHPs in activity reports for each PIHP. Performance scores and validation findings from the activities for all PIHPs are detailed in Section 3 and summarized in tables in Appendix A. Comparisons to prior-year performance, when applicable, can be found in Appendix A, as well.

Definitions

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

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

Quality

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

Timeliness

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

Access

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

[1-2] Department of Health and Human Services Centers for Medicare & Medicaid Services. *Federal Register. Code of Federal Regulations*. Title 42, Vol. 3, October 1, 2005.
[1-3] National Committee on Quality Assurance. 2006 Standards and Guidelines for MBHOs and MCOs.
[1-4] Department of Health and Human Services Centers for Medicare & Medicaid Services. *Federal Register*, Vol. 67, No. 115, June 14, 2002.

Findings

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

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

Quality

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

Table 1-1—Measures Assessing Quality

Measures		Statewide Score	PIHP Low Score	PIHP High Score
Standard IX. Subcontracts and Delegation		95%	86%	100%
Standard X. Provider Network		98%	92%	100%
Standard XI. Credentialing		NA	NA	NA
Standard XIII. Coordination of Care		99%	92%	100%
Standard XIV. Appeals		85%	23%	100%
Standard XV. Advance Directives		82%	17%	100%
Performance Measure Indicator 4a	Children	92.38%	67.67%	100%
	Adults	91.08%	64.20%	100%
Performance Measure Indicator 4b		94.75%	47.37%	100%
Performance Measure Indicator 8		93.85%	83.19%	99.66%
Performance Measure Indicator 12	Children	8.16%	0.00%	24.39%
	Adults	12.27%	1.39%	25.00%
Performance Measure Indicator 13*				
Performance Measure Indicator 14*				
Performance Improvement Projects				
All evaluation elements *Met*		94%	76%	100%
Critical elements *Met*		96%	75%	100%

*Rates were not available for reporting.

Overall, PIHP performance for compliance monitoring in the domain of **quality** indicated a statewide strength. Statewide scores for the six quality-related standards ranged from a low of 82 percent for Advance Directives to a high of 99 percent for Coordination of Care. For each of these compliance standards, several PIHPs achieved a score of 100 percent. Most PIHPs achieved scores of 95 percent or more on the standards related to subcontracts and delegation, provider network, and coordination of care.

The EQR activities related to the validation of PIPs addressed the validity and reliability of the PIHP's processes for conducting valid PIPs. Therefore, for purpose of the EQR technical report, HSAG assigned all PIPs to the **quality** domain. The PIHPs demonstrated strong performance related to the quality of their PIPs, as well as marked improvement over the results from the 2005–2006 validation. Thirteen of the 18 PIHPs received a validation status of *Met* for their PIP, an increase from 2005–2006, when 8 PIHPs received a *Met* validation status. Additionally, the number of PIHPs receiving scores of 100 percent for all evaluation elements *Met* and 100 percent for critical elements *Met* increased from 3 to 8 PIHPs. These findings indicated that, depending on each PIHP's progress in implementing the new PIP, most projects were designed, conducted, and reported in a methodologically sound manner, allowing real improvements in care and giving confidence in the reported results.

The PIHPs' results for performance measures related to **quality** of care and services were mixed. Five of the six indicators received validation ratings of *Fully Compliant* across all PIHPs, while one of the new indicators (Indicator 13) was rated *Substantially Compliant* for three PIHPs. Statewide rates for the performance measures related to **quality** of care and services met or exceeded the performance standard set by MDCH for two indicators: the 30-day readmission rates to an inpatient psychiatric unit for children and adults. Statewide rates did not meet the minimum performance standard for the indicators related to timely follow-up care after discharge from an inpatient psychiatric or detoxification unit, indicating an opportunity for improvement. Rates for two new measures (indicators 13 and 14) were not available for reporting, and one of the indicators related to **quality** of care (indicator 8) did not have a performance standard set by MDCH.

Timeliness

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

Table 1-2—Measures Assessing Timeliness

Measures		Average Across PIHPs	PIHP Low Score	PIHP High Score
Standard XII. Access and Availability		73%	29%	97%
Standard XIV. Appeals		85%	23%	100%
Performance Measure Indicator 1	Children	98.43%	96.81%	100%
	Adults	98.23%	96.50%	100%
Performance Measure Indicator 2		97.77%	94.40%	100%
Performance Measure Indicator 3		95.72%	86.51%	100%
Performance Measure Indicator 4a	Children	92.38%	67.67%	100%
	Adults	91.08%	64.20%	100%
Performance Measure Indicator 4b		94.75%	47.37%	100%

Review of the two compliance monitoring standards assessing **timeliness** of care and services provided by the PIHPs showed lower statewide scores than the standards assessing **quality** or **access**. While several PIHPs achieved 100 percent compliance with requirements related to Appeals, no PIHP received a score of 100 percent for the Access and Availability standard. About three-fourths of all compliance standard scores below 75 percent were in these two areas, reflecting opportunities for improvement.

Timeliness, as addressed by the validation of performance measures, reflected both a statewide strength as well as an opportunity for improvement, with four of the seven indicators related to **timeliness** of care and services achieving statewide averages that met the minimum performance level as specified by MDCH. All the PIHPs met or exceeded the minimum performance standard for timely preadmission screening for children and adults, and only three PIHPs fell below the standard for a timely face-to-face assessment with a professional, and they did so by less than 1 percentage point. However, statewide scores for timely follow-up care failed to meet the performance standard, indicating an opportunity for improvement. The PIHPs demonstrated compliance with technical requirements and specifications in their collection and reporting of performance indicators, with all 18 PIHPs receiving validation scores of *Fully Compliant* for the indicators related to **timeliness** of care and services.

Access

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

Table 1-3—Measures Assessing Access

Measures		Average Across PIHPs	PIHP Low Score	PIHP High Score
Standard X. Provider Network		98%	92%	100%
Standard XII. Access and Availability		73%	29%	97%
Standard XIII. Coordination of Care		99%	92%	100%
Performance Measure Indicator 1	Children	98.43%	96.81%	100%
	Adults	98.23%	96.50%	100%
Performance Measure Indicator 2		97.77%	94.40%	100%
Performance Measure Indicator 3		95.72%	86.51%	100%
Performance Measure Indicator 4a	Children	92.38%	67.67%	100%
	Adults	91.08%	64.20%	100%
Performance Measure Indicator 4b		94.75%	47.37%	100%
Performance Measure Indicator 5		5.69%	4.07%	7.95%

Overall, PIHP performance for compliance monitoring in the domain of **access** indicated another statewide strength. Statewide scores for the three access-related standards ranged from a low of 73 percent for access and availability to a high of 99 percent for coordination of care. Most PIHPs achieved scores of 95 percent or above on the standards related to provider network and coordination of care.

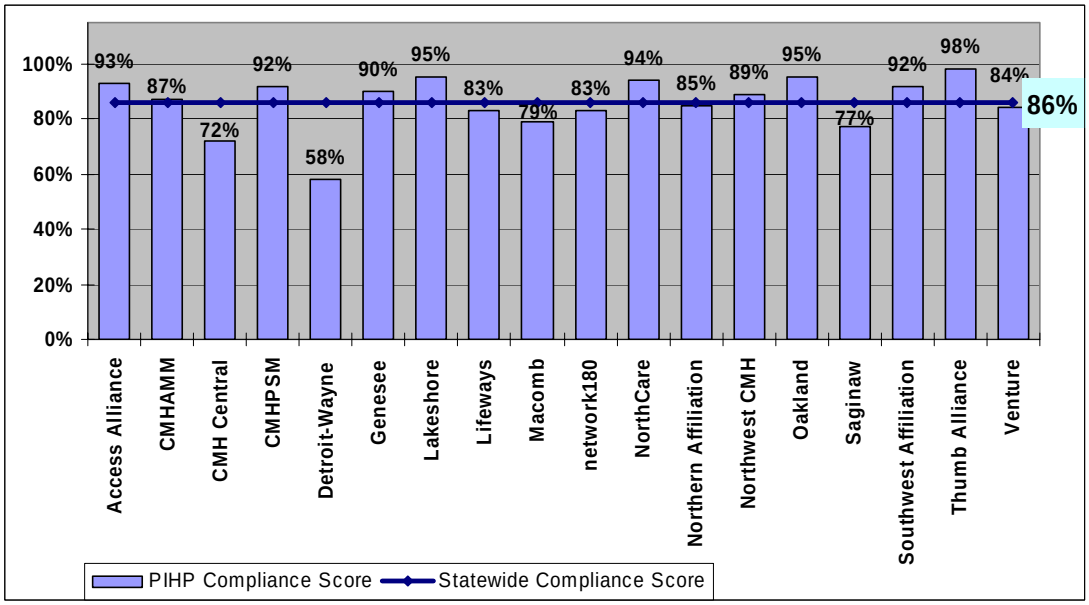
Access, as addressed by the validation of performance measures, reflected both a statewide strength and an opportunity for improvement. PIHP performance, as reflected in the statewide rates, met or exceeded the minimum performance standard for four indicators, but rates of timely follow-up care after discharge fell below the minimum performance standard as specified by MDCH. For five of the six performance measures related to **access** to care and services, all PIHPs received a validation score of *Fully Compliant*; only one PIHP received a score of *Not Valid* for Indicator 5.

Findings for the 2006–2007 Compliance Monitoring Reviews

The regulatory provisions chosen for review in this third year included Subcontracts and Delegation (42 CFR 438.230); Provider Network (438.106, 438.12, 438.206, 438.207, and 438.214); Credentialing (438.12 and 438.214); Access and Availability (438.206); Coordination of Care (438.208); Appeals (438.402, 438.406, 438.408, and 438.410); and Advance Directives (422, 422.128, and 438.6).

Across the six scored standards, the overall compliance rating for the 18 PIHPs was 86 percent, with individual PIHP scores ranging from 58 percent to 98 percent. Scores ranging from 95 percent to 100 percent were rated *Excellent*; those ranging from 85 percent to 94 percent were rated *Good*; those from 75 percent to 84 percent were rated *Average*; and scores of 74 percent and lower were rated *Poor*. Figure 1-1 displays PIHP scores for overall compliance on the six scored compliance monitoring standards. Three PIHPs performed at an overall *Excellent* level. Eight PIHPs were rated *Good*, five were rated *Average*, and two were rated *Poor*.

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



The PIHPs' management and oversight of their provider networks reflected high levels of compliance, with 12 PIHPs performing at the *Excellent* level for Subcontracts and Delegation, 15 at the *Excellent* level for Provider Network, and 15 at the *Excellent* level for Coordination of Care. Recommendations for improvement for these areas primarily addressed strengthening the PIHPs' monitoring activities to assess their subcontractors' performance related to all requirements for all delegated functions. Recommendations addressed the need for additional data in the analysis of provider network sufficiency and improving care coordination with other agencies involved in a beneficiary's care. Compliance with contract requirements related to processing and responding to beneficiary appeals of the PIHP's decision to deny, reduce, suspend, or terminate services showed greater variability across the PIHPs, with 11 of the PIHPs receiving a compliance score of 95 percent or above (*Excellent* level), but 5 PIHPs performing at the *Poor* level. Most recommendations for improvement for the appeals standard related to requirements for the notice of disposition, in terms of both timeliness and

content of the notice. PIHP performance in the area of Advance Directives was mixed, with PIHP scores about evenly split between the *Excellent, Good, Average,* and *Poor* levels. Recommendations for improvement primarily addressed the need for staff education and training concerning policies and procedures on advance directives and the requirement to provide beneficiaries with written information about advance directives. The lowest compliance rates applied to Access and Availability, with only one PIHP performing at the *Excellent* level, and four, six, and seven PIHPs performing at the *Good, Average,* and *Poor* levels, respectively. Most recommendations for improvement addressed the PIHPs' compliance with access standards for timely initiation of services and follow-up care after discharge. Review of the PIHPs' credentialing policies' conformance with MDCH's credentialing policy did not result in a compliance score due to the recent revision of the State's policy and the limited time available to the PIHPs to become compliant with all requirements. The reviews demonstrated that statewide, the PIHPs incorporated many of the requirements of the MDCH policy into their own policies. Ten of the PIHPs met three-fourths of the requirements or more, with five PIHPs needing to address only two or fewer recommendations to achieve full compliance in this area.

Table 1-4 presents the compliance monitoring scores for all PIHPs on the six scored standards.

Table 1-4—Summary of PIHP Compliance Standards Scores

PIHPs	Standard IX Subcontracts and Delegation	Standard X Provider Network	Standard XII Access and Availability	Standard XIII Coordination of Care	Standard XIV Appeals	Standard XV Advance Directives	Overall Compliance Monitoring
Access Alliance of Michigan	100%	100%	76%	100%	98%	100%	93%
CMH Affiliation of Mid-Michigan	96%	98%	76%	100%	90%	71%	87%
CMH for Central Michigan	96%	92%	68%	92%	67%	17%	72%
CMH Partnership of Southeastern Michigan	100%	100%	74%	100%	100%	92%	92%
Detroit-Wayne County CMH Agency	86%	94%	38%	92%	23%	79%	58%
Genesee County CMH	NA	100%	71%	100%	100%	92%	90%
Lakeshore Behavioral Health Alliance	96%	100%	88%	100%	95%	100%	95%
LifeWays	96%	98%	68%	100%	70%	100%	83%
Macomb County CMH Services	89%	95%	79%	100%	57%	83%	79%
network180	93%	100%	77%	100%	82%	54%	83%
NorthCare	100%	100%	82%	100%	100%	92%	94%
Northern Affiliation	93%	100%	91%	92%	67%	71%	85%
Northwest CMH Affiliation	96%	94%	76%	100%	98%	75%	89%
Oakland County CMH Authority	100%	100%	88%	100%	97%	92%	95%
Saginaw County CMH Authority	86%	100%	29%	100%	95%	100%	77%
Southwest Affiliation	96%	98%	85%	100%	97%	79%	92%
Thumb Alliance PIHP	100%	100%	97%	100%	100%	83%	98%
Venture Behavioral Health	96%	98%	50%	100%	98%	96%	84%
Statewide Standard Score	**95%**	**98%**	**73%**	**99%**	**85%**	**82%**	**86%**

Note: Shaded cells show performance below the statewide score.

Additional detail about the PIHPs' performance on the compliance monitoring standards can be found in Section 3 (PIHP-specific findings) and Appendix A (statewide summaries).

Findings for the 2006–2007 Validation of Performance Measures

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

HSAG assessed 10 performance measures for each PIHP for compliance with technical requirements, specifications, and construction. The performance measures were scored as *Fully Compliant* (the PIHP followed the specifications without any deviation), *Substantially Compliant* (some deviation was noted, but the reported rate was not significantly biased), or *Not Valid* (significant deviation from the specifications that resulted in a +/- bias of greater than 5 percent in the final reported rate). The 18 PIHPs calculated and reported a total of 180 performance measures. Table 1-5 presents the results.

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

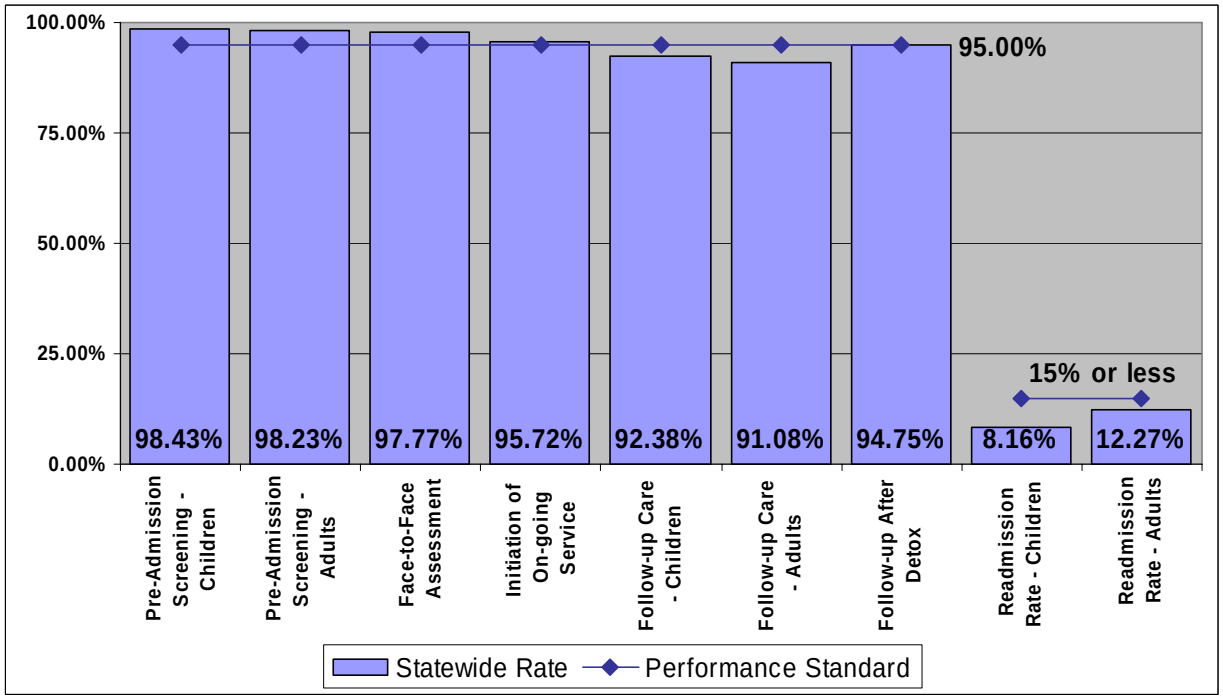
Validation Findings	Performance Indicators	
	Number	Percent
Fully Compliant	176	98%
Substantially Compliant	3	2%
Not Valid	1	<1%
Total	**180**	**100%**

Table 1-6 shows the overall PIHP compliance with the MDCH codebook specifications for each of the 10 performance indicators validated by HSAG. All but 2 of the 10 measures were *Fully Compliant* for all 18 PIHPs. Indicator 5 was scored *Not Valid* for one PIHP, and three PIHPs received a score of *Substantially Compliant* on Indicator 13—a new indicator for this validation cycle. These results reflected a continuing trend of improvement over the results of prior years. Statewide strengths were noted in the increased number of PIHPs that enhanced their information systems in order to capture most, if not all, data for performance indicator reporting, good coordination with affiliated community mental health centers (CMHCs), and much-improved and well-documented oversight of the PIHPs' coordinating agencies, as well as skilled and dedicated PIHP staff involved in performance indicator reporting. Recommendations for improvement primarily related to continuing efforts to automate manual processes for performance indicator reporting, documenting and validating all manual processes, and continuing the clarification and uniform interpretation of indicator specifications.

Table 1-6—Degree of Compliance Across all PIHPs				
Performance Measure		Percent of PIHPs		
		Fully Compliant	*Substantially Compliant*	*Not Valid*
Indicator 1	Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	100%	0%	0%
Indicator 2	Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	100%	0%	0%
Indicator 3	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 calendar days of a nonemergent assessment with a professional.	100%	0%	0%
Indicator 4a	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	100%	0%	0%
Indicator 4b	Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	100%	0%	0%
Indicator 5	Percentage of Medicaid recipients having received PIHP-managed services (Penetration rate).	94%	0%	6%
Indicator 8	Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination (HSW rate).	100%	0%	0%
Indicator 12	Percentage of children and adults readmitted to a psychiatric inpatient unit within 30 days of discharge.	100%	0%	0%
Indicator 13	The annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by the PIHPs.	83%	17%	0%
Indicator 14	Number of sentinel events during the six-month period per 1,000 Medicaid beneficiaries served, by the following populations: adults with mental illness, children with mental illness, persons with developmental disabilities not on the HSW, persons on the HSW, and persons with a substance abuse disorder.	100%	0%	0%

Overall, statewide performance met the MDCH-established performance standards for six of the nine indicators, as shown in Figure 1-2. MDCH did not specify a standard for Indicators 5 and 8. While Indicators 13 and 14 were validated by HSAG, rates for PIHP performance on these indicators were not available for reporting.

Figure 1-2—Statewide Rates for Performance Measures



Indicator 1—pre-admission screenings for children and adults—reflected the highest statewide rate and the highest number of PIHPs meeting the MDCH performance standard (18/18 PIHPs). The lowest statewide rates as well as the lowest number of PIHPs meeting the MDCH performance standard applied to the follow-up care after discharge indicators (Indicators 4a and 4b).

Table 1-7 displays the 2006–2007 PIHP results for the validated performance indicators.

Table 1-7—Year 3 Performance Measures

PIHP	Pre-Admission Screenings—Children	Pre-Admission Screenings—Adults	Initial Assessment Within 14 Days	Initiate Ongoing Service Within 14 Days	7-Day Psychiatric Follow-Up—Children	7-Day Psychiatric Follow-Up—Adults	7-Day Detox Follow-Up	Penetration Rate	HSW Rate	30-Day Readmission Rate—Children	30-Day Readmission Rate—Adults
Access Alliance	100%	98.10%	97.97%	97.55%	100%	100%	90.91%	7.26%	94.95%	4.76%	10.00%
CMHAMM	100%	96.50%	99.40%	97.51%	100%	95.45%	100%	5.77%	97.05%	7.69%	11.43%
CMH Central	100%	100%	94.58%	92.16%	88.89%	100%	100%	7.95%	97.16%	11.11%	8.33%
CMHPSM	98.90%	99.70%	100%	99.00%	100%	96.88%	100%	6.28%	85.03%	0.00%	1.39%
Detroit-Wayne	98.06%	96.83%	94.40%	86.51%	94.85%	86.36%	96.92%	4.57%	89.51%	2.20%	12.55%
Genesee	97.50%	96.98%	99.42%	96.86%	96.55%	95.45%	100%	4.67%	96.07%	24.39%	11.76%
Lakeshore	97.14%	100%	98.80%	94.21%	100%	98.00%	90.91%	Not valid	97.78%	5.88%	11.67%
LifeWays	100%	99.00%	97.78%	97.59%	100%	96.23%	100%	5.70%	91.97%	7.14%	14.55%
Macomb	97.10%	99.11%	96.95%	94.68%	66.67%	64.20%	92.31%	5.78%	98.31%	21.74%	13.58%
network180	97.30%	98.25%	97.78%	88.94%	100%	95.24%	100%	5.44%	95.81%	8.51%	13.39%
NorthCare	98.53%	99.16%	97.94%	98.50%	100%	96.55%	100%	6.57%	95.69%	23.08%	25.00%
Northern Affiliation	100%	98.24%	94.46%	96.37%	100%	100%	100%	6.74%	94.43%	0.00%	6.67%
Northwest CMH	97.83%	99.26%	98.38%	98.80%	81.25%	95.77%	100%	7.16%	93.89%	5.13%	5.95%
Oakland	96.81%	96.59%	97.45%	98.45%	100%	96.61%	100%	7.59%	98.28%	10.71%	18.06%
Saginaw	100%	100%	100%	94.77%	83.33%	80.77%	47.37%	4.07%	83.19%	21.43%	15.15%
Southwest Alliance	100%	99.55%	98.15%	96.41%	100%	98.25%	100%	6.66%	94.85%	4.17%	6.33%
Thumb Alliance	100%	100%	100%	99.53%	100%	98.28%	100%	7.02%	99.66%	12.50%	20.00%
Venture	100%	100%	97.07%	98.20%	80%	86.57%	100%	5.33%	91.02%	9.09%	7.32%
Statewide Rate	**98.43%**	**98.23%**	**97.77%**	**95.72%**	**92.38%**	**91.08%**	**94.75%**	**5.69%**	**93.85%**	**8.16%**	**12.27%**
MDCH Standard	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	NA	NA	≤15%	≤15%

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

Additional detail about the PIHPs' performance on the validation of performance measures can be found in Section 3 (PIHP-specific findings) and Appendix A (comparison to prior-year performance).

Findings for the 2006–2007 Validation of Performance Improvement Projects

For each PIHP, one PIP was validated based on CMS' protocol. The new study topic, *Ongoing Service Within 14 Days of Nonemergent Assessment*, was mandated by MDCH for all but two PIHPs. Two of the PIHPs had met the performance standard and were allowed to select a different PIP study topic. The PIHPs were in different stages of PIP implementation; therefore, the number of CMS PIP protocol activities evaluated differed among the PIHPs.

Table 1-8 presents a summary of the PIHPs' validation status results. Most PIHPs received a *Met* validation status. These results represented marked improvement in the PIHPs' understanding and implementation of the requirements of the CMS protocol for conducting PIPs, as only eight PIPs had received a validation status of *Met* in 2006.

Table 1-8—PIHPs' PIP Validation Status

Validation Status	Number of PIHPs
Met	13
Partially Met	3
Not Met	2

Table 1-9 presents a statewide summary of the PIHPs' PIP validation results for each of the CMS PIP protocol activities. Activities I through V were evaluated for all 18 PIHPs. Almost all of the PIHPs *Met* all critical and noncritical evaluation elements for Activities I, II, III, and IV, while all elements for Activity V were rated *NA* for all PIPs. Only two PIPs had progressed far enough to allow evaluation of Activity IX, and one had progressed to Activity X. Statewide strengths were noted in several areas: overall, interventions were developed based on causes/barriers identified through data analysis and quality improvement processes, data were presented clearly and accurately, and several PIHPs included a detailed data analysis plan. Recommendations for improvement, when noted, primarily related to the PIHPs including a statement that the study topic was selected by the State, the PIP summary form including accurate and complete documentation of the information provided by the State, and the PIHPs selecting only those interventions that were likely to have a long-term effect. Overall, the PIHPs, for the most part, demonstrated compliance with CMS protocol requirements in the areas of the study topic, study question(s), study indicator(s), study population, and, for PIHPs that had progressed far enough, data collection and improvement strategies.

Table 1-9—Summary of Data from Validation of Performance Improvement Projects			
Validation Activity		Number of PIPs Meeting All Evaluation Elements/ Number Reviewed	Number of PIPs Meeting All Critical Elements/ Number Reviewed
I.	Appropriate Study Topic	16/18	17/18
II.	Clearly Defined, Answerable Study Question	17/18	17/18
III.	Clearly Defined Study Indicator(s)	15/18	16/18
IV.	Correctly Identified Study Population	17/18	17/18
V.	Valid Sampling Techniques*	18/18	18/18
VI.	Accurate/Complete Data Collection	13/17	17/17
VII.	Appropriate Improvement Strategies	10/11	10/11
VIII.	Sufficient Data Analysis and Interpretation	8/10	10/10
IX.	Real Improvement Achieved	2/2	NA
X.	Sustained Improvement Achieved	1/1	NA

*For 2006-2007, all evaluation elements were scored *Not Applicable* for all PIPs, as the studies did not use sampling.

Table 1-10 presents the 2006–2007 PIHP results of the PIP validation. Most PIHPs demonstrated high levels of compliance with the CMS PIP protocols.

Table 1-10—PIHPs' PIP Validation Scores for 2006–2007			
PIHP	% of All Elements Met	% of All Critical Elements Met	Validation Status
Access Alliance of Michigan	100%	100%	*Met*
CMH Affiliation of Mid-Michigan	96%	100%	*Met*
CMH for Central Michigan	89%	90%	*Partially Met*
CMH Partnership of Southeastern	100%	100%	*Met*
Detroit-Wayne County CMH Agency	94%	88%	*Partially Met*
Genesee County CMH	100%	100%	*Met*
Lakeshore Behavioral Health Alliance	100%	100%	*Met*
LifeWays	100%	100%	*Met*
Macomb County CMH Services	100%	100%	*Met*
network180	100%	100%	*Met*
NorthCare	94%	100%	*Met*
Northern Affiliation	83%	90%	*Not Met*
Northwest CMH Affiliation	100%	100%	*Met*
Oakland County CMH Authority	94%	100%	*Met*
Saginaw County CMH Authority	76%	75%	*Not Met*
Southwest Affiliation*	96%	100%	*Met*
Thumb Alliance PIHP*	90%	80%	*Partially Met*
Venture Behavioral Health	93%	100%	*Met*

*The PIHP had met the performance standard for the State-mandated PIP and was allowed to select a different topic.

Additional detail about the PIHPs' performance on the validation of PIPs can be found in Section 3 for PIHP-specific findings and Appendix A for comparison to prior-year performance.

Conclusions

Findings from the 2006–2007 EQR activities reflected a continued trend of 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 both improvements over prior-year performance, when applicable, and high levels of compliance with federal, State, and contractual requirements related to the provision of care to beneficiaries.

PIHP performance on the compliance monitoring standards reflected high levels of compliance in several areas, most notably and consistently across the PIHPs in the areas of Coordination of Care, Provider Network, and Subcontracts and Delegation. These findings indicated that overall, the PIHPs have been successful in developing and overseeing delivery systems that provide quality care to beneficiaries. The PIHPs also demonstrated that overall, they are well-positioned to conduct valid PIPs that give confidence in the reported results and have the potential to achieve real improvements in care.

The results from the validation of performance measures show that the PIHPs continued to improve on their processes to collect and report performance indicator data. The PIHPs enhanced their data systems and were reporting more accurate and reliable data. The performance measure rates continued to improve over previous years' results.

2. External Quality Review Activities

Introduction

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

Conclusions drawn from the data and recommendations related to health care quality, timeliness, and access for each PIHP are presented in Section 3 of this report.

Compliance Monitoring Reviews

Objectives

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

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

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

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

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

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

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

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

Technical Methods of Data Collection

Prior to beginning site reviews of the PIHPs, HSAG developed standardized tools for use in the reviews. The content of the tools was based on applicable federal and State laws and regulations, and the requirements set forth in the contract agreement between MDCH and the PIHPs. HSAG also followed the guidelines set forth in the February 11, 2003, CMS protocol, *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs).*

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

- **Pre-review Activities:** In addition to scheduling the on-site review and developing the review agenda, a key pre-review activity was the request and review of various documents (policies, member materials, subcontracts, etc.) and the comprehensive EQR compliance review tool that was adapted from CMS protocols. The focus of the desk review was to identify compliance with the BBA and MDCH contractual rules and regulations.
- Additionally, HSAG developed an appeal record review tool and requested audit samples based on data files supplied by each PIHP. These files included logs of beneficiary appeals for the period of January 1, 2006, through September 30, 2006. From each of these files, HSAG selected random samples of appeal files for review on-site.
- **On-Site Review:** The two-day reviews included an entrance conference, document and record reviews using the HSAG compliance monitoring and record review tools, and interviews with key PIHP staff. An exit conference was conducted at the conclusion of the on-site reviews, when preliminary findings and recommendations were summarized.
- **Compliance Monitoring Report:** After completing the review, analysis, and scoring of the information obtained from the desk audit and the on-site reviews, HSAG prepared a detailed report of the compliance monitoring review findings and recommendations for each PIHP.
- Based on the findings, each PIHP was required to submit a performance improvement plan to MDCH for any standard element receiving a finding of *Substantially Met*, *Partially Met*, or *Not Met*. HSAG provided each PIHP with a template for the corrective action plan. The identified areas for performance improvement will be incorporated into future review and follow-up activities performed as part of the annual EQR compliance monitoring process.

Description of Data Obtained

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

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

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

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

Table 2-1—Description of PIHP Data Sources

Data Obtained	Time Period to Which the Data Applied
Desk Review Documentation	October 1, 2005, to Date of Review
Appeal Records	January 1, 2006, to September 30, 2006
Information From Interviews Conducted	October 1, 2005, to Date of Review

Data Aggregation, Analysis, and How Conclusions Were Drawn

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

Findings for the Access and Availability standard were derived from the Michigan Mission-Based Performance Indicator System—Access Domain, Indicators 1 through 4.b. The PIHPs routinely report quarterly performance data to MDCH. MDCH provided data directly to HSAG for the first, second, and third quarters of 2005–2006.

Each element within the seven standards was evaluated and scored as *Met*, *Substantially Met*, *Partially Met*, *Not Met*, or *Not Applicable*, with the exception that *Substantially Met* was not

applicable to the Access and Availability standard. The overall score for each of the six scored standards was determined by totaling the number of *Met* (value: 1 point), *Substantially Met* (0.75 points), *Partially Met* (0.50 points), *Not Met* (0.00 points), and *Not Applicable* (0.00 points) elements for the standard, then dividing the summed score by the total number of applicable elements for that standard. An overall performance score was not calculated for credentialing, as the MDCH credentialing policy had been revised and issued to the PIHPs too recently for complete implementation prior to the external quality review. The same methodology was used to determine the overall performance rating for each PIHP and the statewide scores, summing the values of the ratings and dividing that sum by the total number of applicable elements.

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

Table 2-2—Assignment of Standards to Performance Domains

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

Validation of Performance Measures

Objectives

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

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

HSAG validated a set of 10 performance indicators that were developed by MDCH and selected for validation. Seven of these indicators were collected and reported by each PIHP on a quarterly basis, with the remaining three being calculated by MDCH.

Technical Methods of Data Collection and Analysis

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

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

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

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

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

Description of Data Obtained

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

- **Information Systems Capabilities Assessment Tool (ISCAT).** This was received 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.** This was obtained from each PIHP (if applicable) and MDCH, and was used to determine compliance with the performance measure definitions.
- **Previous Performance Measure Reports.** These were obtained from each PIHP and reviewed to assess trending patterns and rate reasonability.
- **Supporting Documentation.** This 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.** The calculated results were obtained from MDCH and each of the PIHPs.

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

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

Table 2-3—Description of Data Sources

Data Obtained	Time Period to Which the Data Applied
ISCAT (From PIHPs)	State Fiscal Year (SFY) 2006
Source Code (Programming Language) for Performance Measures (From MDCH)	SFY 2006
Previous Performance Measure Reports (From PIHPs)	SFY 2006
Performance Measure Reports (From PIHPs and MDCH)	First Quarter of SFY 2007
Supporting Documentation (From PIHPs and MDCH)	First Quarter of SFY 2007
On-site Interviews and Demonstrations (From PIHPs and MDCH)	First Quarter of SFY 2007

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

Table 2-4—List of Performance Indicators for PIHPs

	Indicator	Calculation by:	Validation Review Period
1.	Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	PIHP	First Quarter SFY 2007
2.	Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	PIHP	First Quarter SFY 2007
3.	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional.	PIHP	First Quarter SFY 2007
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	PIHP	First Quarter SFY 2007
4b.	Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	PIHP	First Quarter SFY 2007
5.	Percentage of Medicaid recipients having received PIHP-managed services (Penetration rate).	MDCH	First Quarter SFY 2007
8.	Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination (HSW rate).	MDCH	First Quarter SFY 2007

Table 2-4—List of Performance Indicators for PIHPs			
	Indicator	Calculation by:	Validation Review Period
12.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	PIHP	First Quarter SFY 2007
13.	The annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by PIHPs.	MDCH	SFY 2006
14.	Number of sentinel events during the six-month period per 1,000 Medicaid beneficiaries served, by the following populations: adults with mental illness, children with mental illness, persons with developmental disabilities not on the HSW, persons on the HSW, and persons with substance abuse disorder.	PIHP	Last Half of SFY 2006

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

After completing the validation process, HSAG prepared a report of the performance measure review findings and recommendations for each PIHP reviewed. These reports, which complied with 42 CFR 438.364, were forwarded 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			
Performance Measures	Quality	Timeliness	Access
Indicator 1. Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.		✓	✓
Indicator 2. Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.		✓	✓
Indicator 3. Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 calendar days of a nonemergent assessment with a professional.		✓	✓
Indicator 4a. Percentage of discharges from a psychiatric inpatient unit	✓	✓	✓

Table 2-5—Assignment of Performance Measures to Performance Domains			
Performance Measures	**Quality**	**Timeliness**	**Access**
who are seen for follow-up care within seven days.			
Indicator 4b. Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	✓	✓	✓
Indicator 5. Percentage of Medicaid recipients having received PIHP-managed services (Penetration rate).			✓
Indicator 8. Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination (HSW rate).	✓		
Indicator 12. Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	✓		
Indicator 13. The annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by the PIHPs.	✓		
Indicator 14. Number of sentinel events during the six-month period per 1,000 Medicaid beneficiaries served, by the following populations: adults with mental illness, children with mental illness, persons with developmental disabilities not on the HSW, persons on the HSW, and persons with a substance abuse disorder.	✓		

Validation of Performance Improvement Projects

Objectives

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

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

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

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

Technical Methods of Data Collection and Analysis

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

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

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

Description of Data Obtained

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

Table 2-6—Description of PIHP Data Sources

Data Obtained	Time Period to Which the Data Applied
PIP Summary Form (completed by the PIHP)	FY 2006–2007

Data Aggregation, Analysis, and How Conclusions Were Drawn

Each required protocol activity consisted of evaluation elements necessary to complete a valid PIP. The evaluation elements within each activity were scored by the HSAG review team as *Met*, *Partially Met*, *Not Met*, or *Not Applicable*. To ensure a valid and reliable review, some of the elements were designated as critical elements by HSAG. All of the critical elements had to be *Met* for the PIP to produce valid and reliable results.

All PIPs were scored as follows:

- *Met*: All critical elements were *Met* and 80 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*.
- *Not Applicable*: Evaluation elements (including critical elements) were removed from all scoring.

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

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

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

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

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

Table 2-7—Assignment of PIPs to Performance Domains

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

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

Introduction

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

Compliance Monitoring

This section of the report presents the results of the 2006–2007 compliance monitoring reviews, conducted to evaluate the PIHPs' compliance with federal and State regulations and contractual requirements related to the areas of subcontracts and delegation, provider network, credentialing, access and availability, coordination of care, appeals, and advance directives.

Access Alliance of Michigan

Findings

Table 3-1 presents the number of elements for each of the six scored standards that received a score of *Met*, *Substantially Met*, *Partially Met*, *Not Met*, or *NA* and the totals across the six standards, the overall compliance score for each of the six scored standards, and the total compliance score across the six scored standards. Details of the scores for the review of the standards can be found in the 2006–2007 External Quality Review Compliance Monitoring Report for **Access Alliance of Michigan**.

Table 3-1—2006–2007 Compliance Monitoring Scores *for* Access Alliance of Michigan

Standard #	Standard Name	Total Elements	Total Applicable Elements	# *Met*	# *Substantially Met*	# *Partially Met*	# *Not Met*	# *NA*	Total Compliance Score
IX	Subcontracts and Delegation	7	7	7	0	0	0	0	100%
X	Provider Network	12	12	12	0	0	0	0	100%
XI	Credentialing								
XII	Access and Availability	17	17	11		4	2	0	76%
XIII	Coordination of Care	3	3	3	0	0	0	0	100%
XIV	Appeals	15	15	14	1	0	0	0	98%
XV	Advance Directives	6	6	6	0	0	0	0	100%
	Totals	60	60	53	1	4	2	0	93%

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

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

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

Strengths

Access Alliance of Michigan received an overall compliance score of 93 percent across the six scored standards. The PIHP's performance for Subcontracts and Delegation, Provider Network, Coordination of Care, and Advance Directives reflected 100 percent compliance with all requirements, and no recommendations or PIHP corrective actions were required for these standards. **Access Alliance of Michigan** was compliant with almost all elements assessed for the Appeals standard, receiving a 98 percent compliance score.

Recommendations

Recommendations for improving **Access Alliance of Michigan**'s performance addressed Credentialing, Access and Availability, and Appeals. The PIHP should implement corrective actions to ensure that its credentialing policy is compliant with all requirements of the MDCH credentialing policy, that the PIHP meets or exceeds the contractually required performance level for all services and population groups, and that the local appeal process is fully compliant with all requirements.

Summary Assessment Related to Quality, Timeliness, and Access

Access Alliance of Michigan demonstrated strength in the area of compliance monitoring standards related to **quality**, with four of the five scored standards receiving scores of 100 percent compliance and one standard receiving a score of 98 percent. The PIHP had comprehensive policies and procedures and effective processes for managing its network of providers and delegated subcontractors, for ensuring coordination of care among all service providers and systems involved in a beneficiary's care, for managing the local appeal process, and for ensuring compliance with requirements related to advance directives. Findings for the two standards related to **timeliness** indicated an opportunity for improvement with respect to meeting the contractually required minimum performance standards for all indicators and population groups, with the PIHP receiving its lowest score of 76 percent for Access and Availability. The PIHP received a 98 percent compliance rating for Appeals, the second standard in this domain. Performance on the three standards related to **access** varied, with a 76 percent score for Access and Availability and 100 percent compliance for Provider Network and Coordination of Care. The results for these three standards indicated that the PIHP had successfully developed policies, procedures and processes to address beneficiaries' access to services, but needed to ensure more timely access for some services and population groups.

CMH Affiliation of Mid-Michigan

Findings

Table 3-2 presents the number of elements for each of the six scored standards that received a score of *Met*, *Substantially Met*, *Partially Met*, *Not Met*, or *NA* and the totals across the six standards, the overall compliance score for each of the six scored standards, and the total compliance score across the six scored standards. Details of the scores for the review of the standards can be found in the 2006–2007 External Quality Review Compliance Monitoring Report for **CMH Affiliation of Mid-Michigan**.

Table 3-2—2006–2007 Compliance Monitoring Scores *for* CMH Affiliation of Mid-Michigan

Standard #	Standard Name	Total Elements	Total Applicable Elements	# *Met*	# *Substantially Met*	# *Partially Met*	# *Not Met*	# *NA*	Total Compliance Score
IX	Subcontracts and Delegation	7	7	6	1	0	0	0	96%
X	Provider Network	12	12	11	1	0	0	0	98%
XI	Credentialing								
XII	Access and Availability	17	17	12		2	3	0	76%
XIII	Coordination of Care	3	3	3	0	0	0	0	100%
XIV	Appeals	15	15	11	2	2	0	0	90%
XV	Advance Directives	6	6	3	1	1	1	0	71%
	Totals	60	60	46	5	5	4	0	87%

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

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

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

Strengths

CMH Affiliation of Mid-Michigan received an overall compliance score of 87 percent across the six scored standards. The PIHP's performance for Coordination of Care reflected 100 percent compliance with all requirements, and no recommendations or PIHP corrective actions were required for this standard. Other areas of strength included Subcontracts and Delegation and Provider Network, with compliance ratings of 96 percent and 98 percent, respectively.

Recommendations

Recommendations for improving **CMH Affiliation of Mid-Michigan**'s performance addressed Subcontracts and Delegation, Provider Network, Credentialing, Access and Availability, Appeals, and Advance Directives. The PIHP should implement corrective actions to ensure that its policies, procedures, and processes in these areas are fully compliant with all contractual requirements.

Summary Assessment Related to Quality, Timeliness, and Access

CMH Affiliation of Mid-Michigan demonstrated strength in the area of compliance monitoring standards related to **quality**, with three of the five scored standards receiving scores of 95 percent to 100 percent compliance. The PIHP had comprehensive policies and procedures and effective processes addressing most requirements related to managing delegated subcontractors and the network of providers, and related to ensuring coordination of care among all service providers and systems involved in a beneficiary's care. **CMH Affiliation of Mid-Michigan** also received its lowest score of 71 percent in this domain, indicating an opportunity to strengthen its policies and processes related to advance directives. Findings for the two standards related to **timeliness** indicated an opportunity for improvement with respect to meeting the contractually required minimum performance standards for all indicators and population groups, with the PIHP receiving a score of 76 percent for Access and Availability. The PIHP received a 90 percent compliance rating for Appeals, the second standard in this domain. Performance on the three standards related to **access** varied, with a 76 percent score for Access and Availability, 98 percent compliance for Provider Network and 100 percent for Coordination of Care, indicating that the PIHP had successfully developed policies, procedures and processes to address beneficiaries' access to services, but needed to ensure more timely access for some services and population groups.

CMH for Central Michigan

Findings

Table 3-3 presents the number of elements for each of the six scored standards that received a score of *Met*, *Substantially Met*, *Partially Met*, *Not Met*, or *NA* and the totals across the six standards, the overall compliance score for each of the six scored standards, and the total compliance score across the six scored standards. Details of the scores for the review of the standards can be found in the 2006–2007 External Quality Review Compliance Monitoring Report for **CMH for Central Michigan**.

Table 3-3—2006–2007 Compliance Monitoring Scores *for* CMH for Central Michigan

Standard #	Standard Name	Total Elements	Total Applicable Elements	# *Met*	# *Substantially Met*	# *Partially Met*	# *Not Met*	# *NA*	Total Compliance Score
IX	Subcontracts and Delegation	7	7	6	1	0	0	0	96%
X	Provider Network	12	12	9	2	1	0	0	92%
XI	Credentialing								
XII	Access and Availability	17	17	11		1	5	0	68%
XIII	Coordination of Care	3	3	2	1	0	0	0	92%
XIV	Appeals	15	15	5	0	10	0	0	67%
XV	Advance Directives	6	6	0	0	2	4	0	17%
	Totals	60	60	33	4	14	9	0	72%

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

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

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

Strengths

CMH for Central Michigan received an overall compliance score of 72 percent across the six scored standards. Compliance with requirements related to Subcontracts and Delegation received the PIHP's highest compliance score of 96 percent. Other areas of strength for this PIHP included Provider Network and Coordination of Care, both with a 92 percent score.

Recommendations

Recommendations for improving **CMH for Central Michigan**'s performance addressed Subcontracts and Delegation, Provider Network, Credentialing, Access and Availability, Coordination of Care, Appeals, and Advance Directives. The PIHP should implement corrective actions to ensure that its policies, procedures, and processes in these areas are fully compliant with all contractual requirements.

Summary Assessment Related to Quality, Timeliness, and Access

CMH for Central Michigan demonstrated its strongest performance in the area of compliance monitoring standards related to **quality**, with three of the five scored standards receiving scores of 92 percent to 96 percent. The PIHP demonstrated compliance with most requirements related to the oversight of functions delegated to subcontractors, the management of the provider network, and ensuring coordination of care. However, **CMH for Central Michigan** also received its lowest score of 17 percent in this domain, indicating a need to strengthen its policies and processes related to advance directives. Findings for the two standards related to **timeliness** indicated an opportunity for improvement, with the PIHP receiving a score of 68 percent for Access and Availability, and a 67 percent compliance rating for Appeals. Performance on the three standards related to **access** varied, with a 68 percent score for Access and Availability and 92 percent compliance for both Provider Network and Coordination of Care. Findings for the compliance monitoring standards indicated opportunities for improvement across the three domains of **quality**, **timeliness**, and **access**.

CMH Partnership of Southeastern Michigan

Findings

Table 3-4 presents the number of elements for each of the six scored standards that received a score of *Met*, *Substantially Met*, *Partially Met*, *Not Met*, or *NA* and the totals across the six standards, the overall compliance score for each of the six scored standards, and the total compliance score across the six scored standards. Details of the scores for the review of the standards can be found in the 2006–2007 External Quality Review Compliance Monitoring Report for **CMH Partnership of Southeastern Michigan**.

Table 3-4—2006–2007 Compliance Monitoring Scores *for* CMH Partnership of Southeastern Michigan

Standard #	Standard Name	Total Elements	Total Applicable Elements	# *Met*	# *Substantially Met*	# *Partially Met*	# *Not Met*	# *NA*	Total Compliance Score
IX	Subcontracts and Delegation	7	7	7	0	0	0	0	100%
X	Provider Network	12	12	12	0	0	0	0	100%
XI	Credentialing								
XII	Access and Availability	17	17	10		5	2	0	74%
XIII	Coordination of Care	3	3	3	0	0	0	0	100%
XIV	Appeals	15	15	15	0	0	0	0	100%
XV	Advance Directives	6	6	5	0	1	0	0	92%
	Totals	60	60	52	0	6	2	0	92%

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

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

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

Strengths

CMH Partnership of Southeastern Michigan received an overall compliance score of 92 percent across the six scored standards. The PIHP's performance for Subcontracts and Delegation, Provider Network, Coordination of Care, and Appeals reflected 100 percent compliance with all requirements, and no recommendations or PIHP corrective actions were required for these standards. **CMH Partnership of Southeastern Michigan** also met almost all requirements related to Advance Directives and Credentialing.

Recommendations

Recommendations for improving **CMH Partnership of Southeast Michigan**'s performance addressed Credentialing, Access and Availability, and Advance Directives. The PIHP should implement corrective actions to ensure that its credentialing policy is compliant with all requirements of the MDCH credentialing policy, that the PIHP meets or exceeds the contractually required performance level for all services and population groups, and that all requirements related to advance directives are addressed.

Summary Assessment Related to Quality, Timeliness, and Access

CMH Partnership of Southeast Michigan demonstrated strength in the area of compliance monitoring standards related to **quality**, with four of the five scored standards receiving scores of 100 percent compliance. The PIHP had comprehensive policies and procedures and effective processes for managing its delegated subcontractors, the network of providers, and the local appeal process; for ensuring coordination of care among all service providers and systems involved in a beneficiary's care; and for addressing most requirements related to advance directives. Findings for the two standards related to **timeliness** indicated an opportunity for improvement with respect to meeting the contractually required minimum performance standards for all indicators and population groups. For this domain, **CMH Partnership of Southeastern Michigan** received its lowest score of 74 percent for Access and Availability, and a compliance rating of 100 percent for Appeals. Performance on the three standards related to **access** varied, with a 74 percent score for Access and Availability and 100 percent compliance for Provider Network and Coordination of Care. The results for these three standards indicated that the PIHP had successfully developed policies, procedures, and processes to address beneficiaries' access to services, but needed to ensure more timely access for some services and population groups.

Detroit-Wayne County CMH Agency

Findings

Table 3-5 presents the number of elements for each of the six scored standards that received a score of *Met*, *Substantially Met*, *Partially Met*, *Not Met*, or *NA* and the totals across the six standards, the overall compliance score for each of the six scored standards, and the total compliance score across the six scored standards. Details of the scores for the review of the standards can be found in the 2006–2007 External Quality Review Compliance Monitoring Report for **Detroit-Wayne County CMH Agency**.

Table 3-5—2006–2007 Compliance Monitoring Scores *for* Detroit-Wayne County CMH Agency

Standard #	Standard Name	Total Elements	Total Applicable Elements	# *Met*	# *Substantially Met*	# *Partially Met*	# *Not Met*	# *NA*	Total Compliance Score
IX	Subcontracts and Delegation	7	7	4	2	1	0	0	86%
X	Provider Network	12	12	10	1	1	0	0	94%
XI	Credentialing								
XII	Access and Availability	17	17	4		5	8	0	38%
XIII	Coordination of Care	3	3	2	1	0	0	0	92%
XIV	Appeals	15	15	3	0	1	11	0	23%
XV	Advance Directives	6	6	4	1	0	1	0	79%
	Totals	60	60	27	5	8	20	0	58%

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

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

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

Strengths

Detroit-Wayne County CMH Agency received an overall compliance score of 58 percent across the six scored standards. Compliance with requirements related to the Provider Network standard received the PIHP's highest compliance score of 94 percent. Other areas of strength for this PIHP included Coordination of Care, with a 92 percent score, and Subcontracts and Delegation, with a score of 86 percent.

Recommendations

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

Summary Assessment Related to Quality, Timeliness, and Access

Detroit-Wayne County CMH Agency demonstrated its strongest performance in the area of compliance monitoring standards related to **quality**, with the PIHP's highest scores ranging from 86 percent to 94 percent in this domain. **Detroit-Wayne County CMH Agency** had, for the most part, comprehensive policies and procedures related to the management of delegated subcontractors and the provider network. The PIHP also received its lowest score of 23 percent in this domain, indicating a need to strengthen its policies, procedures, and processes related to beneficiary appeals. Findings for the two standards related to **timeliness** indicated an opportunity for improvement, with the PIHP receiving a score of 38 percent for Access and Availability, and a compliance rating of 23 percent for Appeals. Performance on the three standards related to **access** varied, with a 38 percent score for Access and Availability, 94 percent compliance for Provider Network, and 92 percent for Coordination of Care. Findings for the compliance monitoring standards indicated opportunities for improvement across the three domains of **quality**, **timeliness**, and **access**.

Genesee County CMH

Findings

Table 3-6 presents the number of elements for each of the six scored standards that received a score of *Met*, *Substantially Met*, *Partially Met*, *Not Met*, or *NA* and the totals across the six standards, the overall compliance score for each of the six scored standards, and the total compliance score across the six scored standards. Details of the scores for the review of the standards can be found in the 2006–2007 External Quality Review Compliance Monitoring Report for **Genesee County CMH**.

Table 3-6—2006–2007 Compliance Monitoring Scores *for* Genesee County CMH

Standard #	Standard Name	Total Elements	Total Applicable Elements	# *Met*	# *Substantially Met*	# *Partially Met*	# *Not Met*	# *NA*	Total Compliance Score
IX	Subcontracts and Delegation	7	0	0	0	0	0	7	*NA*
X	Provider Network	12	12	12	0	0	0	0	100%
XI	Credentialing								
XII	Access and Availability	17	17	10		4	3	0	71%
XIII	Coordination of Care	3	3	3	0	0	0	0	100%
XIV	Appeals	15	15	15	0	0	0	0	100%
XV	Advance Directives	6	6	5	0	1	0	0	92%
	Totals	60	53	45	0	5	3	7	90%

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

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

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

Strengths

Genesee County CMH received an overall compliance score of 90 percent across the six scored standards. The PIHP received a score of *NA* for the Subcontracts and Delegation standard because the PIHP's only delegated activities were those related to utilization management. The utilization management and related delegation requirements were reviewed previously in the Year I and II EQRs. **Genesee County CMH**'s performance for Provider Network, Coordination of Care, and Appeals reflected 100 percent compliance with all requirements, and no recommendations or PIHP corrective actions were required for these standards. The PIHP also met almost all requirements related to the credentialing standard.

Recommendations

Recommendations for improving **Genesee County CMH**'s performance addressed Credentialing, Access and Availability, and Advance Directives. The PIHP should implement corrective actions to ensure that its credentialing policy is compliant with all requirements of the MDCH credentialing policy, that the PIHP meets or exceeds the contractually required performance level for all services and population groups, and that all requirements related to advance directives are addressed.

Summary Assessment Related to Quality, Timeliness, and Access

Genesee County CMH demonstrated strength in the area of compliance monitoring standards related to **quality**, with three of the four applicable, scored standards receiving scores of 100 percent compliance. The PIHP had comprehensive policies and procedures and effective processes for managing its delegated subcontractors, the network of providers, and the local appeal process; for ensuring coordination of care among all service providers and systems involved in a beneficiary's care; and for addressing most requirements related to advance directives. Findings for the two standards related to **timeliness** indicated an opportunity for improvement with respect to meeting the contractually required minimum performance standards for all indicators and population groups, with the PIHP receiving its lowest score of 71 percent for Access and Availability. **Genesee County CMH** received a rating of 100 percent compliance for Appeals, the second standard in this domain. Performance on the three standards related to **access** varied, with a 71 percent score for Access and Availability and 100 percent compliance for Provider Network and Coordination of Care. The results for these three standards indicated that the PIHP had successfully developed policies, procedures, and processes to address beneficiaries' access to services, but needed to ensure more timely access for some services and population groups.

Lakeshore Behavioral Health Alliance

Findings

Table 3-7 presents the number of elements for each of the six scored standards that received a score of *Met*, *Substantially Met*, *Partially Met*, *Not Met*, or *NA* and the totals across the six standards, the overall compliance score for each of the six scored standards, and the total compliance score across the six scored standards. Details of the scores for the review of the standards can be found in the 2006–2007 External Quality Review Compliance Monitoring Report for **Lakeshore Behavioral Health Alliance**.

Table 3-7—2006–2007 Compliance Monitoring Scores *for* Lakeshore Behavioral Health Alliance

Standard #	Standard Name	Total Elements	Total Applicable Elements	# *Met*	# *Substantially Met*	# *Partially Met*	# *Not Met*	# *NA*	Total Compliance Score
IX	Subcontracts and Delegation	7	7	6	1	0	0	0	96%
X	Provider Network	12	12	12	0	0	0	0	100%
XI	Credentialing								
XII	Access and Availability	17	17	14		2	1	0	88%
XIII	Coordination of Care	3	3	3	0	0	0	0	100%
XIV	Appeals	15	15	13	1	1	0	0	95%
XV	Advance Directives	6	6	6	0	0	0	0	100%
	Totals	60	60	54	2	3	1	0	95%

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

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

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

Strengths

Lakeshore Behavioral Health Alliance received an overall compliance score of 95 percent across the six scored standards. The PIHP's performance for Provider Network, Coordination of Care, and Advance Directives reflected 100 percent compliance with all requirements, and no recommendations or PIHP corrective actions were required for these standards. **Lakeshore Behavioral Health Alliance** was compliant with almost all requirements related to Subcontracts and Delegation, as well as Appeals, receiving compliance scores of 96 percent and 95 percent, respectively.

Recommendations

Recommendations for improving **Lakeshore Behavioral Health Alliance**'s performance addressed Subcontracts and Delegation, Credentialing, Access and Availability, and Appeals. The PIHP should implement corrective actions to ensure that it addresses all requirements related to oversight of delegated functions and the local appeals process, that the credentialing policy is compliant with all requirements of the MDCH credentialing policy, and that the PIHP meets or exceeds the contractually required performance level for all services and population groups.

Summary Assessment Related to Quality, Timeliness, and Access

Lakeshore Behavioral Health Alliance demonstrated strength in the area of compliance monitoring standards related to **quality**, with all standards scoring 95 percent and above, and three of the five scored standards receiving scores of 100 percent compliance. The PIHP had comprehensive policies and procedures and effective processes for managing the network of providers and, for the most part, for managing its delegated subcontractors and the local appeal process; for ensuring coordination of care among all service providers and systems involved in a beneficiary's care; and for addressing requirements related to advance directives. Findings for the two standards related to **timeliness** indicated a few opportunities for improvement with respect to some requirements of the local appeal process and meeting the contractually required minimum performance standards for timely access to services. **Lakeshore Behavioral Health Alliance** received its lowest score of 88 percent for Access and Availability, and a rating of 95 percent compliance for Appeals. Performance on the three standards related to **access** was strong, with an 88 percent score for Access and Availability and 100 percent compliance for Provider Network and Coordination of Care. The results for these three standards indicated that the PIHP had successfully developed policies, procedures, and processes to address beneficiaries' access to services, and ensured timely access for most services and population groups.

LifeWays

Findings

Table 3-8 presents the number of elements for each of the six scored standards that received a score of *Met*, *Substantially Met*, *Partially Met*, *Not Met*, or *NA* and the totals across the six standards, the overall compliance score for each of the six scored standards, and the total compliance score across the six scored standards. Details of the scores for the review of the standards can be found in the 2006–2007 External Quality Review Compliance Monitoring Report for **LifeWays**.

Table 3-8—2006–2007 Compliance Monitoring Scores *for* LifeWays

Standard #	Standard Name	Total Elements	Total Applicable Elements	# *Met*	# *Substantially Met*	# *Partially Met*	# *Not Met*	# *NA*	Total Compliance Score
IX	Subcontracts and Delegation	7	7	6	1	0	0	0	96%
X	Provider Network	12	12	11	1	0	0	0	98%
XI	Credentialing								
XII	Access and Availability	17	17	9		5	3	0	68%
XIII	Coordination of Care	3	3	3	0	0	0	0	100%
XIV	Appeals	15	15	5	4	5	1	0	70%
XV	Advance Directives	6	6	6	0	0	0	0	100%
	Totals	60	60	40	6	10	4	0	83%

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

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

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

Strengths

LifeWays received an overall compliance score of 83 percent across the six scored standards. The PIHP's performance for Coordination of Care and Advance Directives reflected 100 percent compliance with all requirements, and no recommendations or PIHP corrective actions were required for these standards. **LifeWays** was compliant with almost all requirements related Subcontracts and Delegation, as well as Provider Network, receiving compliance scores of 96 percent and 98 percent, respectively.

Recommendations

Recommendations for improving **LifeWays**' performance addressed Subcontracts and Delegation, Provider Network, Credentialing, Access and Availability, and Appeals. The PIHP should implement corrective actions to ensure that it addresses all requirements related to oversight of delegated functions, management of the provider network, and the local appeals process; that the credentialing policy is compliant with all requirements of the MDCH credentialing policy; and that the PIHP meets or exceeds the contractually required performance level for all services and population groups.

Summary Assessment Related to Quality, Timeliness, and Access

LifeWays demonstrated strength in the area of compliance monitoring standards related to **quality**, with four of the five scored standards receiving scores of 96 percent and above. The PIHP, for the most part, had comprehensive policies and procedures and effective processes for managing the network of providers and delegated subcontractors; for ensuring coordination of care among all service providers and systems involved in a beneficiary's care; and for addressing requirements related to advance directives. Findings for the two standards related to **timeliness** indicated an opportunity for improvement with respect to the local appeal process and meeting the contractually required minimum performance standards for all indicators and population groups. **LifeWays** received its lowest scores in this domain, with 68 percent compliance for Access and Availability, and 70 percent compliance for Appeals. Performance on the three standards related to **access** varied, with a 68 percent score for Access and Availability, 98 percent compliance for Provider Network, and 100 percent compliance for Coordination of Care. The results for these three standards indicated that the PIHP had successfully developed policies, procedures, and processes to address beneficiaries' access to services, but needed to ensure more timely access for some services and population groups.

Macomb County CMH Services

Findings

Table 3-9 presents the number of elements for each of the six scored standards that received a score of *Met*, *Substantially Met*, *Partially Met*, *Not Met*, or *NA* and the totals across the six standards, the overall compliance score for each of the six scored standards, and the total compliance score across the six scored standards. Details of the scores for the review of the standards can be found in the 2006–2007 External Quality Review Compliance Monitoring Report for **Macomb County CMH Services**.

Table 3-9—2006–2007 Compliance Monitoring Scores *for* Macomb County CMH Services

Standard #	Standard Name	Total Elements	Total Applicable Elements	# *Met*	# *Substantially Met*	# *Partially Met*	# *Not Met*	# *NA*	Total Compliance Score
IX	Subcontracts and Delegation	7	7	5	1	1	0	0	89%
X	Provider Network	12	11	10	0	1	0	1	95%
XI	Credentialing								
XII	Access and Availability	17	17	13		1	3	0	79%
XIII	Coordination of Care	3	3	3	0	0	0	0	100%
XIV	Appeals	15	15	1	4	9	1	0	57%
XV	Advance Directives	6	6	4	0	2	0	0	83%
	Totals	60	59	36	5	14	4	1	79%

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

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

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

Strengths

Macomb County CMH Services received an overall compliance score of 79 percent across the six scored standards. The PIHP's performance for Coordination of Care reflected 100 percent compliance with all requirements, and no recommendations or PIHP corrective actions were required for these standards. Another area of strengths for the PIHP was the management of the provider network, with a score of 95 percent.

Recommendations

Recommendations for improving **Macomb County CMH Services**' performance addressed Subcontracts and Delegation, Provider Network, Credentialing, Access and Availability, Appeals, and Advance Directives. The PIHP should implement corrective actions to ensure that it addresses all requirements related to the oversight of delegated functions, the management of the provider network, the local appeals process, and advance directives; that the credentialing policy is compliant with all requirements of the MDCH credentialing policy; and that the PIHP meets or exceeds the contractually required performance level for all services and population groups.

Summary Assessment Related to Quality, Timeliness, and Access

Macomb County CMH Services demonstrated its strongest performance in the area of compliance monitoring standards related to **quality**. The PIHP, for the most part, had comprehensive policies and procedures and effective processes for managing the network of providers and delegated subcontractors; for ensuring coordination of care among all service providers and systems involved in a beneficiary's care; and for addressing requirements related to advance directives. Findings for the two standards related to **timeliness** indicated an opportunity for improvement with respect the local appeal process and meeting the contractually required minimum performance standards for all indicators and population groups. **Macomb County CMH Services** received its lowest scores in this domain, with 79 percent compliance for Access and Availability and 57 percent compliance for Appeals. Performance on the three standards related to **access** varied, with a 79 percent score for Access and Availability, 95 percent compliance for Provider Network and 100 percent compliance for Coordination of Care. The results for these three standards indicated that the PIHP had successfully developed policies, procedures, and processes to address beneficiaries' access to services, but needed to ensure more timely access for some services and population groups.

network180

Findings

Table 3-10 presents the number of elements for each of the six scored standards that received a score of *Met*, *Substantially Met*, *Partially Met*, *Not Met*, or *NA* and the totals across the six standards, the overall compliance score for each of the six scored standards, and the total compliance score across the six scored standards. Details of the scores for the review of the standards can be found in the 2006–2007 External Quality Review Compliance Monitoring Report for **network180**.

Table 3-10—2006–2007 Compliance Monitoring Scores *for* network180

Standard #	Standard Name	Total Elements	Total Applicable Elements	# *Met*	# *Substantially Met*	# *Partially Met*	# *Not Met*	# *NA*	Total Compliance Score
IX	Subcontracts and Delegation	7	7	6	0	1	0	0	93%
X	Provider Network	12	12	12	0	0	0	0	100%
XI	Credentialing								
XII	Access and Availability	17	17	12		2	3	0	77%
XIII	Coordination of Care	3	3	3	0	0	0	0	100%
XIV	Appeals	15	15	11	1	1	2	0	82%
XV	Advance Directives	6	6	2	1	1	2	0	54%
	Totals	60	60	46	2	5	7	0	83%

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

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

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

Strengths

network180 received an overall compliance score of 83 percent across the six scored standards. The PIHP's performance for Provider Network and Coordination of Care reflected 100 percent compliance with all requirements, and no recommendations or PIHP corrective actions were required for these standards. Subcontracts and Delegation was strength for the PIHP, with a score of 93 percent.

Recommendations

Recommendations for improving **network180**'s performance addressed Subcontracts and Delegation, Credentialing, Access and Availability, Appeals, and Advance Directives. The PIHP should implement corrective actions to ensure that it addresses all requirements related to the oversight of delegated functions, the management of the local appeals process, and advance directives; that the credentialing policy is compliant with all requirements of the MDCH credentialing policy; and that the PIHP meets or exceeds the contractually required performance level for all services and population groups.

Summary Assessment Related to Quality, Timeliness, and Access

network180 demonstrated strength in the area of compliance monitoring standards related to **quality**. The PIHP had comprehensive policies and procedures and effective processes for managing the network of providers, for most aspects of oversight of delegated subcontractors, and for ensuring coordination of care among all service providers and systems involved in a beneficiary's care. The PIHP also received its lowest score in this domain, with a score of 54 percent for Advance Directives. Findings for the two standards related to **timeliness** indicated an opportunity for improvement with respect to the local appeal process and meeting the contractually required minimum performance standards for all indicators and population groups. **network180** received a 77 percent compliance score for Access and Availability and a score of 82 percent compliance for Appeals. Performance on the three standards related to **access** varied, with a 77 percent score for Access and Availability and 100 percent compliance for Provider Network and Coordination of Care. The results for these three standards indicated that the PIHP had successfully developed policies, procedures, and processes to address beneficiaries' access to services, but needed to ensure more timely access for some services and population groups.

NorthCare

Findings

Table 3-11 presents the number of elements for each of the six scored standards that received a score of *Met*, *Substantially Met*, *Partially Met*, *Not Met*, or *NA* and the totals across the six standards, the overall compliance score for each of the six scored standards, and the total compliance score across the six scored standards. Details of the scores for the review of the standards can be found in the 2006–2007 External Quality Review Compliance Monitoring Report for **NorthCare**.

Table 3-11—2006–2007 Compliance Monitoring Scores *for* NorthCare

Standard #	Standard Name	Total Elements	Total Applicable Elements	# *Met*	# *Substantially Met*	# *Partially Met*	# *Not Met*	# *NA*	Total Compliance Score
IX	Subcontracts and Delegation	7	7	7	0	0	0	0	100%
X	Provider Network	12	12	12	0	0	0	0	100%
XI	Credentialing								
XII	Access and Availability	17	17	12		4	1	0	82%
XIII	Coordination of Care	3	3	3	0	0	0	0	100%
XIV	Appeals	15	15	15	0	0	0	0	100%
XV	Advance Directives	6	6	5	0	1	0	0	92%
	Totals	60	60	54	0	5	1	0	94%

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

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

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

Strengths

NorthCare received an overall compliance score of 94 percent across the six scored standards. The PIHP's performance for Subcontracts and Delegation, Provider Network, Coordination of Care and Appeals reflected 100 percent compliance with all requirements, and no recommendations or PIHP corrective actions were required for these standards. **NorthCare** was compliant with almost all requirements related to Advance Directives, receiving a compliance score of 92 percent.

Recommendations

Recommendations for improving **NorthCare**'s performance addressed Credentialing, Access and Availability, and Advance Directives. The PIHP should implement corrective actions to ensure that it addresses all requirements related advance directives; that the credentialing policy is compliant with all requirements of the MDCH credentialing policy; and that the PIHP meets or exceeds the contractually required performance level for all services and population groups.

Summary Assessment Related to Quality, Timeliness, and Access

NorthCare demonstrated strength in the area of compliance monitoring standards related to **quality**, with four of the five scored standards receiving scores of 100 percent, and the fifth standard receiving a score of 92 percent. The PIHP had comprehensive policies and procedures and effective processes for managing delegated subcontractors, the network of providers, and the local appeals process; for ensuring coordination of care among all service providers and systems involved in a beneficiary's care; and for addressing almost all requirements related to advance directives. Findings for the two standards related to **timeliness** indicated an opportunity for improvement with respect to meeting the contractually required minimum performance standards for all indicators and population groups, with **NorthCare** receiving its lowest score in this domain, 82 percent compliance for Access and Availability. The PIHP's performance on the second standard in this domain was strong, with 100 percent compliance for Appeals. Performance on the three standards related to **access** varied, with a score of 82 percent for Access and Availability and 100 percent compliance for Provider Network and Coordination of Care. The results for these three standards indicated that the PIHP had successfully developed policies, procedures, and processes to address beneficiaries' access to services, but needed to ensure more timely access for some services and population groups.

Northern Affiliation

Findings

Table 3-12 presents the number of elements for each of the six scored standards that received a score of *Met*, *Substantially Met*, *Partially Met*, *Not Met*, or *NA* and the totals across the six standards, the overall compliance score for each of the six scored standards, and the total compliance score across the six scored standards. Details of the scores for the review of the standards can be found in the 2006–2007 External Quality Review Compliance Monitoring Report for **Northern Affiliation**.

Table 3-12—2006–2007 Compliance Monitoring Scores *for* Northern Affiliation

Standard #	Standard Name	Total Elements	Total Applicable Elements	# *Met*	# *Substantially Met*	# *Partially Met*	# *Not Met*	# *NA*	Total Compliance Score
IX	Subcontracts and Delegation	7	7	6	0	1	0	0	93%
X	Provider Network	12	12	12	0	0	0	0	100%
XI	Credentialing								
XII	Access and Availability	17	17	14		3	0	0	91%
XIII	Coordination of Care	3	3	2	1	0	0	0	92%
XIV	Appeals	15	15	8	2	1	4	0	67%
XV	Advance Directives	6	6	3	1	1	1	0	71%
	Totals	60	60	45	4	6	5	0	85%

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

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

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

Strengths

Northern Affiliation received an overall compliance score of 85 percent across the six scored standards. The PIHP's performance for Provider Network reflected 100 percent compliance with all requirements, and no recommendations or PIHP corrective actions were required for this standard. Subcontracts and Delegation and Coordination of Care were other strengths for the PIHP, with compliance scores of 93 percent and 92 percent, respectively.

Recommendations

Recommendations for improving **Northern Affiliation**'s performance addressed Subcontracts and Delegation, Credentialing, Access and Availability, Appeals, and Advance Directives. The PIHP should implement corrective actions to ensure that it addresses all requirements related to oversight of delegated functions, the management of the local appeals process, and advance directives; that the credentialing policy is compliant with all requirements of the MDCH credentialing policy; and that the PIHP meets or exceeds the contractually required performance level for all services and population groups.

Summary Assessment Related to Quality, Timeliness, and Access

Northern Affiliation demonstrated strength in the area of compliance monitoring standards related to **quality**. The PIHP had comprehensive policies and procedures and effective processes for managing the network of providers and, for the most part, for oversight of delegated subcontractors; for ensuring coordination of care among all service providers and systems involved in a beneficiary's care; and for addressing most requirements related to advanced directives. The PIHP also received its lowest score in this domain, with a score of 67 percent for Appeals. Findings for one of the two standards related to **timeliness** indicated opportunities for improvement in the area of the local appeal process, with a compliance score of 67 percent. The second standard in this domain, Access and Availability, received a compliance score of 91 percent. Performance on the three standards related to **access** was strong, with a 91 percent score for Access and Availability, 100 percent compliance for Provider Network, and 92 percent for Coordination of Care. The results for these three standards indicated that the PIHP had successfully developed policies, procedures, and processes to address beneficiaries' access to services, and ensured timely access for most services and population groups.

Northwest CMH Affiliation

Findings

Table 3-13 presents the number of elements for each of the six scored standards that received a score of *Met*, *Substantially Met*, *Partially Met*, *Not Met*, or *NA* and the totals across the six standards, the overall compliance score for each of the six scored standards, and the total compliance score across the six scored standards. Details of the scores for the review of the standards can be found in the 2006–2007 External Quality Review Compliance Monitoring Report for **Northwest CMH Affiliation**.

Table 3-13—2006–2007 Compliance Monitoring Scores *for* Northwest CMH Affiliation

Standard #	Standard Name	Total Elements	Total Applicable Elements	# *Met*	# *Substantially Met*	# *Partially Met*	# *Not Met*	# *NA*	Total Compliance Score
IX	Subcontracts and Delegation	7	7	6	1	0	0	0	96%
X	Provider Network	12	12	9	3	0	0	0	94%
XI	Credentialing								
XII	Access and Availability	17	17	11		4	2	0	76%
XIII	Coordination of Care	3	3	3	0	0	0	0	100%
XIV	Appeals	15	15	14	1	0	0	0	98%
XV	Advance Directives	6	6	3	0	3	0	0	75%
	Totals	60	60	46	5	7	2	0	89%

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

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

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

Strengths

Northwest CMH Affiliation received an overall compliance score of 89 percent across the six scored standards. The PIHP's performance for Coordination of Care reflected 100 percent compliance with all requirements, and no recommendations or PIHP corrective actions were required for this standard. The Appeals standard and Subcontracts and Delegation were additional strengths for the PIHP, with scores of 98 percent and 96 percent, respectively. **Northwest CMH Affiliation** also met almost all of the requirements related to the Credentialing standard.

Recommendations

Recommendations for improving **Northwest CMH Affiliation**'s performance addressed Subcontracts and Delegation, Provider Network, Credentialing, Access and Availability, Appeals, and Advance Directives. The PIHP should implement corrective actions to ensure that it addresses all requirements related to the oversight of delegated functions and the provider network, the local appeals process, and advance directives; that the credentialing policy is compliant with all requirements of the MDCH credentialing policy; and that the PIHP meets or exceeds the contractually required performance level for all services and population groups.

Summary Assessment Related to Quality, Timeliness, and Access

Northwest CMH Affiliation demonstrated strength in the area of compliance monitoring standards related to **quality,** with scores of 94 percent to 100 percent for four of the five scored standards in this domain. The PIHP had comprehensive policies and procedures and effective processes addressing most requirements for managing the network of providers and delegated subcontractors; for ensuring coordination of care among all service providers and systems involved in a beneficiary's care; and for addressing most requirements related to appeals. The PIHP also received its lowest score in this domain, with a score of 75 percent for compliance with requirements related to advance directives. Findings for the two standards related to **timeliness** indicated an opportunity for improvement with respect to meeting the contractually required minimum performance standards for all indicators and population groups, with **Northwest CMH Affiliation** receiving a compliance score of 76 percent for Access and Availability. The PIHP received a score of 98 percent for Appeals, the second standard in this domain. Performance on the three standards related to **access** varied, with a 76 percent score for Access and Availability, 94 percent compliance for Provider Network and 100 percent compliance for Coordination of Care. The results for these three standards indicated that the PIHP had successfully developed policies, procedures, and processes to address beneficiaries' access to services, but needed to ensure more timely access for some services and population groups.

Oakland County CMH Authority

Findings

Table 3-14 presents the number of elements for each of the six scored standards that received a score of *Met*, *Substantially Met*, *Partially Met*, *Not Met*, or *NA* and the totals across the six standards, the overall compliance score for each of the six scored standards, and the total compliance score across the six scored standards. Details of the scores for the review of the standards can be found in the 2006–2007 External Quality Review Compliance Monitoring Report for **Oakland County CMH Authority**.

Table 3-14—2006–2007 Compliance Monitoring Scores *for* Oakland County CMH Authority

Standard #	Standard Name	Total Elements	Total Applicable Elements	# *Met*	# *Substantially Met*	# *Partially Met*	# *Not Met*	# *NA*	Total Compliance Score
IX	Subcontracts and Delegation	7	7	7	0	0	0	0	100%
X	Provider Network	12	12	12	0	0	0	0	100%
XI	Credentialing								
XII	Access and Availability	17	17	15		0	2	0	88%
XIII	Coordination of Care	3	3	3	0	0	0	0	100%
XIV	Appeals	15	15	13	2	0	0	0	97%
XV	Advance Directives	6	6	5	0	1	0	0	92%
	Totals	60	60	55	2	1	2	0	95%

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

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

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

Strengths

Oakland County CMH Authority received an overall compliance score of 95 percent across the six scored standards. The PIHP's performance for Subcontracts and Delegation, Provider Network, and Coordination of Care reflected 100 percent compliance with all requirements, and no recommendations or PIHP corrective actions were required for these standards. **Oakland County CMH Authority** was compliant with almost all elements assessed for the standards on Access and Availability, Appeals, and Advance Directives, receiving compliance scores of 88 percent, 97 percent, and 92 percent. The PIHP also met almost all of the requirements related to the Credentialing standard.

Recommendations

Recommendations for improving **Oakland County CMH Authority**'s performance addressed Credentialing, Access and Availability, Appeals and Advance Directives. The PIHP should implement corrective actions to ensure that its credentialing policy is compliant with all requirements of the MDCH credentialing policy; that the PIHP meets or exceeds the contractually required performance level for all services and population groups; and that the local appeal process and processes related to advance directives are fully compliant with all requirements.

Summary Assessment Related to Quality, Timeliness, and Access

Oakland County CMH Authority demonstrated strength in the area of compliance monitoring standards related to **quality**, with three of the five scored standards receiving scores of 100 percent compliance. The PIHP had comprehensive policies and procedures and effective processes for managing its network of providers and delegated subcontractors; for ensuring coordination of care among all service providers and systems involved in a beneficiary's care; for managing most aspects of the local appeal process; and for ensuring compliance with most requirements related to advance directives. Findings for the two standards related to **timeliness** indicated a few opportunities for improvement with respect to the processing of beneficiary appeals and meeting the contractually required minimum performance standards for all indicators and population groups. The PIHP received its lowest score in this domain, 88 percent for Access and Availability, and a 97 percent compliance rating for appeals. Performance on the three standards related to **access** was strong, with an 88 percent score for Access and Availability, and 100 percent compliance for Provider Network and Coordination of Care. The results for these three standards indicated that **Oakland County CMH Authority** had successfully developed policies, procedures, and processes to address beneficiaries' access to services, and ensured timely access for most services and population groups.

Saginaw County CMH Authority

Findings

Table 3-15 presents the number of elements for each of the six scored standards that received a score of *Met*, *Substantially Met*, *Partially Met*, *Not Met*, or *NA* and the totals across the six standards, the overall compliance score for each of the six scored standards, and the total compliance score across the six scored standards. Details of the scores for the review of the standards can be found in the 2006–2007 External Quality Review Compliance Monitoring Report for **Saginaw County CMH Authority**.

Table 3-15—2006–2007 Compliance Monitoring Scores *for* Saginaw County CMH Authority

Standard #	Standard Name	Total Elements	Total Applicable Elements	# *Met*	# *Substantially Met*	# *Partially Met*	# *Not Met*	# *NA*	Total Compliance Score
IX	Subcontracts and Delegation	7	7	6	0	0	1	0	86%
X	Provider Network	12	12	12	0	0	0	0	100%
XI	Credentialing								
XII	Access and Availability	17	17	5		0	12	0	29%
XIII	Coordination of Care	3	3	3	0	0	0	0	100%
XIV	Appeals	15	15	13	1	1	0	0	95%
XV	Advance Directives	6	6	6	0	0	0	0	100%
	Totals	60	60	45	1	1	13	0	77%

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

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

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

Strengths

Saginaw County CMH Authority received an overall compliance score of 77 percent across the six scored standards. The PIHP's performance for Provider Network, Coordination of Care, and Advance Directives reflected 100 percent compliance with all requirements, and no recommendations or PIHP corrective actions were required for these standards. Another area of strength for **Saginaw County CMH Authority** was the local appeal process, with a compliance score of 95 percent.

Recommendations

Recommendations for improving **Saginaw County CMH Authority**'s performance addressed Subcontracts and Delegation, Credentialing, Access and Availability, and Appeals. The PIHP should implement corrective actions to ensure that it meets all requirements related to the delegation of functions to its subcontractors, that its credentialing policy is compliant with all requirements of the MDCH credentialing policy, that the PIHP meets or exceeds the contractually required performance level for all services and population groups, and that the local appeal process is fully compliant with all requirements.

Summary Assessment Related to Quality, Timeliness, and Access

Saginaw County CMH Authority demonstrated strength in the area of compliance monitoring standards related to **quality**, with three of the five scored standards receiving scores of 100 percent compliance. The PIHP had comprehensive policies and procedures and effective processes for managing its network of providers and, for the most part, oversight of its delegated subcontractors; for ensuring coordination of care among all service providers and systems involved in a beneficiary's care; and for managing most aspects of the local appeal process. Findings for the two standards related to **timeliness** indicated opportunities for improvement with respect to meeting the contractually required minimum performance standards for all indicators and population groups, with the PIHP receiving its lowest score of 29 percent for Access and Availability. The PIHP received a 95 percent compliance rating for Appeals, the second standard in this domain. Performance on the three standards related to **access** varied, with a 29 percent score for Access and Availability and 100 percent compliance for Provider Network and Coordination of Care. The results for these three standards indicated that **Saginaw County CMH Authority** had successfully developed policies, procedures, and processes to address beneficiaries' access to services, but needed to ensure timely access for most services and population groups.

Southwest Affiliation

Findings

Table 3-16 presents the number of elements for each of the six scored standards that received a score of *Met*, *Substantially Met*, *Partially Met*, *Not Met*, or *NA* and the totals across the six standards, the overall compliance score for each of the six scored standards, and the total compliance score across the six scored standards. Details of the scores for the review of the standards can be found in the 2006–2007 External Quality Review Compliance Monitoring Report for **Southwest Affiliation**.

Table 3-16—2006–2007 Compliance Monitoring Scores *for* Southwest Affiliation

Standard #	Standard Name	Total Elements	Total Applicable Elements	# *Met*	# *Substantially Met*	# *Partially Met*	# *Not Met*	# *NA*	Total Compliance Score
IX	Subcontracts and Delegation	7	7	6	1	0	0	0	96%
X	Provider Network	12	12	11	1	0	0	0	98%
XI	Credentialing								
XII	Access and Availability	17	17	13		3	1	0	85%
XIII	Coordination of Care	3	3	3	0	0	0	0	100%
XIV	Appeals	15	15	13	2	0	0	0	97%
XV	Advance Directives	6	6	3	1	2	0	0	79%
	Totals	60	60	49	5	5	1	0	92%

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

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

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

Strengths

Southwest Affiliation received an overall compliance score of 92 percent across the six scored standards. The PIHP's performance on Coordination of Care reflected 100 percent compliance with all requirements, and no recommendations or PIHP corrective actions were required for this standard. Other areas of strength for **Southwest Affiliation** were Provider Network, Appeals, and Subcontracts and Delegation, with compliance scores of 96 percent and above.

Recommendations

Recommendations for improving **Southwest Affiliation**'s performance addressed Subcontracts and Delegation, Provider Network, Credentialing, Access and Availability, Appeals, and Advance Directives. The PIHP should implement corrective actions to ensure that it meets all requirements related to the management of delegation functions, the provider network, and the local appeals process; that its credentialing policy is compliant with all requirements of the MDCH credentialing policy; that the PIHP meets or exceeds the contractually required performance level for all services and population groups; and that the processes related to advance directives are fully compliant with all requirements.

Summary Assessment Related to Quality, Timeliness, and Access

Southwest Affiliation demonstrated strength in the area of compliance monitoring standards related to **quality**, with four of the five scored standards receiving scores of 96 percent to 100 percent. The PIHP, for the most part, had comprehensive policies and procedures and effective processes for managing its network of providers and for oversight of its delegated subcontractors; for ensuring coordination of care among all service providers and systems involved in a beneficiary's care; and for managing most aspects of the local appeal process. Findings for the two standards related to **timeliness** indicated opportunities for improvement with respect to meeting the contractually required minimum performance standards for all indicators and population groups and processing beneficiary appeals, with the PIHP receiving its lowest score of 85 percent for Access and Availability. The PIHP received a 97 percent compliance rating for Appeals, the second standard in this domain. Performance on the three standards related to **access** varied, with an 85 percent score for Access and Availability, 98 percent compliance for Provider Network and 100 percent compliance for Coordination of Care. The results for these three standards indicated that **Southwest Affiliation** had successfully developed policies, procedures, and processes to address beneficiaries' access to services, but needed to ensure more timely access for some services and population groups.

Thumb Alliance PIHP

Findings

Table 3-17 presents the number of elements for each of the six scored standards that received a score of *Met*, *Substantially Met*, *Partially Met*, *Not Met*, or *NA* and the totals across the six standards, the overall compliance score for each of the six scored standards, and the total compliance score across the six scored standards. Details of the scores for the review of the standards can be found in the 2006–2007 External Quality Review Compliance Monitoring Report for **Thumb Alliance PIHP**.

Table 3-17—2006–2007 Compliance Monitoring Scores *for* Thumb Alliance PIHP

Standard #	Standard Name	Total Elements	Total Applicable Elements	# *Met*	# *Substantially Met*	# *Partially Met*	# *Not Met*	# *NA*	Total Compliance Score
IX	Subcontracts and Delegation	7	7	7	0	0	0	0	100%
X	Provider Network	12	12	12	0	0	0	0	100%
XI	Credentialing								
XII	Access and Availability	17	17	16		1	0	0	97%
XIII	Coordination of Care	3	3	3	0	0	0	0	100%
XIV	Appeals	15	15	15	0	0	0	0	100%
XV	Advance Directives	6	6	4	0	2	0	0	83%
	Totals	60	60	57	0	3	0	0	98%

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

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

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

Strengths

Thumb Alliance PIHP received an overall compliance score of 98 percent across the six scored standards. The PIHP's performance for Subcontracts and Delegation, Provider Network, Credentialing, Coordination of Care, and Appeals reflected 100 percent compliance with all requirements, and no recommendations or PIHP corrective actions were required for these standards. **Thumb Alliance PIHP** also met almost all requirements related to Access and Availability.

Recommendations

Recommendations for improving **Thumb Alliance PIHP**'s performance addressed Access and Availability and Advance Directives. The PIHP should implement corrective actions to ensure that the PIHP consistently meets or exceeds the contractually required performance level for all services and population groups, and that all requirements related to advance directives are met.

Summary Assessment Related to Quality, Timeliness, and Access

Thumb Alliance PIHP demonstrated strength in the area of compliance monitoring standards related to **quality**, with four of the five scored standards receiving scores of 100 percent compliance. The PIHP had comprehensive policies and procedures and effective processes for managing its delegated subcontractors, the network of providers, and the local appeal process, and for ensuring coordination of care among all service providers and systems involved in a beneficiary's care. Findings for the two standards related to **timeliness** indicated strong performance, with **Thumb Alliance PIHP** receiving a score of 97 percent for Access and Availability, and a 100 percent compliance rating for Appeals. Performance on the three standards related to **access** was strong, with a 97 percent score for Access and Availability and 100 percent compliance for Provider Network and Coordination of Care. The results for these three standards indicated that the PIHP had successfully developed policies, procedures, and processes to address beneficiaries' access to services, and ensured timely access for almost all services and population groups.

Venture Behavioral Health

Findings

Table 3-18 presents the number of elements for each of the six scored standards that received a score of *Met*, *Substantially Met*, *Partially Met*, *Not Met*, or *NA* and the totals across the six standards, the overall compliance score for each of the six scored standards, and the total compliance score across the six scored standards. Details of the scores for the review of the standards can be found in the 2006–2007 External Quality Review Compliance Monitoring Report for **Venture Behavioral Health**.

Table 3-18—2006–2007 Compliance Monitoring Scores *for* Venture Behavioral Health

Standard #	Standard Name	Total Elements	Total Applicable Elements	# *Met*	# *Substantially Met*	# *Partially Met*	# *Not Met*	# *NA*	Total Compliance Score
IX	Subcontracts and Delegation	7	7	6	1	0	0	0	96%
X	Provider Network	12	12	11	1	0	0	0	98%
XI	Credentialing								
XII	Access and Availability	17	17	8		1	8	0	50%
XIII	Coordination of Care	3	3	3	0	0	0	0	100%
XIV	Appeals	15	15	14	1	0	0	0	98%
XV	Advance Directives	6	6	5	1	0	0	0	96%
	Totals	60	60	47	4	1	8	0	84%

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

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

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

Strengths

Venture Behavioral Health received an overall compliance score of 84 percent across the six scored standards. The PIHP's performance for Coordination of Care reflected 100 percent compliance with all requirements, and no recommendations or PIHP corrective actions were required for this standard. Subcontracts and Delegation, Provider Network, Credentialing, Appeals, and Advance Directives were additional strengths, with the PIHP meeting almost all requirements for these standards.

Recommendations

Recommendations for improving **Venture Behavioral Health**'s performance addressed Subcontracts and Delegation, Provider Network, Credentialing, Access and Availability, Appeals, and Advance Directives. The PIHP should implement corrective actions to ensure that it addresses all requirements related to oversight of delegated functions, management of the local appeals process, and advance directives; that the credentialing policy is compliant with all requirements of the MDCH credentialing policy; and that the PIHP meets or exceeds the contractually required performance level for all services and population groups.

Summary Assessment Related to Quality, Timeliness, and Access

Venture Behavioral Health demonstrated strength in the area of compliance monitoring standards related to **quality**, with compliance scores of 96 percent to 100 percent. The PIHP, for the most part, had comprehensive policies and procedures and effective processes for managing the network of providers and its delegated subcontractors; for ensuring coordination of care among all service providers and systems involved in a beneficiary's care; and for addressing requirements related to appeals and advance directives. Findings for the two standards related to **timeliness** indicated an opportunity for improvement with respect to meeting the contractually required minimum performance standards for all indicators and population groups, with **Venture Behavioral Health** receiving a 50 percent compliance score for Access and Availability. The PIHP received a score of 98 percent for Appeals, the second standard in this domain, as it was compliant with almost all requirements related to the local appeals process. Performance on the three standards related to **access** varied, with a 50 percent score for Access and Availability and high scores on the other two standards. The PIHP scored 100 percent compliance for Coordination of Care and 98 percent compliance for Provider Network, indicating that the PIHP had successfully developed policies, procedures, and processes to address beneficiaries' access to services, but needed to ensure more timely access for some services and population groups.

Validation of Performance Measures

This section of the report presents the results for the validation of performance measures and shows audit designations and reported rates. Indicators 13 and 14 were included in the 2006–2007 validation of performance measures for the first time. While these two indicators received an audit designation, rates for this reporting period were not available.

Access Alliance of Michigan

Findings

Table 3-19 below presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2007 Validation of Performance Measures Report for **Access Alliance of Michigan** includes additional details of the validation results.

Table 3-19—2006–2007 Performance Measure Results *for* Access Alliance of Michigan

Performance Measure	Reported Rate	Audit Designation
Indicator 1. Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children: 100% Adults: 98.10%	*Fully Compliant*
Indicator 2. Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	97.97%	*Fully Compliant*
Indicator 3. Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 calendar days of a nonemergent assessment with a professional.	97.55%	*Fully Compliant*
Indicator 4a. Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children: 100% Adults: 100%	*Fully Compliant*
Indicator 4b. Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	90.91%	*Fully Compliant*
Indicator 5. Percentage of Medicaid recipients having received PIHP-managed services (Penetration rate).	7.26%	*Fully Compliant*
Indicator 8. Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination (HSW rate).	94.95%	*Fully Compliant*
Indicator 12. Percentage of children and adults readmitted to a psychiatric inpatient unit within 30 days of discharge.	Children: 4.76% Adults: 10.00%	*Fully Compliant*
Indicator 13. The annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by the PIHPs.		*Substantially Compliant*
Indicator 14. Number of sentinel events during the six-month period per 1,000 Medicaid beneficiaries served, by the following populations: adults with mental illness, children with mental illness, persons with developmental disabilities not on the HSW, persons on the HSW, and persons with a substance abuse disorder.		*Fully Compliant*

Strengths

Identified strengths for **Access Alliance of Michigan** included use of a standardized system to collect data, work groups and committee structures that helped ensure uniform business practices and efficient communication PIHP-wide, and an excellent feedback loop between the PIHP and the CMHCs for encounter submission and performance indicator data.

Recommendations

Recommendations for improving **Access Alliance of Michigan**'s performance included updates to any outdated policies and procedures and retraining of some CMHC staff regarding reporting requirements for Indicator 13. The PIHP should formalize existing processes for review and monitoring of quality improvement (QI) data in order to continue to improve completeness and accuracy of the data and explore ways to encourage uniform methods for the CMHCs to submit updates to QI data.

Summary Assessment Related to Quality, Timeliness, and Access

Access Alliance of Michigan's performance indicators related to **quality** were fully compliant with MDCH specifications, except for Indicator 13, which received a designation of *Substantially Compliant*. The PIHP met or exceeded four of the five contractually required performance standards related to **quality** of services provided by the PIHP. **Access Alliance of Michigan** improved the rates for timely follow-up care after discharge from a psychiatric inpatient unit to 100 percent and met the standard for 30-day readmission rates. The PIHP's HSW rate of 95 percent was higher than the statewide rate of 94 percent. Performance indicators related to **timeliness** of and **access** to services were *Fully Compliant* with MDCH specifications. The PIHP met or exceeded the contractually required performance standards for all performance measures related to **timeliness** of and **access** to services provided by the PIHP after increasing the rates for timely initial assessments, initial service, and follow-up care above 95 percent. **Access Alliance of Michigan** continued to provide timely preadmission screenings to children and adults. The PIHP's penetration rate of 7 percent exceeded the statewide rate of 6 percent. **Access Alliance of Michigan** demonstrated strong performance across all three domains and marked improvement by increasing the number of indicators that met the minimum performance standard from four indicators in 2005–2006 to eight in this reporting period.

CMH Affiliation of Mid-Michigan

Findings

Table 3-20 below presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2007 Validation of Performance Measures Report for **CMH Affiliation of Mid-Michigan** includes additional details of the validation results.

Table 3-20—2006–2007 Performance Measure Results *for* CMH Affiliation of Mid-Michigan

Performance Measure	Reported Rate	Audit Designation
Indicator 1. Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children: 100% Adults: 96.50%	*Fully Compliant*
Indicator 2. Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	99.40%	*Fully Compliant*
Indicator 3. Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 calendar days of a nonemergent assessment with a professional.	97.51%	*Fully Compliant*
Indicator 4a. Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children: 100% Adults: 95.45%	*Fully Compliant*
Indicator 4b. Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	100%	*Fully Compliant*
Indicator 5. Percentage of Medicaid recipients having received PIHP-managed services (Penetration rate).	5.77%	*Fully Compliant*
Indicator 8. Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination (HSW rate).	97.05%	*Fully Compliant*
Indicator 12. Percentage of children and adults readmitted to a psychiatric inpatient unit within 30 days of discharge.	Children: 7.69% Adults: 11.43%	*Fully Compliant*
Indicator 13. The annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by the PIHPs.		*Fully Compliant*
Indicator 14. Number of sentinel events during the six-month period per 1,000 Medicaid beneficiaries served, by the following populations: adults with mental illness, children with mental illness, persons with developmental disabilities not on the HSW, persons on the HSW, and persons with a substance abuse disorder.		*Fully Compliant*

Strengths

CMH Affiliation of Mid-Michigan demonstrated best practices for documentation and oversight of the CMHCs. The PIHP implemented standardized processes for collection and reporting of QI data across the CMHCs. Data from the coordinating agency (CA) showed commendable improvement over the past year.

Recommendations

Recommendations for **CMH Affiliation of Mid-Michigan** included continued improvement of coordination with the CA, additional oversight of the recipient rights function, and continued efforts toward further automation of the processes for reporting of indicators.

Summary Assessment Related to Quality, Timeliness, and Access

CMH Affiliation of Mid-Michigan's performance indicators related to **quality** were *Fully Compliant* with MDCH specifications. The PIHP met or exceeded the contractually required performance standards for all indicators related to **quality** of services provided by the PIHP. The PIHP's HSW rate of 97 percent was higher than the statewide rate. Performance indicators related to **timeliness** of and **access** to services were *Fully Compliant* with MDCH specifications. The PIHP met or exceeded the contractually required performance standards for all performance measures related to **timeliness** of and **access** to services of services provided by the PIHP. The PIHP's penetration rate equaled the statewide rate. **CMH Affiliation of Mid-Michigan** demonstrated strong performance and improvement over prior years across all three domains. The PIHP improved the three rates for timely follow-up care after discharge, increasing the number of indicators that met the minimum performance standard from six indicators in 2005–2006 to all nine in this reporting period. **CMH Affiliation of Mid-Michigan** also improved its compliance with the specifications for performance measure reporting for the three indicators deemed *Not Valid* in 2005–2006, resulting in all measures receiving audit designations of *Fully Compliant* for the 2006–2007 validation.

CMH for Central Michigan

Findings

Table 3-21 below presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2007 Validation of Performance Measures Report for **CMH for Central Michigan** includes additional details of the validation results.

Table 3-21—2006–2007 Performance Measure Results *for* CMH for Central Michigan

Performance Measure	Reported Rate	Audit Designation
Indicator 1. Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children: 100% Adults: 100%	*Fully Compliant*
Indicator 2. Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	94.58%	*Fully Compliant*
Indicator 3. Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 calendar days of a nonemergent assessment with a professional.	92.16%	*Fully Compliant*
Indicator 4a. Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children: 88.89% Adults: 100%	*Fully Compliant*
Indicator 4b. Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	100%	*Fully Compliant*
Indicator 5. Percentage of Medicaid recipients having received PIHP-managed services (Penetration rate).	7.95%	*Fully Compliant*
Indicator 8. Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination (HSW rate).	97.16%	*Fully Compliant*
Indicator 12. Percentage of children and adults readmitted to a psychiatric inpatient unit within 30 days of discharge.	Children: 11.11% Adults: 8.33%	*Fully Compliant*
Indicator 13. The annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by the PIHPs.		*Fully Compliant*
Indicator 14. Number of sentinel events during the six-month period per 1,000 Medicaid beneficiaries served, by the following populations: adults with mental illness, children with mental illness, persons with developmental disabilities not on the HSW, persons on the HSW, and persons with a substance abuse disorder.		*Fully Compliant*

Strengths

CMH for Central Michigan developed a uniform data system that resulted in enhanced data quality by integrating an extensive amount of automation into the data collection and calculation processes for performance indicator reporting. The PIHP established a formalized communication and feedback loop by making performance indicator and demographic data available to its providers online and in real time, allowing providers to check for possible errors and/or missing data. **CMH for Central Michigan** had established good oversight and monitoring of encounter submissions by pulling all data from the PIHP's centralized data system.

Recommendations

Recommendations for improvement for **CMH for Central Michigan** included formalizing the oversight of the CA and involving the CA in discussions and reviews of the indicator data and results. The PIHP was encouraged to explore automated means for the preparation and submission of the encounter file to MDCH.

Summary Assessment Related to Quality, Timeliness, and Access

CMH for Central Michigan's performance indicators related to **quality** were *Fully Compliant* with MDCH specifications. The PIHP improved the rates for timely follow-up care for adults after discharge from a psychiatric inpatient unit and the 30-day readmission rate for children and met or exceeded four of the five contractually required performance standards related to **quality** of services provided by the PIHP. The PIHP's HSW rate of 97 percent was higher than the statewide rate. Performance indicators related to **timeliness** of and **access** to services were *Fully Compliant* with MDCH specifications. The PIHP met or exceeded the contractually required performance standards for four of the seven performance measures related to **timeliness** of and **access** to services provided by the PIHP. The PIHP's penetration rate of 8 percent exceeded the statewide rate. **CMH for Central Michigan** provided timely pre-admission screenings for adults and children, as well as follow-up care to adults following discharge from a psychiatric inpatient or detox unit. While the PIHP increased the rate of children receiving timely follow-up care, **CMH for Central Michigan** did not meet the minimum performance standard of 95 percent. The PIHP demonstrated its strongest performance in the **quality** domain, showed improvement in all three domains, and increased the number of indicators that met the minimum performance standard from five in 2005–2006 to six in this reporting period.

CMH Partnership of Southeastern Michigan

Findings

Table 3-22 below presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2007 Validation of Performance Measures Report for **CMH Partnership of Southeastern Michigan** includes additional details of the validation results.

Table 3-22—2006–2007 Performance Measure Results *for* CMH Partnership of Southeastern Michigan

Performance Measure	Reported Rate	Audit Designation
Indicator 1. Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children: 98.90% Adults: 99.70%	*Fully Compliant*
Indicator 2. Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	100%	*Fully Compliant*
Indicator 3. Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 calendar days of a nonemergent assessment with a professional.	99.00%	*Fully Compliant*
Indicator 4a. Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children: 100% Adults: 96.88%	*Fully Compliant*
Indicator 4b. Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	100%	*Fully Compliant*
Indicator 5. Percentage of Medicaid recipients having received PIHP-managed services (Penetration rate).	6.28%	*Fully Compliant*
Indicator 8. Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination (HSW rate).	85.03%	*Fully Compliant*
Indicator 12. Percentage of children and adults readmitted to a psychiatric inpatient unit within 30 days of discharge.	Children: 0.00% Adults: 1.39%	*Fully Compliant*
Indicator 13. The annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by the PIHPs.		*Fully Compliant*
Indicator 14. Number of sentinel events during the six-month period per 1,000 Medicaid beneficiaries served, by the following populations: adults with mental illness, children with mental illness, persons with developmental disabilities not on the HSW, persons on the HSW, and persons with a substance abuse disorder.		*Fully Compliant*

Strengths

CMH Partnership of Southeastern Michigan's standardized collection of performance indicators across affiliates continued to be a best practice. Audits of the PIHP's affiliates and the CA led to improved data completeness and accuracy. **CMH Partnership of Southeastern Michigan** demonstrated a proactive approach for integrating Indicator 13 into the PIHP's Encompass reporting system.

Recommendations

Recommendations for improvement for **CMH Partnership of Southeastern Michigan** included trending of encounter data submission in order to more readily identify missing data, developing automated processes for the recipient rights indicator, and continued tracking and trending for identification of outlier hospital discharges.

Summary Assessment Related to Quality, Timeliness, and Access

CMH Partnership of Southeastern Michigan's performance indicators related to **quality** were *Fully Compliant* with MDCH specifications. The PIHP increased its rates of timely follow-up care after discharge from a psychiatric inpatient unit for children and met or exceeded all contractually required performance standards related to **quality** of services provided by the PIHP. The PIHP's HSW rate of 85 percent was lower than the statewide rate. Performance indicators related to **timeliness** of and **access** to services were *Fully Compliant* with MDCH specifications. The PIHP met or exceeded the contractually required performance standards for all performance measures related to **timeliness** of and **access** to services provided by the PIHP. The PIHP's penetration rate equaled the statewide rate of 6 percent. **CMH Partnership of Southeastern Michigan** demonstrated continued strong performance across all three domains, meeting seven of the performance standards in 2005–2006 and all nine in this reporting period.

Detroit-Wayne County CMH Agency

Findings

Table 3-23 below presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2007 Validation of Performance Measures Report for **Detroit-Wayne County CMH Agency** includes additional details of the validation results.

Table 3-23—2006–2007 Performance Measure Results *for* Detroit-Wayne County CMH Agency

Performance Measure	Reported Rate	Audit Designation
Indicator 1. Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children: 98.06% Adults: 96.83%	*Fully Compliant*
Indicator 2. Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	94.40%	*Fully Compliant*
Indicator 3. Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 calendar days of a nonemergent assessment with a professional.	86.51%	*Fully Compliant*
Indicator 4a. Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children: 94.85% Adults: 86.36%	*Fully Compliant*
Indicator 4b. Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	96.92%	*Fully Compliant*
Indicator 5. Percentage of Medicaid recipients having received PIHP-managed services (Penetration rate).	4.57%	*Fully Compliant*
Indicator 8. Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination (HSW rate).	89.51%	*Fully Compliant*
Indicator 12. Percentage of children and adults readmitted to a psychiatric inpatient unit within 30 days of discharge.	Children: 2.20% Adults: 12.55%	*Fully Compliant*
Indicator 13. The annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by the PIHPs.		*Fully Compliant*
Indicator 14. Number of sentinel events during the six-month period per 1,000 Medicaid beneficiaries served, by the following populations: adults with mental illness, children with mental illness, persons with developmental disabilities not on the HSW, persons on the HSW, and persons with a substance abuse disorder.		*Fully Compliant*

Strengths

Detroit-Wayne County CMH Agency demonstrated great improvement in its performance measures compared to last year, with none of the rates receiving an audit designation of *Not Valid* for this reporting period. The PIHP's use of a data warehouse with regular error checking resulted in improved data accuracy and facilitated aggregating the data from the PIHP's provider network. The use of E-forms for data collection of performance measure data ensured data comparability and accuracy. **Detroit-Wayne County CMH Agency** has shown a proactive information technology (IT) approach in moving to a new integrated system.

Recommendations

Recommendations for improvement for **Detroit-Wayne County CMH Agency** included increased documentation and formalization of current oversight activities of the PIHP's comprehensive provider network and expanded documentation of activities related to data completeness. The PIHP should include the CA in the data verification activities.

Summary Assessment Related to Quality, Timeliness, and Access

Detroit-Wayne County CMH Agency's performance indicators related to **quality** were *Fully Compliant* with MDCH specifications. The PIHP met or exceeded three of the five contractually required performance standards related to **quality** of services provided by the PIHP. The PIHP's 30-day readmission rates and the percentage of timely follow-up care following discharge from a detox unit complied with the applicable performance standards. The PIHP's HSW rate of 90 percent was lower than the statewide rate. Performance indicators related to **timeliness** of and **access** to services were *Fully Compliant* with MDCH specifications. The PIHP met or exceeded the contractually required performance standards for three of the seven performance measures related to **timeliness** of and **access** to services provided by the PIHP. The PIHP increased the rates for timely pre-admission screenings for children and adults and continued to provide timely follow-up care following discharge from a detox unit. The PIHP's penetration rate of 5 percent was lower than the statewide rate. While **Detroit-Wayne County CMH Agency** demonstrated improved performance, opportunities for improvement remained across all three domains, as the PIHP met two performance standards in 2005–2006 and five in this reporting period.

Genesee County CMH

Findings

Table 3-24 below presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2007 Validation of Performance Measures Report for **Genesee County CMH** includes additional details of the validation results.

Table 3-24—2006–2007 Performance Measure Results *for* Genesee County CMH

Performance Measure	Reported Rate	Audit Designation
Indicator 1. Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children: 97.50% Adults: 96.98%	*Fully Compliant*
Indicator 2. Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	99.42%	*Fully Compliant*
Indicator 3. Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 calendar days of a nonemergent assessment with a professional.	96.86%	*Fully Compliant*
Indicator 4a. Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children: 96.55% Adults: 95.45%	*Fully Compliant*
Indicator 4b. Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	100%	*Fully Compliant*
Indicator 5. Percentage of Medicaid recipients having received PIHP-managed services (Penetration rate).	4.67%	*Fully Compliant*
Indicator 8. Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination (HSW rate).	96.07%	*Fully Compliant*
Indicator 12. Percentage of children and adults readmitted to a psychiatric inpatient unit within 30 days of discharge.	Children: 24.39% Adults: 11.76%	*Fully Compliant*
Indicator 13. The annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by the PIHPs.		*Substantially Compliant*
Indicator 14. Number of sentinel events during the six-month period per 1,000 Medicaid beneficiaries served, by the following populations: adults with mental illness, children with mental illness, persons with developmental disabilities not on the HSW, persons on the HSW, and persons with a substance abuse disorder.		*Fully Compliant*

Strengths

Genesee County CMH implemented multiple initiatives focusing on data quality and completeness and had processes in place to validate data at all levels of the organization. The PIHP used programmatic code to extract data for performance indicator reporting and validated the data through peer review.

Recommendations

Recommendation for improvement for **Genesee County CMH** included automation of processes to improve data completeness and exploring the development of a custom-built application for data submission by the CA in order to replace the current IT application, CareNet.

Summary Assessment Related to Quality, Timeliness, and Access

Genesee County CMH's performance indicators related to **quality** were *Fully Compliant* with MDCH specifications, except for Indicator 13, which received a designation of *Substantially Compliant*. The PIHP increased its rates for timely follow-up care after discharge from a psychiatric inpatient or detox unit and met or exceeded four of the five contractually required performance standards related to **quality** of services provided by the PIHP. **Genesee County CMH** exceeded the standard for the 30-day readmission rate for children. The PIHP's HSW rate of 96 percent was higher than the statewide rate. Performance indicators related to **timeliness** of and **access** to services were *Fully Compliant* with MDCH specifications. The PIHP met or exceeded the contractually required performance standards for all performance measures related to **timeliness** of and **access** to services provided by the PIHP after increasing the rates of timely follow-up care as well as timely initiation of needed, ongoing services. The PIHP's penetration rate of 5 percent was lower than the statewide rate. **Genesee County CMH** demonstrated strong performance and improvement over last year's rates across all three domains, increasing the number of indicators that met the minimum performance standard from four indicators in 2005–2006 to eight for this reporting period.

Lakeshore Behavioral Health Alliance

Findings

Table 3-25 below presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2007 Validation of Performance Measures Report for **Lakeshore Behavioral Health Alliance** includes additional details of the validation results.

Table 3-25—2006–2007 Performance Measure Results *for* Lakeshore Behavioral Health Alliance

Performance Measure	Reported Rate	Audit Designation
Indicator 1. Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children: 97.14% Adults: 100%	*Fully Compliant*
Indicator 2. Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	98.80%	*Fully Compliant*
Indicator 3. Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 calendar days of a nonemergent assessment with a professional.	94.21%	*Fully Compliant*
Indicator 4a. Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children: 100% Adults: 98.00%	*Fully Compliant*
Indicator 4b. Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	90.91%	*Fully Compliant*
Indicator 5. Percentage of Medicaid recipients having received PIHP-managed services (Penetration rate).	*Not Valid*	*Not Valid*
Indicator 8. Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination (HSW rate).	97.78%	*Fully Compliant*
Indicator 12. Percentage of children and adults readmitted to a psychiatric inpatient unit within 30 days of discharge.	Children: 5.88% Adults: 11.67%	*Fully Compliant*
Indicator 13. The annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by the PIHPs.		*Fully Compliant*
Indicator 14. Number of sentinel events during the six-month period per 1,000 Medicaid beneficiaries served, by the following populations: adults with mental illness, children with mental illness, persons with developmental disabilities not on the HSW, persons on the HSW, and persons with a substance abuse disorder.		*Fully Compliant*

Strengths

Adequate collaboration between the PIHP and its subcontractors ensured complete and accurate data submission and uniform interpretation of performance indicators. The PIHP facilitated uniform data completion and reporting activities through the implementation and continued use of the Avatar system. **Lakeshore Behavioral Health Alliance** demonstrated its commitment to quality and accurate data.

Recommendations

Recommendations for improvement for **Lakeshore Behavioral Health Alliance** included continued work with the Avatar system to ensure that encounter data can be reported from the Avatar system to MDCH. Performance Indicator 5, penetration rate, was again found to be *Not Valid* due to continuing system conversion issues. The PIHP should formalize a validation process for a review of the performance indicator (PI) data entry prior to submission of data to MDCH and continue to work on automating the performance indicator processes.

Summary Assessment Related to Quality, Timeliness, and Access

Lakeshore Behavioral Health Alliance's performance indicators related to **quality** were *Fully Compliant* with MDCH specifications. The PIHP improved its rate of follow-up care for children and met or exceeded four of the five contractually required performance standards related to **quality** of services provided by the PIHP. The PIHP's 30-day readmission rates for children and adults and the percentage of timely follow-up care for children and adults following discharge from an inpatient unit complied with the applicable performance standards. The PIHP's HSW rate of 98 percent was higher than the statewide rate. Performance indicators related to **timeliness** were *Fully Compliant* with MDCH specifications. For indicators related to **access** to services, the PIHP also received audit designations of *Fully Compliant* for all measures except one: the penetration rate received an audit designation of *Not Valid*. The PIHP met or exceeded the contractually required performance standards for five of the seven performance measures related to **timeliness** of and **access** to services by providing timely preadmission screenings and initial assessments, and follow-up care following discharge from a psychiatric inpatient unit. The PIHP demonstrated improvement over last year's rate in a measure that related to all three domains and met the performance standard for a total of seven indicators in 2005–2006 and 2006–2007.

LifeWays

Findings

Table 3-26 below presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2007 Validation of Performance Measures Report for **LifeWays** includes additional details of the validation results.

Table 3-26—2006–2007 Performance Measure Results *for* LifeWays

Performance Measure	Reported Rate	Audit Designation
Indicator 1. Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children: 100% Adults: 99.00%	*Fully Compliant*
Indicator 2. Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	97.78%	*Fully Compliant*
Indicator 3. Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 calendar days of a nonemergent assessment with a professional.	97.59%	*Fully Compliant*
Indicator 4a. Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children: 100% Adults: 96.23%	*Fully Compliant*
Indicator 4b. Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	100%	*Fully Compliant*
Indicator 5. Percentage of Medicaid recipients having received PIHP-managed services (Penetration rate).	5.70%	*Fully Compliant*
Indicator 8. Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination (HSW rate).	91.97%	*Fully Compliant*
Indicator 12. Percentage of children and adults readmitted to a psychiatric inpatient unit within 30 days of discharge.	Children: 7.14% Adults: 14.55%	*Fully Compliant*
Indicator 13. The annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by the PIHPs.		*Fully Compliant*
Indicator 14. Number of sentinel events during the six-month period per 1,000 Medicaid beneficiaries served, by the following populations: adults with mental illness, children with mental illness, persons with developmental disabilities not on the HSW, persons on the HSW, and persons with a substance abuse disorder.		*Fully Compliant*

Strengths

LifeWays enhanced the accuracy of performance measure reporting through monthly error/exception analysis of the performance indicator and QI data and subsequent discussion in QI meetings. **LifeWays'** staff demonstrated thorough knowledge of the PIHP data and the performance measure reporting process and a commitment to accurate performance measure reporting.

Recommendations

LifeWays should continue to work toward automation of the processes for the calculation of the performance measures and consider using only standard claims forms, eliminating the use of nonstandard proprietary forms, to ensure collection of all necessary data to support performance measure reporting.

Summary Assessment Related to Quality, Timeliness, and Access

LifeWays' performance indicators related to **quality** were *Fully Compliant* with MDCH specifications. The PIHP improved its rates for timely follow-up after discharge from a psychiatric inpatient unit and the 30-day readmission rate for adults and met or exceeded all contractually required performance standards related to **quality** of services provided by the PIHP. The PIHP's HSW rate of 92 percent was lower than the statewide rate. Performance indicators related to **timeliness** of and **access** to services were *Fully Compliant* with MDCH specifications. The PIHP improved its rates for follow-up care and timely initial assessments and met or exceeded the contractually required performance standards for all performance measures related to **timeliness** of and **access** to services provided by the PIHP. The PIHP's penetration rate equaled the statewide rate. **LifeWays** demonstrated improvement in its compliance with MDCH specifications for the performance measures, raising the audit designation for six indicators from *Substantially Compliant* in 2005–2006 to *Fully Compliant* in 2006–2007. The PIHP increased the number of indicators that met the minimum performance standard from five in 2005–2006 to all nine in this reporting period. **LifeWays** demonstrated strong performance across all three domains.

Macomb County CMH Services

Findings

Table 3-27 below presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2007 Validation of Performance Measures Report for **Macomb County CMH Services** includes additional details of the validation results.

Table 3-27—2006–2007 Performance Measure Results *for* Macomb County CMH Services

Performance Measure	Reported Rate	Audit Designation
Indicator 1. Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children: 97.10% Adults: 99.11%	*Fully Compliant*
Indicator 2. Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	96.95%	*Fully Compliant*
Indicator 3. Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 calendar days of a nonemergent assessment with a professional.	94.68%	*Fully Compliant*
Indicator 4a. Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children: 66.67% Adults: 64.20%	*Fully Compliant*
Indicator 4b. Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	92.31%	*Fully Compliant*
Indicator 5. Percentage of Medicaid recipients having received PIHP-managed services (Penetration rate).	5.78%	*Fully Compliant*
Indicator 8. Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination (HSW rate).	98.31%	*Fully Compliant*
Indicator 12. Percentage of children and adults readmitted to a psychiatric inpatient unit within 30 days of discharge.	Children: 21.74% Adults: 13.58%	*Fully Compliant*
Indicator 13. The annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by the PIHPs.		*Fully Compliant*
Indicator 14. Number of sentinel events during the six-month period per 1,000 Medicaid beneficiaries served, by the following populations: adults with mental illness, children with mental illness, persons with developmental disabilities not on the HSW, persons on the HSW, and persons with a substance abuse disorder.		*Fully Compliant*

Strengths

Macomb County CMH Services transitioned all data processes into one system, which facilitated accurate and complete aggregate performance measure reporting. The PIHP demonstrated a proactive approach to data integrity and accuracy, and its staff continued to demonstrate a thorough knowledge of PIHP data and the performance measure reporting process. Because **Macomb County CMH Services** functioned as the CA, definitions and interpretations of performance measure indicators were uniform across the PIHP.

Recommendations

Recommendations for **Macomb County CMH Services** included automating the recipient rights measure; developing a systematic, but secure, process for tracking sentinel event data; and continuing to transition providers from paper submission to direct entry of claims.

Summary Assessment Related to Quality, Timeliness, and Access

Macomb County CMH Services' performance indicators related to **quality** were *Fully Compliant* with MDCH specifications. The PIHP met or exceeded one of the five contractually required performance standards related to **quality** of services provided by the PIHP. The PIHP's 30-day readmission rate for adults increased to meet the applicable performance standards. The PIHP's HSW rate of 98 percent was higher than the statewide rate. Performance indicators related to **timeliness** of and **access** to services were *Fully Compliant* with MDCH specifications. The PIHP continued to meet or exceeded the contractually required performance standards for three of the seven performance measures related to **timeliness** of and **access** to services by providing timely preadmission screenings and initial assessments. The PIHP's penetration rate equaled the statewide rate. **Macomb County CMH Services** met five of the performance standards in 2005–2006 and four in this reporting period. Several opportunities for improvement continued to exist across all three domains.

network180

Findings

Table 3-28 below presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2007 Validation of Performance Measures Report for **network180** includes additional details of the validation results.

Table 3-28—2006–2007 Performance Measure Results *for* network180

Performance Measure	Reported Rate	Audit Designation
Indicator 1. Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children: 97.30% Adults: 98.25%	*Fully Compliant*
Indicator 2. Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	97.78%	*Fully Compliant*
Indicator 3. Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 calendar days of a nonemergent assessment with a professional.	88.94%	*Fully Compliant*
Indicator 4a. Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children: 100% Adults: 95.24%	*Fully Compliant*
Indicator 4b. Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	100%	*Fully Compliant*
Indicator 5. Percentage of Medicaid recipients having received PIHP-managed services (Penetration rate).	5.44%	*Fully Compliant*
Indicator 8. Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination (HSW rate).	95.81%	*Fully Compliant*
Indicator 12. Percentage of children and adults readmitted to a psychiatric inpatient unit within 30 days of discharge.	Children: 8.51% Adults: 13.39%	*Fully Compliant*
Indicator 13. The annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by the PIHPs.		*Fully Compliant*
Indicator 14. Number of sentinel events during the six-month period per 1,000 Medicaid beneficiaries served, by the following populations: adults with mental illness, children with mental illness, persons with developmental disabilities not on the HSW, persons on the HSW, and persons with a substance abuse disorder.		*Fully Compliant*

Strengths

network180 demonstrated a strong commitment to data integrity, completeness, and accuracy, with an emphasis on having accurate data for reporting and assessing the impact on care. PIHP staff exhibited teamwork across all business practices. **network180**'s implementation of an incentive program linked to performance indicators was identified as a best practice.

Recommendations

Recommendations for improvement for **network180** addressed exploring possibilities to facilitate more complete encounter data, validation of data entry for recipient rights data, and electronic data submission by providers.

Summary Assessment Related to Quality, Timeliness, and Access

network180's performance indicators related to **quality** were *Fully Compliant* with MDCH specifications. The PIHP improved the rates for follow-up care for adults and the 30-day readmission rate for adults and met or exceeded all contractually required performance standards related to **quality** of services provided by the PIHP. The PIHP's HSW rate of 96 percent was higher than the statewide rate. Performance indicators related to **timeliness** of and **access** to services were *Fully Compliant* with MDCH specifications. The PIHP met or exceeded the contractually required performance standards for six of the seven performance measures related to **timeliness** of and **access** to services provided by the PIHP. **network180** provided timely preadmission screenings, initial assessments, and follow-up care after discharge from a psychiatric inpatient or detox unit. The PIHP's penetration rate of 5 percent was lower than the statewide rate. **network180** demonstrated strong performance and improvement across all three domains by increasing the number of indicators that met the minimum performance standard from five indicators in 2005–2006 to eight in this reporting period.

NorthCare

Findings

Table 3-29 below presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2007 Validation of Performance Measures Report for **NorthCare** includes additional details of the validation results.

Table 3-29—2006–2007 Performance Measure Results *for* NorthCare

Performance Measure	Reported Rate	Audit Designation
Indicator 1. Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children: 98.53% Adults: 99.16%	*Fully Compliant*
Indicator 2. Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	97.94%	*Fully Compliant*
Indicator 3. Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 calendar days of a nonemergent assessment with a professional.	98.50%	*Fully Compliant*
Indicator 4a. Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children: 100% Adults: 96.55%	*Fully Compliant*
Indicator 4b. Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	100%	*Fully Compliant*
Indicator 5. Percentage of Medicaid recipients having received PIHP-managed services (Penetration rate).	6.57%	*Fully Compliant*
Indicator 8. Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination (HSW rate).	95.69%	*Fully Compliant*
Indicator 12. Percentage of children and adults readmitted to a psychiatric inpatient unit within 30 days of discharge.	Children: 23.08% Adults: 25.00%	*Fully Compliant*
Indicator 13. The annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by the PIHPs.		*Fully Compliant*
Indicator 14. Number of sentinel events during the six-month period per 1,000 Medicaid beneficiaries served, by the following populations: adults with mental illness, children with mental illness, persons with developmental disabilities not on the HSW, persons on the HSW, and persons with a substance abuse disorder.		*Fully Compliant*

Strengths

NorthCare staff demonstrated a strong commitment to the performance measure process. Collaboration between the PIHP and its affiliates enhanced the completeness and accuracy of the data reporting processes. The PIHP implemented weekly reports that assisted in maintaining a high level of data integrity and completeness. The increased control of data and the ability to submit data in an 837 format were additional strengths for the PIHP.

Recommendations

Recommendations for improvement for **NorthCare** addressed selecting and implementing a standardized data system across the PIHP, documentation of quality control processes, and more detailed discussion of the data oversight processes in the meeting minutes of the Data Warehouse Committee. The PIHP should consider reviewing the Medicaid performance audits performed by the CMHCs.

Summary Assessment Related to Quality, Timeliness, and Access

NorthCare's performance indicators related to **quality** were *Fully Compliant* with MDCH specifications. The PIHP increased its rate of timely follow-up care to adults after discharge from a psychiatric inpatient or detox unit and met or exceeded three of the five contractually required performance standards related to **quality** of services provided by the PIHP. The PIHP's HSW rate of 96 percent was higher than the statewide rate. Performance indicators related to **timeliness** of and **access** to services were *Fully Compliant* with MDCH specifications. The PIHP increased its rate of timely follow-up care, timely initial assessments, and timely initiation of ongoing services; continued to provide timely preadmission screenings; and met or exceeded the contractually required performance standards for all performance measures related to **timeliness** of and **access** to services provided by the PIHP. The PIHP's penetration rate of 7 percent exceeded the statewide rate. **NorthCare** demonstrated strong performance and improvement across all three domains and increased the number of indicators that met the minimum performance standard from four indicators in 2005–2006 to seven in this reporting period.

Northern Affiliation

Findings

Table 3-30 below presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2007 Validation of Performance Measures Report for **Northern Affiliation** includes additional details of the validation results.

Table 3-30—2006–2007 Performance Measure Results *for* Northern Affiliation

Performance Measure	Reported Rate	Audit Designation
Indicator 1. Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children: 100% Adults: 98.24%	*Fully Compliant*
Indicator 2. Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	94.46%	*Fully Compliant*
Indicator 3. Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 calendar days of a nonemergent assessment with a professional.	96.37%	*Fully Compliant*
Indicator 4a. Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children: 100% Adults: 100%	*Fully Compliant*
Indicator 4b. Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	100%	*Fully Compliant*
Indicator 5. Percentage of Medicaid recipients having received PIHP-managed services (Penetration rate).	6.74%	*Fully Compliant*
Indicator 8. Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination (HSW rate).	94.43%	*Fully Compliant*
Indicator 12. Percentage of children and adults readmitted to a psychiatric inpatient unit within 30 days of discharge.	Children: 0.00% Adults: 6.67%	*Fully Compliant*
Indicator 13. The annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by the PIHPs.		*Fully Compliant*
Indicator 14. Number of sentinel events during the six-month period per 1,000 Medicaid beneficiaries served, by the following populations: adults with mental illness, children with mental illness, persons with developmental disabilities not on the HSW, persons on the HSW, and persons with a substance abuse disorder.		*Fully Compliant*

Strengths

Northern Affiliation's unified data system and single access center for all affiliates ensured comparable data and facilitated aggregate performance measure reporting. The PIHP strengthened completeness of encounter data through monthly performance unit tracking reports and the new utilization management dashboard. **Northern Affiliation**'s use of MDCH quality improvement data fields as PIHP performance measures along with monthly reporting and verification were identified as an industry best practice.

Recommendations

Recommendations for improvement for **Northern Affiliation** addressed continued, comprehensive oversight of CA performance indicator data, more formal documentation of audit and verification processes, and development of an overall data completeness and accuracy report and assessment tool. The PIHP should consider expanding the process of medical record review documentation and perform data-entry checks for the manually entered performance indicator data.

Summary Assessment Related to Quality, Timeliness, and Access

Northern Affiliation's performance indicators related to **quality** were *Fully Compliant* with MDCH specifications. The PIHP increased its rate of timely follow-up care after discharge from a detox unit and met or exceeded all contractually required performance standards related to **quality** of services provided by the PIHP. The PIHP's HSW rate of 94 percent was higher than the statewide rate. Performance indicators related to **timeliness** of and **access** to services were *Fully Compliant* with MDCH specifications. The PIHP met or exceeded the contractually required performance standards for six of the seven performance measures related to **timeliness** of and **access** to services provided by the PIHP. **Northern Affiliation** provided timely preadmission screenings, increased the rate of timely initiation of ongoing services, and provided timely follow-up care after discharge from a psychiatric inpatient or detox unit. The PIHP's penetration rate of 7 percent was higher than the statewide rate. **Northern Affiliation** continued to demonstrate strong performance across all three domains and increased the number of indicators that met the minimum performance standard from seven in 2005–2006 to eight in this reporting period.

Northwest CMH Affiliation

Findings

Table 3-31 below presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2007 Validation of Performance Measures Report for **Northwest CMH Affiliation** includes additional details of the validation results.

Table 3-31—2006–2007 Performance Measure Results *for* Northwest CMH Affiliation

Performance Measure	Reported Rate	Audit Designation
Indicator 1. Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children: 97.83% Adults: 99.26%	*Fully Compliant*
Indicator 2. Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	98.38%	*Fully Compliant*
Indicator 3. Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 calendar days of a nonemergent assessment with a professional.	98.80%	*Fully Compliant*
Indicator 4a. Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children: 81.25% Adults: 95.77%	*Fully Compliant*
Indicator 4b. Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	100%	*Fully Compliant*
Indicator 5. Percentage of Medicaid recipients having received PIHP-managed services (Penetration rate).	7.16%	*Fully Compliant*
Indicator 8. Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination (HSW rate).	93.89%	*Fully Compliant*
Indicator 12. Percentage of children and adults readmitted to a psychiatric inpatient unit within 30 days of discharge.	Children: 5.13% Adults: 5.95%	*Fully Compliant*
Indicator 13. The annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by the PIHPs.		*Fully Compliant*
Indicator 14. Number of sentinel events during the six-month period per 1,000 Medicaid beneficiaries served, by the following populations: adults with mental illness, children with mental illness, persons with developmental disabilities not on the HSW, persons on the HSW, and persons with a substance abuse disorder.		*Fully Compliant*

Strengths

Northwest CMH Affiliation demonstrated excellent communication and collaboration with its affiliates and the CA. The PIHP implemented good reconciliation and validation processes for all aspects of data reporting to MDCH. **Northwest CMH Affiliation** improved its data extraction capabilities and increased its confidence in data completeness as a result of the implementation of the new Avatar system.

Recommendations

Recommendations for improvement for **Northwest CMH Affiliation** addressed continued monitoring of CA data, particularly with respect to timely data submission; documentation of exclusions for performance indicators; and continued efforts to move toward further automation of performance indicator reporting.

Summary Assessment Related to Quality, Timeliness, and Access

Northwest CMH Affiliation's performance indicators related to **quality** were *Fully Compliant* with MDCH specifications. The PIHP increased its rate for timely follow-up care after discharge from a psychiatric inpatient unit for adults and met or exceeded four of the five contractually required performance standards related to **quality** of services provided by the PIHP. The PIHP provided timely follow-up care for adults after discharge from a psychiatric inpatient or detox unit and met the performance standard for 30-day readmissions for children and adults. The PIHP's HSW rate of 94 percent was the same as the statewide rate. Performance indicators related to **timeliness** of and **access** to services provided by the PIHP were *Fully Compliant* with MDCH specifications. The PIHP met or exceeded the contractually required performance standards for six of the seven performance measures related to **timeliness** of and **access** to services. **Northwest CMH Affiliation** increased the rate of timely initiation of ongoing services and provided timely pre-admission screenings and initial assessments, as well as follow-up care to children and adults following discharge from a psychiatric inpatient or detox unit. The PIHP's penetration rate of 7 percent exceeded the statewide rate. **Northwest CMH Affiliation** demonstrated strong performance and improvement across all three domains and increased the number of indicators that met the minimum performance standard from six in 2005–2006 to eight in this reporting period.

Oakland County CMH Authority

Findings

Table 3-32 below presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2007 Validation of Performance Measures Report for **Oakland County CMH Authority** includes additional details of the validation results.

Table 3-32—2006–2007 Performance Measure Results *for* Oakland County CMH Authority

Performance Measure	Reported Rate	Audit Designation
Indicator 1. Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children: 96.81% Adults: 96.59%	*Fully Compliant*
Indicator 2. Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	97.45%	*Fully Compliant*
Indicator 3. Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 calendar days of a nonemergent assessment with a professional.	98.45%	*Fully Compliant*
Indicator 4a. Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children: 100% Adults: 96.61%	*Fully Compliant*
Indicator 4b. Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	100%	*Fully Compliant*
Indicator 5. Percentage of Medicaid recipients having received PIHP-managed services (Penetration rate).	7.59%	*Fully Compliant*
Indicator 8. Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination (HSW rate).	98.28%	*Fully Compliant*
Indicator 12. Percentage of children and adults readmitted to a psychiatric inpatient unit within 30 days of discharge.	Children: 10.71% Adults: 18.06%	*Fully Compliant*
Indicator 13. The annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by the PIHPs.		*Fully Compliant*
Indicator 14. Number of sentinel events during the six-month period per 1,000 Medicaid beneficiaries served, by the following populations: adults with mental illness, children with mental illness, persons with developmental disabilities not on the HSW, persons on the HSW, and persons with a substance abuse disorder.		*Fully Compliant*

Strengths

Oakland County CMH Authority had strong oversight and validation processes in place to ensure the accuracy and completeness of data submitted by its providers. The PIHP's use of the Peter Chang Enterprises (PCE) and PEARL systems provided multiple reporting capabilities beyond those required by MDCH.

Recommendations

Recommendations for improvement for **Oakland County CMH Authority** addressed continued movement toward automation of data collection for the reporting of performance indicators and continued close monitoring and oversight of the system conversion process by some of the PIHP's providers.

Summary Assessment Related to Quality, Timeliness, and Access

Oakland County CMH Authority's performance indicators related to **quality** were *Fully Compliant* with MDCH specifications. The PIHP increased its rate for timely follow-up care after discharge from a detox unit and met or exceeded four of the five contractually required performance standards related to **quality** of services provided by the PIHP. The PIHP provided timely follow-up care after discharge from a psychiatric inpatient or detox unit and met the performance standard for 30-day readmissions for children. The PIHP's HSW rate of 98 percent was higher than the statewide rate. Performance indicators related to **timeliness** of and **access** to services were *Fully Compliant* with MDCH specifications. **Oakland County CMH Authority** provided timely pre-admission screenings, timely initial assessments, and timely initiation of ongoing services, as well as follow-up care following discharge from a psychiatric inpatient or detox unit. The PIHP met or exceeded the contractually required performance standards for all performance measures related to **timeliness** of and **access** to services provided by the PIHP. The PIHP's penetration rate of 7 percent exceeded the statewide rate. **Oakland County CMH Authority** demonstrated strong performance across all three domains, as well as improvement, by increasing the number of indicators that met the performance standard from five in 2005–2006 to eight in this reporting period.

Saginaw County CMH Authority

Findings

Table 3-33 below presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2007 Validation of Performance Measures Report for **Saginaw County CMH Authority** includes additional details of the validation results.

Table 3-33—2006–2007 Performance Measure Results *for* Saginaw County CMH Authority

Performance Measure	Reported Rate	Audit Designation
Indicator 1. Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children: 100% Adults: 100%	*Fully Compliant*
Indicator 2. Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	100%	*Fully Compliant*
Indicator 3. Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 calendar days of a nonemergent assessment with a professional.	94.77%	*Fully Compliant*
Indicator 4a. Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children: 83.33% Adults: 80.77%	*Fully Compliant*
Indicator 4b. Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	47.37%	*Fully Compliant*
Indicator 5. Percentage of Medicaid recipients having received PIHP-managed services (Penetration rate).	4.07%	*Fully Compliant*
Indicator 8. Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination (HSW rate).	83.19%	*Fully Compliant*
Indicator 12. Percentage of children and adults readmitted to a psychiatric inpatient unit within 30 days of discharge.	Children: 21.43% Adults: 15.15%	*Fully Compliant*
Indicator 13. The annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by the PIHPs.		*Substantially Compliant*
Indicator 14. Number of sentinel events during the six-month period per 1,000 Medicaid beneficiaries served, by the following populations: adults with mental illness, children with mental illness, persons with developmental disabilities not on the HSW, persons on the HSW, and persons with a substance abuse disorder.		*Fully Compliant*

Strengths

Saginaw County CMH Authority increased its monitoring and oversight of the CA and implemented processes to formally track and validate exclusions for Indicator 4. PIHP staff demonstrated a solid team approach to the information systems conversion and performance indicator reporting. The PIHP began implementation of the new Encompass system to ensure reliable data moving forward.

Recommendations

Recommendations for improvement for **Saginaw County CMH Authority** addressed implementation of formal validation processes for all performance indicators prior to submitting data to MDCH and reprogramming of the system to account for exceptions to performance indicator data, eliminating the need for manual follow-up.

Summary Assessment Related to Quality, Timeliness, and Access

Saginaw County CMH Authority's performance indicators related to **quality** were *Fully Compliant* with MDCH specifications, except for Indicator 13, which received a designation of S*ubstantially Compliant*. The PIHP did not meet any of the five contractually required performance standards related to **quality** of services provided by the PIHP. The PIHP's HSW rate of 83 percent was lower than the statewide rate. Performance indicators related to **timeliness** of and **access** to services were *Fully Compliant* with MDCH specifications. The PIHP met or exceeded the contractually required performance standards for three of the seven performance measures related to **timeliness** of and **access** to services provided by the PIHP. **Saginaw County CMH Authority** provided timely preadmission screenings and increased its rate of timely initial assessments. The PIHP's penetration rate of 4 percent was lower than the statewide rate. While **Saginaw County CMH Authority** demonstrated improvement by achieving audit designations of *Fully Compliant* for the five measures previously rated *Substantially Compliant* or *Not Valid* in 2005–2006, the PIHP continued to demonstrate opportunities for improvement across all three domains, meeting three performance standards in 2005–2006 and three in this reporting period.

Southwest Affiliation

Findings

Table 3-34 below presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2007 Validation of Performance Measures Report for **Southwest Affiliation** includes additional details of the validation results.

Table 3-34—2006–2007 Performance Measure Results *for* Southwest Affiliation

Performance Measure	Reported Rate	Audit Designation
Indicator 1. Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children: 100% Adults: 99.55%	*Fully Compliant*
Indicator 2. Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	98.15%	*Fully Compliant*
Indicator 3. Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 calendar days of a nonemergent assessment with a professional.	96.41%	*Fully Compliant*
Indicator 4a. Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children: 100% Adults: 98.25%	*Fully Compliant*
Indicator 4b. Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	100%	*Fully Compliant*
Indicator 5. Percentage of Medicaid recipients having received PIHP-managed services (Penetration rate).	6.66%	*Fully Compliant*
Indicator 8. Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination (HSW rate).	94.85%	*Fully Compliant*
Indicator 12. Percentage of children and adults readmitted to a psychiatric inpatient unit within 30 days of discharge.	Children: 4.17% Adults: 6.33%	*Fully Compliant*
Indicator 13. The annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by the PIHPs.		*Fully Compliant*
Indicator 14. Number of sentinel events during the six-month period per 1,000 Medicaid beneficiaries served, by the following populations: adults with mental illness, children with mental illness, persons with developmental disabilities not on the HSW, persons on the HSW, and persons with a substance abuse disorder.		*Fully Compliant*

Strengths

Southwest Affiliation facilitated aggregate reporting and outlier verification by using a data warehouse. The multilevel verification process for outliers enhanced data accuracy and demonstrated the PIHP's proactive approach to data integrity and accuracy. **Southwest Affiliation**'s staff continued to demonstrate thorough knowledge of PIHP data and the performance measure reporting process and a commitment to accurate performance measure reporting.

Recommendations

Recommendations for improvement for **Southwest Affiliation** addressed documentation of the oversight of the community mental health services programs (CMHSPs) related to performance indicator calculation, development of formal policies and procedures for the audit process, and the need for consistent definitions for indicator reporting. In addition to the existing verification processes, the PIHP should consider checking the accuracy of the encounter data at the PIHP level prior to submitting data to MDCH.

Summary Assessment Related to Quality, Timeliness, and Access

Southwest Affiliation's performance indicators related to **quality** were *Fully Compliant* with MDCH specifications. The PIHP met or exceeded all contractually required performance standards related to **quality** of services provided by the PIHP. The PIHP increased its rates of timely follow-up care for children and adults after discharge from a psychiatric inpatient unit, maintained the rate for follow-up care after discharge from a detox unit, and lowered the rates for 30-day readmissions for children and adults to meet the standard. The PIHP's HSW rate of 95 percent was higher than the statewide rate. Performance indicators related to **timeliness** of and **access** to services were *Fully Compliant* with MDCH specifications. The PIHP met or exceeded the contractually required performance standards for all performance measures related to **timeliness** of and **access** to services provided by the PIHP. **Southwest Affiliation** provided timely pre-admissions screenings, timely initial assessments, timely initiation of ongoing services, and timely follow-up care following discharge from a psychiatric inpatient or detox unit. The PIHP's penetration rate of 7 percent exceeded the statewide rate. **Southwest Affiliation** demonstrated strong performance across all three domains and increased the number of indicators that met the performance standard from five in 2005–2006 to all nine in this reporting period.

Thumb Alliance PIHP

Findings

Table 3-35 below presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2007 Validation of Performance Measures Report for **Thumb Alliance PIHP** includes additional details of the validation results.

Table 3-35—2006–2007 Performance Measure Results *for* Thumb Alliance PIHP

Performance Measure	Reported Rate	Audit Designation
Indicator 1. Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children: 100% Adults: 100%	*Fully Compliant*
Indicator 2. Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	100%	*Fully Compliant*
Indicator 3. Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 calendar days of a nonemergent assessment with a professional.	99.53%	*Fully Compliant*
Indicator 4a. Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children: 100% Adults: 98.28%	*Fully Compliant*
Indicator 4b. Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	100%	*Fully Compliant*
Indicator 5. Percentage of Medicaid recipients having received PIHP-managed services (Penetration rate).	7.02%	*Fully Compliant*
Indicator 8. Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination (HSW rate).	99.66%	*Fully Compliant*
Indicator 12. Percentage of children and adults readmitted to a psychiatric inpatient unit within 30 days of discharge.	Children: 12.50% Adults: 20.00%	*Fully Compliant*
Indicator 13. The annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by the PIHPs.		*Fully Compliant*
Indicator 14. Number of sentinel events during the six-month period per 1,000 Medicaid beneficiaries served, by the following populations: adults with mental illness, children with mental illness, persons with developmental disabilities not on the HSW, persons on the HSW, and persons with a substance abuse disorder.		*Fully Compliant*

Strengths

Thumb Alliance PIHP's document for assessment of data completeness, Review of Data Accuracy and Completeness, reflected a best practice. The weekly/monthly outlier review and correction process was another PIHP best practice. The PIHP's interactive and cooperative relationship with the CMHCs enhanced data accuracy. **Thumb Alliance PIHP**'s staff continued to demonstrate thorough knowledge of PIHP data and the performance measure validation process, as well as a commitment to accurate performance measure reporting.

Recommendations

Recommendations for improvement for **Thumb Alliance PIHP** addressed continued integration of CA data to ensure data completeness and accuracy and activities toward automating the calculation of performance measures. The PIHP should consider expanding the data warehouse to include all data sources to facilitate additional exploratory analysis.

Summary Assessment Related to Quality, Timeliness, and Access

Thumb Alliance PIHP's performance indicators related to **quality** were *Fully Compliant* with MDCH specifications. The PIHP increased the rates of timely follow-up care after discharge from a psychiatric inpatient unit for children and adults and met or exceeded four of the five contractually required performance standards related to **quality** of services provided by the PIHP. The PIHP provided timely follow-up care for children and adults after discharge from a psychiatric inpatient or detox unit and met the performance standard for 30-day readmissions for children. The PIHP's HSW rate of 100 percent was higher than the statewide rate. Performance indicators related to **timeliness** of and **access** to services were *Fully Compliant* with MDCH specifications. The PIHP met or exceeded the contractually required performance standards for all performance measures related to **timeliness** of and **access** to services provided by the PIHP. **Thumb Alliance PIHP** provided timely pre-admission screenings, timely initial assessments, timely initiation of ongoing services, and timely follow-up care following discharge from a psychiatric inpatient or detox unit. The PIHP's penetration rate of 7 percent exceeded the statewide rate. **Thumb Alliance PIHP** demonstrated strong performance across all three domains and increased the number of indicators that met the performance standard from six in 2005–2006 to eight in this reporting period.

Venture Behavioral Health

Findings

Table 3-36 below presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2007 Validation of Performance Measures Report for **Venture Behavioral Health** includes additional details of the validation results.

Table 3-36—2006–2007 Performance Measure Results *for* Venture Behavioral Health

Performance Measure	Reported Rate	Audit Designation
Indicator 1. Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children: 100% Adults: 100%	*Fully Compliant*
Indicator 2. Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	97.07%	*Fully Compliant*
Indicator 3. Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 calendar days of a nonemergent assessment with a professional.	98.20%	*Fully Compliant*
Indicator 4a. Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children: 80% Adults: 86.57%	*Fully Compliant*
Indicator 4b. Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	100%	*Fully Compliant*
Indicator 5. Percentage of Medicaid recipients having received PIHP-managed services (Penetration rate).	5.33%	*Fully Compliant*
Indicator 8. Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination (HSW rate).	91.02%	*Fully Compliant*
Indicator 12. Percentage of children and adults readmitted to a psychiatric inpatient unit within 30 days of discharge.	Children: 9.09% Adults: 7.32%	*Fully Compliant*
Indicator 13. The annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by the PIHPs.		*Fully Compliant*
Indicator 14. Number of sentinel events during the six-month period per 1,000 Medicaid beneficiaries served, by the following populations: adults with mental illness, children with mental illness, persons with developmental disabilities not on the HSW, persons on the HSW, and persons with a substance abuse disorder.		*Fully Compliant*

Strengths

Venture Behavioral Health ensured comparability of data across its affiliates and facilitated aggregate performance measure reporting through use of a data warehouse. The PIHP's process of monthly error reporting for all data types and subsequent discussion in the monthly MDCH quality assurance task force enhanced the accuracy of performance measure reporting. PIHP staff demonstrated continued, thorough knowledge of PIHP data and the performance measure reporting process, as well as a commitment to accurate performance measure reporting.

Recommendations

Recommendations for improvement for **Venture Behavioral Health** addressed the need for a more formal assessment of data completeness and the development of oversight processes by the affiliates for entry of external paper claims. The PIHP should increase its oversight and monitoring of the CA's data and continue working toward the automation of input and receipt of performance indicator data elements.

Summary Assessment Related to Quality, Timeliness, and Access

Venture Behavioral Health's performance indicators related to **quality** were *Fully Compliant* with MDCH specifications. The PIHP met or exceeded three of the five contractually required performance standards related to **quality** of services provided by the PIHP. **Venture Behavioral Health** increased its rate of timely follow-up care after discharge from a detox unit and met the standards for 30-day readmission rates for children and adults. The PIHP's HSW rate of 91 percent was lower than the statewide rate. Performance indicators related to **timeliness** of and **access** to services provided by the PIHP were *Fully Compliant* with MDCH specifications. The PIHP met or exceeded the contractually required performance standards for five of the seven performance measures related to **timeliness** of and **access** to services. **Venture Behavioral Health** increased its rates for timely initial assessments and the timely initiation of ongoing services and provided timely pre-admission screenings and follow-up care after discharge from a detox unit. The PIHP's penetration rate of 5 percent was lower than the statewide rate. **Venture Behavioral Health** demonstrated strong performance across all three domains and increased the number of indicators that met the performance standard from five in 2005–2006 to seven in this reporting period.

Validation of Performance Improvement Projects

This section of the report presents the results of the validation of PIPs. For the 2006–2007 validation, MDCH provided the PIHPs with a new study topic, *Ongoing Service Within 14 Days of Nonemergent Assessment*, to target the lowest-scoring of the five population groups for each PIHP. Two PIHPs, **Thumb Alliance PIHP** and **Southwest Affiliation**, met the performance standard for each population and were allowed to select their own topic. Because this was the first year of the new PIP, PIHPs differed in how far their study had progressed. Consequently, several of the activities of the CMS PIP Protocol were not assessed for all PIHPs. The validation of PIPs addresses the validity and reliability of the PIHP's processes for conducting valid PIPs. Therefore, for the purpose of the EQR technical report, HSAG assigned all PIPs to the **quality** domain.

Access Alliance of Michigan

Findings

Table 3–37 and Table 3–38 show **Access Alliance of Michigan**'s scores based on HSAG's PIP evaluation. For additional details, please refer to the 2006–2007 PIP Validation Report for **Access Alliance of Michigan**. Validation of Activities I through VI resulted in a validation status of *Met*, with an overall score of 100 percent and a score of 100 percent for critical elements.

Table 3–37—2006–2007 PIP Validation Scores *for* Ongoing Service Within 14 Days of Nonemergent Assessment *for* Access Alliance of Michigan

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

Table 3–38—2006–2007 PIP Validation Score *for* Ongoing Service Within 14 Days of Nonemergent Assessment *for* Access Alliance of Michigan

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

Strengths

Access Alliance of Michigan provided comprehensive background information for the study topic and a thorough explanation of the study population. **Access Alliance of Michigan**'s description of the data collection methodology and staff members performing data collection was complete.

Recommendations

There were no opportunities for improvement identified during this validation cycle.

Summary Assessment Related to Quality, Timeliness, and Access

Access Alliance of Michigan recognized that while MDCH selected the statewide PIP topic, the study provided an opportunity to improve the timeliness of access to care and services across health care delivery systems for its beneficiaries. The focus of the study was to improve the percentage of new cases of children with serious emotional disturbance (SED) starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional. **Access Alliance of Michigan** had not progressed far enough in the study to begin assessing the impact of the PIP on the **quality** of care and services.

CMH Affiliation of Mid-Michigan

Findings

Table 3–39 and Table 3–40 show **CMH Affiliation of Mid-Michigan**'s scores based on HSAG's PIP evaluation. For additional details, please refer to the 2006–2007 PIP Validation Report for **CMH Affiliation of Mid-Michigan**. Validation of Activities I through VII resulted in a validation status of *Met*, with an overall score of 96 percent and a score of 100 percent for critical elements.

Table 3–39—2006–2007 PIP Validation Scores *for* Ongoing Service Within 14 Days of Nonemergent Assessment *for* CMH Affiliation of Mid-Michigan

Review Activity	Total Possible Evaluation Elements (Including Critical Elements)	Total *Met*	Total *Partially Met*	Total *Not Met*	Total *NA*	Total Possible Critical Elements	Total Critical Elements *Met*	Total Critical Elements *Partially Met*	Total Critical Elements *Not Met*	Total Critical Elements *NA*
I. Appropriate Study Topic	6	6	0	0	0	1	1	0	0	0
II. Clearly Defined, Answerable Study Question	2	2	0	0	0	2	2	0	0	0
III. Clearly Defined Study Indicator(s)	7	7	0	0	0	3	3	0	0	0
IV. Correctly Identified Study Population	3	2	0	0	1	2	2	0	0	0
V. Valid Sampling Techniques	6	0	0	0	6	1	0	0	0	1
VI. Accurate/Complete Data Collection	11	5	0	1	5	1	0	0	0	1
VII. Appropriate Improvement Strategies	4	2	0	0	2	1	1	0	0	0
VIII. Sufficient Data Analysis and Interpretation	9	Not Assessed				2	Not Assessed			
IX. Real Improvement Achieved	4	Not Assessed				No Critical Elements				
X. Sustained Improvement Achieved	1	Not Assessed				No Critical Elements				
Totals for All Activities	**53**	**24**	**0**	**1**	**14**	**13**	**9**	**0**	**0**	**2**

Table 3–40—2006–2007 PIP Validation Overall Score *for* Ongoing Service Within 14 Days of Nonemergent Assessment *for* CMH Affiliation of Mid-Michigan

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

Strengths

CMH Affiliation of Mid-Michigan chose appropriate interventions based on a causal/barrier analysis and linked the selected interventions with the identified barriers.

Recommendations

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

The study documentation in Activity I should include the fact that the study topic was selected by the State and provide plan-specific data as to why the topic was relevant to **CMH Affiliation of Mid-Michigan.** The measurement periods for the study indicators should be complete date ranges. The study documentation should include a definition of "new" as it related to the study population. The PIP documentation should include a clearly defined, systematic process for collecting baseline and remeasurement data.

Summary Assessment Related to Quality, Timeliness, and Access

CMH Affiliation of Mid-Michigan recognized that while MDCH selected the statewide PIP topic, the study provided an opportunity to improve the timeliness of access to care and services across health care delivery systems for its beneficiaries. The focus of the study was to improve the percentage of new cases of persons with substance abuse disorder starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional. **CMH Affiliation of Mid-Michigan** had not progressed far enough in the study to begin assessing the impact of the PIP on the **quality** of care and services.

CMH for Central Michigan

Findings

Table 3–41 and Table 3–42 show **CMH for Central Michigan**'s scores based on HSAG's PIP evaluation. For additional details, please refer to the 2006–2007 PIP Validation Report for **CMH for Central Michigan**. Validation of Activities I through VIII resulted in a validation status of *Partially Met*, with an overall score of 89 percent and a score of 90 percent for critical elements.

Table 3–41—2006–2007 PIP Validation Scores
***for* Ongoing Service Within 14 Days of Nonemergent Assessment**
***for* CMH for Central Michigan**

Review Activity	Total Possible Evaluation Elements (Including Critical Elements)	Total *Met*	Total *Partially Met*	Total *Not Met*	Total *NA*	Total Possible Critical Elements	Total Critical Elements *Met*	Total Critical Elements *Partially Met*	Total Critical Elements *Not Met*	Total Critical Elements *NA*
I. Appropriate Study Topic	6	6	0	0	0	1	1	0	0	0
II. Clearly Defined, Answerable Study Question	2	2	0	0	0	2	2	0	0	0
III. Clearly Defined Study Indicator(s)	7	5	0	0	2	3	3	0	0	0
IV. Correctly Identified Study Population	3	3	0	0	0	2	2	0	0	0
V. Valid Sampling Techniques	6	0	0	0	6	1	0	0	0	1
VI. Accurate/Complete Data Collection	11	6	0	0	5	1	0	0	0	1
VII. Appropriate Improvement Strategies	4	0	2	0	2	1	0	1	0	0
VIII. Sufficient Data Analysis and Interpretation	9	3	0	1	5	2	1	0	0	1
IX. Real Improvement Achieved	4	Not Assessed				No Critical Elements				
X. Sustained Improvement Achieved	1	Not Assessed				No Critical Elements				
Totals for All Activities	**53**	**25**	**2**	**1**	**20**	**13**	**9**	**1**	**0**	**3**

Table 3–42—2006–2007 PIP Validation Overall Score
***for* Ongoing Service Within 14 Days of Nonemergent Assessment**
***for* CMH for Central Michigan**

Percentage Score of Evaluation Elements *Met*	**89%**
Percentage Score of Critical Elements *Met*	**90%**
Validation Status	***Partially Met***

Strengths

CMH for Central Michigan provided a detailed and complete description of the data collection methodology.

Recommendations

HSAG made the following recommendations:

CMH for Central Michigan should define the meaning of "new" as it related to the study population. The PIP documentation should include the causal/barrier analysis or quality improvement process that **CMH for Central Michigan** used to identify the listed barriers. The PIP documentation should clarify the permanence of the process and the procedures to follow in case the quality analyst is absent and cannot perform the daily checking and follow-through intervention. The documentation should also include a discussion regarding factors, internal or external, that threatened the validity of the data results. If there were no such factors, the documentation should reflect this information.

Summary Assessment Related to Quality, Timeliness, and Access

CMH for Central Michigan recognized that while MDCH selected the statewide PIP topic, the study provided an opportunity to improve the timeliness of access to care and services across health care delivery systems for its beneficiaries. The focus of the study was to improve the percentage of new cases of persons with substance abuse disorder starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional. **CMH for Central Michigan** had not progressed far enough in the study to begin assessing the impact of the PIP on the **quality** of care and services.

CMH Partnership of Southeastern Michigan

Findings

Table 3–43 and Table 3–44 show **CMH Partnership of Southeastern Michigan**'s scores based on HSAG's PIP evaluation. For additional details, please refer to the 2006–2007 PIP Validation Report for **CMH Partnership of Southeastern Michigan**. Validation of Activities I through VIII resulted in a validation status of *Met*, with an overall score of 100 percent and a score of 100 percent for critical elements.

Table 3–43—2006–2007 PIP Validation Scores *for* Ongoing Service Within 14 Days of Nonemergent Assessment *for* CMH Partnership of Southeastern Michigan

Review Activity	Total Possible Evaluation Elements (Including Critical Elements)	Total *Met*	Total *Partially Met*	Total *Not Met*	Total *NA*	Total Possible Critical Elements	Total Critical Elements *Met*	Total Critical Elements *Partially Met*	Total Critical Elements *Not Met*	Total Critical Elements *NA*
I. Appropriate Study Topic	6	6	0	0	0	1	1	0	0	0
II. Clearly Defined, Answerable Study Question	2	2	0	0	0	2	2	0	0	0
III. Clearly Defined Study Indicator(s)	7	5	0	0	2	3	3	0	0	0
IV. Correctly Identified Study Population	3	2	0	0	1	2	2	0	0	0
V. Valid Sampling Techniques	6	0	0	0	6	1	0	0	0	1
VI. Accurate/Complete Data Collection	11	6	0	0	5	1	0	0	0	1
VII. Appropriate Improvement Strategies	4	2	0	0	2	1	1	0	0	0
VIII. Sufficient Data Analysis and Interpretation	9	4	0	0	5	2	1	0	0	1
IX. Real Improvement Achieved	4	Not Assessed				No Critical Elements				
X. Sustained Improvement Achieved	1	Not Assessed				No Critical Elements				
Totals for All Activities	**53**	**27**	**0**	**0**	**21**	**13**	**10**	**0**	**0**	**3**

Table 3–44—2006–2007 PIP Validation Overall Score *for* Ongoing Service Within 14 Days of Nonemergent Assessment *for* CMH Partnership of Southeastern Michigan

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

Strengths

CMH Partnership of Southeastern Michigan provided comprehensive background information for the study topic and a detailed explanation of the study population. The PIHP based the selected intervention on a causal/barrier analysis and linked the interventions with identified barriers.

Recommendations

There were no opportunities for improvement identified during this validation cycle.

Summary Assessment Related to Quality, Timeliness, and Access

CMH Partnership of Southeastern Michigan recognized that while MDCH selected the statewide PIP topic, the study provided an opportunity to improve the timeliness of access to care and services across health care delivery systems for its beneficiaries. The focus of the study was to improve the percentage of new cases of adults with developmental disabilities starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional. **CMH Partnership of Southeastern Michigan** had not progressed far enough in the study to begin assessing the impact of the PIP on the **quality** of care and services.

Detroit-Wayne County CMH Agency

Findings

Table 3–45 and Table 3–46 show **Detroit-Wayne County CMH Agency**'s scores based on HSAG's PIP evaluation. For additional details, please refer to the 2006–2007 PIP Validation Report for **Detroit-Wayne County CMH Agency**. Validation of Activities I through VI resulted in a validation status of *Partially Met*, with an overall score of 94 percent and a score of 88 percent for critical elements.

Table 3–45—2006–2007 PIP Validation Scores *for* Ongoing Service Within 14 Days of Nonemergent Assessment *for* Detroit-Wayne County CMH Agency

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

Table 3–46—2006–2007 PIP Validation Overall Score *for* Ongoing Service Within 14 Days of Nonemergent Assessment *for* Detroit-Wayne County CMH Agency

Percentage Score of Evaluation Elements *Met*	**94%**
Percentage Score of Critical Elements *Met*	**88%**
Validation Status	***Partially Met***

Strengths

Detroit-Wayne County CMH Agency included a detailed description of the data analysis plan in the study documentation.

Recommendations

HSAG made the following recommendations:

Although the State selected the study topic, **Detroit-Wayne County CMH Agency**'s PIP documentation should include plan-specific data as to why the study topic was pertinent to the health plan. The study question should be stated the same way it was by the State to ensure consistency. The PIP documentation should define the study population as it was defined by the State and include a definition of "new" in the study population's definition.

Summary Assessment Related to Quality, Timeliness, and Access

Detroit-Wayne County CMH Agency recognized that while MDCH selected the PIP topic, the study provided an opportunity to improve the timeliness of access to care and services across health care delivery systems for its beneficiaries. The focus of the study was to improve the percentage of new cases of persons with developmental disabilities starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional. **Detroit-Wayne County CMH Agency** had not progressed far enough in the study to begin assessing the impact of the PIP on the **quality** of care and services.

Genesee County CMH

Findings

Table 3–47 and Table 3–48 show **Genesee County CMH**'s scores based on HSAG's PIP evaluation. For additional details, please refer to the 2006–2007 PIP Validation Report for **Genesee County CMH**. Validation of Activities I through X resulted in a validation status of *Met*, with an overall score of 100 percent and a score of 100 percent for critical elements.

Table 3–47—2006–2007 PIP Validation Scores *for* Ongoing Service Within 14 Days of Nonemergent Assessment *for* Genesee County CMH

Review Activity	Total Possible Evaluation Elements (Including Critical Elements)	Total *Met*	Total *Partially Met*	Total *Not Met*	Total *NA*	Total Possible Critical Elements	Total Critical Elements *Met*	Total Critical Elements *Partially Met*	Total Critical Elements *Not Met*	Total Critical Elements *NA*
I. Appropriate Study Topic	6	6	0	0	0	1	1	0	0	0
II. Clearly Defined, Answerable Study Question	2	2	0	0	0	2	2	0	0	0
III. Clearly Defined Study Indicator(s)	7	6	0	0	1	3	3	0	0	0
IV. Correctly Identified Study Population	3	2	0	0	1	2	2	0	0	0
V. Valid Sampling Techniques	6	0	0	0	6	1	0	0	0	1
VI. Accurate/Complete Data Collection	11	6	0	0	5	1	0	0	0	1
VII. Appropriate Improvement Strategies	4	3	0	0	1	1	1	0	0	0
VIII. Sufficient Data Analysis and Interpretation	9	8	0	0	1	2	1	0	0	1
IX. Real Improvement Achieved	4	4	0	0	0	No Critical Elements				
X. Sustained Improvement Achieved	1	1	0	0	0	No Critical Elements				
Totals for All Activities	**53**	**38**	**0**	**0**	**15**	**13**	**10**	**0**	**0**	**3**

Table 3–48—2006–2007 PIP Validation Overall Score *for* Ongoing Service Within 14 Days of Nonemergent Assessment *for* Genesee County CMH

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

Strengths

Genesee County CMH provided a comprehensive description of the data collection methodology. The PIHP determined appropriate interventions through a causal/barrier analysis and linked the selected interventions with identified barriers.

Recommendations

Genesee County CMH should address the points of clarification in the validation tool.

Summary Assessment Related to Quality, Timeliness, and Access

Genesee County CMH recognized that while MDCH selected the PIP topic, the study provided an opportunity to improve the timeliness of access to care and services across health care delivery systems for its beneficiaries. The focus of the study was to improve the percentage of new cases of children with SED starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional. **Genesee County CMH** demonstrated an increase in the rate of children with SED starting an ongoing service within 14 days of a nonemergent assessment. This increase was observed over three remeasurement periods that covered a nine-month span. In the second and third remeasurement periods, the PIHP exceeded the minimum performance standard of 95 percent. **Genesee County CMH** improved the **quality** of care and services by increasing the number of children with SED who started needed, ongoing services in a timely manner.

Lakeshore Behavioral Health Alliance

Findings

Table 3–49 and Table 3–50 show **Lakeshore Behavioral Health Alliance**'s scores based on HSAG's PIP evaluation. For additional details, please refer to the 2006–2007 PIP Validation Tool Report for **Lakeshore Behavioral Health Alliance**. Validation of Activities I through VI resulted in a validation status of *Met*, with an overall score of 100 percent and a score of 100 percent for critical elements.

Table 3–49—2006–2007 PIP Validation Scores *for* Ongoing Service Within 14 Days of Nonemergent Assessment *for* Lakeshore Behavioral Health Alliance

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

Table 3–50—2006–2007 PIP Validation Overall Score *for* Ongoing Service Within 14 Days of Nonemergent Assessment *for* Lakeshore Behavioral Health Alliance

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

Strengths

Lakeshore Behavioral Health Alliance provided a comprehensive description of the administrative data collection methodology.

Recommendations

HSAG made the following recommendation:

The PIP study population should include the MDCH definition of "new" in the documentation for Activity IV.

Summary Assessment Related to Quality, Timeliness, and Access

Lakeshore Behavioral Health Alliance recognized that while MDCH selected the PIP topic, the study provided an opportunity to improve the timeliness of access to care and services across health care delivery systems for its beneficiaries. The focus of the study was to improve the percentage of new cases of adults with developmental disabilities starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional. **Lakeshore Behavioral Health Alliance** had not progressed far enough in the study to begin assessing the impact of the PIP on the **quality** of care and services.

LifeWays

Findings

Table 3-51 and Table 3-52 show **LifeWays**' scores based on HSAG's PIP evaluation. For additional details, please refer to the 2006–2007 PIP Validation Report for **LifeWays**. Validation of Activities I through VI resulted in a validation status of *Met*, with an overall score of 100 percent and a score of 100 percent for critical elements.

Table 3-51—2006–2007 PIP Validation Scores *for* Ongoing Service Within 14 Days of Nonemergent Assessment *for* LifeWays

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

Table 3-52—2006–2007 PIP Validation Overall Score *for* Ongoing Service Within 14 Days of Nonemergent Assessment *for* LifeWays

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

Strengths

LifeWays included comprehensive background information for the study topic in the PIP documentation. The PIHP provided a detailed description of the administrative data collection methodology.

Recommendations

No opportunities for improvement were identified during this validation cycle.

Summary Assessment Related to Quality, Timeliness, and Access

LifeWays recognized that while MDCH selected the PIP topic, the study provided an opportunity to improve the timeliness of access to care and services across health care delivery systems for its beneficiaries. The focus of the study was to improve the percentage of new cases of persons with substance abuse disorder starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional. **LifeWays** had not progressed far enough in the study to begin assessing the impact of the PIP on the **quality** of care and services.

Macomb County CMH Services

Findings

Table 3-53 and Table 3-54 show **Macomb County CMH Services**' scores based on HSAG's PIP evaluation. For additional details, please refer to the 2006–2007 PIP Validation Report for **Macomb County CMH Services**. Validation of Activities I through VI resulted in a validation status of *Met*, with an overall score of 100 percent and a score of 100 percent for critical elements.

Table 3-53—2006–2007 PIP Validation Scores *for* Ongoing Service Within 14 Days of Nonemergent Assessment *for* Macomb County CMH Services

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

Table 3-54—2006–2007 PIP Validation Overall Score *for* Ongoing Service Within 14 Days of Nonemergent Assessment *for* Macomb County CMH Services

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

Strengths

Macomb County CMH Services provided comprehensive background information for the study topic and a detailed explanation of the study population. The PIHP described the administrative data collection methodology in depth.

Recommendations

No opportunities for improvement were identified during this validation cycle.

Summary Assessment Related to Quality, Timeliness, and Access

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

network180

Findings

Table 3-55 and Table 3-56 show **network180**'s scores based on HSAG's PIP evaluation. For additional details, please refer to the 2006–2007 PIP Validation Report for **network180**. Validation of Activities I through VIII resulted in a validation status of *Met*, with an overall score of 100 percent and a score of 100 percent for critical elements.

Table 3-55—2006–2007 PIP Validation Scores
***for* Ongoing Service Within 14 Days of Nonemergent Assessment**
***for* network180**

Review Activity	Total Possible Evaluation Elements (Including Critical Elements)	Total *Met*	Total *Partially Met*	Total *Not Met*	Total *NA*	Total Possible Critical Elements	Total Critical Elements *Met*	Total Critical Elements *Partially Met*	Total Critical Elements *Not Met*	Total Critical Elements *NA*
I. Appropriate Study Topic	6	6	0	0	0	1	1	0	0	0
II. Clearly Defined, Answerable Study Question	2	2	0	0	0	2	2	0	0	0
III. Clearly Defined Study Indicator(s)	7	5	0	0	2	3	3	0	0	0
IV. Correctly Identified Study Population	3	2	0	0	1	2	2	0	0	0
V. Valid Sampling Techniques	6	0	0	0	6	1	0	0	0	1
VI. Accurate/Complete Data Collection	11	6	0	0	5	1	0	0	0	1
VII. Appropriate Improvement Strategies	4	2	0	0	2	1	1	0	0	0
VIII. Sufficient Data Analysis and Interpretation	9	4	0	0	5	2	1	0	0	1
IX. Real Improvement Achieved	4	Not Assessed				No Critical Elements				
X. Sustained Improvement Achieved	1	Not Assessed				No Critical Elements				
Totals for All Activities	**53**	**27**	**0**	**0**	**21**	**13**	**10**	**0**	**0**	**3**

Table 3-56—2006–2007 PIP Validation Overall Score
***for* Ongoing Service Within 14 Days of Nonemergent Assessment**
***for* network180**

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

Strengths

network180 provided a comprehensive description of the administrative data collection methodology. The PIHP developed appropriate interventions and linked them with identified barriers.

Recommendations

HSAG made the following recommendations:

network180's PIP documentation should provide more plan-specific data as to why the study topic was relevant to the PIHP. **network180** should include a definition of what constitutes a "serious emotional disturbance" as it related to the study population.

Summary Assessment Related to Quality, Timeliness, and Access

network180 recognized that while MDCH selected the PIP topic, the study provided an opportunity to improve the timeliness of access to care and services across health care delivery systems for its beneficiaries. The focus of the study was to improve the percentage of new cases of children with SED starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional. **network180** had not progressed far enough in the study to begin assessing the impact of the PIP on the **quality** of care and services.

NorthCare

Findings

Table 3-57 and Table 3-58 show **NorthCare**'s scores based on HSAG's PIP evaluation. For additional details, please refer to the 2006–2007 PIP Validation Report for **NorthCare**. Validation of Activities I through VIII resulted in a validation status of *Met*, with an overall score of 94 percent and a score of 100 percent for critical elements.

Table 3-57—2006–2007 PIP Validation Scores *for* Ongoing Service Within 14 Days of Nonemergent Assessment *for* NorthCare

Review Activity	Total Possible Evaluation Elements (Including Critical Elements)	Total *Met*	Total *Partially Met*	Total *Not Met*	Total *NA*	Total Possible Critical Elements	Total Critical Elements *Met*	Total Critical Elements *Partially Met*	Total Critical Elements *Not Met*	Total Critical Elements *NA*
I. Appropriate Study Topic	6	6	0	0	0	1	1	0	0	0
II. Clearly Defined, Answerable Study Question	2	2	0	0	0	2	2	0	0	0
III. Clearly Defined Study Indicator(s)	7	5	0	0	2	3	3	0	0	0
IV. Correctly Identified Study Population	3	2	0	0	1	2	2	0	0	0
V. Valid Sampling Techniques	6	0	0	0	6	1	0	0	0	1
VI. Accurate/Complete Data Collection	11	9	2	0	0	1	1	0	0	0
VII. Appropriate Improvement Strategies	4	2	0	0	2	1	1	0	0	0
VIII. Sufficient Data Analysis and Interpretation	9	4	0	0	5	2	1	0	0	1
IX. Real Improvement Achieved	4	Not Assessed				No Critical Elements				
X. Sustained Improvement Achieved	1	Not Assessed				No Critical Elements				
Totals for All Activities	**53**	**30**	**2**	**0**	**16**	**13**	**11**	**0**	**0**	**2**

Table 3-58—2006–2007 PIP Validation Overall Score *for* Ongoing Service Within 14 Days of Nonemergent Assessment *for* NorthCare

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

Strengths

NorthCare provided comprehensive background information for the study topic and a detailed description of the administrative data collection methodology. The PIHP selected appropriate interventions and linked them with identified barriers. **NorthCare**'s description of the data analysis plan was comprehensive.

Recommendations

HSAG made the following recommendations:

NorthCare should include in the study documentation the qualifications and experience of each staff member involved in the manual data collection process. The written instructions for the manual data collection tool should include an overview of the study.

Summary Assessment Related to Quality, Timeliness, and Access

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

Northern Affiliation

Findings

Table 3-59 and Table 3-60 show **Northern Affiliation**'s scores based on HSAG's PIP evaluation. For additional details, please refer to the 2006–2007 PIP Validation Report for **Northern Affiliation**. Validation of Activities I through IX resulted in a validation status of *Not Met*, with an overall score of 83 percent and a score of 90 percent for critical elements.

Table 3-59—2006–2007 PIP Validation Scores *for* Ongoing Service Within 14 Days of Nonemergent Assessment *for* Northern Affiliation

Review Activity	Total Possible Evaluation Elements (Including Critical Elements)	Total *Met*	Total *Partially Met*	Total *Not Met*	Total *NA*	Total Possible Critical Elements	Total Critical Elements *Met*	Total Critical Elements *Partially Met*	Total Critical Elements *Not Met*	Total Critical Elements *NA*
I. Appropriate Study Topic	6	3	0	3	0	1	0	0	1	0
II. Clearly Defined, Answerable Study Question	2	2	0	0	0	2	2	0	0	0
III. Clearly Defined Study Indicator(s)	7	5	0	0	2	3	3	0	0	0
IV. Correctly Identified Study Population	3	2	0	0	1	2	2	0	0	0
V. Valid Sampling Techniques	6	0	0	0	6	1	0	0	0	1
VI. Accurate/Complete Data Collection	11	6	0	0	5	1	0	0	0	1
VII. Appropriate Improvement Strategies	4	3	0	0	1	1	1	0	0	0
VIII. Sufficient Data Analysis and Interpretation	9	5	2	1	1	2	1	0	0	1
IX. Real Improvement Achieved	4	4	0	0	0	No Critical Elements				
X. Sustained Improvement Achieved	1	Not Assessed				No Critical Elements				
Totals for All Activities	**53**	**30**	**2**	**4**	**16**	**13**	**9**	**0**	**1**	**3**

Table 3-60—2006–2007 PIP Validation Overall Score *for* Ongoing Service Within 14 Days of Nonemergent Assessment *for* Northern Affiliation

Percentage Score of Evaluation Elements *Met*	**83%**
Percentage Score of Critical Elements *Met*	**90%**
Validation Status	***Not Met***

Strengths

Northern Affiliation provided a detailed description of the administrative data collection methodology and a comprehensive data analysis plan. The PIHP selected appropriate interventions and linked them with identified barriers.

Recommendations

HSAG made the following recommendations:

Northern Affiliation's PIP documentation should include that the study topic was selected by the State, plan-specific data as to why the study topic was relevant to **Northern Affiliation,** and how the study topic had the potential to affect beneficiaries' health status, functional status, or satisfaction.

Future PIP documentation should include the fact that the State provided the structure of the study indicator. The documentation should include the MDCH definition of "new" within the narrative description of the study population. The PIP documentation should clearly define any factors that threaten the internal or external validity of the data analysis results or could affect the ability to compare remeasurement periods. **Northern Affiliation** should use traditionally acceptable methods for interpreting the study results.

Summary Assessment Related to Quality, Timeliness, and Access

Northern Affiliation recognized that while MDCH selected the PIP topic, the study provided an opportunity to improve the timeliness of access to care and services across health care delivery systems for its beneficiaries. The focus of the study was to improve the percentage of new cases of persons with substance abuse disorder starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional. **Northern Affiliation** had not progressed far enough in the study to begin assessing the impact of the PIP on the **quality** of care and services.

Northwest CMH Affiliation

Findings

Table 3-61 and Table 3-62 show **Northwest CMH Affiliation**'s scores based on HSAG's PIP evaluation. For additional details, please refer to the 2006–2007 PIP Validation Report for **Northwest CMH Affiliation**. Validation of Activities I through V resulted in a validation status of *Met*, with an overall score of 100 percent and a score of 100 percent for critical elements.

Table 3-61—2006–2007 PIP Validation Scores *for* Ongoing Service Within 14 Days of Nonemergent Assessment *for* Northwest CMH Affiliation

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

Table 3-62—2006–2007 PIP Validation Overall Score *for* Ongoing Service Within 14 Days of Nonemergent Assessment *for* Northwest CMH Affiliation

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

Strengths

Northwest CMH Affiliation's study documentation included the required information that MDCH had provided to the PIHPs. HSAG did not identify additional strengths for the PIP.

Recommendations

There were no opportunities for improvement identified during this validation cycle.

Summary Assessment Related to Quality, Timeliness, and Access

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

Oakland County CMH Authority

Findings

Table 3-63 and Table 3-64 show **Oakland County CMH Authority**'s scores based on HSAG's PIP evaluation. For additional details, please refer to the 2006–2007 PIP Validation Report for **Oakland County CMH Authority**. Validation of Activities I through VIII resulted in a validation status of *Met*, with an overall score of 94 percent and a score of 100 percent for critical elements.

Table 3-63—2006–2007 PIP Validation Scores *for* Ongoing Service Within 14 Days of Nonemergent Assessment *for* Oakland County CMH Authority

Review Activity	Total Possible Evaluation Elements (Including Critical Elements)	Total *Met*	Total *Partially Met*	Total *Not Met*	Total *NA*	Total Possible Critical Elements	Total Critical Elements *Met*	Total Critical Elements *Partially Met*	Total Critical Elements *Not Met*	Total Critical Elements *NA*
I. Appropriate Study Topic	6	6	0	0	0	1	1	0	0	0
II. Clearly Defined, Answerable Study Question	2	2	0	0	0	2	2	0	0	0
III. Clearly Defined Study Indicator(s)	7	5	0	0	2	3	3	0	0	0
IV. Correctly Identified Study Population	3	2	0	0	1	2	2	0	0	0
V. Valid Sampling Techniques	6	0	0	0	6	1	0	0	0	1
VI. Accurate/Complete Data Collection	11	9	2	0	0	1	1	0	0	0
VII. Appropriate Improvement Strategies	4	2	0	0	2	1	1	0	0	0
VIII. Sufficient Data Analysis and Interpretation	9	4	0	0	5	2	1	0	0	1
IX. Real Improvement Achieved	4	Not Assessed				No Critical Elements				
X. Sustained Improvement Achieved	1	Not Assessed				No Critical Elements				
Totals for All Activities	**53**	**30**	**2**	**0**	**16**	**13**	**11**	**0**	**0**	**2**

Table 3-64—2006–2007 PIP Validation Overall Score *for* Ongoing Service Within 14 Days of Nonemergent Assessment *for* Oakland County CMH Authority

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

Strengths

Oakland County CMH Authority provided comprehensive background information for the study topic and a complete explanation of the study population. The PIHP included in its study documentation a detailed description of the administrative data collection methodology.

Recommendations

HSAG made the following recommendations:

Oakland County CMH Authority should provide the qualifications and experience of the staff members involved in the manual data collection process. The PIHP should include clear and concise written instructions for completing the manual data collection tool. An overview of the study should be included with the instructions.

Summary Assessment Related to Quality, Timeliness, and Access

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

Saginaw County CMH Authority

Findings

Table 3–65 and Table 3–66 show **Saginaw County CMH Authority**'s scores based on HSAG's PIP evaluation. For additional details, please refer to the 2006–2007 PIP Validation Report for **Saginaw County CMH Authority**. Validation of Activities I through VI resulted in a validation status of *Not Met*, with an overall score of 76 percent and a score of 75 percent for critical elements.

Table 3–65—2006–2007 PIP Validation Scores *for* Ongoing Service Within 14 Days of Nonemergent Assessment *for* Saginaw County CMH Authority

Review Activity	Total Possible Evaluation Elements (Including Critical Elements)	Total *Met*	Total *Partially Met*	Total *Not Met*	Total *NA*	Total Possible Critical Elements	Total Critical Elements *Met*	Total Critical Elements *Partially Met*	Total Critical Elements *Not Met*	Total Critical Elements *NA*
I. Appropriate Study Topic	6	6	0	0	0	1	1	0	0	0
II. Clearly Defined, Answerable Study Question	2	2	0	0	0	2	2	0	0	0
III. Clearly Defined Study Indicator(s)	7	2	1	2	2	3	1	1	1	0
IV. Correctly Identified Study Population	3	2	0	0	1	2	2	0	0	0
V. Valid Sampling Techniques	6	0	0	0	6	1	0	0	0	1
VI. Accurate/Complete Data Collection	11	4	0	2	5	1	0	0	0	1
VII. Appropriate Improvement Strategies	4	Not Assessed				1	Not Assessed			
VIII. Sufficient Data Analysis and Interpretation	9	Not Assessed				2	Not Assessed			
IX. Real Improvement Achieved	4	Not Assessed				No Critical Elements				
X. Sustained Improvement Achieved	1	Not Assessed				No Critical Elements				
Totals for All Activities	**53**	**16**	**1**	**4**	**14**	**13**	**6**	**1**	**1**	**2**

Table 3–66—2006–2007 PIP Validation Overall Score *for* Ongoing Service Within 14 Days of Nonemergent Assessment *for* Saginaw County CMH Authority

Percentage Score of Evaluation Elements *Met*	**76%**
Percentage Score of Critical Elements *Met*	**75%**
Validation Status	***Not Met***

Strengths

Saginaw County CMH Authority's study documentation included the required information that MDCH had provided to the PIHPs. HSAG did not identify additional strengths for the PIP.

Recommendations

HSAG made the following recommendations:

Saginaw County CMH Authority should include in the PIP documentation that the study topic was selected by the State, as well as any plan-specific data as to why the study topic was relevant to **Saginaw County CMH Authority**. The PIHP should restructure the study indicator as discussed in the validation tool. A defined and systematic process to collect baseline and remeasurement data should be provided in the PIP documentation. Documentation should include the development of a systematic process for administrative data collection consisting of an ordered sequence of steps. The PIHP should include an explanation or description of the process to determine the estimated degree of administrative data completeness (reported as 100 percent).

Summary Assessment Related to Quality, Timeliness, and Access

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

Southwest Affiliation

Findings

Southwest Affiliation had met the MDCH performance standard for the State-mandated PIP topic and selected a different PIP topic.

Table 3-67 and Table 3-68 show **Southwest Affiliation**'s scores based on HSAG's PIP evaluation. For additional details, please refer to the 2006–2007 PIP Validation Report for **Southwest Affiliation**. Validation of Activities I through VIII resulted in a validation status of *Met*, with an overall score of 96 percent and a score of 100 percent for critical elements.

Table 3-67—2006–2007 PIP Validation Scores
***for* Timely Access to Services: Request-to-Assessment for Nonemergent Substance Abuse Services**
***for* Southwest Affiliation**

Review Activity	Total Possible Evaluation Elements (Including Critical Elements)	Total *Met*	Total *Partially Met*	Total *Not Met*	Total *NA*	Total Possible Critical Elements	Total Critical Elements *Met*	Total Critical Elements *Partially Met*	Total Critical Elements *Not Met*	Total Critical Elements *NA*
I. Appropriate Study Topic	6	5	0	1	0	1	1	0	0	0
II. Clearly Defined, Answerable Study Question	2	2	0	0	0	2	2	0	0	0
III. Clearly Defined Study Indicator(s)	7	6	0	0	1	3	3	0	0	0
IV. Correctly Identified Study Population	3	2	0	0	1	2	2	0	0	0
V. Valid Sampling Techniques	6	0	0	0	6	1	0	0	0	1
VI. Accurate/Complete Data Collection	11	6	0	0	5	1	0	0	0	1
VII. Appropriate Improvement Strategies	4	2	0	0	2	1	1	0	0	0
VIII. Sufficient Data Analysis and Interpretation	9	4	0	0	5	2	1	0	0	1
IX. Real Improvement Achieved	4	Not Assessed				No Critical Elements				
X. Sustained Improvement Achieved	1	Not Assessed				No Critical Elements				
Totals for All Activities	**53**	**27**	**0**	**1**	**20**	**13**	**10**	**0**	**0**	**3**

Table 3-68—2006–2007 PIP Validation Overall Score
***for* Timely Access to Services: Request-to-Assessment for Nonemergent Substance Abuse Services**
***for* Southwest Affiliation**

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

Strengths

Southwest Affiliation provided comprehensive background information for the study topic and a complete explanation of the study population. The PIHP included in its study documentation a detailed description of the administrative data collection methodology.

Recommendations

HSAG made the following recommendation:

Southwest Affiliation's PIP documentation should include a discussion about including or excluding beneficiaries with special health care needs.

Summary Assessment Related to Quality, Timeliness, and Access

Southwest Affiliation selected a PIP study topic that provided an opportunity to improve the timeliness of access to care and services across health care delivery systems for its beneficiaries. The focus of the study was to improve the percentage of new cases of persons who request nonemergency substance abuse services and receive a face-to-face assessment with a professional within 14 days of the request. **Southwest Affiliation** had not progressed far enough in the study to begin assessing the impact of the PIP on the **quality** of care and services.

Thumb Alliance PIHP

Findings

Thumb Alliance PIHP had met the MDCH performance standard for the State-mandated PIP topic and selected a different PIP topic.

Table 3-69 and Table 3-70 show **Thumb Alliance PIHP**'s scores based on HSAG's PIP evaluation. For additional details, please refer to the 2006–2007 PIP Validation Report for **Thumb Alliance PIHP**. Validation of Activities I through VIII resulted in a validation status of *Partially Met*, with an overall score of 90 percent and a score of 80 percent for critical elements.

Table 3-69—2006–2007 PIP Validation Scores *for* Co-Occurring Disorders *for* Thumb Alliance PIHP

Review Activity	Total Possible Evaluation Elements (Including Critical Elements)	Total *Met*	Total *Partially Met*	Total *Not Met*	Total *NA*	Total Possible Critical Elements	Total Critical Elements *Met*	Total Critical Elements *Partially Met*	Total Critical Elements *Not Met*	Total Critical Elements *NA*
I. Appropriate Study Topic	6	6	0	0	0	1	1	0	0	0
II. Clearly Defined, Answerable Study Question	2	1	1	0	0	2	1	1	0	0
III. Clearly Defined Study Indicator(s)	7	4	2	0	1	3	2	1	0	0
IV. Correctly Identified Study Population	3	2	0	0	1	2	2	0	0	0
V. Valid Sampling Techniques	6	0	0	0	6	1	0	0	0	1
VI. Accurate/Complete Data Collection	11	8	0	0	3	1	1	0	0	0
VII. Appropriate Improvement Strategies	4	1	0	0	3	1	0	0	0	1
VIII. Sufficient Data Analysis and Interpretation	9	4	0	0	5	2	1	0	0	1
IX. Real Improvement Achieved	4	Not Assessed				No Critical Elements				
X. Sustained Improvement Achieved	1	Not Assessed				No Critical Elements				
Totals for All Activities	**53**	**26**	**3**	**0**	**19**	**13**	**8**	**2**	**0**	**3**

Table 3-70—2006–2007 PIP Validation Overall Score *for* Co-Occurring Disorders *for* Thumb Alliance PIHP

Percentage Score of Evaluation Elements *Met*	**90%**
Percentage Score of Critical Elements *Met*	**80%**
Validation Status	***Partially Met***

Strengths

Thumb Alliance PIHP provided comprehensive background information for the study topic and a detailed explanation of the study population and the administrative data collection methodology. The PIHP chose appropriate interventions based on a causal/barrier analysis and linked the selected interventions with the identified barriers.

Recommendations

HSAG made the following recommendation:

Thumb Alliance PIHP should restructure the study question and study indicator to better capture the intent of the study.

Summary Assessment Related to Quality, Timeliness, and Access

Thumb Alliance PIHP selected a PIP study topic that provided an opportunity to improve the timeliness of access to care and services across health care delivery systems for its beneficiaries. The focus of the study was to improve the number of beneficiaries with a serious mental illness diagnosis and a substance-related diagnosis (co-occurring disorder (COD) beneficiaries). **Thumb Alliance PIHP** had not progressed far enough in the study to begin assessing the impact of the PIP on the **quality** of care and services.

Venture Behavioral Health

Findings

Table 3-71 and Table 3-72 show **Venture Behavioral Health**'s scores based on HSAG's PIP evaluation. For additional details, please refer to the 2006–2007 PIP Validation Report for **Venture Behavioral Health**. Validation of Activities I through VIII resulted in a validation status of *Met*, with an overall score of 93 percent and a score of 100 percent for critical elements.

Table 3-71—2006–2007 PIP Validation Scores *for* Ongoing Service Within 14 Days of Nonemergent Assessment *for* Venture Behavioral Health

Review Activity	Total Possible Evaluation Elements (Including Critical Elements)	Total *Met*	Total *Partially Met*	Total *Not Met*	Total *NA*	Total Possible Critical Elements	Total Critical Elements *Met*	Total Critical Elements *Partially Met*	Total Critical Elements *Not Met*	Total Critical Elements *NA*
I. Appropriate Study Topic	6	6	0	0	0	1	1	0	0	0
II. Clearly Defined, Answerable Study Question	2	2	0	0	0	2	2	0	0	0
III. Clearly Defined Study Indicator(s)	7	4	2	0	1	3	3	0	0	0
IV. Correctly Identified Study Population	3	2	0	0	1	2	2	0	0	0
V. Valid Sampling Techniques	6	0	0	0	6	1	0	0	0	1
VI. Accurate/Complete Data Collection	11	6	0	0	5	1	0	0	0	1
VII. Appropriate Improvement Strategies	4	2	0	0	2	1	1	0	0	0
VIII. Sufficient Data Analysis and Interpretation	9	4	0	0	5	2	1	0	0	1
IX. Real Improvement Achieved	4	Not Assessed				No Critical Elements				
X. Sustained Improvement Achieved	1	Not Assessed				No Critical Elements				
Totals for All Activities	**53**	**26**	**2**	**0**	**20**	**13**	**10**	**0**	**0**	**3**

Table 3-72—2006–2007 PIP Validation Overall Score *for* Ongoing Service Within 14 Days of Nonemergent Assessment *for* Venture Behavioral Health

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

Strengths

Venture Behavioral Health provided comprehensive background information for the study topic. The PIHP included a detailed description of the data analysis plan and an extensive narrative description of the proposed interventions.

Recommendations

HSAG made the following recommendations:

Venture Behavioral Health should add an additional question and study indicator that is specific to this population. The study documentation should define what constitutes "new" child cases with respect to the study population.

Summary Assessment Related to Quality, Timeliness, and Access

Venture Behavioral Health recognized that while MDCH selected the PIP topic, the study provided an opportunity to improve the timeliness of access to care and services across health care delivery systems for its beneficiaries. The focus of the study was to improve the percentage of new cases of child plan beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional. **Venture Behavioral Health** had not progressed far enough in the study to begin assessing the impact of the PIP on the **quality** of care and services.

4. Assessment of PIHP Follow-up on Prior Recommendations

Introduction

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

The 2006–2007 compliance monitoring reviews evaluated the PIHPs' performance on a new set of standards; therefore, the results presented in this section address follow-up on recommendations on the first set of standards evaluated in 2004–2005 and 2005–2006. The EQR activities conducted in 2006–2007 did not assess whether the PIHPs had completed any remaining corrective action; consequently, the following summary does not reflect any progress the PIHPs had made since the 2005–2006 EQR review in implementing any remaining corrective actions.

The 2005–2006 recommendations for improvement addressed the PIHPs' processes related to the reporting of performance indicator data and oversight of subcontractors' performance indicator reporting activities. The assessment of the PIHPs' follow-up on these recommendations was, therefore, independent of any changes to the actual indicators that were included in the validation. (The 2006–2007 validation of performance measures included two new indicators—Indicators 13 and 14. Also, some of the indicators validated in 2005–2006—Indicators 9, 10, and 11—were no longer included.)

MDCH selected a new topic for the PIHPs' performance improvement projects validated this year. As a result of having a new topic, several PIHPs did not progress far enough in their study to permit validation of all activities. In addition, the PIHPs used different methodologies in their new PIP. Thus, PIHP implementation of many of the prior recommendations could not be assessed during this validation cycle.

Access Alliance of Michigan

Compliance Monitoring

Table 4-1 below shows the results for **Access Alliance of Michigan** from the 2004–2005 and 2005–2006 compliance monitoring reviews.

Table 4-1—Compliance Following 2004–2005 and 2005–2006 Reviews *for* Access Alliance of Michigan

Standard		Full Compliance		One or more remaining corrective action(s)
		Achieved 2004–2005	Achieved after follow-up 2005–2006	
I	QAPI Plan and Structure		✓	
II	Performance Measurement and Improvement	✓		
III	Practice Guidelines	✓		
IV	Staff Qualifications and Training	✓		
V	Utilization Management		✓	
VI	Customer Service		✓	
VII	Recipient Grievance Process		✓	
VIII	Enrollee Rights and Protections			✓

The 2004–2005 compliance monitoring review resulted in 43 recommendations for improvement in the following areas: QAPI Plan and Structure, Utilization Management, Customer Service, Recipient Grievance Process, and Enrollee Rights and Protections. The PIHP addressed recommendations through corrective action plans and implemented numerous improvements. Subsequent to the 2005–2006 follow-up review, **Access Alliance of Michigan** achieved full compliance on seven of the eight standards, with only two continuing recommendations for Enrollee Rights and Protections.

Validation of Performance Measures

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

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

2005–2006 Recommendation	2007 Status
Many of **Access Alliance of Michigan**'s performance indicators were still hand-generated, potentially leading to errors and taking more time and effort to produce. The PIHP should move toward a fully automated system from which reports could be generated.	The PIHP obtained electronic performance indicator (PI) data directly from the CMHCs through the PI database, or the CMHCs submitted an Excel/Access file. All the PI data were imported into the PI database, where queries and calculations were then completed. Data were also available for extraction to review performance and production using this database. There were still several manual steps for performance measure data capture occurring at the CMHC-level, such as time calculation for Indicator 1 and the determination of treatment within 90 days for Indicators 2 and 3. There was some manual finalization of data for Indicator 12. Overall, the PIHP had made significant strides in moving toward full automation of its performance indicator data capture and reporting process.

Access Alliance of Michigan demonstrated progress toward implementation of the recommendations for improvement.

Validation of Performance Improvement Projects

Table 4-3 below displays activities/elements scored *Partially Met* or *Not Met* for **Access Alliance of Michigan** during the 2006 validation of PIPs, as well as results of the assessment of these elements from the 2007 EQR.

Table 4-3—Follow-Up on Prior Recommendations *for* Access Alliance of Michigan

Activity/ Element	2005–2006 Score	2006–2007 Score	2006–2007 Comment
VI.5	*Partially Met*	*NA*	Manual data collection was not used for this study.
VI.6	*Partially Met*	*NA*	Manual data collection was not used for this study.
VI.9	*Partially Met*	*NA*	Manual data collection was not used for this study.
VII.2	*Partially Met*	Not assessed	
VII.3	*Partially Met*	Not assessed	
VIII.4	*Partially Met*	Not assessed	
VIII.4	*Partially Met*	Not assessed	
VIII.7	*Not Met*	Not assessed	
IX.3	*Partially Met*	Not assessed	
IX.4	*Not Met*	Not assessed	
X	*Partially Met*	Not assessed	

PIHP performance on the elements cited for improvement in the 2005–2006 validation could not be evaluated because a new study topic had been selected. The new study used a different method for data collection and had not progressed far enough to allow for evaluation of all activities.

CMH Affiliation of Mid-Michigan

Compliance Monitoring

Table 4-4 below shows the results for **CMH Affiliation of Mid-Michigan** from the 2004–2005 and 2005–2006 compliance monitoring reviews.

Table 4-4—Compliance Following 2004–2005 and 2005–2006 Reviews *for* CMH Affiliation of Mid-Michigan

Standard		Full Compliance		One or more remaining corrective action(s)
		Achieved 2004–2005	Achieved after follow-up 2005–2006	
I	QAPI Plan and Structure		✓	
II	Performance Measurement and Improvement		✓	
III	Practice Guidelines	✓		
IV	Staff Qualifications and Training	✓		
V	Utilization Management		✓	
VI	Customer Service		✓	
VII	Recipient Grievance Process		✓	
VIII	Enrollee Rights and Protections			✓

The 2004–2005 compliance monitoring review resulted in 51 recommendations for improvement in the following areas: QAPI Plan and Structure, Performance Measurement and Improvement, Utilization Management, Customer Service, Recipient Grievance Process, and Enrollee Rights and Protections. The PIHP addressed recommendations through corrective action plans and implemented numerous improvements. Subsequent to the 2005–2006 follow-up review, **CMH Affiliation of Mid-Michigan** achieved full compliance on seven of the eight standards, with only two continuing recommendations remaining for Enrollee Rights and Protections.

Validation of Performance Measures

Table 4-5 below shows the recommendations for improvement for **CMH Affiliation of Mid-Michigan** from the 2006 validation of performance measures and the status of the PIHP's follow-up on these recommendations at the time of the 2007 EQR.

Table 4-5—Follow-Up on Prior Recommendations *for* CMH Affiliation of Mid-Michigan

2005–2006 Recommendation	2007 Status
CMH Affiliation of Mid-Michigan should focus efforts on implementing oversight functions for the CA. The PIHP should ensure that quality audits assess performance indicator compliance and validation of results. The PIHP should consider having all affiliates trace sample cases (both compliant and noncompliant) through the indicator logic to ensure correct reporting of cases.	The reviewers noted a commendable improvement in the CA's data over the past year. The PIHP implemented all recommendations for improvement suggested from the previous year's audit.

CMH Affiliation of Mid-Michigan successfully addressed all recommendations for improvement.

Validation of Performance Improvement Projects

Table 4-6 below displays activities/elements scored *Partially Met* or *Not Met* for **CMH Affiliation of Mid-Michigan** during the 2006 validation of PIPs, as well as results of the assessment of these elements from the 2007 EQR.

Table 4-6—Follow-Up on Prior Recommendations *for* CMH Affiliation of Mid-Michigan

Activity/ Element	2005–2006 Score	2006–2007 Score	2006–2007 Comment
III. 1	*Partially Met*	*Met*	The study indicator was well-defined, objective, and measurable as defined by the State. Point of clarification: The measurement period dates should be complete date ranges (i.e., October 1, 2006–December 31, 2006).
III. 3	*Partially Met*	*Met*	The study indicator allowed for the study question to be answered.
VI. 5	*Partially Met*	*NA*	Manual data collection was not used in this study.

CMH Affiliation of Mid-Michigan successfully addressed all recommendations for improvement for elements that were applicable to the new PIP.

CMH for Central Michigan

Compliance Monitoring

Table 4-7 below shows the results for **CMH for Central Michigan** from the 2004–2005 and 2005–2006 compliance monitoring reviews.

Table 4-7—Compliance Following 2004–2005 and 2005–2006 Reviews *for* CMH for Central Michigan

Standard		Full Compliance		One or more remaining corrective action(s)
		Achieved 2004–2005	Achieved after follow-up 2005–2006	
I	QAPI Plan and Structure		✓	
II	Performance Measurement and Improvement		✓	
III	Practice Guidelines	✓		
IV	Staff Qualifications and Training	✓		
V	Utilization Management			✓
VI	Customer Service		✓	
VII	Recipient Grievance Process			✓
VIII	Enrollee Rights and Protections			✓

The 2004–2005 compliance monitoring review resulted in 40 recommendations for improvement in the following areas: QAPI Plan and Structure, Performance Measurement and Improvement, Utilization Management, Customer Service, Recipient Grievance Process, and Enrollee Rights and Protections. The PIHP addressed recommendations through corrective action plans and implemented numerous improvements. Subsequent to the 2005–2006 follow-up review, **CMH for Central Michigan** achieved full compliance on five of the eight standards, with 15 continuing recommendations remaining for Utilization Management, Recipient Grievance Process, and Enrollee Rights and Protections.

Validation of Performance Measures

Table 4-8 below shows the recommendations for improvement for **CMH for Central Michigan** from the 2006 validation of performance measures and the status of the PIHP's follow-up on these recommendations at the time of the 2007 EQR.

Table 4-8—Follow-Up on Prior Recommendations *for* CMH for Central Michigan

2005–2006 Recommendation	2007 Status
CMH for Central Michigan should conduct cross-training among staff and document the performance indicator generation process in policies and procedures or a training manual.	The PIHP demonstrated that cross-training had occurred among staff and that the performance measure generation process had been documented.

CMH for Central Michigan fully addressed the recommendation for improvement.

Validation of Performance Improvement Projects

Table 4-9 below displays activities/elements scored *Partially Met* or *Not Met* for **CMH for Central Michigan** during the 2006 validation of PIPs, as well as results of the assessment of these elements from the 2007 EQR.

Table 4-9—Follow-Up on Prior Recommendations *for* CMH for Central Michigan

Activity/ Element	2005–2006 Score	2006–2007 Score	2006–2007 Comment
II.1	*Partially Met*	*Met*	The study question was required by the State, was stated in simple terms, and met all CMS PIP Protocol requirements.
II.2	*Partially Met*	*Met*	The study question was answerable.
III.3	*Partially Met*	*Met*	The study indicator allowed for the study question to be answered.
VI.1	*Partially Met*	*Met*	The data elements collected were identified through the PIP documentation.
VI.4	*Partially Met*	*Met*	A timeline that included both baseline and remeasurement data collection was provided.
VI.6	*Partially Met*	*NA*	Manual data collection was not used in this study.
VI.7	*Not Met*	*NA*	Manual data collection was not used in this study.
VI.8	*Partially Met*	*NA*	Manual data collection was not used in this study.
VI.9	*Not Met*	*NA*	Manual data collection was not used in this study.
VI.10	*Not Met*	*Met*	The administrative data collection process was included in the PIP documentation.
VI.11	*Not Met*	*Met*	The estimated degree of administrative data completeness was reported as 100 percent.
VII.1	*Partially Met*	*Partially Met*	The PIP documentation included a barrier on the barrier/intervention table; however, there was no discussion of how a causal/barrier analysis was performed or the QI processes that took place that identified the listed barrier.
VIII.1	*Not Met*	*Met*	Baseline results were analyzed according to the data analysis plan in the study.
VIII. 3	*Not Met*	*Not Met*	There was no discussion in the PIP documentation regarding internal or external factors that threatened the validity of study results.
VIII. 4	*Not Met*	*Met*	The PIP documentation included an interpretation of the baseline findings.

CMH for Central Michigan successfully addressed most recommendations from the 2005–2006 validation of its performance improvement project that were applicable to the 2007 PIP.

CMH Partnership of Southeastern Michigan

Compliance Monitoring

Table 4-10 below shows the results for **CMH Partnership of Southeastern Michigan** from the 2004–2005 and 2005–2006 compliance monitoring reviews.

Table 4-10—Compliance Following 2004–2005 and 2005–2006 Reviews *for* CMH Partnership of Southeastern Michigan

Standard		Full Compliance		One or more remaining corrective action(s)
		Achieved 2004–2005	Achieved after follow-up 2005–2006	
I	QAPI Plan and Structure		✓	
II	Performance Measurement and Improvement	✓		
III	Practice Guidelines			✓
IV	Staff Qualifications and Training			✓
V	Utilization Management		✓	
VI	Customer Service		✓	
VII	Recipient Grievance Process		✓	
VIII	Enrollee Rights and Protections			✓

The 2004–2005 compliance monitoring review resulted in 43 recommendations for improvement in the following areas: QAPI Plan and Structure, Practice Guidelines, Staff Qualifications and Training, Utilization Management, Customer Service, Recipient Grievance Process, and Enrollee Rights and Protections. The PIHP addressed recommendations through corrective action plans and implemented numerous improvements. Subsequent to the 2005–2006 follow-up review, **CMH Partnership of Southeastern Michigan** achieved full compliance on five of the eight standards, with only three continuing recommendations remaining for Practice Guidelines, Staff Qualifications and Training, and Enrollee Rights and Protections.

Validation of Performance Measures

Table 4-11 below shows the recommendations for improvement for **CMH Partnership of Southeastern Michigan** from the 2006 validation of performance measures and the status of the PIHP's follow-up on these recommendations at the time of the 2007 EQR.

Table 4-11—Follow-Up on Prior Recommendations *for* CMH Partnership of Southeastern Michigan

2005–2006 Recommendation	2007 Status
CMH Partnership of Southeastern Michigan should explore systematic mechanisms to ensure that each service results in an encounter record. The PIHP should focus efforts on consistently collecting the minimum wage variable in the QI data. The PIHP should also explore methods to further automate performance indicator reporting to capture exception reasons. The PIHP should focus efforts on implementing oversight functions for the CA. The PIHP should ensure that quality audits assess performance indicator compliance and validation of results.	Over the past three years, the PIHP converted all CMHSP data into the Encompass system and standardized processes, forms, data, and trainings to align work at each agency. The Encompass system offered a platform to compare data across the region and run comparative analysis to identify differences. The PIHP continued to work to standardize more of the clinical record across the region. The use of Encompass for the entire region was a great accomplishment. The PIHP demonstrated sufficient oversight of its CA. Face-to-face meetings and conference calls were used to enhance communication between the entities.

CMH Partnership of Southeastern Michigan addressed all recommendations for improvement.

Validation of Performance Improvement Projects

There were no opportunities for improvement identified for **CMH Partnership of Southeastern Michigan** during the 2006 validation of PIPs.

Detroit-Wayne County CMH Agency

Compliance Monitoring

Table 4-12 below shows the results for **Detroit-Wayne County CMH Agency** from the 2004–2005 and 2005–2006 compliance monitoring reviews.

Table 4-12—Compliance Following 2004–2005 and 2005–2006 Reviews *for* Detroit-Wayne County CMH Agency

Standard		Full Compliance		One or more remaining corrective action(s)
		Achieved 2004–2005	Achieved after follow-up 2005–2006	
I	QAPI Plan and Structure			✓
II	Performance Measurement and Improvement			✓
III	Practice Guidelines		✓	
IV	Staff Qualifications and Training	✓		
V	Utilization Management			✓
VI	Customer Service			✓
VII	Recipient Grievance Process			✓
VIII	Enrollee Rights and Protections			✓

The 2004–2005 compliance monitoring review resulted in 58 recommendations for improvement in the following areas: QAPI Plan and Structure, Performance Measurement and Improvement, Practice Guidelines, Utilization Management, Customer Service, Recipient Grievance Process, and Enrollee Rights and Protections. The PIHP addressed recommendations through corrective action plans and implemented numerous improvements. Subsequent to the 2005–2006 follow-up review, **Detroit-Wayne County CMH Agency** achieved full compliance on two of the eight standards, with 22 continuing recommendations remaining for QAPI Plan and Structure, Performance Measurement and Improvement, Utilization Management, Customer Service, Recipient Grievance Process, and Enrollee Rights and Protections.

Validation of Performance Measures

Table 4-13 below shows the recommendations for improvement for **Detroit-Wayne County CMH Agency** from the 2006 validation of performance measures and the status of the PIHP's follow-up on these recommendations at the time of the 2007 EQR.

Table 4-13—Follow-Up on Prior Recommendations *for* Detroit-Wayne County CMH Agency	
2005–2006 Recommendation	**2007 Status**
The **Detroit-Wayne County CMH Agency** should formalize and expand Managed Comprehensive Provider Network oversight activities through documentation of oversight activities and develop formal policies and procedures addressing verification and oversight of data accuracy and completeness. The PIHP should increase use of performance metric analysis/reporting and the use of multidisciplinary teams (i.e., quality improvement, utilization management, information technology, and finance teams) in the oversight of performance indicator reporting activities.	While the **Detroit-Wayne County CMH Agency** had been working on these recommendations, the PIHP was still in the process of fully implementing them.

Detroit-Wayne County CMH Agency had not completed the process of implementing the recommendations for improvement.

Validation of Performance Improvement Projects

Table 4-14 below displays activities/elements scored *Partially Met* or *Not Met* for **Detroit-Wayne County CMH Agency** during the 2006 validation of PIPs and results of the assessment of these elements from the 2007 EQR.

Table 4-14—Follow-Up on Prior Recommendations *for* Detroit-Wayne County CMH Agency			
Activity/ Element	**2005–2006 Score**	**2006–2007 Score**	**2006–2007 Comment**
VI. 3	*Not Met*	*NA*	Although the PIHP believed that automated data collection from electronic sources would be appropriate, it was prepared to conduct manual data abstraction. At the time of the 2007 validation, a decision as to which type of data collection to conduct had not been made. For this reason, neither automated nor manual data collection materials and information had been prepared.

Detroit-Wayne County CMH Agency had not addressed the recommendation for improvement because the PIHP had not finalized decisions about the study data collection. The related element received a score of *NA* for the 2007 validation.

Genesee County CMH

Compliance Monitoring

Table 4-15 below shows the results for **Genesee County CMH** from the 2004–2005 and 2005–2006 compliance monitoring reviews.

Table 4-15—Compliance Following 2004–2005 and 2005–2006 Reviews *for* Genesee County CMH

Standard		Full Compliance		One or more remaining corrective action(s)
		Achieved 2004–2005	Achieved after follow-up 2005–2006	
I	QAPI Plan and Structure	✓		
II	Performance Measurement and Improvement	✓		
III	Practice Guidelines	✓		
IV	Staff Qualifications and Training	✓		
V	Utilization Management		✓	
VI	Customer Service	✓		
VII	Recipient Grievance Process		✓	
VIII	Enrollee Rights and Protections		✓	

The 2004–2005 compliance monitoring review resulted in 17 recommendations for improvement in the following areas: Utilization Management, Recipient Grievance Process, and Enrollee Rights and Protections. The PIHP addressed recommendations through corrective action plans and implemented numerous improvements. Subsequent to the 2005–2006 follow-up, there were no continuing recommendations for improvement as **Genesee County CMH** had achieved full compliance on all standards.

Validation of Performance Measures

Table 4-16 below shows the recommendations for improvement for **Genesee County CMH** from the 2006 validation of performance measures and the status of the PIHP's follow-up on these recommendations at the time of the 2007 EQR.

Table 4-16—Follow-Up on Prior Recommendations *for* Genesee County CMH	
2005–2006 Recommendation	**2007 Status**
Genesee County CMH should continue to improve its current performance indicator calculation processes.	The PIHP used programmatic code to extract the data necessary for performance indicator reporting, which was then peer-reviewed as an additional validation step.
The PIHP should continue its efforts to fully integrate the CA data into its system.	The PIHP integrated the CA function fully into its organization. The result has been positive, with the PIHP having complete control and oversight of CA data, and uniform interpretation of performance indicators across the PIHP.

Genesee County CMH successfully addressed all recommendations for improvement.

Validation of Performance Improvement Projects

Table 4-17 below displays activities/elements scored *Partially Met* or *Not Met* for **Genesee County CMH** during the 2006 validation of PIPs and results of the assessment of these elements from the 2007 EQR.

Table 4-17—Follow-Up on Prior Recommendations *for* Genesee County CMH			
Activity/ Element	**2005–2006 Score**	**2006–2007 Score**	**2006–2007 Comment**
VI. 4	*Partially Met*	*Met*	A timeline that included both baseline and remeasurement data was included in the PIP study documentation.
VI. 9	*Not Met*	*NA*	Manual data collection was not used in this study.
VI. 10	*Partially Met*	*Met*	The administrative data collection process was completely defined in the PIP.
VIII. 8	*Partially Met*	*Met*	The study identified factors that affected the ability to compare baseline and remeasurement results.
X	*Partially Met*	*Met*	Study Indicator 7, a State-mandated indicator, demonstrated sustained improvement over comparable time periods.

Genesee County CMH successfully addressed all recommendations for improvement that were applicable to the new PIP.

Lakeshore Behavioral Health Alliance

Compliance Monitoring

Table 4-18 below shows the results for **Lakeshore Behavioral Health Alliance** from the 2004–2005 and 2005–2006 compliance monitoring reviews.

Table 4-18—Compliance Following 2004–2005 and 2005–2006 Reviews *for* Lakeshore Behavioral Health Alliance

Standard		Full Compliance		One or more remaining corrective action(s)
		Achieved 2004–2005	Achieved after follow-up 2005–2006	
I	QAPI Plan and Structure		✓	
II	Performance Measurement and Improvement		✓	
III	Practice Guidelines		✓	
IV	Staff Qualifications and Training	✓		
V	Utilization Management		✓	
VI	Customer Service	✓		
VII	Recipient Grievance Process		✓	
VIII	Enrollee Rights and Protections			✓

The 2004–2005 compliance monitoring review resulted in 22 recommendations for improvement in the following areas: QAPI Plan and Structure, Performance Measurement and Improvement, Practice guidelines, Utilization Management, Recipient Grievance Process, and Enrollee Rights and Protections. The PIHP addressed recommendations through corrective action plans and implemented numerous improvements. Subsequent to the 2005–2006 follow-up review, **Lakeshore Behavioral Health Alliance** achieved full compliance on seven of the eight standards, with only two continuing recommendations remaining for Enrollee Rights and Protections.

Validation of Performance Measures

Table 4-19 below shows the recommendations for improvement for **Lakeshore Behavioral Health Alliance** from the 2006 validation of performance measures and the status of the PIHP's follow-up on these recommendations at the time of the 2007 EQR.

Table 4-19—Follow-Up on Prior Recommendations *for* Lakeshore Behavioral Health Alliance	
2005–2006 Recommendation	**2007 Status**
Lakeshore Behavioral Health Alliance should develop a more detailed and specific process/written procedure for correction of provider errors on claims. The PIHP should formalize an audit process for manual data entry of paper claims, even if the volume is small.	The PIHP implemented processes for dealing with provider errors on claims. The PIHP had an internal policy that indicated that all data entry supervisors would assure compliance with the agency standard for accuracy of data entry of 99 percent or higher by using the monitoring system described in the procedure.

Lakeshore Behavioral Health Alliance successfully addressed all recommendations for improvement.

Validation of Performance Improvement Projects

Table 4-20 below displays activities/elements scored *Partially Met* or *Not Met* for **Lakeshore Behavioral Health Alliance** during the 2006 validation of PIPs, as well as the results of the assessment of these elements from the 2007 EQR.

Table 4-20—Follow-Up on Prior Recommendations *for* Lakeshore Behavioral Health Alliance			
Activity/ Element	**2005–2006 Score**	**2006–2007 Score**	**2006–2007 Comment**
V. 3	*Not Met*	*NA*	Sampling was not used in this study.
V. 4	*Not Met*	*NA*	Sampling was not used in this study.
VIII. 8	*Not Met*	Not Assessed	
VIII. 9	*Not Met*	Not Assessed	

Lakeshore Behavioral Health Alliance's performance on the elements cited for improvement in the 2005–2006 validation could not be evaluated because a new study topic had been selected. The new study used a different method for data collection and had not progressed far enough to allow for evaluation of all activities.

LifeWays

Compliance Monitoring

Table 4-21 below shows the results for **LifeWays** from the 2004–2005 and 2005–2006 compliance monitoring reviews.

Table 4-21—Compliance Following 2004–2005 and 2005–2006 Reviews *for* LifeWays

Standard		Full Compliance		One or more remaining corrective action(s)
		Achieved 2004–2005	Achieved after follow-up 2005–2006	
I	QAPI Plan and Structure	✓		
II	Performance Measurement and Improvement	✓		
III	Practice Guidelines	✓		
IV	Staff Qualifications and Training	✓		
V	Utilization Management	✓		
VI	Customer Service	✓		
VII	Recipient Grievance Process		✓	
VIII	Enrollee Rights and Protections		✓	

The 2004–2005 compliance monitoring review resulted in nine recommendations for improvement in the following areas: Recipient Grievance Process and Enrollee Rights and Protections. The PIHP addressed recommendations through corrective action plans and implemented numerous improvements. Subsequent to the 2005–2006 follow-up, there were no continuing recommendations for improvement as **LifeWays** had achieved full compliance on all standards.

Validation of Performance Measures

Table 4-22 below shows the recommendations for improvement for **LifeWays** from the 2006 validation of performance measures and the status of the PIHP's follow-up on these recommendations at the time of the 2007 EQR.

Table 4-22—Follow-Up on Prior Recommendations *for* LifeWays

2005–2006 Recommendation	2007 Status
LifeWays should consider more automation in the performance indicator calculation process to minimize potential errors and improve work flow. The PIHP should continue to increase the documentation of all its data oversight activities.	The PIHP followed up on the previous year's performance indicator validation (PMV) audit recommendations, including more automation of the PI calculation process, and conducted a full review of the specifications for the performance indicators at all site reviews. The PIHP improved documentation of oversight activities. The PIHP sent quarterly quality reports to its CA and performed annual site audits.

LifeWays successfully addressed all recommendations for improvement.

Validation of Performance Improvement Projects

Table 4-23 below displays activities/elements scored *Partially Met* or *Not Met* for **LifeWays** during the 2006 validation of PIPs, as well as the results of the assessment of these elements from the 2007 EQR.

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

Activity/ Element	2005–2006 Score	2006–2007 Score	2006–2007 Comment
VI. 9	*Not Met*	*NA*	Manual data collection was not used in the study.
VII. 1	*Partially Met*	Not Assessed	
VIII. 1	*Partially Met*	Not Assessed	
VIII. 6	*Partially Met*	Not Assessed	
VIII. 7	*Not Met*	Not Assessed	
VIII. 9	*Partially Met*	Not Assessed	
IX. 1	*Partially Met*	Not Assessed	
IX. 2	*Partially Met*	Not Assessed	
IX. 3	*Not Met*	Not Assessed	
IX. 4	*Not Met*	Not Assessed	

LifeWays' performance on the elements cited for improvement in the 2005–2006 validation could not be evaluated because a new study topic had been selected. The new study used a different method for data collection and had not progressed far enough to allow for evaluation of all activities.

Macomb County CMH Services

Compliance Monitoring

Table 4-24 below shows the results for **Macomb County CMH Services** from the 2004–2005 and 2005–2006 compliance monitoring reviews.

Table 4-24—Compliance Following 2004–2005 and 2005–2006 Reviews *for* Macomb County CMH Services

Standard		Full Compliance		One or more remaining corrective action(s)
		Achieved 2004–2005	Achieved after follow-up 2005–2006	
I	QAPI Plan and Structure			✓
II	Performance Measurement and Improvement		✓	
III	Practice Guidelines	✓		
IV	Staff Qualifications and Training	✓		
V	Utilization Management	✓		
VI	Customer Service	✓		
VII	Recipient Grievance Process		✓	
VIII	Enrollee Rights and Protections			✓

The 2004–2005 compliance monitoring review resulted in 29 recommendations for improvement in the following areas: QAPI Plan and Structure, Performance Measurement and Improvement, Recipient Grievance Process, and Enrollee Rights and Protections. The PIHP addressed recommendations through corrective action plans and implemented numerous improvements. Subsequent to the 2005–2006 follow-up review, **Macomb County CMH Services** achieved full compliance on six of the eight standards, with only two continuing recommendations remaining for QAPI Plan and Structure and Enrollee Rights and Protections.

Validation of Performance Measures

Table 4-25 below shows the recommendations for improvement for **Macomb County CMH Services** from the 2006 validation of performance measures and the status of the PIHP's follow-up on these recommendations at the time of the 2007 EQR.

Table 4-25—Follow-Up on Prior Recommendations *for* Macomb County CMH Services

2005–2006 Recommendation	2007 Status
Macomb County CMH Services should continue its comprehensive approach to encounter data completeness and accuracy as it moves to the new information system.	The PIHP transitioned to a new data system (FOCUS) and the system had sufficient edits in place to ensure accurate and complete encounter data.
Macomb County CMH Services should expand the oversight activities used for service data to include QI data. These additional QI data oversight activities should focus on data completeness in particular.	The PIHP made great strides to ensure QI data completeness with the transition to its new system.

Macomb County CMH Services successfully addressed all recommendations for improvement.

Validation of Performance Improvement Projects

There were no opportunities for improvement identified for **Macomb County CMH Services** during the 2006 validation of PIPs.

network180

Compliance Monitoring

Table 4-26 below shows the results for **network180** from the 2004–2005 and 2005–2006 compliance monitoring reviews.

Table 4-26—Compliance Following 2004–2005 and 2005–2006 Reviews *for* network180

Standard		Full Compliance		One or more remaining corrective action(s)
		Achieved 2004–2005	Achieved after follow-up 2005–2006	
I	QAPI Plan and Structure		✓	
II	Performance Measurement and Improvement	✓		
III	Practice Guidelines			✓
IV	Staff Qualifications and Training	✓		
V	Utilization Management			✓
VI	Customer Service		✓	
VII	Recipient Grievance Process			✓
VIII	Enrollee Rights and Protections			✓

The 2004–2005 compliance monitoring review resulted in 18 recommendations for improvement in the following areas: QAPI Plan and Structure, Practice Guidelines, Utilization Management, Customer Service, Recipient Grievance Process, and Enrollee Rights and Protections. The PIHP addressed recommendations through corrective action plans and implemented numerous improvements. Subsequent to the 2005–2006 follow-up review, **network180** achieved full compliance on four of the eight standards, with 11 continuing recommendations remaining for Practice Guidelines, Utilization Management, Recipient Grievance Process, and Enrollee Rights and Protections.

Validation of Performance Measures

Table 4-27 below shows the recommendations for improvement for **network180** from the 2006 validation of performance measures and the status of the PIHP's follow-up on these recommendations at the time of the 2007 EQR.

Table 4-27—Follow-Up on Prior Recommendations *for* network180	
2005–2006 Recommendation	**2007 Status**
network180 should implement a more detailed process, including written procedures, for correction of provider errors on claims.	The PIHP had documented the processes for correcting provider errors on claims.
The PIHP should continue its efforts to move toward a totally electronic data environment.	The PIHP continued its efforts toward an electronic data environment.
network180 should continue to encourage timely submission of data by its providers.	The PIHP implemented an incentive program to encourage providers to submit performance indicator data in a timely manner.

network180 successfully addressed all recommendations for improvement.

Validation of Performance Improvement Projects

Table 4-28 below displays activities/elements scored *Partially Met* or *Not Met* for **network180** during the 2006 validation of PIPs, as well as the results of the assessment of these elements from the 2007 EQR.

Table 4-28—Follow-Up on Prior Recommendations *for* network180			
Activity/ Element	**2005–2006 Score**	**2006–2007 Score**	**2006–2007 Comment**
VI. 6	*Partially Met*	*NA*	Manual data collection was not used in this study.
VI. 8	*Partially Met*	*NA*	Manual data collection was not used in this study.
VI. 9	*Not Met*	*NA*	Manual data collection was not used in this study.
VI. 11	*Not Met*	*Met*	The estimated degree of administrative data completeness was reported as 95 percent.
IX. 2	*Partially Met*	Not Assessed	

network180 successfully addressed one of the recommendations for improvement. The PIHP's performance on the remaining elements cited for improvement in the 2005–2006 validation could not be evaluated because a new study topic had been selected. The new study used a different method for data collection and had not progressed far enough to allow for evaluation of all activities.

NorthCare

Compliance Monitoring

Table 4-29 below shows the results for **NorthCare** from the 2004–2005 and 2005–2006 compliance monitoring reviews.

Table 4-29—Compliance Following 2004–2005 and 2005–2006 Reviews *for* NorthCare

Standard		Full Compliance		One or more remaining corrective action(s)
		Achieved 2004–2005	Achieved after follow-up 2005–2006	
I	QAPI Plan and Structure	✓		
II	Performance Measurement and Improvement	✓		
III	Practice Guidelines	✓		
IV	Staff Qualifications and Training	✓		
V	Utilization Management		✓	
VI	Customer Service		✓	
VII	Recipient Grievance Process			✓
VIII	Enrollee Rights and Protections			✓

The 2004–2005 compliance monitoring review resulted in 21 recommendations for improvement in the following areas: Utilization Management, Customer Service, Recipient Grievance Process, and Enrollee Rights and Protections. The PIHP implemented numerous improvements. Subsequent to the 2005–2006 follow-up review, **NorthCare** achieved full compliance on six of the eight standards, with 17 continuing recommendations remaining for the Recipient Grievance Process and Enrollee Rights and Protections.

Validation of Performance Measures

Table 4-30 below shows the recommendations for improvement for **NorthCare** from the 2006 validation of performance measures and the status of the PIHP's follow-up on these recommendations at the time of the 2007 EQR.

Table 4-30—Follow-Up on Prior Recommendations *for* NorthCare

2005–2006 Recommendation	2007 Status
NorthCare should work to improve the documentation of data audit processes and oversight activities currently being performed to facilitate the demonstration of data completeness and accuracy. The PIHP should continue to work toward timely encounter data submission and ensure that all QI data fields used in performance indicators are captured in a timely manner. **NorthCare** should move toward automated, PIHP-level indicator calculation using the data warehouse to minimize the administrative burden and potential for error.	The PIHP had documented audit processes and oversight activities. The PIHP was moving toward an electronic medical record and a standardized data system across all affiliates, which will further improve the timeliness and quality of the data.

NorthCare successfully addressed all recommendations for improvement.

Validation of Performance Improvement Projects

There were no opportunities for improvement identified for **NorthCare** during the 2006 validation of PIPs.

Northern Affiliation

Compliance Monitoring

Table 4-31 below shows the results for **Northern Affiliation** from the 2004–2005 and 2005–2006 compliance monitoring reviews.

Table 4-31—Compliance Following 2004–2005 and 2005–2006 Reviews *for* Northern Affiliation

Standard		Full Compliance		One or more remaining corrective action(s)
		Achieved 2004–2005	Achieved after follow-up 2005–2006	
I	QAPI Plan and Structure		✓	
II	Performance Measurement and Improvement		✓	
III	Practice Guidelines			✓
IV	Staff Qualifications and Training	✓		
V	Utilization Management			✓
VI	Customer Service		✓	
VII	Recipient Grievance Process			✓
VIII	Enrollee Rights and Protections			✓

The 2004–2005 compliance monitoring review resulted in 22 recommendations for improvement in the following areas: QAPI Plan and Structure, Performance Measurement and Improvement, Practice Guidelines, Utilization Management, Customer Service, Recipient Grievance Process, and Enrollee Rights and Protections. The PIHP addressed recommendations through corrective action plans and implemented numerous improvements. Subsequent to the 2005–2006 follow-up review, **Northern Affiliation** achieved full compliance on four of the eight standards, with 11 continuing recommendations remaining for Practice Guidelines, Utilization Management, Recipient Grievance Process, and Enrollee Rights and Protections.

Validation of Performance Measures

Table 4-32 shows the recommendations for improvement for **Northern Affiliation** from the 2006 performance measures and the status of the PIHP's follow-up on these recommendations at the time of the 2007 EQR.

Table 4-32—Follow-Up on Prior Recommendations *for* Northern Affiliation	
2005–2006 Recommendation	**2007 Status**
Northern Affiliation should work to expand the documentation of the data audit processes currently being performed.	The PIHP had documentation of the audit process in place across the affiliation; however, the PIHP should continue to formalize these processes.
The PIHP should implement a more systematic process for evaluation of encounter data completeness that considers all of its activities.	The PIHP had processes in place to evaluate encounter data completeness; however, the PIHP should continue to work on these efforts.
Northern Affiliation should continue its efforts to improve the timely submission of QI data by its affiliates.	The PIHP improved efforts to receive timely submission of QI data from its affiliates.

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

Validation of Performance Improvement Projects

Table 4-33 below displays activities/elements scored *Partially Met* or *Not Met* for **Northern Affiliation** during the 2006 validation of PIPs, as well as the results of the assessment of these elements from the 2007 EQR.

Table 4-33—Follow-Up on Prior Recommendations *for* Northern Affiliation			
Activity/ Element	**2005–2006 Score**	**2006–2007 Score**	**2006–2007 Comment**
II. 1	*Partially Met*	*Met*	The study question stated the problem to be studied in simple terms.
II. 2	*Partially Met*	*Met*	The stated study question was answerable.
III. 1	*Partially Met*	*Met*	The study indicator was well-defined, objective, and measurable.
III. 3	*Partially Met*	*Met*	The study indicator allowed for the study question to be answered.
VI. 9	*Not Met*	*NA*	Manual data collection was not used in this study.
VIII. 3	*Not Met*	*Partially Met*	The performance indicator, QI, and 837 validation/audit process documentation included and referenced in the PIP listed what appeared to be threats to the internal/external validity of the data analysis findings; however, the PIP documentation did not specifically state in the text that these were the factors that threatened the internal/external validity. Future submissions of the PIP documentation should clearly identify these factors as threats to the data analysis validity.

Northern Affiliation successfully addressed almost all recommendations for improvement that were applicable to the new PIP.

Northwest CMH Affiliation

Compliance Monitoring

Table 4-34 below shows the results for **Northwest CMH Affiliation** from the 2004–2005 and 2005–2006 compliance monitoring reviews.

Table 4-34—Compliance Following 2004–2005 and 2005–2006 Reviews *for* Northwest CMH Affiliation

Standard		Full Compliance		One or more remaining corrective action(s)
		Achieved 2004–2005	Achieved after follow-up 2005–2006	
I	QAPI Plan and Structure	✓		
II	Performance Measurement and Improvement	✓		
III	Practice Guidelines	✓		
IV	Staff Qualifications and Training	✓		
V	Utilization Management		✓	
VI	Customer Service	✓		
VII	Recipient Grievance Process		✓	
VIII	Enrollee Rights and Protections			✓

The 2004–2005 compliance monitoring review resulted in 22 recommendations for improvement in the following areas: Utilization Management, Recipient Grievance Process, and Enrollee Rights and Protections. The PIHP addressed recommendations through corrective action plans and implemented numerous improvements. Subsequent to the 2005–2006 follow-up review, **Northwest CMH Affiliation** achieved full compliance on seven of the eight standards, with only two continuing recommendations remaining for Enrollee Rights and Protections.

Validation of Performance Measures

Table 4-35 shows the recommendations for improvement for **Northwest CMH Affiliation** from the 2006 performance measures and the status of the PIHP's follow-up on these recommendations at the time of the 2007 EQR.

Table 4-35—Follow-Up on Prior Recommendations *for* Northwest CMH Affiliation	
2005–2006 Recommendation	**2007 Status**
Northwest CMH Affiliation should continue efforts to capture all data for services rendered to consumers. The PIHP should formalize processes for oversight of the CMHCs and the CA. **Northwest CMH Affiliation** should continue to encourage timely submission of data by its providers, especially those identified as performing under par.	The PIHP implemented the new Avatar system, which enhanced the completeness of all service data. However, the PIHP still needed to improve capturing exclusion data. The PIHP had formalized its processes for oversight of the CMHCs by transitioning to a new vendor for its provider system. The PIHP has been working with its vendor to make improvements in the quality and timeliness of reporting. However, the PIHP needed to continue to closely monitor CA data and encourage timely CA data submission.

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

Validation of Performance Improvement Projects

Table 4-36 below displays activities/elements scored *Partially Met* or *Not Met* for **Northwest CMH Affiliation** during the 2006 validation of PIPs, as well as the results of the assessment of these elements from the 2007 EQR.

Table 4-36—Follow-Up on Prior Recommendations *for* Northwest CMH Affiliation			
Activity/ Element	**2005–2006 Score**	**2006–2007 Score**	**2006–2007 Comment**
II. 1	*Partially Met*	*Met*	The study question was required by the State and was stated in simple terms.
V. 5	*Partially Met*	*NA*	Sampling was not used in this study.
V. 6	*Not Met*	*NA*	Sampling was not used in this study.
VI. 5	*Partially Met*	Not Assessed	
VI. 9	*Not Met*	Not Assessed	
VI. 11	*Not Met*	Not Assessed	
VII. 1	*Partially Met*	Not Assessed	
VII. 3	*Partially Met*	Not Assessed	
VIII. 1	*Partially Met*	Not Assessed	
VIII. 2	*Not Met*	Not Assessed	
VIII. 3	*Not Met*	Not Assessed	
VIII. 5	*Partially Met*	Not Assessed	
VIII. 7	*Partially Met*	Not Assessed	

Northwest CMH Affiliation successfully addressed one recommendation for improvement. The remaining activities/elements were not applicable to the new PIP, or the study had not progressed to the point at which performance could be evaluated.

Oakland County CMH Authority

Compliance Monitoring

Table 4-37 below shows the results for **Oakland County CMH Authority** from the 2004–2005 and 2005–2006 compliance monitoring reviews.

Table 4-37—Compliance Following 2004–2005 and 2005–2006 Reviews *for* Oakland County CMH Authority

Standard		Full Compliance		One or more remaining corrective action(s)
		Achieved 2004–2005	Achieved after follow-up 2005–2006	
I	QAPI Plan and Structure		✓	
II	Performance Measurement and Improvement	✓		
III	Practice Guidelines	✓		
IV	Staff Qualifications and Training	✓		
V	Utilization Management		✓	
VI	Customer Service		✓	
VII	Recipient Grievance Process		✓	
VIII	Enrollee Rights and Protections			✓

The 2004–2005 compliance monitoring review resulted in 25 recommendations for improvement in the following areas: QAPI Plan and Structure, Utilization Management, Customer Service, Recipient Grievance Process, and Enrollee Rights and Protections. The PIHP addressed recommendations through corrective action plans and implemented numerous improvements. Subsequent to the 2005–2006 follow-up review, **Oakland County CMH Authority** achieved full compliance on seven of the eight standards, with only three continuing recommendations remaining for Enrollee Rights and Protections.

Validation of Performance Measures

Table 4-38 below shows the recommendations for improvement for **Oakland County CMH Authority** from the 2006 validation of performance measures and the status of the PIHP's follow-up on these recommendations at the time of the 2007 EQR.

Table 4-38—Follow-Up on Prior Recommendations *for* Oakland County CMH Authority	
2005–2006 Recommendation	**2007 Status**
Oakland County CMH Authority should explore methods to use a more programmatic approach for performance measure reporting. This could minimize errors inherent in the current, extensive query/Excel calculation method.	The PIHP adopted a new data system and should continue its efforts to fully automate the calculation of performance indicator data.

Oakland County CMH Authority successfully addressed the recommendation for improvement.

Validation of Performance Improvement Projects

Table 4-39 below displays activities/elements scored *Partially Met* or *Not Met* for **Oakland County CMH Authority** during the 2006 validation of PIPs, as well as the results of the assessment of these elements from the 2007 EQR.

Table 4-39—Follow-Up on Prior Recommendations *for* Oakland County CMH Authority			
Activity/ Element	**2005–2006 Score**	**2006–2007 Score**	**2006–2007 Comment**
VI. 6	*Not Met*	*Met*	Documentation included a manual data collection tool that ensured consistent and accurate collection of data according to indicator specifications.
VI. 7	*Not Met*	*Met*	The manual data collection tool was structured to support interrater reliability.
VI. 8	*Not Met*	*Partially Met*	Clear and concise written instructions for completing the aggregate, statewide tool were supplied by the State; however, there were no instructions provided in the documentation on how to use the beneficiary-level tool supplied by the plan.
VI. 9	*Not Met*	*Met*	The written instructions were given by the State and included rationale that served as an overview of the study. Point of clarification: With future submissions, the plan should include an overview in the instructions that are used for the member-level tool supplied by the health plan.

Oakland County CMH Authority successfully addressed almost all recommendations for improvement.

Saginaw County CMH Authority

Compliance Monitoring

Table 4-40 below shows the results for **Saginaw County CMH Authority** from the 2004–2005 and 2005–2006 compliance monitoring reviews.

Table 4-40—Compliance Following 2004–2005 and 2005–2006 Reviews *for* Saginaw County CMH Authority

Standard		Full Compliance		One or more remaining corrective action(s)
		Achieved 2004–2005	Achieved after follow-up 2005–2006	
I	QAPI Plan and Structure		✓	
II	Performance Measurement and Improvement	✓		
III	Practice Guidelines	✓		
IV	Staff Qualifications and Training	✓		
V	Utilization Management		✓	
VI	Customer Service		✓	
VII	Recipient Grievance Process			✓
VIII	Enrollee Rights and Protections			✓

The 2004–2005 compliance monitoring review resulted in 23 recommendations for improvement in the following areas: QAPI Plan and Structure, Utilization Management, Customer Service, Recipient Grievance Process, and Enrollee Rights and Protections. The PIHP addressed recommendations through corrective action plans and implemented numerous improvements. Subsequent to the 2005–2006 follow-up review, **Saginaw County CMH Authority** achieved full compliance on six of the eight standards, with eight continuing recommendations remaining for the Recipient Grievance Process and Enrollee Rights and Protections.

Validation of Performance Measures

Table 4-41 shows the recommendations for improvement for **Saginaw County CMH Authority** from the 2006 performance measures and the status of the PIHP's follow-up on these recommendations at the time of the 2007 EQR.

Table 4-41—Follow-Up on Prior Recommendations *for* Saginaw County CMH Authority	
2005–2006 Recommendation	**2007 Status**
Saginaw County CMH Authority should establish documentation to support manual functions related to performance indicator data collection. The PIHP should focus efforts on consistently collecting the minimum wage variable in the QI data. **Saginaw County CMH Authority** should move toward a more formal process, including written policies and procedures, to ensure that the CA is interpreting the indicator definitions according to specifications and collecting the data accordingly.	Through the implementation of the Encompass data system, performance indicator and QI data were collected consistently across the PIHP. The PIHP increased and formalized its oversight of the CA. This included reviewing performance indicator data and having monthly and quarterly meetings, where discussions regarding indicator definitions took place to ensure uniform interpretation and collection of data.

Saginaw County CMH Authority successfully addressed all recommendations for improvement.

Validation of Performance Improvement Projects

Table 4-42 below displays activities/elements scored *Partially Met* or *Not Met* for **Saginaw County CMH Authority** during the 2006 validation of PIPs, as well as the results of the assessment of these elements from the 2007 EQR.

Table 4-42—Follow-Up on Prior Recommendations *for* Saginaw County CMH Authority			
Activity/ Element	**2005–2006 Score**	**2006–2007 Score**	**2006–2007 Comment**
VI. 3	*Not Met*	*Not Met*	A clearly defined and systematic process for collecting the baseline and remeasurement data was not provided in the documentation.
VI. 10	*Not Met*	*Not Met*	Administrative data collection algorithms, flow chart, or narrative description of the administrative data collection process were not included in the study report.
VI. 11	*Not Met*	*Met*	The estimated degree of administrative data completeness was reported as 100 percent.

Saginaw County CMH Authority successfully addressed one of the recommendations for improvement, but continued to receive scores of *Not Met* on the other two elements cited for improvement in the 2006 validation.

Southwest Affiliation

Compliance Monitoring

Table 4-43 below shows the results for **Southwest Affiliation** from the 2004–2005 and 2005–2006 compliance monitoring reviews.

Table 4-43—Compliance Following 2004–2005 and 2005–2006 Reviews *for* Southwest Affiliation

Standard		Full Compliance		One or more remaining corrective action(s)
		Achieved 2004–2005	Achieved after follow-up 2005–2006	
I	QAPI Plan and Structure	✓		
II	Performance Measurement and Improvement	✓		
III	Practice Guidelines	✓		
IV	Staff Qualifications and Training	✓		
V	Utilization Management	✓		
VI	Customer Service	✓		
VII	Recipient Grievance Process		✓	
VIII	Enrollee Rights and Protections			✓

The 2004–2005 compliance monitoring review resulted in nine recommendations for improvement in the following areas: Recipient Grievance Process and Enrollee Rights and Protections. The PIHP addressed recommendations through corrective action plans and implemented numerous improvements. Subsequent to the 2005–2006 follow-up review, **Southwest Affiliation** achieved full compliance on seven of the eight standards, with only four continuing recommendations remaining for Enrollee Rights and Protections.

Validation of Performance Measures

Table 4-44 below shows the recommendations for improvement for **Southwest Affiliation** from the 2006 validation of performance measures and the status of the PIHP's follow-up on these recommendations at the time of the 2007 EQR.

Table 4-44—Follow-Up on Prior Recommendations *for* Southwest Affiliation

2005–2006 Recommendation	2007 Status
Southwest Affiliation should work on formalizing its oversight activities. This can be accomplished through the development of formal policies and procedures and documentation of current oversight activities. The PIHP should also continue to incorporate the CA into its oversight activities.	The PIHP had not yet completed a more formal, documented oversight process for the PI data calculation process (i.e., the development of policies and procedures and an audit process). The PIHP functioned as the CA. The completeness and accuracy of CA data was monitored in monthly Data Integrity Monitoring Team meetings.

Southwest Affiliation demonstrated progress in addressing the recommendations for improvement.

Validation of Performance Improvement Projects

Table 4-45 below displays activities/elements scored *Partially Met* or *Not Met* for **Southwest Affiliation** during the 2006 validation of PIPs, as well as the results of the assessment of these elements from the 2007 EQR.

Table 4-45—Follow-Up on Prior Recommendations *for* Southwest Affiliation

Activity/ Element	2005–2006 Score	2006–2007 Score	2006–2007 Comment
VI. 8	*Partially Met*	*NA*	Manual data collection was not used in this study.
VI. 9	*Not Met*	*NA*	Manual data collection was not used in this study.

Southwest Affiliation's new PIP used a different data collection method; therefore, the PIHP's follow-up on the recommendations for improvement could not be assessed.

Thumb Alliance PIHP

Compliance Monitoring

Table 4-46 below shows the results for **Thumb Alliance PIHP** from the 2004–2005 and 2005–2006 compliance monitoring reviews.

Table 4-46—Compliance Following 2004–2005 and 2005–2006 Reviews *for* Thumb Alliance PIHP

Standard		Full Compliance		One or more remaining corrective action(s)
		Achieved 2004–2005	Achieved after follow-up 2005–2006	
I	QAPI Plan and Structure	✓		
II	Performance Measurement and Improvement		✓	
III	Practice Guidelines	✓		
IV	Staff Qualifications and Training	✓		
V	Utilization Management	✓		
VI	Customer Service	✓		
VII	Recipient Grievance Process		✓	
VIII	Enrollee Rights and Protections		✓	

The 2004–2005 compliance monitoring review resulted in 13 recommendations for improvement in the following areas: Performance Measurement and Improvement, Recipient Grievance Process, and Enrollee Rights and Protections. The PIHP addressed recommendations through corrective action plans and implemented numerous improvements. Subsequent to the 2005–2006 follow-up, there were no continuing recommendations for improvement as **Thumb Alliance PIHP** had achieved full compliance on all standards.

Validation of Performance Measures

Table 4-47 shows the recommendations for improvement for **Thumb Alliance PIHP** from the 2006 validation of performance measures and the status of the PIHP's follow-up on these recommendations at the time of the 2007 EQR.

Table 4-47—Follow-Up on Prior Recommendations for Thumb Alliance PIHP	
2005–2006 Recommendation	**2007 Status**
The PIHP should piece together all of its audit and assessment activities to develop an overall/aggregate assessment of data completeness and accuracy. The PIHP should also consider a more programmatic approach to performance indicator calculation to minimize the potential for error and lessen the administrative burden of performance indicator reporting.	The PIHP had a document that contained an assessment of data completeness and accuracy. The PIHP also conducted a weekly/monthly outlier review and correction process. The interactive and cooperative relationship with the CMHCs enhanced data accuracy.

Thumb Alliance PIHP successfully addressed all recommendations for improvement.

Validation of Performance Improvement Projects

Table 4-48 displays activities/elements scored *Partially Met* or *Not Met* for **Thumb Alliance PIHP** during the 2006 validation of PIPs, as well as the results of the assessment of these elements from the 2007 EQR.

Table 4-48—Follow-Up on Prior Recommendations for Thumb Alliance PIHP			
Activity/ Element	**2005–2006 Score**	**2006–2007 Score**	**2006–2007 Comment**
II. 1	*Partially Met*	*Met*	The study question was stated in simple terms. Point of clarification: The study question was structured to look at an incident rate versus a compliance rate. The study question should be restructured to capture the true intent of the study.
VI. 9	*Not Met*	*NA*	The study report stated that the overview of the study in the written instructions was "pending" because it was not due at this stage of the PIP.
VIII. 1	*Partially Met*	*Met*	The baseline data results were complete and analyzed according to the plan in the study design.
VIII. 3	*Not Met*	*Met*	The study addressed factors that threatened the internal/external validity of the data findings.
VIII. 5	*Not Met*	*Met*	The documentation presented the baseline results in a clear and easily understood format.
VIII. 7	*Partially Met*	*NA*	This was a baseline study with no remeasurement periods.
VIII. 8	*Not Met*	*NA*	This was a baseline study with no remeasurement periods.
VIII. 9	*Partially Met*	*NA*	This was a baseline study with no remeasurement periods.
IX. 2	*Partially Met*	Not Assessed	
IX. 4	*Partially Met*	Not Assessed	
X	*Partially Met*	Not Assessed	

Thumb Alliance PIHP successfully addressed all recommendations for improvement that were applicable to the new PIP.

Venture Behavioral Health

Compliance Monitoring

Table 4-49 below shows the results for **Venture Behavioral Health** from the 2004–2005 and 2005–2006 compliance monitoring reviews.

Table 4-49—Compliance Following 2004–2005 and 2005–2006 Reviews *for* Venture Behavioral Health

Standard		Full Compliance		One or more remaining corrective action(s)
		Achieved 2004–2005	Achieved after follow-up 2005–2006	
I	QAPI Plan and Structure	✓		
II	Performance Measurement and Improvement	✓		
III	Practice Guidelines	✓		
IV	Staff Qualifications and Training	✓		
V	Utilization Management		✓	
VI	Customer Service		✓	
VII	Recipient Grievance Process		✓	
VIII	Enrollee Rights and Protections		✓	

The 2004–2005 compliance monitoring review resulted in six recommendations for improvement in the following areas: Utilization Management, Customer Service, Recipient Grievance Process, and Enrollee Rights and Protections. The PIHP addressed recommendations through corrective action plans and implemented numerous improvements. Subsequent to the 2005–2006 follow-up, there were no continuing recommendations for improvement as **Venture Behavioral Health** had achieved full compliance with all standards.

Validation of Performance Measures

Table 4-50 below shows the recommendations for improvement for **Venture Behavioral Health** from the 2006 validation of performance measures and the status of the PIHP's follow-up on these recommendations at the time of the 2007 EQR.

Table 4-50—Follow-Up on Prior Recommendations *for* Venture Behavioral Health

2005–2006 Recommendation	2007 Status
Venture Behavioral Health should increase monitoring of affiliates and the CA, focusing more attention on data accuracy and completeness. Oversight of how data are captured by the affiliates should also be conducted to ensure consistency for the performance measures.	The PIHP's data warehouse provided opportunity for daily updates of affiliate data, which allowed for real-time data monitoring and enhanced quality oversight. However, the PIHP was not reviewing or scrubbing the data from its CA. The PIHP was only collecting data from the CA in order to pass it on to MDCH. The PIHP produced affiliate-level error reports and reviewed them with the CMHCs. Additionally, the PIHP reviewed QI and performance improvement data monthly in committees and task forces.

Venture Behavioral Health successfully addressed most of the recommendations for improvement.

Validation of Performance Improvement Projects

Table 4-51 below displays activities/elements scored *Partially Met* or *Not Met* for **Venture Behavioral Health** during the 2006 validation of PIPs, as well as the results of the assessment of these elements from the 2007 EQR.

Table 4-51—Follow-Up on Prior Recommendations *for* Venture Behavioral Health

Activity/ Element	2005–2006 Score	2006–2007 Score	2006–2007 Comment
V. 3	*Partially Met*	*NA*	Sampling was not used in this study.
V. 4	*Partially Met*	*NA*	Sampling was not used in this study.
VI. 11	*Not Met*	*Met*	The estimated degree of administrative data completeness was reported as 98.4 percent.

Venture Behavioral Health successfully addressed the one recommendation for improvement that was applicable to the new PIP.

Appendix A. Summary Tables of External Quality Review Activity Results

Introduction

This section of the report presents two-year comparison tables for statewide and PIHP scores for the validation of performance measures and the validation of performance improvement projects. Since compliance monitoring focused on a new set of standards for the 2006–2007 reviews, comparisons to prior years were not possible. Instead, tables and graphs present statewide and PIHP performance related to each of the standards assessed in the 2006–2007 compliance monitoring reviews.

Results for Compliance Monitoring

PIHP and Statewide 2006–2007 Compliance Scores

Figure A-1 through Figure A-7 present compliance scores for each of the 18 PIHPs as well as the statewide score for each of the six scored standards: Standard IX, Subcontracts and Delegation; Standard X, Provider Network; Standard XII, Access and Availability; Standard XIII: Coordination of Care; Standard XIV, Appeals; and Standard XV, Advance Directives. For Standard XI: Credentialing, each element was reviewed and received a score of *Met*, *Substantially Met*, *Partially Met*, *Not Met*, or *NA*. However, a total score for the standard was not calculated. The graph for this standard shows for each PIHP the percentage of applicable elements assessed that received a score of *Met*. Therefore, percentages in this graph are not comparable to the graphs for the other six standards.

Figure A-1—Standard IX: Subcontracts and Delegation

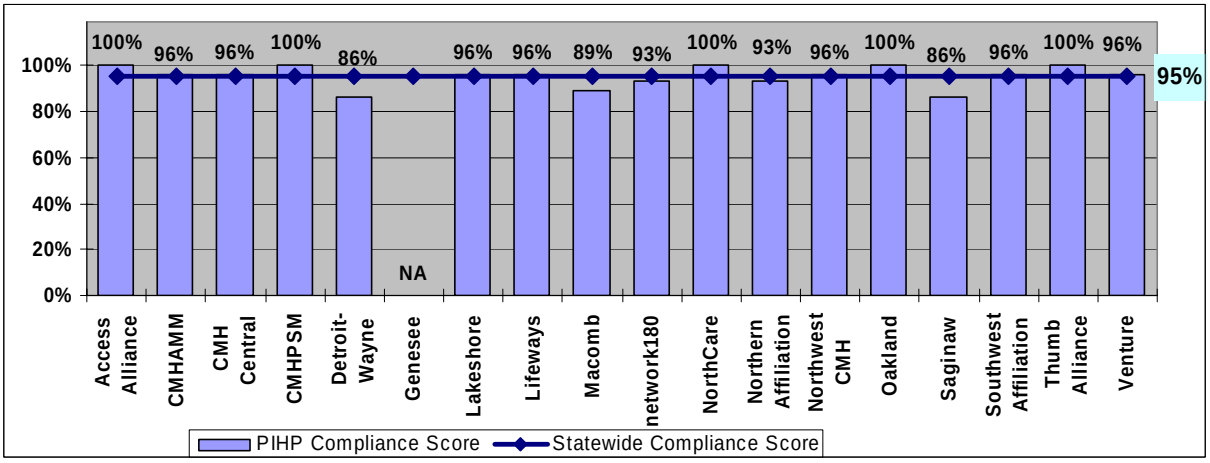


Figure A-2—Standard X: Provider Network

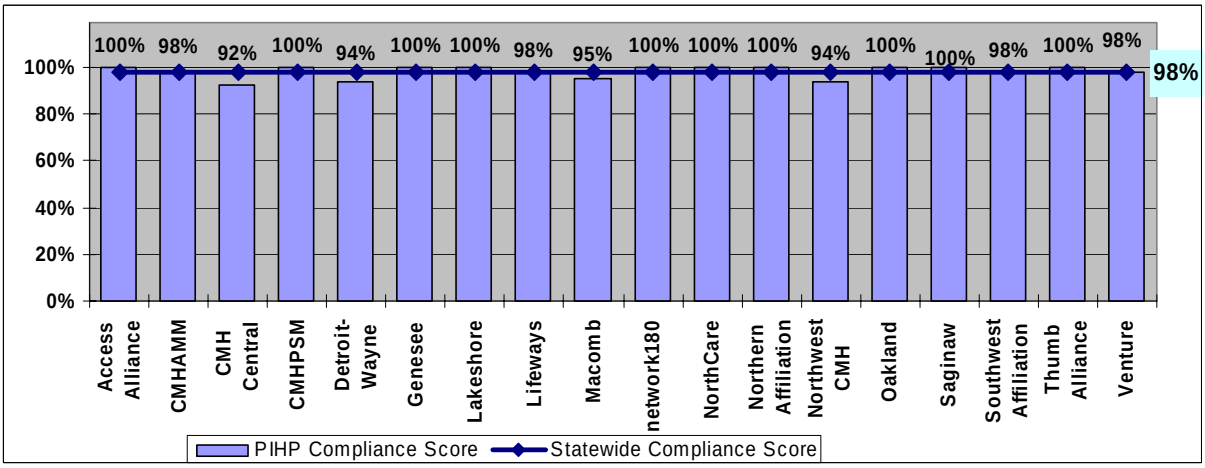


Figure A-3—Standard XII: Access and Availability

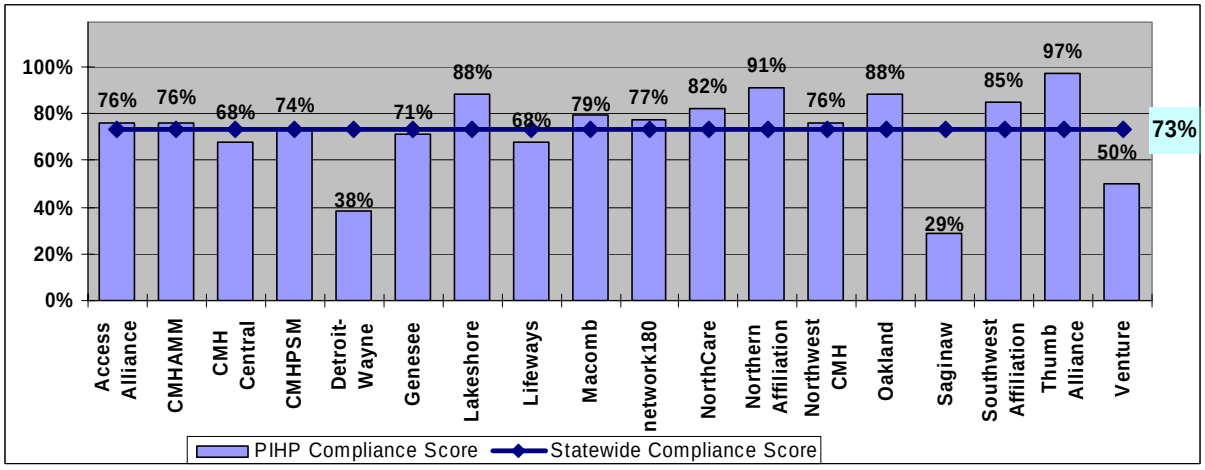


Figure A-4—Standard XIII: Coordination of Care

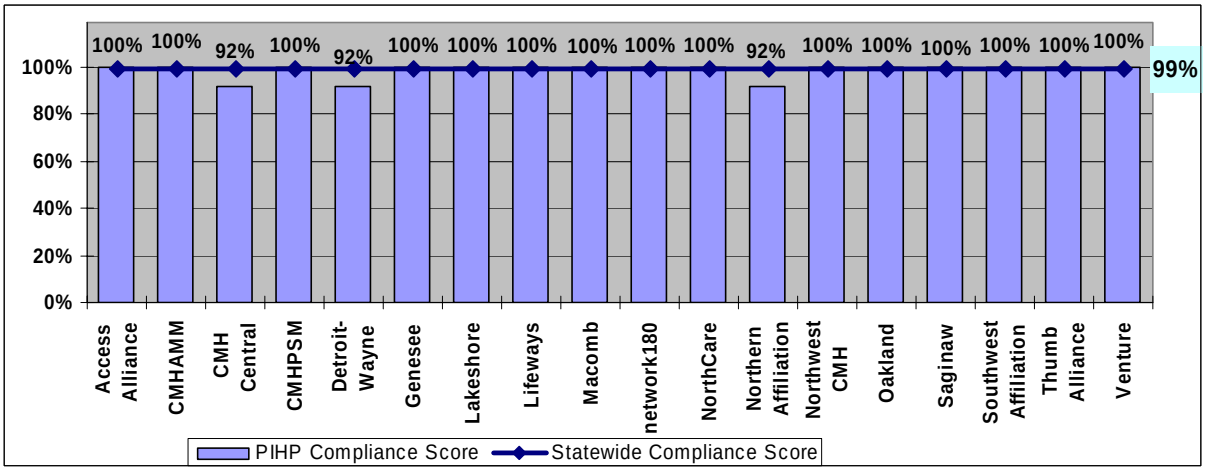


Figure A-5—Standard XIV: Appeals

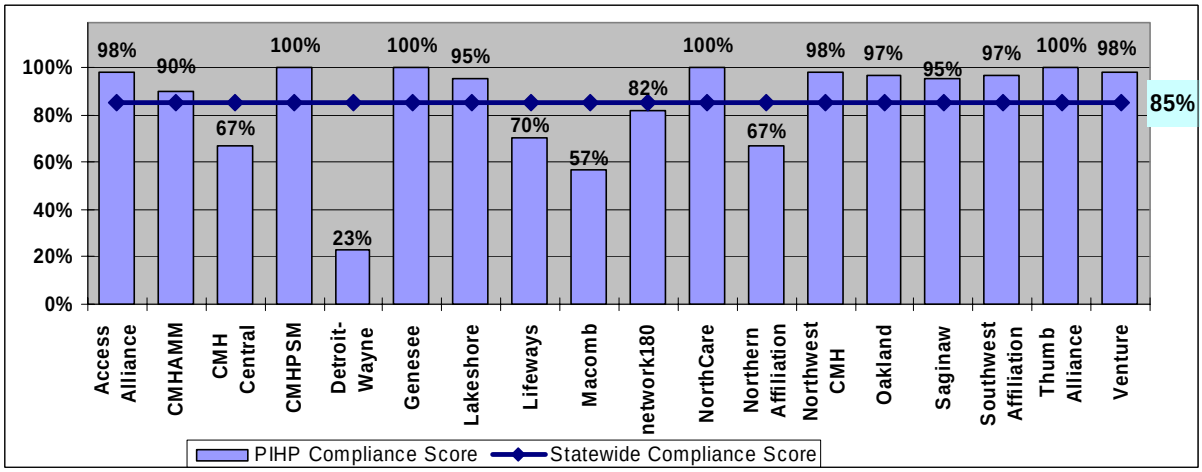


Figure A-6—Standard XV: Advance Directives

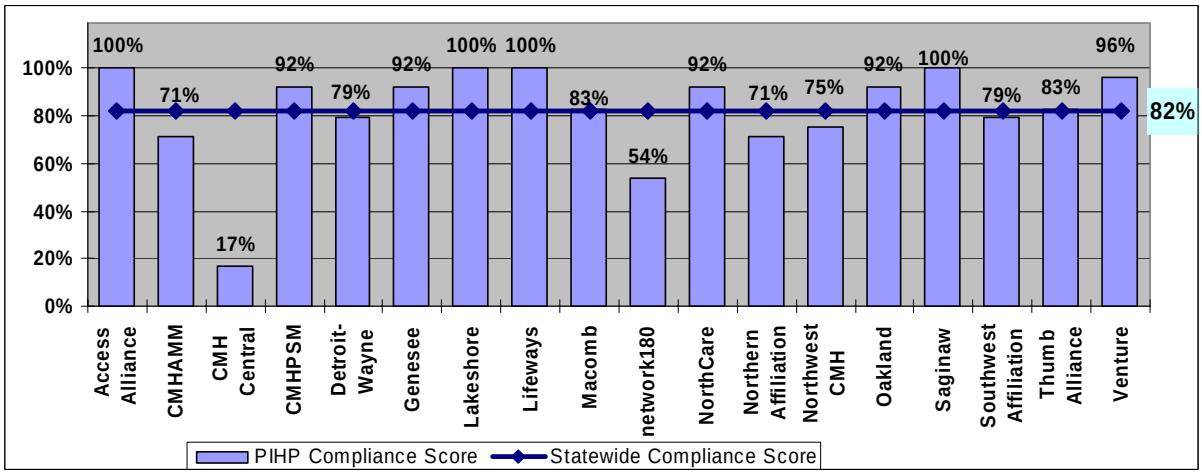
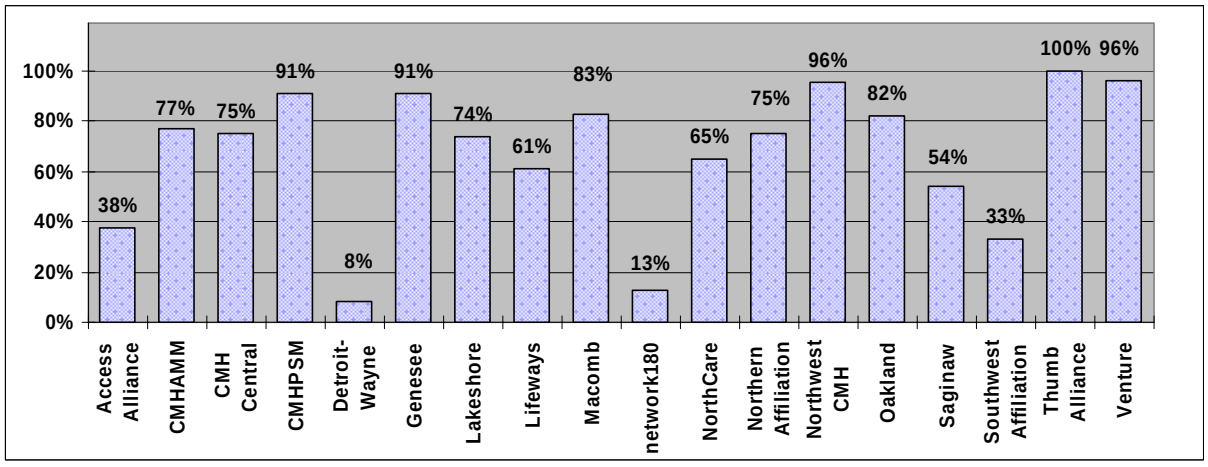


Figure A-7—Standard XI: Credentialing (Percentage of Applicable Elements Scored *Met*)

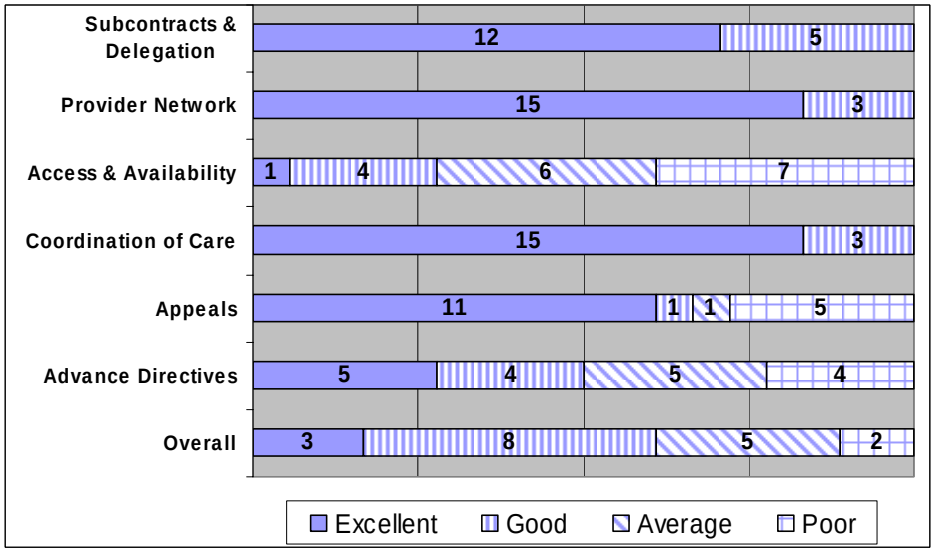


PIHP Compliance Scores

Compliance monitoring scores were rated as follows: scores ranging from 95 percent to 100 percent were rated *Excellent*, those from 85 percent to 94 percent were rated *Good*, those from 75 percent to 84 percent were considered *Average*, and scores of 74 percent and lower were rated *Poor*.

Figure A-8 presents the number of PIHPs receiving *Excellent/Good/Average/Poor* compliance scores overall and for each of the six scored standards.

Figure A-8—Number of PIHPs Receiving *Excellent/Good/Average/Poor* Compliance Scores



Results for Validation of Performance Measures

Table A-1 shows the overall statewide PIHP compliance with the MDCH codebook specifications for performance indicators validated by HSAG in 2005–2006 and 2006–2007.

Table A-1—Degree of Compliance for Performance Measures

Performance Measure		Percent of PIHPs					
		Fully Compliant		*Substantially Compliant*		*Not Valid*	
		05–06	06–07	05–06	06–07	05–06	06–07
Indicator 1	Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	78%	100%	22%	0%	0%	0%
Indicator 2	Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	78%	100%	22%	0%	0%	0%
Indicator 3	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 calendar days of a nonemergent assessment with a professional.	83%	100%	11%	0%	6%	0%
Indicator 4a	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	83%	100%	11%	0%	6%	0%
Indicator 4b	Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	78%	100%	11%	0%	11%	0%
Indicator 5	Percentage of Medicaid recipients having received PIHP-managed services (Penetration rate).	94%	94%	0%	0%	6%	6%
Indicator 8	Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination (HSW rate).	100%	100%	0%	0%	0%	0%
Indicator 12	Percentage of children and adults readmitted to a psychiatric inpatient unit within 30 days of discharge.	89%	100%	11%	0%	0%	0%
Indicator 13	The annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by the PIHPs.		83%		17%		0%
Indicator 14	Number of sentinel events during the six-month period per 1,000 Medicaid beneficiaries served, by the following populations: adults with mental illness, children with mental illness, persons with developmental disabilities not on the HSW, persons on the HSW, and persons with a substance abuse disorder.		100%		0%		0%

Note: Indicators 13 and 14 were not included in the 2005–2006 validation of performance measures.

Table A-2 displays the statewide 2005–2006 and 2006–2007 results for the validated performance indicators.

Table A-2—Performance Measure Results for 2005–2006 and 2006–2007			
Performance Measure		Reported Rate	
		2005–2006	2006–2007
Indicator 1	Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.		
	Children	98%	98%
	Adults	96%	98%
Indicator 2	Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	96%	98%
Indicator 3	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 calendar days of a nonemergent assessment with a professional.	92%	96%
Indicator 4a	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.		
	Children	86%	92%
	Adults	86%	91%
Indicator 4b	Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	92%	95%
Indicator 5	Percentage of Medicaid recipients having received PIHP-managed services (Penetration rate).	6%	6%
Indicator 8.	Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination (HSW rate).	97%	94%
Indicator 12	Percentage of children and adults readmitted to a psychiatric inpatient unit within 30 days of discharge.		
	Children	10%	8%
	Adults	13%	12%
Indicator 13	The annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by the PIHPs.		
Indicator 14	Number of sentinel events during the six-month period per 1,000 Medicaid beneficiaries served, by the following populations: adults with mental illness, children with mental illness, persons with developmental disabilities not on the HSW, persons on the HSW, and persons with a substance abuse disorder.		

Note: Indicators 13 and 14 were not included in the 2005–2006 validation of performance measures, and rates for these measures for the first quarter of SFY 2007 were not available for reporting.

Table A-3 displays a comparison of the 2005–2006 and 2006–2007 PIHP results for the validated performance indicators. Only indicators reported for both periods are included in the table.

Table A-3—Comparison of 2005–2006 (Year 2) and 2006–2007 (Year 3) PIHP Performance Measure Results

PIHP	Preadmission Screening—Children	Preadmission Screening—Adults	Face-to-Face Assessment Within 14 Days	Initiate Ongoing Service Within 14 Days	7-Day Psychiatric Follow-Up—Children	7-Day Psychiatric Follow-Up—Adults	7-Day Detox Follow-Up	Penetration Rate	HSW Rate	30-Day Readmission Rate—Children	30-Day Readmission Rate—Adults
Reported Rate	Year 2: 2005–2006 Year 3: 2006–2007										
Access Alliance	100% 100%	99.00% 98.10%	92.42% 97.97%	89.11% 97.55%	83.33% 100%	88.24% 100%	91.67% 90.91%	8.20% 7.26%	98.48% 94.95%	0.0% 4.76%	14.93% 10.00%
CMHAMM	100% 100%	98.94% 96.50%	99.28% 99.40%	98.39% 97.51%	91.30% 100%	91.94% 95.45%	NV 100%	5.71% 5.77%	99.19% 97.05%	0.0% 7.69%	11.11% 11.43%
CMH Central	96.00% 100%	99.00% 100%	97.00% 94.58%	93.28% 92.16%	50.00% 88.89%	69.05% 100%	100% 100%	6.95% 7.95%	98.24% 97.16%	16.67% 11.11%	6.98% 8.33%
CMHPSM	100% 98.90%	100% 99.70%	99.00% 100%	95.00% 99.00%	92.00% 100%	87.00% 96.88%	98.00% 100%	6.31% 6.28%	85.60% 85.03%	8.00% 0.00%	13.00% 1.39%
Detroit-Wayne	93.58% 98.06%	71.78% 96.83%	NV 94.40%	NV 86.51%	68.67% 94.85%	72.24% 86.36%	100% 96.92%	4.61% 4.57%	98.84% 89.51%	11.24% 2.20%	15.19% 12.55%
Genesee	98.00% 97.50%	96.00% 96.98%	98.05% 99.42%	84.18% 96.86%	83.33% 96.55%	87.74% 95.45%	92.31% 100%	4.85% 4.67%	97.76% 96.07%	18.75% 24.39%	11.48% 11.76%
Lakeshore	100% 97.14%	98.00% 100%	98.57% 98.80%	95.51% 94.21%	87.50% 100%	95.12% 98.00%	75.00% 90.91%	NV NV	98.69% 97.78%	13.33% 5.88%	4.17% 11.67%
LifeWays	95.24% 100%	97.41% 99.00%	94.44% 97.78%	100% 97.59%	78.95% 100%	93.33% 96.23%	100% 100%	5.56% 5.70%	94.78% 91.97%	0.00% 7.14%	15.15% 14.55%
Macomb	100% 97.10%	100% 99.11%	95.86% 96.95%	95.15% 94.68%	73.08% 66.67%	42.61% 64.20%	100% 92.31%	5.11% 5.78%	99.36% 98.31%	11.11% 21.74%	18.03% 13.58%
network180	95.31% 97.30%	95.31% 98.25%	97.59% 97.78%	77.10% 88.94%	96.30% 100%	92.05% 95.24%	71.43% 100%	4.59% 5.44%	96.82% 95.81%	11.76% 8.51%	19.79% 13.39%
NorthCare	98.80% 98.53%	98.80% 99.16%	94.80% 97.94%	92.70% 98.50%	100% 100%	93.50% 96.55%	93.50% 100%	6.12% 6.57%	99.45% 95.69%	8.70% 23.08%	20.90% 25.00%
Northern Affiliation	100% 100%	98.00% 98.24%	98.46% 94.46%	93.85% 96.37%	100% 100%	100% 100%	75.00% 100%	5.99% 6.74%	98.14% 94.43%	0.00% 0.00%	10.00% 6.67%
Northwest CMH	95.00% 97.83%	96.00% 99.26%	96.34% 98.38%	91.57% 98.80%	75.00% 81.25%	83.67% 95.77%	100% 100%	6.36% 7.16%	96.13% 93.89%	4.76% 5.13%	5.17% 5.95%
Oakland	99.10% 96.81%	94.07% 96.59%	100% 97.45%	93.63% 98.45%	100% 100%	98.21% 96.61%	94.44% 100%	7.44% 7.59%	99.08% 98.28%	13.16% 10.71%	16.67% 18.06%
Saginaw	100% 100%	98.00% 100%	84.00% 100%	84.37% 94.77%	NV 83.33%	NV 80.77%	NV 47.37%	4.01% 4.07%	98.26% 83.19%	9.09% 21.43%	17.94% 15.15%
Southwest Alliance	98.00% 100%	96.90% 99.55%	99.60% 98.15%	96.00% 96.41%	93.80% 100%	83.80% 98.25%	100% 100%	6.51% 6.66%	96.06% 94.85%	52.60% 4.17%	17.50% 6.33%
Thumb Alliance	100% 100%	99.27% 100%	99.40% 100%	98.40% 99.53%	91.67% 100%	90.32% 98.28%	100% 100%	6.45% 7.02%	100% 99.66%	0.00% 12.50%	11.29% 20.00%
Venture	100% 100%	100% 100%	89.67% 97.07%	84.05% 98.20%	91.67% 80.00%	95.83% 86.57%	73.08% 100%	5.56% 5.33%	94.34% 91.02%	8.33% 9.09%	9.72% 7.32%

NV = Not Valid

Results for Validation of Performance Improvement Projects

Table A-4 presents a two-year comparison of the statewide PIP validation status.

Table A-4—Comparison of PIHPs' PIP Validation Status in 2005–2006 and 2006–2007		
Validation Status	Number of PIHPs	
	2005–2006	2006–2007
Met	8	13
Partially Met	6	3
Not Met	4	2

Table A-5 presents a two-year comparison of statewide PIP scores.

Table A-5—Summary of Data From Validation of Performance Improvement Projects					
Validation Activity		Number of PIPs Meeting All Evaluation Elements/ Number Reviewed		Number of PIPs Meeting All Critical Elements/ Number Reviewed	
		2005–2006	2006–2007	2005–2006	2006–2007
I.	Appropriate Study Topic	18/18	16/18	18/18	17/18
II.	Clearly Defined, Answerable Study Question	14/18	17/18	14/18	17/18
III.	Clearly Defined Study Indicator(s)	15/18	15/18	15/18	16/18
IV.	Correctly Identified Study Population	18/18	17/18	18/18	17/18
V.	Valid Sampling Techniques	15/18	18/18*	17/18	18/18*
VI.	Accurate/Complete Data Collection	3/17	13/17	13/17	17/17
VII.	Appropriate Improvement Strategies	10/15	10/11	11/15	10/11
VIII.	Sufficient Data Analysis and Interpretation	4/13	8/10	8/13	10/10
IX.	Real Improvement Achieved	4/9	2/2	*NA*	*NA*
X.	Sustained Improvement Achieved	1/4	1/1	*NA*	*NA*

*For 2006–2007, all evaluation elements for Activity V. Valid Sampling Techniques were scored NA for all PIPs as the studies did not use sampling.

Table A-6 presents a two-year comparison of PIP scores for each PIHP.

Table A-6—Comparison of Each PIHP's PIP Validation Scores for 2005–2006 and 2006–2007						
PIHP	% of All Evaluation Elements *Met*		% of All Critical Elements *Met*		Validation Status	
	2005–2006	2006–2007	2005–2006	2006–2007	2005–2006	2006–2007
Access Alliance of Michigan	78%	100%	92%	100%	*Partially Met*	*Met*
CMH Affiliation of Mid-Michigan	90%	96%	80%	100%	*Partially Met*	*Met*
CMH for Central Michigan	61%	89%	54%	90%	*Not Met*	*Partially Met*
CMH Partnership of Southeastern Michigan	100%	100%	100%	100%	*Met*	*Met*
Detroit-Wayne County CMH Agency	77%	94%	85%	88%	*Not Met*	*Partially Met*
Genesee County CMH	90%	100%	100%	100%	*Met*	*Met*
Lakeshore Behavioral Health Alliance	94%	100%	100%	100%	*Met*	*Met*
LifeWays	79%	100%	85%	100%	*Partially Met*	*Met*
Macomb County CMH Services	100%	100%	100%	100%	*Met*	*Met*
network180	90%	100%	92%	100%	*Partially Met*	*Met*
NorthCare	100%	94%	100%	100%	*Met*	*Met*
Northern Affiliation	86%	83%	69%	90%	*Partially Met*	*Not Met*
Northwest CMH Affiliation	71%	100%	62%	100%	*Not Met*	*Met*
Oakland County CMH Authority	92%	94%	92%	100%	*Not Met*	*Met*
Saginaw County CMH Authority	90%	76%	100%	75%	*Met*	*Not Met*
Southwest Affiliation	95%	96%	100%	100%	*Met*	*Met*
Thumb Alliance PIHP	78%	90%	85%	80%	*Partially Met*	*Partially Met*
Venture Behavioral Health	89%	93%	100%	100%	*Met*	*Met*

Appendix B. Compliance Monitoring Tool

The compliance monitoring tool appendix follows this cover page.

Standard IX—Subcontracts and Delegation

The PIHP oversees and is accountable for any functions and responsibilities that it delegates to any subcontractor.

438.230(a)(1)

Some contracts/delegation agreements were reviewed in Year I in association with Standard I—QAPIP; Standard II—Performance Measurement and Improvement; Standard III—Practice Guidelines; Standard V—Utilization Management; Standard VII—Grievance Process; and Standard VIII—Recipient (Beneficiary) Rights and Protections. Contracts/agreements previously reviewed will not be re-reviewed. Other delegated functions and/or agreements will be the subject of review for this standard, i.e., coordinating agency contracts, data processing services, etc.

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
1. Predelegation Assessment Prior to entering into delegation subcontracts or agreements, the PIHP evaluates the proposed subcontractor's ability to perform the activities to be delegated. 438.230(b)		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
2. Written Agreements The PIHP has a written agreement with each delegated subcontractor. 438.230(b)(2)		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Standard IX—Subcontracts and Delegation

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
3. Content of Agreement—Activities The written agreement specifies the activities delegated to the subcontractor. 438.230(b)(2)(i) MDCH 6.4.2		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
4. Content of Agreement—Reports The written agreement specifies the report responsibilities delegated to the subcontractor. 438.230(b)(2)(i) MDCH 6.4.2		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
5. Content of Agreement—Revocation/Sanctions The written agreement includes provisions for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate. 438.230(b)(2)(ii)		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Standard IX—Subcontracts and Delegation

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
6. Monitoring of Delegates The PIHP monitors the performance of the subcontractor on an ongoing basis and subjects it to formal review according to a periodic schedule. 438.230(b)(3) MDCH 6.4.3		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
7. Corrective Action If the PIHP identifies deficiencies or areas for improvement, the PIHP and the subcontractor take corrective action. 438.230(b)(4) MDCH 6.4.3		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Results—Standard IX						
Met	=	0	X	1.00	=	0.0
Substantially Met	=	0	X	.75	=	0.0
Partially Met	=	0	X	.50	=	0.0
Not Met	=	0	X	.00	=	0.0
Not Applicable	=	0				
Total Applicable	=	0	Total Score		=	0.0
Total Score ÷ Total Applicable					=	0.0%

Standard X—Provider Network

The PIHP maintains and monitors a network of appropriate providers supported by written agreements sufficient to provide adequate access to all services. §438.206(b)(1)

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
1. Provider Written Agreements The PIHP maintains a network of providers supported by written agreements. 438.206(b)(1)		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
2. Sufficiency of Agreements Written agreements provide adequate access to all services covered under the contract. 438.206(b)(1)		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
3. Content of Agreements Written agreements ensure that beneficiaries are not held liable when the PIHP does not pay the health care provider furnishing services under the contract. 438.106(b)(2)		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Standard X—Provider Network

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
4. Content of Agreements Written agreements ensure that beneficiaries are not held liable for payment of covered services furnished under the contract if those payments are in excess of the amount that the beneficiary would owe if the PIHP provided the service directly. 438.106(c)		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Findings

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

Findings

Standard X—Provider Network

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
6. Geographic Access for Mental Health and Substance Abuse Services The PIHP ensures geographic access to covered, alternative, and allowable supports and services in accordance with the following standards: For office or site-based services, the PIHP's primary service providers (e.g., case managers, psychiatrists, primary therapists) must be: ◆ Within 30 miles or 30 minutes of the recipient's residence in urban areas ◆ Within 60 miles or 60 minutes in rural areas. MDCH 3.1		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
7. Excluded Providers The PIHP does not employ or contract with providers excluded from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act. 438.214(d)		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Findings

Standard X—Provider Network

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
8. Reason For Decision To Decline If the PIHP declines to include individual providers or groups of providers in its network, it gives the affected providers written notice of the reason for its decision. 438.12 MDCH 6.4.1		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
9. Network Changes The PIHP notifies MDCH within seven days of any significant changes to the provider network composition that affect adequate capacity and services. 438.207(c)(2) MDCH 6.4(F)		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
10. Out-Of-Network Services If a necessary service covered under the contract is unavailable within the network, the PIHP adequately and timely covers the service out of network for as long as the PIHP is unable to provide it. 438.206(b)(4) MDCH 3.4.6		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Standard X—Provider Network

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
11. Requirements Related to Payment The PIHP requires out-of-network providers to coordinate with the PIHP regarding payment and ensures that any cost to the beneficiary is no greater than it would be if the services were furnished within the network. 438.206(b)(5)		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
12. Second Opinion The PIHP provides for a second opinion from a qualified health care professional within the network or arranges for the beneficiary to obtain one outside the network at no cost to the beneficiary. 438.206(b)(3) MDCH 3.4.5		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Results—Standard X						
Met	=	0	X	1.00	=	0.0
Substantially Met	=	0	X	.75	=	0.0
Partially Met	=	0	X	.50	=	0.0
Not Met	=	0	X	.00	=	0.0
Not Applicable	=	0				
Total Applicable	=	0	Total Score		=	0.0
Total Score ÷ Total Applicable					=	0.0%

Standard XI—Credentialing

The PIHP demonstrates that its providers are credentialed as required by Sec. 438.214.
438.206(b)(6)
Each State must establish a uniform credentialing and recredentialing policy that each PIHP must follow.
438.214(b)(1)

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
1. Credentialing The PIHP follows a documented process consistent with State policy for credentialing and recredentialing of providers who are employed by or have signed contracts or participation agreements with the PIHP. 438.214(b)(2) MDCH 6.4.3		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
2. Health Care Professionals The PIHP's processes for credentialing and recredentialing are conducted and documented for at least the following health care professionals: ◆ Physicians (MDs or DOs) ◆ Physician assistants ◆ Psychologists (licensed, limited license, or temporary license) ◆ Social workers (licensed master's, licensed bachelor's, limited license, or registered social service technicians) ◆ Licensed professional counselors ◆ Nurse practitioners, registered nurses, or licensed practical nurses ◆ Occupational therapists or occupational therapist assistants ◆ Physical therapists or physical therapist assistants ◆ Speech pathologists		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Standard XI—Credentialing

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
3. Written Policy—Criteria, Scope, Timeline, and Process The credentialing policy reflects the scope, criteria, timeliness, and process for credentialing and recredentialing providers.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
4. Provider Discrimination The PIHP has processes to ensure: ◆ That the credentialing and recredentialing processes do not discriminate against: ▪ A health care professional solely on the basis of license, registration, or certification. ▪ A health care professional who serves high-risk populations or who specializes in the treatment of conditions that require costly treatment. ◆ Compliance with Federal Requirements that prohibit employment or contracts with providers excluded from participation under either Medicare or Medicaid. 438.12 and 438.214(c) MDCH 6.4.1 and Credentialing Policy		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Findings

Standard XI—Credentialing

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
5. Written Policy—Authorities The PIHP's credentialing policy was approved by the PIHP's governing body and identifies the PIHP administrative staff member responsible for oversight of the process.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
6. Written Policy—Responsibility The PIHP's policy identifies the administrative staff member and entity (e.g., credentialing committee) responsible for oversight and implementation of the process and delineates their role.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
7. Written Policy—Documentation The policy describes the methodology to document that each credentialing or recredentialing file was complete and reviewed prior to presentation to the credentialing committee for evaluation.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Standard XI—Credentialing

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
8. Written Policy—Integration With QAPIP The credentialing policy describes how findings of the PIHP's Quality Assessment and Performance Improvement Program (QAPIP) are incorporated into the recredentialing process.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
9. Written Policy—Provider Role The policy describes any use of participating providers in making credentialing decisions.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
10. Credentialing Files The PIHP's processes require that an individual file be maintained for each credentialed provider and that each file include: ◆ The initial credentialing and all subsequent recredentialing applications. ◆ Information gained through primary source verification. ◆ Any other pertinent information used in determining whether or not the provider met the PIHP's credentialing standards.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Standard XI—Credentialing

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
11. Initial Credentialing—Application The PIHP's policy and procedures require that the written application is completed, signed, and dated by the applicant and attests to the following elements: ◆ Lack of present illegal drug use ◆ Any history of loss of license and/or felony convictions ◆ Any history of loss or limitation of privileges or disciplinary action ◆ Attestation by the applicant of the correctness and completeness of the application		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
12. Initial Credentialing—Requirements The PIHP's policy and procedures require that the initial credentialing of an applicant include: ◆ An evaluation of the applicant's work history for the past five years. ◆ Primary source verification of licensure or certification. ◆ Primary source verification of board certification or highest level of credentials attained, if applicable, or completion of any required internships/residency programs or other postgraduate training. ◆ Documentation of graduation from an accredited school. ◆ A National Practitioner Data Bank (NPDB) query, or, in lieu of an NPDB query, verification of all of the following: ▪ A minimum five-year history of professional liability claims resulting in a judgment or settlement ▪ Disciplinary status with a regulatory board or agency ▪ A Medicare/Medicaid sanctions query		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Standard XI—Credentialing

Note: If the individual practitioner undergoing credentialing is a physician, then the physician profile information obtained from the American Medical Association may be used to satisfy the primary source verification of the first three items above.		

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
13. Temporary/Provisional Credentialing of Individual Practitioners		
a. Policies and Limitations The PIHP has a policy and procedures to address granting of temporary or provisional credentials and the policy and procedures require that the temporary or provisional credentials are not granted for more than 150 days.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
b. Application The PIHP's policy and procedures require that, at a minimum, a provider must complete a signed application that includes the following items: ◆ Lack of present illegal drug use ◆ History of loss of license, registration, or certification and/or felony convictions ◆ History of loss or limitation of privileges or disciplinary action ◆ A summary of the provider's work history for the prior five years ◆ Attestation by the applicant of the correctness and completeness of the application		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Standard XI—Credentialing

c. Review and Primary Source Verification The PIHP's designee reviews the information obtained and determines whether to grant provisional credentials. If approved, the PIHP conducts primary source verification of the following: ◆ Licensure or certification ◆ Board certification, if applicable, or the highest level of credential attained ◆ Medicare/Medicaid sanctions		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
d. Timeliness of the PIHP Decision The PIHP's policy and procedures require that the PIHP has up to 31 days from the receipt of a complete application and the minimum required documents within which to render a decision regarding temporary or provisional credentialing.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
14. Recredentialing—Timelines The PIHP's policy requires recredentialing of physicians and other licensed, registered, or certified health care providers at least every two years.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Standard XI—Credentialing

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
15. Recredentialing Requirements for Individual Practitioners The PIHP's policy and procedures for recredentialing require, at a minimum: ◆ An update of information obtained during the initial credentialing. ◆ A process for ongoing monitoring, and intervention when appropriate, of provider sanctions, complaints, and quality issues pertaining to the provider, which must include, at a minimum, a review of: ▪ Medicare/Medicaid sanctions. ▪ State sanctions or limitations on licensure, registration, or certification. ▪ Beneficiary concerns, which include grievances (complaints) and appeals information. ▪ PIHP quality issues		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
16. Delegation of PIHP Responsibilities for Credentialing/ Recredentialing If responsibilities for credentialing/recredentialing are delegated by the PIHP, the PIHP: ◆ Retains the right to approve, suspend, or terminate providers selected by the entity. ◆ Must meet all requirements associated with the delegation. ◆ Specifies in the delegation agreement/subcontract the functions that are delegated and those that are retained. ◆ Is responsible for oversight of delegated credentialing or recredentialing decisions.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Standard XI—Credentialing

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
17. Credentialing Organizational Providers The PIHP must validate, and revalidate at least every two years, that an organizational provider is licensed as necessary to operate within the State and has not been excluded from Medicaid or Medicare.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
18. Organizational Providers—Delegation of Credentialing for Individuals Employed by, or Contracted with, an Organizational Provider If the PIHP delegates to another entity any of the responsibilities of credentialing/recredentialing or selection of providers, the PIHP: ◆ Retains the right to approve, suspend, or terminate a provider selected by that entity. ◆ Must meet all requirements associated with the delegation of PIHP functions. ◆ Is responsible for oversight regarding delegated credentialing or re-credentialing decisions.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Findings

Standard XI—Credentialing

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
19. Deeming If the PIHP accepts the credentialing decision of another PIHP for an individual or organizational provider, it maintains copies of the current credentialing PIHP's decision in its administrative records.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
20. Notification of Adverse Credentialing Decision The PIHP's policy and procedures address the requirement for the PIHP to inform an individual or organizational provider in writing of the reasons for the PIHP's adverse credentialing decisions.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
21. Provider Appeals The PIHP's policy and procedures address the PIHP's appeal process (consistent with State and federal regulations) that is available to providers for instances when the PIHP denies, suspends, or terminates a provider for any reason other than lack of need.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Standard XI—Credentialing

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
22. Reporting Requirements The PIHP has procedures for reporting, to appropriate authorities (i.e., MDCH, the provider's regulatory board or agency, the Attorney General, etc.), improper known organizational provider or individual practitioner conduct which results in suspension of termination from the PIHP's provider network. The procedures are consistent with current federal and State requirements, including those specified in the MDCH Medicaid Managed Specialty Supports and Services Contract.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Standard XII—Access And Availability

The PIHP meets and requires its providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services.

438.206(c)

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

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
Access Standards—Preadmission Reports The PIHP reports its performance on the standards in accordance with PIHP reporting requirements for Medicaid specialty supports and services beneficiaries. MDCH 3.1 P6.5.1.1 (10/01/05)	MDCH will provide data directly to HSAG (in the first, second, and third quarters of 2005-2006).	☐ **Met** ☐ **Partially Met** ☐ **Not Met**
1. Access Standards—Preadmission Screening The PIHP ensures that 95 percent of children and adults receive a preadmission screening for psychiatric inpatient care within three hours.		
a. Children		☐ **Met** ☐ **Partially Met** ☐ **Not Met**
b. Adult		☐ **Met** ☐ **Partially Met** ☐ **Not Met**
Findings		

Standard XII—Access And Availability

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

Standard XII—Access And Availability

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

Standard XII—Access And Availability

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

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

Standard XII—Access And Availability

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

Findings

Results—Standard XII						
Met	=	0	X	1.00	=	0.0
Partially Met	=	0	X	.50	=	0.0
Not Met	=	0	X	.00	=	0.0
Total Applicable	=	0	**Total Score**		=	0.0
Total Score ÷ Total Applicable					=	0.0%

Standard XIII—Coordination of Care

The PIHP must coordinate the services it furnishes to beneficiaries with other services the beneficiary receives.
438.208(b)(2)

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
1. Coordination Procedures/Primary Care Providers The PIHP has procedures to ensure that coordination occurs between primary care physicians and the PIHP and/or its network. MDCH 6.4.4 and 6.8.3		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

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

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

Results—Standard XIII						
Met	=	0	X	1.00	=	0.0
Substantially Met	=	0	X	.75	=	0.0
Partially Met	=	0	X	.50	=	0.0
Not Met	=	0	X	.00	=	0.0
Not Applicable	=	0				
Total Applicable	=	0	Total Score		=	0.0
Total Score ÷ Total Applicable					=	0.0%

Standard XIV—Appeals

Each PIHP must have a system that includes an appeal process and access to the State's fair hearing system.
§438.402

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

Standard XIV—Appeals

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

Standard XIV—Appeals

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

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

Standard XIV—Appeals

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

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

Standard XIV—Appeals

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

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

Standard XIV—Appeals

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

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

Results—Standard XIV						
Met	=	0	X	1.00	=	0.0
Substantially Met	=	0	X	.75	=	0.0
Partially Met	=	0	X	.50	=	0.0
Not Met	=	0	X	.00	=	0.0
Not Applicable	=	0				
Total Applicable	=	0	Total Score		=	0.0
Total Score ÷ Total Applicable					=	0.0%

Standard XV—Advance Directives

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
1. Written Policy and Procedures The PIHP has a written advance directives policy and procedures. 438.6(i) 422.128		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings		

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
2. Documentation in the Beneficiary's Record The policy requires that there is documentation in a prominent part of the beneficiary's current medical record as to whether or not the beneficiary has executed an advance directive. 422.128		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings		

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
3. Education of Staff The PIHP provides for education of staff concerning its policies and procedures on advance directives. 422(a)(2)(H)		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings		

Standard XV—Advance Directives

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
4. Subcontracts PIHP subcontracts, as applicable, contain advance directive requirements appropriate to the subcontract. 438.6(l)		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings		

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
5. Information for Adult Beneficiaries The PIHP provides all adult beneficiaries with written information on advance directive policies, including a description of applicable State laws. This includes information on the beneficiary's right to make decisions concerning his or her medical care, including the right to accept or refuse treatment, and the right to formulate advance directives. 438.6(i)(3) 422.128		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings		

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
6. Changes in State Law The information provided to adult beneficiaries must reflect changes in State law as soon as possible, but no later than 90 days after the effective date of the change. 438.6(i)(4)		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings		

Results—Standard XV						
Met	=	0	X	1.00	=	0.0
Substantially Met	=	0	X	.75	=	0.0
Partially Met	=	0	X	.50	=	0.0
Not Met	=	0	X	.00	=	0.0
Not Applicable	=	0				
Total Applicable	=	0	Total Score		=	0.0
Total Score ÷ Total Applicable					=	0.0%

Appendix C. Performance Measure Validation Tool

The performance measure validation tool appendix follows this cover page.

The PIHPs were given the Information Systems Capabilities Assessment Tool (ISCAT) to complete and submit as a part of the performance measure validation process. A modified, abbreviated version of the ISCAT (mini-ISCAT) was submitted by PIHP subcontractors as well.

HSAG HEALTH SERVICES ADVISORY GROUP

Michigan Department of Community Health
Information Systems Capabilities Assessment (ISCA)
for Prepaid Inpatient Health Plans (PIHPs)

I. GENERAL INFORMATION

Please provide the following general information:

Note: When completing this ISCA, answer the questions in the context of the performance indicators reported to MDCH, and the QI and encounter data submitted to MDCH only. If a question does not apply whatsoever to the performance indicator calculation and reporting, QI data, or encounter data submission, enter an N/A response. Coordinating Agencies (CAs) should be considered a subcontractor, on the same level as a Community Mental Health Service Provider (CMHSP) or a Managed Comprehensive Provider Network (MCPN).
ITEMS HIGHLIGHTED IN YELLOW INDICATE CHANGES FROM LAST YEAR'S VERSION.

A. Contact Information

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

PIHP Name: _____
Contact Name and Title: _____
Mailing Address: _____
Phone Number: _____
Fax Number: _____
E-Mail Address: _____
Chief Information Officer (CIO) Name and Title: _____
Phone Number: _____
E-Mail Address: _____

HSAG HEALTH SERVICES ADVISORY GROUP

I. GENERAL INFORMATION

B. PIHP Model Type

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

- ☐ PIHP – stand alone
- ☐ PIHP – affiliation
- ☐ PIHP – MCPN Network
- ☐ PIHP – other (describe): _____

PIHP Structure

Please indicate general structure (if other, please specify):

- ☐ Centralized (All information system functions are performed by the PIHP)
- ☐ Mixed (Some information system functions are delegated to other entities)
- ☐ Delegated (All information system functions are delegated to other entities)
- ☐ Other (describe): _____

C. Please provide a brief narrative description of any changes that were made to your organization within the last year, including organization structure, information systems, key staff, or other significant changes: _____

D. Unduplicated Count of Medicaid Consumers Receiving Services as of:

June 2006 _____

July 2006 _____

August 2006 _____

September 2006 _____

October 2006 _____

November 2006 _____

December 2006 _____

I. GENERAL INFORMATION

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

☐ Yes

☐ No

If *yes*, who performed the assessment? _____

When was the assessment completed? _____

F. In an attachment to the ISCA, please describe how your PIHP's data process flow is configured for its entire network. Label as Attachment 8.

This will likely require a multi-dimensional presentation and data flow chart. Please include any IS functions that have been delegated downstream to the Community Mental Health Service Providers (CMHSPs), MCPNs (if applicable), the Coordinating Agency (CA) office, and sub-panel contract agencies of both the CA/CMHSPs. Identify which entity-level is responsible for which kind of data collection and submission, which entity has overall data validation responsibilities, and the data validation process involved. A typical response should generally be a two-to-three-page write-up, with some graphical flow charts attached. This description will help immensely with the reviewers' understanding of your PIHP and will help make the validation process run smoothly and efficiently.

II. INFORMATION SYSTEMS: DATA PROCESSING PROCEDURES AND PERSONNEL

1. What database management system (DBMS) or systems does your organization use to store Medicaid claims and encounter (service) data?

_____

2. How would you characterize this/these DBMSs? *(Check all that apply.)*

- ☐ Relational
- ☐ Hierarchical
- ☐ Indexed
- ☐ Other
- ☐ Network
- ☐ Flat File
- ☐ Proprietary
- ☐ Don't Know

3. Into what DBMS(s), if any, do you extract relevant Medicaid encounter/service/eligibility detail for analytic reporting purposes?

_____

4. How would you characterize this/these DBMS(s)? *(Check all that apply.)*

- ☐ Relational
- ☐ Hierarchical
- ☐ Indexed
- ☐ Other
- ☐ Network
- ☐ Flat File
- ☐ Proprietary
- ☐ Don't Know

II. INFORMATION SYSTEMS: DATA PROCESSING PROCEDURES AND PERSONNEL

5. What programming languages do your programmers use to create Medicaid data extracts or analytic reports? A *programmer* is defined as an individual who develops and/or runs computer programs or queries to manipulate data for submission to MDCH (QI data and encounter data) or performance indicator reporting.

The intent of this question is to help the reviewers understand how the performance indicators are calculated by your PIHP.

_____

How many programmers (internal staff or external vendors) are trained and capable of modifying these programs?

_____

6. Approximately what percentage of your organization's programming work is outsourced?

This question pertains to the programming work necessary for the calculation of the performance measures reported to MDCH, and to the submission of encounter data to MDCH.

_____%

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

_____ years

8. What steps are necessary to meet performance indicator and encounter data reporting requirements? Your response should address the steps necessary to prepare and submit encounter data to MDCH.

If your PIHP has this information already documented, please submit the documentation or notate that you will make the documentation available to the reviewers during the site visit.

_____

9. What is the process for version control when computer programming code is revised?

This question applies to internal programmers or vendors who develop and/or run computer programming to manipulate data for encounter data submission or performance indicator reporting.

_____

II. INFORMATION SYSTEMS: DATA PROCESSING PROCEDURES AND PERSONNEL

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

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

11. Staffing

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

_____

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

_____

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

11d. What is the annual turnover? _____

II. INFORMATION SYSTEMS: DATA PROCESSING PROCEDURES AND PERSONNEL

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

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

_____

How frequently are system back-ups performed? _____

Where are back-up data stored? _____

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

_____

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

_____

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

_____

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

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

☐ Consumers

☐ Providers

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

_____

III. DATA ACQUISITION CAPABILITIES

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

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

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

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

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

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

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

III. DATA ACQUISITION CAPABILITIES

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

Please fill in the following table with the appropriate percentages:

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

Comments:

III. DATA ACQUISITION CAPABILITIES

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

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

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

III. DATA ACQUISITION CAPABILITIES

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

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

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

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

5. Principal and Secondary Diagnoses

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

☐ Yes

☐ No

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

_____

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

Institutional Data: _____

Professional Data: _____

III. DATA ACQUISITION CAPABILITIES

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

_____

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

_____

9. Medicaid Claims/Encounters

9a. How are Medicaid claims/encounters received?

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

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

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

_____

III. DATA ACQUISITION CAPABILITIES

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

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

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

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

_____

III. DATA ACQUISITION CAPABILITIES

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

☐ New system purchased and installed to replace old system.

Description/implementation dates _____

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

Description/implementation dates _____

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

Description/implementation dates _____

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

Description/implementation dates _____

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

Description/implementation dates _____

Comments: _____

III. DATA ACQUISITION CAPABILITIES

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

_____

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

_____

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

If batch, how often is it run? _____

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

_____

How is completeness estimated? How is completeness defined?

_____

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

_____

Are Medicaid encounters audited regularly? Randomly?

_____

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

_____

III. DATA ACQUISITION CAPABILITIES

19. Are diagnostic and procedure codes edited for validity? Please provide detail on system edits that are targeted to field content and consistency.

This question is to help reviewers get a sense of how accurate and valid your claims/encounter data are. If you have an existing document that identifies what edits you have in place, you may submit it as an attachment, or make it available for the reviewers on-site. If you do the latter, please note that in your response.

III. DATA ACQUISITION CAPABILITIES

20. Please complete the following table for Medicaid claims and encounter data and other Medicaid administrative data that is used for performance indicator reporting, or submitted to MDCH as QI or encounter data. For the purposes of this ISCA, a *claim* is defined as a service for which direct reimbursement is made (FFS). An *encounter* is defined as a capitated service, in which no direct reimbursement for the service is provided—rather, the provider receives a capitation payment based on member panels. *Administrative data* is defined as any service data that is housed electronically in a database that is not represented in claims or encounters. Examples would include Sub-Element Cost Report (CMHs), authorization systems, consumer surveys, etc.

Provide any documentation that should be reviewed to explain the data that are being submitted.

	Claims	Encounters	QI Data
Percent of Total Service Volume	___%	___%	
Percent Complete	___%	___%	___%
Other Administrative Data (list types)	_____		
How Are the Above Statistics Quantified?	_____		
Incentives for Data Submission	_____		

Comments: _____

21. Describe the Medicaid claims/encounter suspend ("pend") process, including timeliness of reconciling pended services.

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

_____

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

What triggers a processor to follow up on "pended" claims? How frequent are these triggers?

_____

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.

III. DATA ACQUISITION CAPABILITIES

☐ Yes

☐ No

If *yes*, what were the results?

_____

24. Claims/Encounters Systems

24a. If multiple systems are used to process performance indicator data (i.e., each CMHSP has its own IS system to process data), document how the performance data are ultimately merged into one PIHP rate.

_____

With what frequency are performance indicator data merged?

_____

24b. Beginning with receipt of a Medicaid claim or encounter in-house, describe the claim/encounter handling, logging, and processes that precede adjudication.

When are Medicaid claims/encounters assigned a document control number and logged or scanned into the system? When are Medicaid claims/encounters microfilmed? If there is a delay in microfilming, how do processors access a claim/encounter that is logged into the system, but is not yet filmed?

Note: This question should only be answered by those entities that receive paper claims and process them manually.

_____

III. DATA ACQUISITION CAPABILITIES

24c. Discuss which decisions in processing a Medicaid claim and encounter (service data) are automated, which are prompted by automated messages appearing on the screen, and which are manual. Document the opportunities a processor has for overriding the system manually.

Is there a report documenting overrides or "exceptions" generated on each processor and reviewed by the claim supervisor? Please describe this report.

The intent of this question is to understand how much manual intervention is required to either data-enter a claim/encounter or to adjudicate a claim. The less manual intervention there is, the less room there is for error.

_____

III. DATA ACQUISITION CAPABILITIES

24d. Are there any outside parties or contractors used to complete adjudication, including but not limited to:

- Bill auditors (hospital claims, claims over a certain dollar amount)

☐ Yes

☐ No

- Peer or medical reviewers

☐ Yes

☐ No

- Sources for additional charge data (usual and customary)

☐ Yes

☐ No

- Bill "re-pricing" for any services provided

☐ Yes

☐ No

How are these data incorporated into your organization's data?

_____

24e. Describe the system's editing capabilities that assure that Medicaid claims and encounters (service data) are processed correctly.

Keep your responses only in the context of the data used for performance indicator reporting. Keep your responses fairly general (i.e., listing the following edits: valid diagnosis and procedure codes, valid recipient ID, valid date of service, mandatory fields, etc.). If your documentation is voluminous, please simply make it available to the reviewers during the site visit.

Provide a list of the specific edits that are performed on claims as they are adjudicated, and note:

1. Whether the edits are performed pre- or post-payment, and
2. Which are manual and which are automated functions.

_____

III. DATA ACQUISITION CAPABILITIES

24f. Please describe how Medicaid eligibility files are updated before providing services, how frequently they updated for ongoing clients, and who has "change" authority. How and when does Medicaid eligibility verification take place (prior to beginning services, monthly, semi-annually, etc.)?

_____

24g. Describe how your systems and procedures handle validation and payment of Medicaid claims and encounters (service data) when procedure codes are not provided.

_____

24h. Where does the system-generated output (EOBs, remittance advices, pend/rejection reports, etc.) reside?

☐ In-house?

☐ In a separate facility?

If located elsewhere, how is such work tracked and accounted for?

_____

25. Describe all performance monitoring standards for Medicaid claims/encounters processing and recent actual performance results.

This question addresses only those staff who are involved with data entry of claims/encounters and/or adjudication of claims.

_____

26. Describe processor-specific performance goals and supervision of actual versus target performance. Do processors have to meet goals for processing speed? Do they have to meet goals for accuracy?

Again, this question addresses those staff who are involved with data entry of claims/encounters and/or adjudication of claims.

_____

III. DATA ACQUISITION CAPABILITIES

27. Other Administrative Data Used for Performance Indicator Reporting

27a. Identify other administrative data sources used. Include all data sources that are utilized to calculate performance measures by your PIHP: (*check all that apply)*

- ☐ Sub-Element Cost Report (CMHSPs) or Legislative Boiler Plate Report (CAs)
- ☐ QI Data
- ☐ Appointment/Access Database
- ☐ Consumer Surveys
- ☐ Preadmission Screening Data
- ☐ Case Management Authorization System
- ☐ Client Assessment Records
- ☐ Supported Employment Data
- ☐ Recipient Complaints
- ☐ Telephone Service Data
- ☐ Outcome Measurement Data
- ☐ Other: _____
- ☐ Other: _____

27b. For each data source identified above, describe the flow of data from the point of origin through the point of entry into an administrative database, data warehouse, or reporting system maintained by your PIHP. Dataflow diagrams may be included as an attachment.

_____

27c. For each data source identified above, identify the data elements captured within the administrative database, data warehouse, or reporting system, and used for performance measure reporting. This may be included as a separate attachment and may be documentation of table structures or a data dictionary. If the documentation is voluminous, please make it available to the reviewers during the site visit and indicate this below:

_____

27d. For each data source identified above, describe the validation activities performed by your PIHP to ensure the data in the administrative database are accurate.

_____

III. DATA ACQUISITION CAPABILITIES

B. Eligibility System

1. Please describe any major changes/updates that have taken place in the last three years in your Medicaid eligibility data system. *(Be sure to identify specific dates on which changes were implemented.)*

Examples:

☐ New **eligibility** system purchased and installed to replace old system

☐ New **eligibility** system purchased and installed to replace most of old system —old system still used

☐ Major enhancements to old system (please also explain the types)

☐ The use of a vendor-provided eligibility service/system

☐ Modifications to eligibility data due to organizational restructuring

_____

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

_____

3. How does your PIHP uniquely identify consumers?

_____

4. How does your PIHP assign unique consumer IDs? Is this number assigned by the PIHP only or do your affiliate CMHSPs also assign unique consumer IDs?

_____

III. DATA ACQUISITION CAPABILITIES

5. How do you track consumer eligibility? Does the individual retain the same ID (unique consumer ID)?

III. DATA ACQUISITION CAPABILITIES

6. Can your systems track consumers who switch from one payer source (e.g., Medicaid, commercial plan, federal block grant) to another?

☐ Yes

☐ No

6a. Can you track previous claims/encounter data for consumers who switch from one payer source to another?

☐ Yes

☐ No

6b. Are you able to link previous claims/encounter data across payer sources? For example, if a consumer received services under one payer source (e.g., state monies) and then additional services under another payer source (e.g., Medicaid), could the PIHP identify all the services rendered to the individual, regardless of the payer source?

☐ Yes

☐ No

7. Under what circumstances, if any, can a Medicaid member exist under more than one identification number within your PIHP's information management systems?

This applies to your internal ID, Medicaid ID, etc. How many numbers can one consumer have within your system?

Under what circumstances, if any, can a member's identification number change?

_____

8. How often is Medicaid enrollment information updated (e.g., how often does your PIHP receive eligibility updates)?

_____

9. Can you track and maintain Medicaid eligibility over time, including retro-active eligibility?

_____

III. DATA ACQUISITION CAPABILITIES

C. Incorporating Data from Subcontractor Systems

Use this section to record information on stand-alone systems or benefits provided through subcontracts, such as CMHSPs, MCPNs, CAs, sub-contract agencies, and other organizational providers.

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

Measure	Subcontractors
The percent of children and adults receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	_____
The percent of new persons receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service.	_____
The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional.	_____
The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days. The percent of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	_____ _____
The percent of Medicaid recipients having received PIHP managed services (this indicator is calculated by MDCH).	_____
The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination. (This indicator is calculated by MDCH)	_____
The percent of adults with mental illness and the percent of adults with developmental disabilities served by PIHPs who are in competitive employment. (This indicator is calculated by MDCH). The validation will focus on the first quarter of FY07 for this indicator.	_____

III. DATA ACQUISITION CAPABILITIES

The percent of adults with mental illness and the percent of adults with developmental disabilities served by CMHSPs and PIHPs who earn minimum wage or more from employment activities (competitive, supported or self employment, or sheltered workshop). (This indicator is calculated by MDCH). The validation will focus on the first quarter of FY07 for this indicator.	_____
The percent of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	_____

III. DATA ACQUISITION CAPABILITIES

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

_____

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

_____

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

_____

5. Do you evaluate the quality of this information?

If so, how?

_____

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

_____

III. DATA ACQUISITION CAPABILITIES

D. Integration and Control of Data for Performance Measure Reporting

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

File Consolidation

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

_____

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

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

  ☐ Yes

  ☐ No

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

  ☐ Yes

  ☐ No

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

  _____

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

  ☐ Yes

  ☐ No

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

  _____

III. DATA ACQUISITION CAPABILITIES

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

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

_____

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

_____

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

_____

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

_____

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

_____

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

_____

III. DATA ACQUISITION CAPABILITIES

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

☐ Yes

☐ No

If yes, please describe: _____

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

☐ Yes

☐ No

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

_____

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

☐ Yes

☐ No

III. DATA ACQUISITION CAPABILITIES

Subcontractor Data Integration

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

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

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

III. DATA ACQUISITION CAPABILITIES

Performance Measure Repository Structure

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

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

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

☐ Yes

☐ No

Report Production

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

_____

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

_____

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

_____

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

_____

III. DATA ACQUISITION CAPABILITIES

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

III. DATA ACQUISITION CAPABILITIES

E. Provider Data

Compensation Structure

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

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

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

   _____

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

   _____

Summary of Requested Documentation

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

Requested Document	Details	Label Number
Previous Medicaid Performance Measure Reports	Please attach final documentation from any previous Medicaid performance measure reporting calculated by your PIHP for the last 4 quarters.	**1.**
Organizational Chart	Please attach an organizational chart for your PIHP. The chart should make clear the relationship among key individuals/departments responsible for information management, including performance measure reporting.	**2.**
Data Integration Flow Chart	Please provide a flowchart that gives an overview of the structure of your management IS. Be sure to show how all claims, encounter, membership, provider, vendor, and other data are integrated for performance measure reporting.	**3.**
Performance Measure Repository File Structure (if applicable)	Provide a complete file structure, file format, and field definitions for the performance measure repository.	**4.**
Program/Query Language for Performance Measure Repository Reporting (if applicable)	Provide full documentation on the software programs or codes used to convert performance measure repository data to performance measures.	**5.**
Medicaid Claims Edits	List of specific edits performed on claims/encounters as they are adjudicated with notation of performance timing (pre- or post-payment) and whether they are manual or automated functions.	**6.**
Statistics on Medicaid claims/encounters and other administrative data	Documentation that explains statistics reported in the ISCA.	**7.**
Health Information System Configuration for Network	Attachment 8	**8.**
_____	_____	**9.**

Comments:_____

Appendix D. Performance Improvement Project Validation Tool

The performance improvement project validation tool and summary form appendix follows this cover page.

Section 3: Michigan 2006–2007 PIP Validation Tool: <PIP Topic> *for* <PIHP Full Name>

DEMOGRAPHIC INFORMATION	
PIHP or ID: **<PIHP Full Name>**	
Study Leader Name: _____ Title: _____	
Telephone Number: _____ E-mail Address: _____	
Name of Project/Study: ***<PIP Topic>***	
Type of Study: ☐ Clinical ☐ Nonclinical	
Date of Study: _____ to _____	
_____ Number of Medicaid Enrollees Served by PIHP _____ Number of Medicaid Enrollees in Project/Study	**Section to be completed by HSAG** _____ Year 1 Validation _____ Initial Submission _____ Resubmission _____ Year 2 Validation _____ Initial Submission _____ Resubmission _____ Year 3 Validation _____ Initial Submission _____ Resubmission

Section 3: Michigan 2006–2007 PIP Validation Tool: <PIP Topic> *for* <PIHP Full Name>

ACTIVITIES		EVALUATION ELEMENTS	SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation				
I. Appropriate Study Topic		**Topics selected for the study should reflect the Medicaid enrollment in terms of demographics characteristics, prevalence of disease, and the potential consequences (risks) of the disease. Topics could also address the need for a specific service. The goal of the project should be to improve processes and outcomes of health care. The topic may be specified by the State Medicaid agency or on the basis of Medicaid beneficiary input.**		
	—	1. Reflects high-volume or high-risk conditions (or was selected by the State). **N/A** is not applicable to this element for scoring.	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A	
	—	2. Is selected following collection and analysis of data (or was selected by the State). **N/A** is not applicable to this element for scoring.	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A	
	—	3. Addresses a broad spectrum of care and services (or was selected by the State). The scoring for this element will be **Met** or **Not Met.**	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A	
	—	4. Includes all eligible populations that meet the study criteria. **N/A** is not applicable to this element for scoring.	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A	
	—	5. Does not exclude beneficiaries with special health care needs. The scoring for this element will be **Met** or **Not Met.**	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A	

Section 3: Michigan 2006–2007 PIP Validation Tool: <PIP Topic> *for* <PIHP Full Name>

ACTIVITIES		EVALUATION ELEMENTS	SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation				
I. Appropriate Study Topic		**Topics selected for the study should reflect the Medicaid enrollment in terms of demographics characteristics, prevalence of disease, and the potential consequences (risks) of the disease. Topics could also address the need for a specific service. The goal of the project should be to improve processes and outcomes of health care. The topic may be specified by the State Medicaid agency or on the basis of Medicaid beneficiary input.**		
	C*	6. Has the potential to affect beneficiary health, functional status, or satisfaction. The scoring for this element will be **Met** or **Not Met.**	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A	
Totals for Activity I	1**		☐ Met ☐ Partially Met ☐ Not Met ☐ N/A	

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

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

Section 3: Michigan 2006–2007 PIP Validation Tool: <PIP Topic> *for* <PIHP Full Name>

ACTIVITIES		EVALUATION ELEMENTS	SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation				
II. Clearly Defined, Answerable Study Question		**Stating the study question(s) helps maintain the focus of the PIP and sets the framework for data collection, analysis, and interpretation.**		
	C*	1. States the problem to be studied in simple terms. **N/A** is not applicable to this element for scoring.	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A	
	C*	2. Is answerable. **N/A** is not applicable to this element for scoring.	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A	
Totals for Activity II	2**		☐ Met ☐ Partially Met ☐ Not Met ☐ N/A	

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

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

Section 3: Michigan 2006–2007 PIP Validation Tool: <PIP Topic> *for* <PIHP Full Name>

ACTIVITIES		EVALUATION ELEMENTS	SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation				
III. Clearly Defined Study Indicator(s)		**A study indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event (e.g., an older adult has not received a flu shot in the last 12 months), or a status (e.g., a beneficiary's blood pressure is or is not below a specified level) that is to be measured. The selected indicators should track performance or improvement over time. The indicators should be objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research.**		
	C*	1. Are well-defined, objective, and measurable. **N/A** is not applicable to this element for scoring.	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A	
	—	2. Are based on current evidence-based practice guidelines, pertinent peer review literature, or other consensus expert panels.	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A	
	C*	3. Allow for the study question to be answered. **N/A** is not applicable to this element for scoring.	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A	
	—	4. Measure changes (outcomes) in health or functional status, beneficiary satisfaction, or valid process alternatives. **N/A** is not applicable to this element for scoring.	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A	
	C*	5. Have available data that can be collected on each indicator. **N/A** is not applicable to this element for scoring.	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A	
	—	6. Are nationally recognized measures such as HEDIS specifications, when appropriate. The scoring for this element will be either **Met or N/A.**	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A	
	—	7. Includes the basis on which each indicator was adopted, if internally developed.	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A	
Totals for Activity III	3**		☐ Met ☐ Partially Met ☐ Not Met ☐ N/A	

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

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

ACTIVITIES		EVALUATION ELEMENTS	SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation				
IV. Correctly Identified Study Population		**The selected topic should represent the entire eligible Medicaid enrollment population with systemwide measurement and improvement efforts to which the PIP study indicators apply.**		
	C*	1. Is accurately and completely defined. **N/A** is not applicable to this element for scoring.	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A	
	—	2. Includes requirements for the length of an beneficiary's enrollment in the PIHP.	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A	
	C*	3. Captures all beneficiaries to whom the study question applies. **N/A** is not applicable to this element for scoring.	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A	
Totals for Activity IV	2**		☐ Met ☐ Partially Met ☐ Not Met ☐ N/A	

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

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

Section 3: Michigan 2006–2007 PIP Validation Tool: <PIP Topic> *for* <PIHP Full Name>

ACTIVITIES		EVALUATION ELEMENTS	SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation				
V. Valid Sampling Techniques		**(This activity is only scored if sampling was used.) If sampling is to be used to select beneficiaries of the study, proper sampling techniques are necessary to provide valid and reliable information on the quality of care provided. The true prevalence or incidence rate for the event in the population may not be known the first time a topic is studied.**		
	—	1. Consider and specify the true or estimated frequency of occurrence.	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A	
	—	2. Identify the sample size.	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A	
	—	3. Specify the confidence level.	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A	
	—	4. Specify the acceptable margin of error.	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A	
	C*	5. Ensure a representative sample of the eligible population.	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A	
	—	6. Are in accordance with generally accepted principles of research design and statistical analysis.	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A	
Totals for Activity V	1**		☐ Met ☐ Partially Met ☐ Not Met ☐ N/A	

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

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

Section 3: Michigan 2006–2007 PIP Validation Tool: <PIP Topic> *for* <PIHP Full Name>

ACTIVITIES		EVALUATION ELEMENTS	SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation				
VI. Accurate/ Complete Data Collection		**Data collection must ensure that the data collected on the PIP indicators are valid and reliable. Validity is an indication of the accuracy of the information obtained. Reliability is an indication of the repeatability or reproducibility of a measurement.**		
	—	1. The identification of data elements to be collected. **N/A** is not applicable to this element for scoring.	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A	
	—	2. The identification of specified sources of data. **N/A** is not applicable to this element for scoring.	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A	
	—	3. A defined and systematic process for collecting baseline and remeasurement data. **N/A** is not applicable to this element for scoring.	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A	
	—	4. A timeline for the collection of baseline and remeasurement data. **N/A** is not applicable to this element for scoring.	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A	
	—	5. Qualified staff and personnel to abstract manual data.	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A	
	C*	6. A manual data collection tool that ensures consistent and accurate collection of data according to indicator specifications.	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A	
	—	7. A manual data collection tool that supports interrater reliability.	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A	
	—	8. Clear and concise written instructions for completing the manual data collection tool.	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A	

ACTIVITIES		EVALUATION ELEMENTS	SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation				
VI. Accurate/ Complete Data Collection		**Data collection must ensure that the data collected on the PIP indicators are valid and reliable. Validity is an indication of the accuracy of the information obtained. Reliability is an indication of the repeatability or reproducibility of a measurement.**		
	—	9. An overview of the study in written instructions.	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A	
	—	10. Administrative data collection algorithms/flow charts that show activities in the production of indicators.	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A	
	—	11. An estimated degree of administrative data completeness. Met=80-100% Partially Met=50-79% Not Met=<50% or not provided	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A	
Totals for Activity VI	1**		☐ Met ☐ Partially Met ☐ Not Met ☐ N/A	

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

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

ACTIVITIES		EVALUATION ELEMENTS	SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation				
VII. Appropriate Improvement Strategies		**Real, sustained improvements in care result from a continuous cycle of measuring and analyzing performance, and developing and implementing systemwide improvements in care. Interventions designed to change behavior at an institutional, practitioner, or beneficiary level.**		
	C*	1. Related to causes/barriers identified through data analysis and quality improvement processes. **N/A** is not applicable to this element for scoring.	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A	
	—	2. System changes that are likely to induce permanent change.	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A	
	—	3. Revised if the original interventions were not successful.	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A	
	—	4. Standardized and monitored if interventions were successful.	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A	
Totals for Activity VII	1*		☐ Met ☐ Partially Met ☐ Not Met ☐ N/A	

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

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

Section 3: Michigan 2006–2007 PIP Validation Tool: <PIP Topic> *for* <PIHP Full Name>

ACTIVITIES		EVALUATION ELEMENTS	SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation				
VIII. Sufficient Data Analysis and Interpretation		**Describe the data analysis process on the selected clinical or nonclinical study indicators. Include the statistical analysis techniques used.**		
	C*	1. Is conducted according to the data analysis plan in the study design. **N/A** is not applicable to this element for scoring.	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A	
	C*	2. Allows for generalization of results to the study population if a sample was selected. If sampling was not used, this score will be **N/A.**	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A	
	—	3. Identifies factors that threaten internal or external validity of findings.	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A	
	—	4. Includes an interpretation of findings.	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A	
	—	5. Is presented in a way that provides accurate, clear, and easily understood information.	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A	
	—	6. Identifies initial measurement and remeasurement of study indicators.	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A	
	—	7. Identifies statistical differences between initial measurement and remeasurement.	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A	
	—	8. Identifies factors that affect the ability to compare initial measurement with remeasurement.	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A	
	—	9. Includes interpretation of the extent to which the study was successful.	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A	
Totals for Activity VIII	2**		☐ Met ☐ Partially Met ☐ Not Met ☐ N/A	

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

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

ACTIVITIES		EVALUATION ELEMENTS	SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation				
IX. Real Improvement Achieved		**Describe any meaningful change in performance observed during baseline measurement. Discuss any random, year-to-year variation, population changes, and sampling error that may have occurred during the measurement process.**		
	—	1. Remeasurement methodology is the same as baseline methodology.	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A	
	—	2. There is documented improvement in processes or outcomes of care.	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A	
	—	3. The improvement appears to be the result of planned intervention(s).	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A	
	—	4. There is statistical evidence that observed improvement is true improvement.	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A	
Totals for Activity IX	0		☐ Met ☐ Partially Met ☐ Not Met ☐ N/A	

ACTIVITIES		EVALUATION ELEMENTS	SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation				
X. Sustained Improvement Achieved		**Describe any demonstrated improvement through repeated measurements over comparable time periods. Discuss any random, year-to-year variation, population changes, and sampling error that may have occurred during the remeasurement process.**		
	—	1. Repeated measurements over comparable time periods demonstrate sustained improvement, or that a decline in improvement is not statistically significant.	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A	
Totals for Activity X	0		☐ Met ☐ Partially Met ☐ Not Met ☐ N/A	

Section 3: Michigan 2006–2007 PIP Validation Tool: <PIP Topic> *for* <PIHP Full Name>

Table 3-1—2006–2007 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 N/A**	**Total Possible Critical Elements**	**Total Critical Elements Met**	**Total Critical Elements Partially Met**	**Total Critical Elements Not Met**	**Total Critical Elements N/A**
I. Appropriate Study Topic	6					1				
II. Clearly Defined, Answerable Study Question	2					2				
III. Clearly Defined Study Indicator(s)	7					3				
IV. Correctly Identified Study Population	3					2				
V. Valid Sampling Techniques	6					1				
VI. Accurate/Complete Data Collection	11					1				
VII. Appropriate Improvement Strategies	4					1				
VIII. Sufficient Data Analysis and Interpretation	9					2				
IX. Real Improvement Achieved	4					No Critical Elements				
X. Sustained Improvement Achieved	1					No Critical Elements				
Totals for All Activities	**53**					**13**				

Table 3-2—2006–2007 PIP Validation Report Overall Scores *for* <PIP Topic> *for* <PIHP Full Name>	
Percentage Score of Evaluation Elements Met*	%
Percentage Score of Critical Elements Met**	%
Validation Status***	*<Met/Partially Met/Not Met>*

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

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

*** *Met* equals confidence/high confidence that the PIP was valid.
Partially Met equals low confidence that the PIP was valid.
Not Met equals reported PIP results that were not credible.

Section 3: Michigan 2006–2007 PIP Validation Tool: <PIP Topic> *for* <PIHP Full Name>

EVALUATION OF THE OVERALL VALIDITY AND RELIABILITY OF PIP/STUDY RESULTS
HSAG assessed the implications of the study's findings on the likely validity and reliability of the results based on CMS protocols. HSAG also assessed whether the state should have confidence in the reported PIP findings.
***Met* = Confidence/high confidence in reported PIP results** ****Partially Met = Low confidence in reported PIP results** *****Not Met = Reported PIP results not credible**
Summary of Aggregate Validation Findings *** ☐ Met ** ☐ Partially Met *** ☐ Not Met**

Summary statement on the validation findings: Activities xx through xx were assessed for this PIP validation report. Based on the validation of this PIP study, HSAG's assessment determined confidence in the results.

Appendix D: PIP Summary Form: <PIP Topic> *for* <PIHP Full Name>

DEMOGRAPHIC INFORMATION			
PIHP Name or ID:	**<PIHP Full Name>**		
Study Leader Name:	_____	Title:	_____
Telephone Number:	_____	E-Mail Address:	_____
Name of Project/Study:	***<PIP Topic>***		
Type of Study:	☐ Clinical	☐ Nonclinical	

_____ Number of Medicaid Consumers _____ Number of Medicaid Consumers in Study	**Section to be completed by HSAG** _____ Year 1 Validation _____ Initial Submission _____ Re-submission _____ Year 2 Validation _____ Initial Submission _____ Re-submission _____ Year 3 Validation _____ Initial Submission _____ Re-submission

Appendix D: PIP Summary Form: <PIP Topic> *for* <PIHP Full Name>

A. Activity 1: Choose the study topic. PIP topics should target improvement in relevant areas of services and reflect the population in terms of demographic characteristics, prevalence of disease, and the potential consequences (risks) of the disease. Topics may be derived from utilization data (ICD-9 or CPT coding data related to diagnoses and procedures; NDC codes for medications; HCPCS codes for medications, medical supplies, and medical equipment; adverse events; admissions; readmissions; etc.); grievances and appeals data; survey data; provider access or appointment availability data; enrollee characteristics data such as race/ethnicity/language; other fee-for-service data; local or national data related to Medicaid risk populations; etc. The goal of the project should be to improve processes and outcomes of health care or services in order to have a potentially significant impact on enrollee health, functional status, or satisfaction. The topic may be specified by the State Medicaid agency or CMS and be based on input from enrollees. Over time, topics must cover a broad spectrum of key aspects of enrollee care and services, including clinical and nonclinical areas, and should include all enrolled populations (i.e., certain subsets of enrollees should not be consistently excluded from studies).
Study topic:

Appendix D: PIP Summary Form: <PIP Topic> *for* <PIHP Full Name>

B. Activity 2: Define the study question(s). Stating the question(s) helps maintain the focus of the PIP and sets the framework for data collection, analysis, and interpretation.
Study question:

Appendix D: PIP Summary Form: <PIP Topic> *for* <PIHP Full Name>

C. Activity 3: Select the study indicator(s). A study indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event (e.g., an older adult has not received an influenza vaccination in the last twelve months), or a status (e.g., a consumer's blood pressure is/is not below a specified level) that is to be measured. The selected indicators should track performance or improvement over time. The indicators should be objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research.

Study Indicator 1	**Describe the rationale for selection of the study indicator:**
Numerator	
Denominator	
First Measurement Period Dates	
Benchmark	
Source of Benchmark	
Baseline Goal	
Study Indicator 2	**Describe the rationale for selection of the study indicator:**
Numerator	
Denominator	
First Measurement Period Dates	
Benchmark	
Source of Benchmark	
Baseline Goal	
Study Indicator 3	**Describe the rationale for selection of the study indicator:**
Numerator	
Denominator	
First Measurement Period Dates	
Benchmark	
Source of Benchmark	
Baseline Goal	

Appendix D: PIP Summary Form: <PIP Topic> *for* <PIHP Full Name>

D. Activity 4: Identify the study population. The selected topic should represent the entire Medicaid enrolled population, with system wide measurement and improvement efforts to which the PIP study indicators apply. Once the population is identified, a decision must be made whether to review data for the entire population or a sample of that population.
Study population:

Appendix D: PIP Summary Form: <PIP Topic> *for* <PIHP Full Name>

E. Activity 5: Use sound sampling methods. If sampling is to be used to select consumers of the study, proper sampling techniques are necessary to provide valid and reliable information on the quality of care provided. The true prevalence or incidence rate for the event in the population may not be known the first time a topic is studied.

Measure	Sample Error and Confidence Level	Sample Size	Population	Method for Determining Size (*describe*)	Sampling Method (*describe*)

Appendix D: PIP Summary Form: <PIP Topic> *for* <PIHP Full Name>

F. Activity 6a: Use valid and reliable data collection procedures. Data collection must ensure that the data collected on PIP indicators are valid and reliable. Validity is an indication of the accuracy of the information obtained. Reliability is an indication of the repeatability or reproducibility of a measurement.

Data Sources

[ ] Hybrid (medical/treatment records and administrative)

[ ] Medical/Treatment Record Abstraction

Record Type

[ ] Outpatient
[ ] Inpatient
[ ] Other _____

Other Requirements

[ ] Data collection tool attached
[ ] Data collection instructions attached
[ ] Summary of data collection training attached
[ ] IRR process and results attached

[ ] Other data

Description of data collection staff (include training, experience and qualifications):

[ ] Administrative Data

Data Source

[ ] Programmed pull from claims/encounters
[ ] Complaint/appeal
[ ] Pharmacy data
[ ] Telephone service data /call center data
[ ] Appointment/access data
[ ] Delegated entity/vendor data _____
[ ] Other _____

Other Requirements

[ ] Data completeness assessment attached
[ ] Coding verification process attached

[ ] Survey Data

Fielding Method

[ ] Personal interview
[ ] Mail
[ ] Phone with CATI script
[ ] Phone with IVR
[ ] Internet
[ ] Other _____

Other Requirements

[ ] Number of waves _____
[ ] Response rate _____
[ ] Incentives used _____

Appendix D: PIP Summary Form: <PIP Topic> *for* <PIHP Full Name>

F. Activity 6b: Determine the data collection cycle.	Determine the data analysis cycle.
[ ] Once a year [ ] Twice a year [ ] Once a season [ ] Once a quarter [ ] Once a month [ ] Once a week [ ] Once a day [ ] Continuous [ ] Other (list and describe):	[ ] Once a year [ ] Once a season [ ] Once a quarter [ ] Once a month [ ] Continuous [ ] Other (list and describe):

F. Activity 6c. Data analysis plan and other pertinent methodological features. Complete only if needed.

Estimated percentage degree of administrative data completeness: _____ percent.

Supporting documentation:

Appendix D: PIP Summary Form: <PIP Topic> *for* <PIHP Full Name>

G. Activity 7a: Include improvement strategies (interventions for improvement as a result of analysis). List chronologically the interventions that have had the most impact on improving the measure. Describe only the interventions and provide quantitative details whenever possible (e.g., "Hired four customer service representatives" as opposed to "Hired customer service representatives"). Do not include intervention planning activities.

Date Implemented (MMYY)	Check if Ongoing	Interventions	Barriers That Interventions Address

Appendix D: PIP Summary Form: <PIP Topic> *for* <PIHP Full Name>

G. Activity 7b: Implement intervention and improvement strategies. Real, sustained improvements in care result from a continuous cycle of measuring and analyzing performance, and developing and implementing systemwide improvements in care. Describe interventions designed to change behavior at an institutional, practitioner, or beneficiary level.
Describe interventions: **Baseline to Remeasurement 1:** **Remeasurement 1 to Remeasurement 2:** **Remeasurement 2 to Remeasurement 3:**

Appendix D: PIP Summary Form: <PIP Topic> *for* <PIHP Full Name>

H. Activity 8a. Data analysis: Describe the data analysis process in accordance with the analysis plan and any ad hoc analysis done on the selected clinical or nonclinical study indicators. Include the statistical analysis techniques used and *p* values.

Data analysis process:

Baseline Measurement:

Remeasurement 1:

Remeasurement 2:

Remeasurement 3

Appendix D: PIP Summary Form: <PIP Topic> *for* <PIHP Full Name>

H. Activity 8b. Interpretation of study results: Describe the results of the statistical analysis, interpret the findings, discuss the successfulness of the study, and indicate follow-up activities. Also, identify any factors that could influence the measurement or validity of the findings.

Interpretation of study results:

Address factors that threaten internal or external validity of the findings for each measurement period.

Baseline Measurement:

Remeasurement 1:

Remeasurement 2:

Remeasurement 3:

Appendix D: PIP Summary Form: <PIP Topic> *for* <PIHP Full Name>

I. Activity 9: Report improvement. Describe any meaningful change in performance observed during baseline measurement that was demonstrated.

Quantifiable Measure No. 1:

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

Quantifiable Measure No. 2:

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

Quantifiable Measure No. 3:

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

* Specify the test, *p* value, and specific measurements (e.g., baseline to Remeasurement 1, Remeasurement #1 to Remeasurement 2, etc., or baseline to final remeasurement) included in the calculations.

Appendix D: PIP Summary Form: <PIP Topic> *for* <PIHP Full Name>

J. Activity 10: Describe sustained improvement. Describe any demonstrated improvement through repeated measurements over comparable time periods. Discuss any random year-to-year variation, population changes, sampling error, or statistically significant declines that may have occurred during the remeasurement process
Sustained improvement: