Michigan Department of Health & Human Services

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Behavioral Health and Developmental Disabilities Administration

2015–2016 External Quality Review Technical Report

for

Prepaid Inpatient Health Plans

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HSAG Health Services Advisory Group

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HSAG HEALTH SERVICES ADVISORY GROUP

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Purpose of Report

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

In 2013, MDHHS defined new regional boundaries for the PIHPs' service areas and selected one PIHP per region to manage the Medicaid specialty benefit for the entire region and to contract with Community Mental Health Services Programs (CMHSPs) and other providers within the region to deliver Medicaid-funded mental health, substance use disorder, and developmental disabilities supports and services.

MDHHS contracted with the following 10 PIHPs:

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

Scope of EQR Activities Conducted

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

- **Compliance monitoring:** The 2015–2016 compliance monitoring review was designed to assess the PIHPs' implementation of corrective actions for these standards to address areas of noncompliance identified in the 2014–2015 reviews and determined the degree to which the PIHPs had moved into compliance with the related requirements.
- **Validation of performance measures:** HSAG validated the performance measures identified by MDHHS to evaluate the accuracy of the rates reported by or on behalf of a PIHP. The validation also determined the extent to which Medicaid-specific performance measures calculated by a PIHP followed the specifications established by MDHHS.
- **Validation of performance improvement projects (PIPs):** For each PIHP, HSAG reviewed one PIP to ensure that the PIHP designed, conducted, and reported on the project in a methodologically sound manner, allowing real improvements in care and giving confidence in the reported improvements.

HSAG reported its results from these three EQR activities to MDHHS and the PIHPs in activity reports for each PIHP. Section 3 and Appendix A detail the findings from the activities for all PIHPs. Appendix A also presents comparisons to prior-year performance.

Definitions

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

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]

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

[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.

Timeliness

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

Access

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

Findings Related to Quality, Timeliness, and Access

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

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

[1-3] 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.

Overview

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

Table 1-1—Assignment of Activities to Performance Domains

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

[1-5] The compliance monitoring reviews addressed an additional standard (Standard XV—Disclosure of Ownership, Control, and Criminal Convictions), which was not related to any of the domains and was therefore not included in Table 1-1.

Quality

Table 1-2 displays the statewide scores and the lowest and highest scores among the PIHPs for measures assessing the **quality** of care and services. Table 1-7 contains a detailed description of the performance measure indicators.

Table 1-2—Measures Assessing Quality

Measure			Statewide Score	PIHP Low Score	PIHP High Score
Compliance Monitoring Standards					
Standard I.	QAPIP Plan and Structure		100%	99%	100%
Standard II.	Performance Measurement and Improvement		100%	100%	100%
Standard III.	Practice Guidelines		100%	100%	100%
Standard IV.	Staff Qualifications and Training		100%	100%	100%
Standard VI.	Customer Services		100%	100%	100%
Standard VII.	Enrollee Grievance Process		100%	98%	100%
Standard VIII.	Enrollee Rights and Protections		100%	100%	100%
Standard IX.	Subcontracts and Delegation		99%	94%	100%
Standard X.	Provider Network		100%	96%	100%
Standard XI.	Credentialing		100%	100%	100%
Standard XIII.	Coordination of Care		100%	100%	100%
Standard XIV.	Appeals		100%	99%	100%
Performance Measures Indicators					
Indicator 4a:	Follow-Up Care	Children	98.86%	96.55%	100%
		Adults	96.72%	91.16%	99.12%
Indicator 4b:	Follow-Up Care After Detox		98.18%	90.10%	100%
Indicator 6:	Habilitation Supports Waiver (HSW) Rate		98.26%	95.40%	99.79%
Indicator 8:	Competitive Employment	MI Adults	13.17%	7.84%	15.00%
		DD Adults	9.18%	5.08%	14.16%
		MI/DD Adults	7.76%	4.82%	13.18%
Indicator 9:	Earning Minimum Wage	MI Adults	76.86%	62.12%	86.49%
		DD Adults	36.95%	15.89%	60.48%
		MI/DD Adults	37.59%	20.47%	66.67%
Indicator 10†:	Readmission Rate	Children	10.61%	0.00%	15.38%
		Adults	13.05%	7.55%	19.31%
Indicator 13:	Adults with DD living in a private residence		16.66%	9.26%	25.04%
Indicator 14:	Adults with MI living in a private residence		42.29%	28.57%	53.03%
Performance Improvement Projects					
		All evaluation elements *Met*	97%	86%	100%
		Critical elements *Met*	94%	67%	100%

† Lower rates are better for this measure.
MI =mental illness DD =developmental disability MI/DD=dually diagnosed with mental illness and developmental disability

PIHP performance on the compliance monitoring standards in the domain of **quality** continued to be a statewide strength. Twelve standards in the 2014–2015 review cycle addressed this domain. Three of the standards in this domain (Standard III—Practice Guidelines, Standard IV—Staff Qualifications and Training, Standard VI—Customer Services) were not included in the 2015-2016 follow-up compliance reviews as all PIHPs had achieved full compliance in the prior review. The highest statewide scores were found in this domain, with these additional standards achieving scores of 100 percent: Standard I—Quality Improvement and Performance Improvement Program (QAPIP) Plan and Structure, Standard II—Performance Measurement and Improvement, VII—Enrollee Grievance Process, Standard VIII—Enrollee Rights and Protections, Standard X—Provider Network, Standard XI—Credentialing, Standard XIII—Coordination of Care, and Standard XIV—Appeals. The only standard in the **quality** domain with a 2015–2016 statewide score of less than 100 percent was Standard IX—Subcontracts and Delegation.

The PIHPs continued to demonstrate strength in their validation results for performance measures related to **quality** of care and services. Eight PIHPs achieved validation findings of *Report* for all performance measures (also referred to as indicators in this report) in the **quality** domain, reflecting that the measures were fully compliant with MDHHS specifications. Two of the eight indicators in the **quality** domain received validation ratings of *Report* across all PIHPs. One PIHP received a validation status of *Not Reported* (*NR*) for most indicators in this domain, and one PIHP received a validation status of *NR* for Indicator 4a.

Performance on the measures related to **quality** of care and services—timely follow-up care for beneficiaries discharged from a psychiatric inpatient or detoxification (detox) unit and 30-day readmission rates for children and adults—represented a statewide strength. Eighty-nine percent (42 of 47) of the reported rates in the **quality** domain exceeded the respective minimum performance standards set by MDHHS (95 percent for follow-up care and 15 percent for readmission rates). Statewide rates exceeded the performance standards for all indicators in this domain. Six PIHPs met the performance standards for all reported measures in the **quality** domain, while the remaining PIHPs fell below the standard for one or two of the five indicators related to **quality** of care and services. MDHHS did not specify a minimum performance standard for the remaining indicators in this domain.

For the 2015–2016 validation cycle, the PIHPs provided the third-year submissions on their chosen topic related to the integration of physical and mental healthcare. These topics addressed the **quality** of care and services. Increased continuity of care and coordination of physical and behavioral healthcare services can result in improved **quality** of care and a more holistic experience for beneficiaries. HSAG validated Activities I through IX for the 10 PIHPs, assessing the Design, Implementation, and Outcomes stages of each PIP. Seven PIHPs received a validation status of *Met*, indicating that the PIHPs designed, conducted, and reported their projects in a methodologically sound manner—allowing real improvements in care—and achieved statistically significant improvement in the study indicator rate when compared to the baseline rate.

Timeliness

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

Table 1-3—Measures Assessing Timeliness

Measure			Statewide Score	PIHP Low Score	PIHP High Score
Compliance Monitoring Standards					
Standard II.	Performance Measurement/Improvement		100%	100%	100%
Standard V.	Utilization Management		99%	95%	100%
Standard VII.	Enrollee Grievance Process		100%	98%	100%
Standard XII.	Access and Availability		99%	94%	100%
Standard XIV.	Appeals		100%	99%	100%
Performance Measure Indicators					
Indicator 1:	Preadmission Screening	Children	99.48%	97.97%	100%
		Adults	99.51%	97.99%	100%
Indicator 2:	Face-to-Face Assessment	MI Children	98.63%	87.10%	99.59%
		MI Adults	98.79%	95.26%	99.78%
		DD Children	98.67%	89.74%	100%
		DD Adults	99.40%	94.44%	100%
		Medicaid SA	98.01%	95.32%	100%
		Total	98.45%	96.12%	99.77%
Indicator 3:	First Service	MI Children	97.22%	95.42%	100%
		MI Adults	97.70%	94.65%	100%
		DD Children	96.48%	88.24%	100%
		DD Adults	94.05%	82.86%	100%
		Medicaid SA	98.54%	95.71%	100%
		Total	97.87%	96.33%	99.75%
Indicator 4a:	Follow-Up Care	Children	98.86%	96.55%	100%
		Adults	96.72%	91.16%	99.12%
Indicator 4b:	Follow-Up Care After Detox		98.18%	90.10%	100%

Medicaid SA = Medicaid beneficiaries with substance use disorders

Statewide performance on the compliance monitoring standards in the **timeliness** domain was strong, with statewide scores of 100 percent for Standard II—Performance Measurement and Improvement, Standard VII—Enrollee Grievance Process, and Standard XIV—Appeals. Standard V—Utilization Management and Standard XII—Access and Availability achieved statewide scores of 99 percent. In this domain, the standards with the highest number of PIHPs in full compliance were Standards II and VII, with 10 and nine of the 10 PIHPs, respectively, achieving compliance scores of 100 percent on these standards. Most of the continued recommendations from the 2015–2016 compliance reviews addressed the **timeliness** domain.

Timeliness, as addressed by the validation of performance measures, continued to represent a statewide strength. Forty-four of the 50 rates addressing **timeliness** of care and services received validation findings of *Report*, reflecting full compliance with MDHHS specifications. Sixteen of the 17 indicators related to **timeliness** of care and services achieved statewide averages that exceeded the minimum performance level as specified by MDHHS, with a below-standard rate for timely first service for adults with a developmental disability. Performance on this indicator for children and adults with a developmental disability represented an opportunity for improvement, as about half of the PIHP-level rates fell below the performance standard. Three PIHPs met the minimum performance standards for all reported measures in the **timeliness** domain; and statewide, 90 percent—or 136 of 151—of reported rates in this domain met the MDHHS benchmarks.

Access

Table 1-4 displays the statewide scores and the lowest and highest scores among the PIHPs for measures assessing **access** to care and services.

Table 1-4—Measures Assessing Access

Measure			Statewide Score	PIHP Low Score	PIHP High Score
Compliance Monitoring Standards					
Standard V.	Utilization Management		99%	95%	100%
Standard VI.	Customer Services		100%	100%	100%
Standard X.	Provider Network		100%	96%	100%
Standard XII.	Access and Availability		99%	94%	100%
Standard XIII.	Coordination of Care		100%	100%	100%
Performance Measure Indicators					
Indicator 1:	Preadmission Screening	Children	99.48%	97.97%	100%
		Adults	99.51%	97.99%	100%
Indicator 2:	Face-to-Face Assessment	MI Children	98.63%	87.10%	99.59%
		MI Adults	98.79%	95.26%	99.78%
		DD Children	98.67%	89.74%	100%
		DD Adults	99.40%	94.44%	100%
		Medicaid SA	98.01%	95.32%	100%
		Total	98.45%	96.12%	99.77%
Indicator 3:	First Service	MI Children	97.22%	95.42%	100%
		MI Adults	97.70%	94.65%	100%
		DD Children	96.48%	88.24%	100%
		DD Adults	94.05%	82.86%	100%
		Medicaid SA	98.54%	95.71%	100%
		Total	97.87%	96.33%	99.75%
Indicator 4a:	Follow-Up Care	Children	98.86%	96.55%	100%
		Adults	96.72%	91.16%	99.12%

Measure		Statewide Score	PIHP Low Score	PIHP High Score
Indicator 4b:	Follow-Up Care After Detox	98.18%	90.10%	100%
Indicator 5:	Penetration Rate	7.09%	5.56%	8.00%
Performance Improvement Projects				
	All evaluation elements *Met*	97%	86%	100%
	Critical elements *Met*	94%	67%	100%

Performance on the compliance monitoring standards in the **access** domain continued to reflect another statewide strength. One of the standards in this domain (Standard VI—Customer Services) was not included in the 2015-2016 follow-up compliance reviews as all PIHPs had achieved full compliance in the prior year. The 2015–2016 follow-up compliance reviews resulted in a statewide score of 100 percent for Standard X—Provider Network and Standard XIII—Coordination of Care. Statewide scores for the remaining two standards in the **access** domain were 99 percent for Standard V—Utilization Management and Standard XII—Access and Availability. About two-thirds of the continued opportunities for improvement identified in the 2015–2016 compliance review cycle addressed this domain.

Access, as assessed by the validation of performance measures, indicated a statewide strength. Seven PIHPs received a validation designation of *Report* for all indicators related to **access** to care and services. Statewide rates for all but one of the indicators in this domain and 90 percent of the reported PIHP-level rates exceeded the respective minimum performance standards, reflecting that the PIHPs provided timely preadmission screenings, face-to-face assessments, access to ongoing services, and follow-up care after discharge from a psychiatric inpatient or detox unit.

The PIPs validated in 2015–2016 also addressed the **access** domain. Ensuring that mental health care providers have knowledge of beneficiaries' physical health issues—and implementing actions to integrate care—can improve **access** to necessary screenings, tests, and other medical services. As the methodologically sound studies progressed to the Outcomes stage, HSAG assessed whether or not the PIPs achieved real improvement. Seven of the ten PIPs achieved an overall *Met* validation status, indicating statistically significant improvement in the study indicator over the baseline rate. As the PIPs progress to reporting Remeasurement 2 results, the studies' impact on the **access**ibility of care and services will be further evaluated.

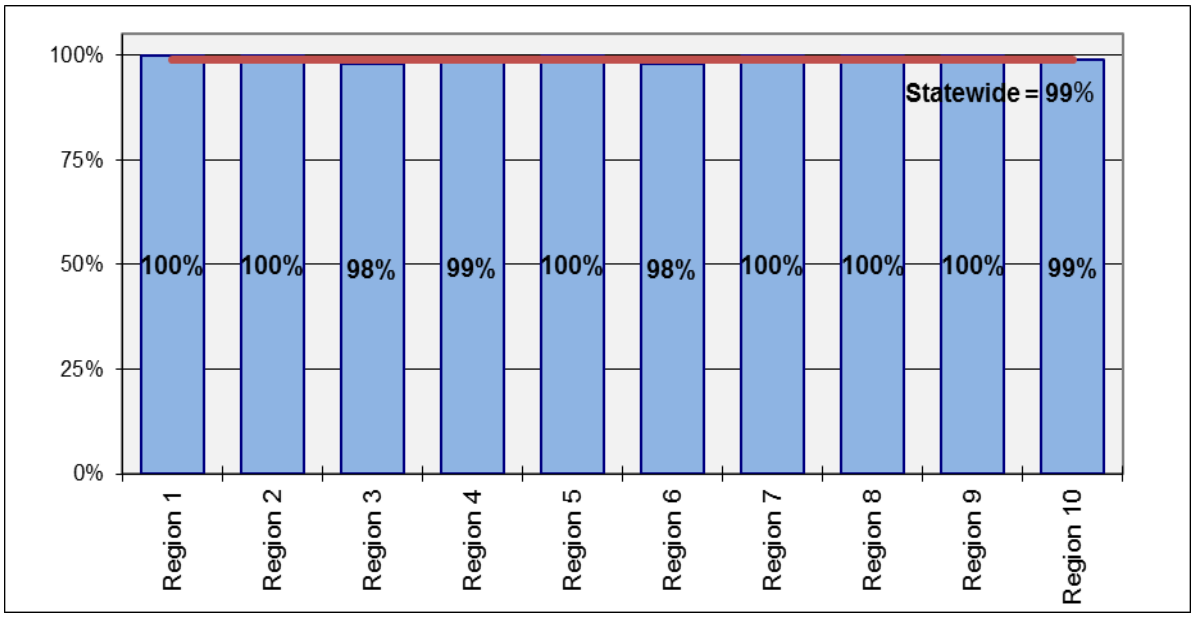
Findings for the Compliance Monitoring Reviews

The regulatory provisions addressed in the 2015–2016 follow-up compliance monitoring reviews included Quality Assessment and Performance Improvement Program (42 CFR 438.240); Quality Assessment and Performance Improvement—Access Standards, Coverage and Authorization of Services (42 CFR 438.210); Grievance System (42 CFR 438.228, 438.400–408, 438.414, and 438.416); Enrollee Rights and Information Requirements (42 CFR 438.10, 438.100, and 438.218); Subcontracts and Delegation (42 CFR 438.230); Provider Network (42 CFR 438.12, 438.106, 438.206, 438.207, and 438.214); Credentialing (42 CFR 438.12 and 438.214); Access and Availability (42 CFR 438.206); Coordination of Care (42 CFR 438.208); Appeals (42 CFR 438.402, 438.406, 438.408, and 438.410); and an additional area related but not specific to BBA regulations — Disclosure of Ownership, Control, and Criminal Convictions (42 CFR 455.104–106).

The individual PIHP follow-up compliance reviews included only those standards that had received a compliance score of less than 100 percent during the review in 2014–2015 and only those elements that had received an initial score of less than *Met*. No PIHPs required a follow-up review for Standard III—Practice Guidelines, Standard IV—Staff Qualifications and Training, or Standard VI—Customer Services as all PIHPs had demonstrated full compliance with all related requirements during the prior-year review cycle.

The overall compliance rating across all standards for the 10 PIHPs was 99 percent, with individual PIHP overall scores ranging from 98 percent to 100 percent. Scores ranging from 95 percent to 100 percent were rated *Excellent*, scores ranging from 85 percent to 94 percent were rated *Good*, scores ranging from 75 percent to 84 percent were rated *Average*, and scores of 74 percent and lower were rated *Poor*. Figure 1-1 displays 2015–2016 PIHP scores for overall compliance across all compliance monitoring standards. All 10 PIHPs performed at an overall *Excellent* level, indicating statewide strong performance on the compliance monitoring standards.

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



In the 2015–2016 follow-up compliance monitoring reviews, PIHPs demonstrated high levels of compliance with federal and contractual requirements in all areas assessed. In addition to the three standards for which all PIHPs had demonstrated full compliance with all requirements in the prior review cycle (Standard III—Practice Guidelines, Standard IV—Staff Qualifications and Training, and Standard VI—Customer Services), all 10 PIHPs achieved 100 percent compliance in the follow-up review for Standard II—Performance Measurement and Improvement, Standard VIII—Enrollee Rights and Protections, Standard XI—Credentialing, and Standard XIII—Coordination of Care.

Other standards for which all PIHPs performed at the *Excellent* level included Standard I—QAPIP Plan and Structure, Standard V— Utilization Management, Standard VII—Enrollee Grievance Process, Standard X—Provider Network, and Standard XIV—Appeals. Continued recommendations for these standards addressed collection of data for the Behavior Treatment Plan Review Committee (BTPRC); utilization management (UM) processes to review and approve services, identify and correct over- and under-utilization of services, and manage provider appeals; grievance logs; monitoring of delegated network management and appeals functions; and enrollee information about appeals processes.

For Standard IX—Subcontracts and Delegation and Standard XII—Access and Availability, nine PIHPs performed at the *Excellent* level and one PIHP performed at the *Good* level. One PIHP received a continued recommendation related to pre-delegation assessments. Of the eight PIHPs with prior-year recommendations on Standard XII, four PIHPs achieved improvement in the previously below-standard rates and in the 2015–2016 follow-up review met the respective MDHHS performance standard. The remaining four PIHPs received continued recommendations for timely access to ongoing services for children or adults with a developmental disability or timely follow-up care after discharge from a detoxification unit.

Performance on Standard XV—Disclosure of Ownership, Control, and Criminal Convictions was mixed. Seven PIHPs successfully addressed the recommendations from the 2014–2015 review and achieved compliance scores of 100 percent. Seven PIHPs performed at the *Excellent* level, one PIHP ranked at the *Good* level, and two PIHPs scored in the *Poor* range. All PIHPs demonstrated compliance with the requirements to search the Office of Inspector General (OIG) database for providers excluded from participation in federal healthcare programs and to require corrective action when monitoring of subcontractors' performance identifies deficiencies related to disclosures. However, some PIHPs should strengthen processes to ensure that contractors submit full disclosures of information about individuals with ownership or control interests and to identify and notify the State of criminal convictions as specified in the Social Security Act.[1-6]

The 2015–2016 compliance monitoring reviews identified no statewide opportunities for improvement.

[1-6] Sections 1128(a) and 1128(b)(1), (2), or (3) of the Social Security Act

Table 1-5 presents the PIHPs' combined compliance monitoring scores (percentages of compliance) after the 2015–2016 follow-up reviews for each of the 15 standards reviewed as well as an overall compliance score per region across all 15 standards.

Table 1-5—Summary of PIHP Compliance Monitoring Scores (Percentage of Compliance)

PIHP	I. QAPIP Plan and Structure	II. Performance Measurement and Improvement	III. Practice Guidelines	IV. Staff Qualifications and Training	V. Utilization Management	VI. Customer Services	VII. Enrollee Grievance Process	VIII. Enrollee Rights and Protections	IX. Subcontracts and Delegation	X. Provider Network	XI. Credentialing	XII. Access and Availability	XIII. Coordination of Care	XIV. Appeals	XV. Disclosure of Ownership	Overall
Region 1—NorthCare	*100*	*100*	*100*	*100*	*100*	*100*	*100*	*100*	*100*	*100*	*100*	**100**	*100*	**100**	**100**	**100**
Region 2—Northern MI	**100**	*100*	*100*	*100*	*100*	*100*	*100*	*100*	*100*	*100*	*100*	**94**	*100*	*100*	**100**	**100**
Region 3—Lakeshore	**100**	**100**	*100*	*100*	**99**	*100*	*100*	*100*	**94**	**96**	**100**	**100**	*100*	**100**	**50**	**98**
Region 4—Southwest MI	**99**	*100*	*100*	*100*	*100*	*100*	**100**	*100*	*100*	**100**	*100*	**97**	**100**	**99**	**94**	**99**
Region 5—Mid-State	*100*	*100*	*100*	*100*	*100*	*100*	*100*	*100*	**100**	*100*	**100**	*100*	*100*	*100*	**100**	**100**
Region 6—CMHPSM	*100*	*100*	*100*	*100*	*100*	*100*	**100**	*100*	*100*	*100*	*100*	**97**	*100*	**99**	**56**	**98**
Region 7—Detroit	*100*	*100*	*100*	*100*	*100*	*100*	*100*	**100**	*100*	*100*	*100*	**100**	*100*	*100*	**100**	**100**
Region 8—Oakland	**100**	*100*	*100*	*100*	*100*	*100*	**100**	*100*	*100*	*100*	**100**	**100**	*100*	*100*	**100**	**100**
Region 9—Macomb	*100*	*100*	*100*	*100*	*100*	*100*	*100*	*100*	*100*	*100*	*100*	**97**	**100**	*100*	**100**	**100**
Region 10 PIHP	**100**	**100**	*100*	*100*	**95**	*100*	**98**	*100*	**100**	**100**	**100**	*100*	*100*	**100**	**100**	**99**
Statewide Score	**100**	**100**	**100**	**100**	**99**	**100**	**100**	**100**	**99**	**100**	**100**	**99**	**100**	**100**	**90**	**99**

Notes: *Scores* in italics indicate that no follow-up review was required.
Scores in **bold** reflect performance after the 2015–2016 follow-up review.
Shaded cells show 2015–2016 PIHP performance below the statewide score.

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

Findings for the Validation of Performance Measures

CMS designed the validation of performance measures activity to ensure the accuracy of the results reported by the PIHPs to MDHHS. 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 MDHHS Codebook specifications.

HSAG assessed 12 performance measures for each PIHP for compliance with technical requirements, specifications, and construction. HSAG scored the performance measures as *Report* (the indicator was compliant with the State's specifications, and the rate can be reported); *Not Reported* (this designation was assigned to measures for which the rate was materially biased, or the PIHP was not required to report); or *No Benefit* (the indicator was not reported because the PIHP did not offer the benefit required by the indicator).

Table 1-6 below presents the validation results for the individual indicators that were calculated by either the PIHPs or MDHHS, as detailed in Section 2 of this report (Table 2-4).

Table 1-6—Overall Performance Indicator Compliance With MDHHS Specifications Across All PIHPs

Validation Finding	Percent
Report (R)	92%
Not Reported (NR)	8%
No Benefit (NB)	0%

Table 1-7 shows overall PIHP compliance with the MDHHS codebook specifications for each of the 12 performance measures validated by HSAG.

Table 1-7—Performance Measure Results—Validation Designation

Performance Measure		Percentage of PIHPs		
		R	*NR*	*NB*
1.	The percentage of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	80%	20%	0%
2.	The percentage of new Medicaid beneficiaries during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service.	80%	20%	0%
3.	The percentage of new Medicaid beneficiaries during the quarter starting any needed ongoing service within 14 days of a non-emergent face-to-face assessment with a professional.	100%	0%	0%
4a.	The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.	90%	10%	0%
4b.	The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.	90%	10%	0%
5.	The percent of Medicaid recipients having received PIHP managed services.	100%	0%	0%

Performance Measure		Percentage of PIHPs		
		R	*NR*	*NB*
6.	The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	100%	0%	0%
8.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who are employed competitively.	90%	10%	0%
9.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.	90%	10%	0%
10.	The percentage of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.	100%	0%	0%
13.	The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	90%	10%	0%
14.	The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	90%	10%	0%

R = Report, NR = Not Reported, NB= No Benefit

HSAG validated the performance measures for each PIHP. Four of the 12 measures (Indicators 3, 5, 6, and 10) received a validation designation of *Report* for all 10 PIHPs, reflecting that the PIHPs demonstrated compliance with technical requirements and specifications for the collection and reporting of these performance indicators. Indicators 1 and 2 had a validation designation of *Not Reported* for two PIHPs. Nine of the ten PIHPs received validation ratings of *Report* for Indicators 4a, 4b, 8, 9, 13, and 14. Overall, seven of the 10 PIHPs received a validation designation of *Report* for all 12 performance indicators.

HSAG validated the data integration and control process used by the PIHPs and determined that, statewide, the processes in place were acceptable. Overall, the PIHPs had sufficient and complete documentation of performance indicator calculations. PIHPs with regions spanning multiple counties provided adequate oversight of the affiliated community mental health centers and in some cases strengthened monitoring processes to ensure accuracy and completeness of data submitted to the State. Statewide, the PIHPs demonstrated compliance with requirements for receiving and processing eligibility data, claims, and encounters. Due to implementation of a new process to collect demographic data, MDHHS did not require the PIHPs to meet the 95 percent completeness requirement for the first quarter of SFY 2016. For the reporting period of SFY 2015, six PIHPs met the MDHHS requirement for data completeness for age, disability designation, employment status, and minimum wage, while the remaining four PIHPs each fell below the standard for one of these data elements.

Continued strengths for the PIHPs included a strong commitment to performance indicator and quality improvement data reporting. Several PIHPs added new staff members who had experience with behavioral health data and who were familiar with performance indicator calculation processes, quality improvement measures, and data reporting requirements. The PIHPs' claims

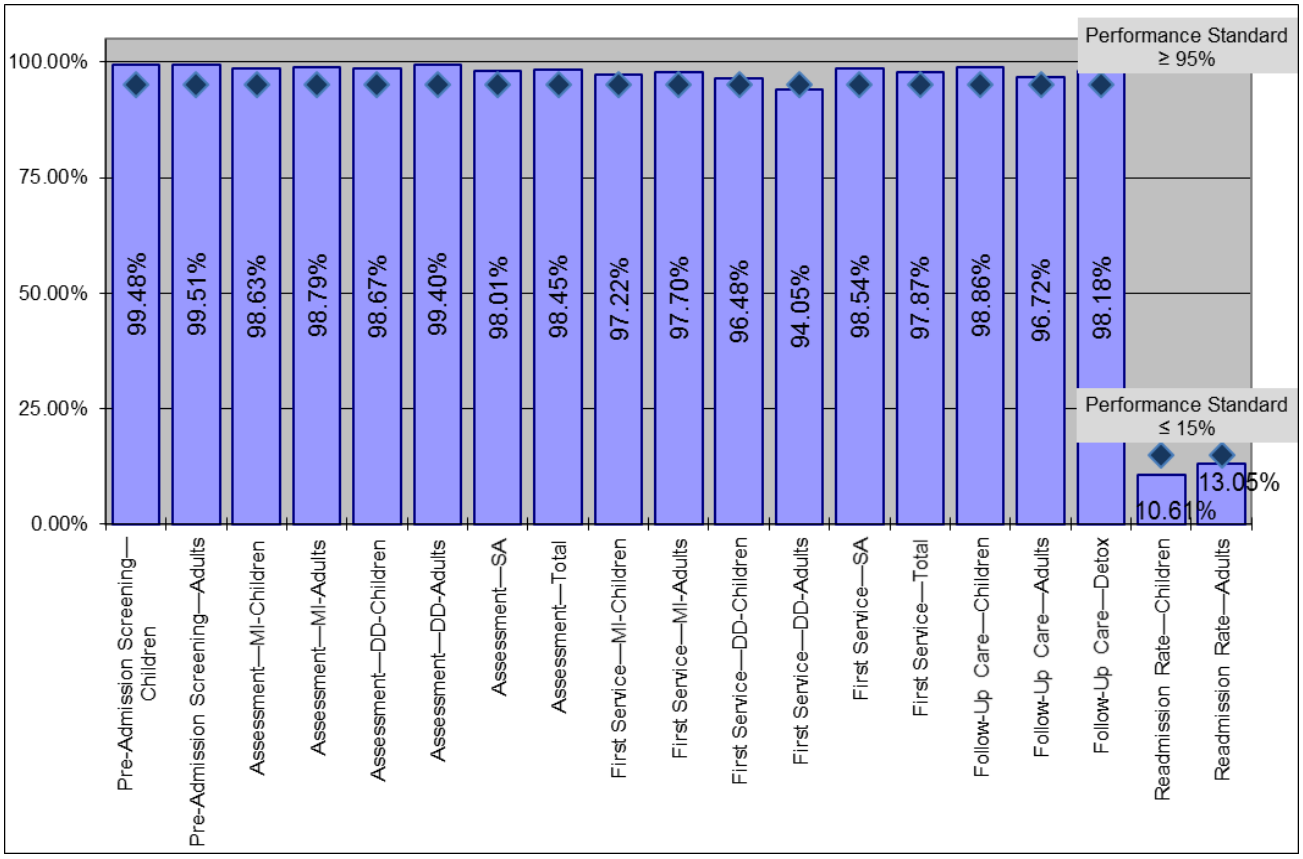
systems were successfully modified to accept only ICD-10 codes for claims with dates of service on or after October 1, 2015.

Opportunities for improvement identified in the 2015–2016 validation cycle included the following: Several PIHPs should strengthen oversight activities to ensure data completeness and accuracy. Some PIHPs received recommendations to improve processes for indicator rate calculation and reporting. In October 2015, the previously submitted quality improvement data files were replaced with the Behavioral Health Treatment Episode Data Set (BH-TEDS) data files. Completeness of BH-TEDS data was identified as an area for improvement for some PIHPs.

Statewide rates were calculated by summing the number of cases that met the requirements of the indicator across all PIHPs (e.g., for all 10 PIHPS, the total number of adults who received a timely follow-up service) and dividing this number by the number of applicable cases across all PIHPs (e.g., for all 10 PIHPS, the total number of adults discharged from psychiatric inpatient facilities). This calculation excluded any rates with an *NR* validation finding designation; therefore, the number of PIHPs included in the statewide rates was reduced for some indicators: eight PIHPs for Indicators 1 and 2 and nine PIHPs for Indicators 4, 8, 9, 13, and 14. MDHHS did not specify a standard for Indicators 5, 6, 8, 9, 10, 13, or 14.

Statewide performance exceeded the MDHHS-established minimum performance standards for all indicators except one (Indicator 3—Timeliness of First Service for Adults with a Developmental Disability), as shown in Figure 1-2.

Figure 1-2—Statewide Rates for Performance Measures



Continued strong performance resulted in statewide rates that exceeded the MDHHS benchmark for 18 of the 19 indicators. Only Indicator 3—Timeliness of First Service fell below the 95 percent standard for adults with a developmental disability (DD) (94.05 percent). Indicator 1—Pre-Admission Screenings showed the highest statewide rates with 99.48 percent for children and 99.51 percent for adults. Performance on Indicator 2—Face-to-Face Assessments (total rate of 98.45 percent and rates ranging from 99.40 percent for developmentally disabled adults to 98.01 percent for beneficiaries with a substance use disorder) was also strong. Readmission rates (Indicator 10) represented another statewide area of strength, with statewide rates meeting the performance standard of 15 percent or less.

Compared to performance in the prior validation cycle, most statewide rates for indicators with a specified minimum performance indicator remained essentially unchanged with a change in rate of about 1 percent or less. However, the readmission rate for children and the rate for timely follow-up care after discharge from a detox unit indicators demonstrated a more marked increase of 2 percent and over 5 percent, respectively. The rate for timely first service for children with a developmental disability dropped by almost 2 percent, while the rate for developmentally disabled adults saw a decrease of almost 4 percent, resulting in a below-standard rate for this indicator. Statewide rates for competitive employment and minimum wage saw increases up to almost 4 percent, and living in private residences increased by over 4 percent for adults with a mental illness; while the rate for developmentally disabled adults declined by 2 percent.

Table 1-8 and Table 1-9 display the 2015–2016 results for the validated performance indicators for each PIHP. Most indicators (Indicators 1 through 6 and Indicator 10) were reported and validated for first quarter SFY 2016. Indicators 8, 9, 13, and 14 were reported and validated for SFY 2015.

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

Table 1-8—PIHP Performance Measure Percentage Scores

PIHP	1. Timeliness/ Inpatient Screening		2. Timeliness/ Face-to-Face Assessment						3. Timeliness/ First Service						4. Continuity of Care		
	Children	Adults	MI—Children	MI—Adults	DD—Children	DD—Adults	Medicaid SA	Total	MI—Children	MI—Adults	DD—Children	DD—Adults	Medicaid SA	Total	Follow-Up Care—Children	Follow-Up Care—Adults	Follow-Up Care—Detox
Region 1—NorthCare	100	99.55	98.32	99.30	100	***94.44***	95.32	96.99	99.07	95.10	***88.24***	100	100	98.56	100	95.74	95.24
Region 2—Northern MI	97.97	99.07	99.38	99.11	100	100	95.82	98.09	95.81	98.68	***93.75***	***90.48***	95.71	96.33	97.14	95.87	95.12
Region 3—Lakeshore	98.34	97.99	99.59	99.70	100	100	100	99.77	97.26	98.46	***94.29***	***94.74***	97.40	97.46	96.92	97.86	98.73
Region 4—Southwest MI	99.43	99.54	98.77	98.58	100	100	100	98.87	95.42	97.39	100	***90.00***	100	97.35	100	***91.16***	100
Region 5—Mid-State	99.80	99.72	98.92	99.78	100	100	98.38	99.10	96.30	97.69	98.00	98.08	100	98.40	97.53	98.14	100
Region 6—CMHPSM	100	99.81	98.35	96.59	100	100	96.43	96.98	100	100	100	96.15	96.56	97.60	96.55	98.73	***90.10***
Region 7—Detroit	*NR*	*NR*	98.49	97.19	99.06	100	98.32	98.19	98.01	96.20	97.22	95.24	98.62	97.78	100	96.33	*NR*
Region 8—Oakland	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	100	99.80	100	100	99.58	99.75	*NR*	*NR*	99.20
Region 9—Macomb	100	100	***87.10***	95.26	***89.74***	96.00	98.04	96.12	97.81	***94.65***	***93.18***	***82.86***	98.74	97.00	98.31	96.07	98.52
Region 10 PIHP	100	100	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	96.34	98.93	100	***93.75***	98.11	97.90	100	99.12	100
Statewide Rate	99.48	99.51	98.63	98.79	98.67	99.40	98.01	98.45	97.22	97.70	96.48	94.05	98.54	97.87	98.86	96.72	98.18
MDHHS Standard	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%

Notes: Rates in ***blue*** font indicate performance not meeting the MDHHS minimum performance standard. *NR*: Rate could not be reported.

Table 1-9—PIHP Performance Measure Percentage Scores

PIHP	5.	6.	8. Competitive Employment			9. Minimum Wage			10. Inpatient Recidivism		13/14. Private Residence	
	Penetration Rate	HSW Rate	MI—Adults	DD—Adults	MI/DD Adults	MI—Adults	DD—Adults	MI/DD Adults	Children	Adults	DD— Adults	MI—Adults
Region 1—NorthCare	7.87	99.72	15.00	5.99	5.60	86.49	33.57	44.92	0.00	13.33	18.80	49.06
Region 2—Northern MI	8.00	99.37	12.90	13.97	13.18	77.27	45.76	56.27	6.52	10.93	25.04	53.03
Region 3—Lakeshore	5.78	97.35	13.01	8.10	8.28	80.53	34.65	37.55	7.32	7.55	10.19	39.10
Region 4—Southwest MI	7.01	98.94	14.68	7.92	7.01	73.74	42.86	40.00	6.98	9.12	16.95	49.46
Region 5—Mid-State	7.28	95.40	13.73	8.33	7.29	83.67	33.45	37.81	6.31	9.18	16.82	45.91
Region 6—CMHPSM	7.46	98.31	14.03	10.22	7.99	76.05	60.48	66.67	13.51	13.11	24.70	28.57
Region 7—Detroit	7.41	98.96	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	***15.38***	***17.05***	*NR*	*NR*
Region 8—Oakland	7.80	99.40	14.73	14.16	11.18	62.12	40.64	29.70	0.00	11.02	18.73	34.46
Region 9—Macomb	5.56	99.79	11.45	5.08	4.93	80.93	37.50	29.60	14.52	***19.31***	13.52	29.76
Region 10 PIHP	7.37	99.54	7.84	5.32	4.82	70.44	15.89	20.47	9.28	14.48	9.26	42.65
Statewide Rate	7.09	98.26	13.17	9.18	7.76	76.86	36.95	37.59	10.61	13.05	16.66	42.29
MDHHS Standard	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	≤15%	≤15%	*NA*	*NA*

Notes: Rates in ***blue*** font indicate performance not meeting the MDHHS minimum performance standard. *NR*: Rate could not be reported. *NA*: Not Applicable

Findings for the Validation of Performance Improvement Projects

For each PIHP, HSAG validated one PIP based on CMS' protocol. For the current validation cycle, the PIHPs provided third-year submissions on their PIP topics related to the integration of physical and mental healthcare. Table 1-10 presents a summary of the 2015–2016 PIP validation status results. Seven of the 10 PIPs (70 percent) each received an overall validation status of *Met*.

Table 1-10—PIP Validation Status

Validation Status	Number of PIHPs
Met	7
Partially Met	0
Not Met	3

Table 1-11 presents a statewide summary of the PIHPs' 2015–2016 validation results for each of the CMS PIP protocol activities.

Table 1-11—Summary of Data From Validation of Performance Improvement Projects

Review Activity		Number of PIPs Meeting All Evaluation Elements/ Number Reviewed	Number of PIPs Meeting All Critical Elements/ Number Reviewed
Design			
I.	Appropriate Study Topic	10/10	10/10
II.	Clearly Defined, Answerable Study Question(s)	10/10	10/10
III.	Correctly Identified Study Population	10/10	10/10
IV.	Clearly Defined Study Indicator(s)	10/10	10/10
V.	Valid Sampling Techniques*	*NA*	*NA*
VI.	Accurate/Complete Data Collection**	9/10	0/10
Implementation and Evaluation			
VII.	Sufficient Data Analysis and Interpretation	8/10	9/10
VIII.	Appropriate Improvement Strategies	7/10	9/10
Outcomes			
IX.	Real Improvement Achieved	8/10	8/10
X.	Sustained Improvement Achieved	Not Assessed	No Critical Elements

*HSAG scored all elements for Activity V as *Not Applicable (NA)* for all PIPs.
** HSAG scored the critical element in Activity VI as *NA* for nine of the 10 PIPs.

For the 2015–2016 validation cycle, HSAG validated Activities I through IX for all PIPs. All elements in Activity V received ratings of *Not Applicable* across all PIPs as the studies did not use sampling.

The PIHPs continued with their PIPs related to the integration of physical and mental healthcare. For the 2015–2016 validation cycle, the PIHPs completed the Design stage of the PIPs (which included Activities I–VI), the Implementation stage, (which included Activities VII and VIII), and advanced to the Outcomes stage, completing Activity IX. Performance on the activities of the first two stages of the PIPs represented a statewide strength.

The initial validation of the 2015–2016 PIP submissions identified opportunities for improvement primarily in Activity VII—Sufficient Data Analysis and Interpretation and Activity VIII—Appropriate Improvement Activities. Recommendations from the initial validation included discussing possible threats to the validity of the Remeasurement 1 data, strengthening the interpretation of findings, and documenting how the interventions were evaluated for effectiveness. Five of the ten PIHPs resubmitted PIPs after receiving technical assistance and correcting the identified deficiencies, thus improving validation results.

As the PIPs were outcome-focused, the study indicators had to demonstrate statistically significant improvement from the baseline in order for the PIP to achieve an overall *Met* validation status. The validation of the 2015–2016 PIP submissions resulted in an overall validation status of *Met* for seven PIPs, indicating that the PIHPs designed scientifically sound studies supported by the use of key research principles and identified barriers using quality improvement tools such as brainstorming, fishbone diagrams, and data mining. The PIHPs implemented interventions likely to impact outcomes and achieved statistically significant improvement in the study indicators from baseline to Remeasurement 1. Successful interventions included enhancements to the medical record systems or reports to facilitate documentation and tracking of events related to the study indicator; education and training for providers, staff, and beneficiaries on aspects of the PIPs; and focus on improving care coordination between the PIHP staff and primary care providers. Five PIPs, each with a validation status of *Met*, received a score of 100 percent *Met* for all evaluation elements and all critical elements. Three PIPs had *Not Met* validation statuses, as two studies failed to achieve statistically significant improvement and the third—while achieving statistically significant improvement—did not provide all required information for the causal/barrier analysis and evaluation of interventions.

For the 2015–2016 validation, the PIHPs completed the final step in Activity VIII—Appropriate Improvement Strategies, requiring an evaluation of the effectiveness of the implemented improvement strategies. The PIP submissions provided examples of effective process evaluations, using the Plan-Do-Study-Act cycle and other methods to assess the success of the interventions. Some PIHPs did not fully meet that requirement and should address the recommendations to evaluate each intervention for effectiveness; provide the results of that evaluation; and use those results to make decisions about continuing, discontinuing, or revising interventions.

For the next annual validation cycle, the PIHPs will progress to reporting Remeasurement 2 results. PIHPs that achieved statistically significant improvement from baseline to Remeasurement 1 will be assessed for sustained improvement, while the remaining PIHPs will be assessed for statistically significant improvement from baseline to Remeasurement 2.

Table 1-12 presents the results of the 2015–2016 PIP validation.

Table 1-12—PIP Validation Results by PIHP

PIHP	% of All Elements *Met*	% of All Critical Elements *Met*	Overall Validation Status
Region 1—NorthCare	96%	88%	*Not Met*
Region 2—Northern MI	100%	100%	*Met*
Region 3—Lakeshore	100%	100%	*Met*
Region 4—Southwest MI	92%	100%	*Met*
Region 5—Mid-State	100%	100%	*Met*
Region 6—CMHPSM	96%	100%	*Met*
Region 7—Detroit	100%	100%	*Met*
Region 8—Oakland	100%	100%	*Met*
Region 9—Macomb	86%	67%	*Not Met*
Region 10 PIHP	96%	88%	*Not Met*

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

Conclusions

Findings from the 2015–2016 EQR activities reflected continued improvement in the **quality** and **timeliness** of, and **access** to, care and services provided by the PIHPs. Across all three EQR activities, the PIHPs demonstrated strong performance and high levels of compliance with federal, State, and contractual requirements related to the provision of care to beneficiaries.

Results from the 2015–2016 follow-up compliance monitoring review reflected high levels of compliance across all standards. After the follow-up review, all 10 PIHPs demonstrated full compliance with Standard II—Performance Measurement and Improvement, Standard VIII—Enrollee Rights and Protections, Standard XI—Credentialing, and Standard XIII—Coordination of Care. Ninety-seven percent (145/150) of the compliance scores fell within the *Excellent* range. The PIHPs demonstrated having implemented corrective actions to address recommendations from the 2014–2015 compliance review. Continued recommendations identified in the 2015–2016 follow-up compliance review addressed primarily standards in the **timeliness** domain: Standard V—Utilization Management and Standard XII—Access and Availability. The findings indicated that, overall, the PIHPs achieved compliance with the federal and State requirements addressed in this review cycle and demonstrated strong performance across the domains of **quality**, **timeliness**, and **access**.

Results from the validation of performance measures reflected continued compliance with technical requirements and specifications in the collection and reporting of performance indicators, resulting in most indicators being fully compliant with MDHHS specifications across the PIHPs. Reported rates for this validation cycle continued to demonstrate strong performance across the three domains of **quality**, **timeliness**, and **access**; with 18 of the 19 statewide rates and 89 percent of individual PIHP-level rates exceeding the respective MDHHS benchmark for the indicator.

For the 2015–2016 validation cycle, HSAG validated Activities I–IX in the Design, Implementation, and Outcomes stages of the PIPs, focusing on improving the quality of care by identifying and documenting risk factors for co-morbid physical conditions and monitoring whether or not beneficiaries received care and services for those conditions. The studies demonstrated high levels of compliance with the requirements of the CMS PIP protocol for the validated activities, reflected in a validation status of *Met* for seven of the 10 PIPs. The results of the 2015–2016 validation suggest that the PIHPs designed scientifically sound studies to measure outcomes for the integration of physical and mental healthcare, completed causal/barrier analyses using quality improvement tools, and implemented interventions likely to impact outcomes. Most PIPs demonstrated statistically significant improvement in the study indicators from baseline to the first remeasurement. The next annual validation will assess for each PIP whether or not repeated measurements over comparable time periods demonstrated sustained improvement over the baseline, or—for PIPs that did not show statistically significant improvement at Remeasurement 1—compare baseline rates with the respective Remeasurement 2 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.

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

Compliance Monitoring

Objectives

Private accreditation organizations, state licensing and Medicaid agencies, and the federal Medicare program all recognize that having standards is only the first step in promoting safe and effective healthcare. Making sure that the standards are followed is the second step. According to 42 CFR 438.358, a state or its EQRO must conduct a review within a three-year period to determine the PIHPs' compliance with standards for access to care, structure and operations, and quality measurement and improvement. To complete this requirement, HSAG, through its EQRO contract with the State of Michigan, performed compliance monitoring reviews of the 10 PIHPs with which the State contracts.

The prior year 2014–2015 compliance monitoring reviews evaluated the PIHPs' compliance with selected federal and State regulations and contractual requirements related to the following standards:

- Standard I—QAPIP Plan and Structure
- Standard II—Performance Measurement and Improvement
- Standard III—Practice Guidelines
- Standard IV—Staff Qualifications and Training
- Standard V—Utilization Management
- Standard VI—Customer Services
- Standard VII—Enrollee Grievance Process
- Standard VIII—Enrollee Rights and Protections
- Standard IX—Subcontracts and Delegation
- Standard X—Provider Network
- Standard XI—Credentialing
- Standard XII—Access and Availability
- Standard XIII—Coordination of Care
- Standard XIV—Appeals
- Standard XV—Disclosure of Ownership, Control, and Criminal Convictions

The 2015–2016 follow-up reviews evaluated the PIHPs' progress in achieving compliance with federal and State regulations and contractual requirements related to those elements on the standards listed preceding that scored less than *Met* in the previous review of the standard. No PIHPs required any follow-up on Standard III—Practice Guidelines, Standard IV—Staff Qualifications and Training, or Standard VI—Customer Services as all PIHPs had achieved 100 percent compliance during the previous compliance reviews.

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

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

The results from these reviews will provide an opportunity to inform MDHHS and the PIHPs of areas of strength and any corrective actions needed.

Technical Methods of Data Collection

Prior to beginning compliance reviews of the PIHPs, HSAG developed standardized tools for use in the reviews. The content of the tools was based on applicable federal and State laws and regulations and the requirements set forth in the contract agreement between MDHHS and the PIHPs. The review processes and scoring methodology used by HSAG in evaluating the PIHPs' compliance were consistent with the Centers for Medicare & Medicaid Services (CMS) publication, *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[2-1] For the 2015–2016 follow-up compliance reviews, the tools were customized for each PIHP, based on each PIHP's performance in 2014–2015, to include only those standards for which the PIHP had scored less than 100 percent and only those elements for which the PIHP had scored *Substantially Met*, *Partially Met*, or *Not Met*.

For each of the PIHP reviews in 2015–2016, HSAG followed the same basic steps:

- **Pre-review Activities:** In addition to scheduling the follow-up review and developing the review agenda, HSAG conducted the key pre-review activity of requesting and reviewing various documents to demonstrate the implementation of the corrective action plan developed in response to the 2014–2015 review (policies, consumer materials, subcontracts, etc.) and the customized comprehensive EQR compliance review tool—the *Documentation Request and Evaluation Tool*. The focus of the desk review was to identify compliance with BBA and MDHHS contractual rules and regulations.
- **Record Reviews:** The 2015–2016 follow-up reviews included no record reviews.

[2-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html. Accessed on: Feb 19, 2013.

- **Compliance Monitoring Reviews:** The 2015–2016 compliance monitoring reviews were conducted via telephone conference calls between key PIHP staff and the HSAG review team. The telephonic reviews included an opening statement to detail the review process and objectives, followed by discussions with key PIHP staff to evaluate the implementation of the corrective action plans and the degree of compliance for each standard and element included in the follow-up review, and then concluded with a closing statement.
- **Compliance Monitoring Report:** After completing the review, analysis, and scoring of the information obtained from the desk audit and the telephonic interviews, HSAG prepared a report of the compliance monitoring review findings and—when applicable— recommendations for improvement for each PIHP.
- Based on the findings, each PIHP that did not receive a score of *Met* for all elements reviewed was required to submit a performance improvement plan to MDHHS for any standard element not fully compliant. HSAG provided these PIHPs with a template for their corrective action plans.

Description of Data Obtained

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

- Committee meeting agendas, minutes, and handouts.
- Policies and procedures.
- The Quality Assessment and Performance Improvement Program (QAPIP) plan, work plan, and annual evaluation.
- Management/monitoring reports.
- Provider service and delegation agreements and contracts.
- The provider manual and directory.
- The consumer handbook and informational materials.
- Consumer satisfaction results.
- Correspondence.

Interviews with PIHP staff (e.g., PIHP leadership, customer services staff, utilization management staff, etc.) provided additional information. Table 2-1 lists the PIHP data sources used in the compliance determinations and the time period to which the data applied.

Table 2-1—Description of PIHP Data Sources

Data Obtained	Time Period to Which the Data Applied
Desk Review Documentation	Date of Corrective Action Plan to Date of Review
Information From Interviews Conducted	Date of Corrective Action Plan to Date of Review

Data Aggregation, Analysis, and How Conclusions Were Drawn

Reviewers used the compliance monitoring tools to document findings regarding PIHP compliance with the standards. Based on the evaluation of findings, reviewers noted compliance with each element. The compliance monitoring tool listed the score for each element evaluated.

Findings for the Access and Availability standard were derived from the Michigan Mission-Based Performance Indicator System—Access Domain, Indicators 1 through 4.b. The PIHPs routinely reported quarterly performance data to MDHHS. HSAG calculated an aggregated rate across the three reporting quarters from January through September 2015.

HSAG evaluated and scored each element addressed in the compliance monitoring review as *Met (M)*, *Substantially Met (SM)*, *Partially Met (PM)*, *Not Met (NM)*, or *Not Applicable (NA)*, except that *Substantially Met* was not applicable to the Access and Availability standard. HSAG determined the overall score for each standard by totaling the number of *Met* (value: 1 point) elements from both the 2014–2015 and 2015–2016 reviews and the number of *Substantially Met* (0.75 points), *Partially Met* (0.50 points), *Not Met* (0.00 points), and *Not Applicable* (0.00 points) elements for the standard from the follow-up review, then dividing the summed score by the total number of applicable elements for that standard. Using the same methodology, HSAG determined the overall score across all standards for each PIHP and the statewide scores, summing the values of the ratings and dividing that sum by the total number of applicable elements.

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

Table 2-2—Assignment of Compliance Monitoring Standards to Performance Domains

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

The compliance monitoring reviews addressed an additional standard (Standard XV—Disclosure of Ownership, Control, and Criminal Convictions), which was not related to any of the domains and was therefore not included in Table 2-2.

Validation of Performance Measures

Objectives

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

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

HSAG validated a set of 12 performance indicators developed and selected by MDHHS for validation. Six of these indicators were to be reported by the PIHPs quarterly, with MDHHS calculating the remaining six. The majority of the performance indicators were reported and validated for the first quarter of the Michigan SFY 2016, as shown in Table 2-4.

Technical Methods of Data Collection and Analysis

HSAG conducted the performance measure validation activities in accordance with CMS guidelines in *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.

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

- **Pre-audit Strategy**
  - HSAG obtained a list of the indicators that were selected by MDHHS for validation. Indicator definitions and reporting templates were also provided by MDHHS for review by the HSAG validation team. Based on the indicator definitions and reporting guidelines, HSAG developed indicator-specific worksheets derived from Attachment I of the CMS performance measure validation protocol.
  - HSAG prepared a documentation request, which included the Information Systems Capabilities Assessment Tool (ISCAT), Appendix V of the CMS performance measure validation protocol, PMV activity timeline, list of performance indicators selected by MDHHS for validation, and helpful tips for ISCAT completion. Working in collaboration with MDHHS and PIHP participants, HSAG customized the ISCAT to collect the necessary data consistent with Michigan's mental health service delivery model. The ISCAT was forwarded to each PIHP with a timetable for completion and instructions for submission. A mini version of the ISCAT was also received for each CMHSP. HSAG fielded ISCAT-related questions directly from the PIHPs during the pre-on-site phase.
  - HSAG prepared an agenda describing all on-site visit activities and indicating the type of staff needed for each session. The agendas were forwarded to the respective PIHPs

approximately one month prior to the on-site visit. When requested, HSAG conducted pre-on-site conference calls with the PIHPs to discuss any outstanding ISCAT questions and on-site visit activities.

- Upon receiving the completed ISCATs/mini-ISCATs from the PIHPs/CMHSPs, HSAG conducted a desk review of the tool and any supporting documentation submitted by the PIHPs. HSAG identified any potential issues, concerns, or items that required additional clarification. HSAG also conducted a line-by-line review of the source code submitted by the PIHPs/MDHHS for the performance indicators.
- HSAG reviewed the PIHP performance indicator reports provided by MDHHS for the specified measurement period (i.e., first quarter SFY 2016). HSAG used previous reports to assess trending patterns and rate reasonability.

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

Description of Data Obtained

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

- Information Systems Capabilities Assessment Tool—HSAG received this tool from each PIHP. The completed ISCATs provided HSAG with background information on MDHHS's and the PIHPs' policies, processes, and data in preparation for the on-site validation activities.
- Source Code (Programming Language) for Performance Measures—HSAG obtained source code from each PIHP (if applicable) and MDHHS (for the indicators calculated by MDHHS). If the PIHP did not produce source code to generate the performance indicators, they submitted a description of the steps taken for measure calculation from the point the service was rendered through the final calculation process. HSAG reviewed the source code or process description to determine compliance with the performance indicator specifications provided by MDHHS.
- Previous Performance Measure Results Reports—HSAG obtained these reports from MDHHS and reviewed the reports to assess trending patterns and rate reasonability.
- Supporting Documentation—This documentation provided additional information needed by HSAG reviewers to complete the validation process, including performance measure definitions, file layouts, system flow diagrams, system log files, policies and procedures, data collection process descriptions, and file consolidations or extracts.
- Current Performance Measure Results—HSAG obtained the calculated results from MDHHS and each of the PIHPs.
- On-site Interviews and Demonstrations—HSAG also obtained information through interaction, discussion, and formal interviews with key PIHP and MDHHS staff members, as well as through onsite systems demonstrations.

Table 2-3 displays the data sources HSAG obtained for the validation of performance measures activities and the time period to which the data applied.

Table 2-3—Description of Data Sources

Data Obtained	Time Period to Which the Data Applied
ISCAT and mini-ISCAT(s), if applicable (From PIHPs)	SFY 2015
Source Code/Programming Language for Performance Measures (From PIHPs and MDHHS) or Description of the Performance Measure Calculation Process (From PIHPs)	SFY 2015
Previous Performance Measure Results Reports (From MDHHS)	SFY 2015
Performance Measure Results (From PIHPs and MDHHS)	First Quarter SFY 2016
Supporting Documentation (From PIHPs and MDHHS)	SFY 2015
On-site Interviews and Systems Demonstrations (From PIHPs and MDHHS)	During site visit

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

Table 2-4—List of Performance Indicators for PIHPs

	Indicator	Calculation by:	Validation Review Period
1.	The percentage of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	PIHP	First Quarter SFY 2016
2.	The percentage of new Medicaid beneficiaries during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service.	PIHP	First Quarter SFY 2016
3.	The percentage of new Medicaid beneficiaries during the quarter starting any needed ongoing service within 14 days of a non-emergent face-to-face assessment with a professional.	PIHP	First Quarter SFY 2016
4a.	The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.	PIHP	First Quarter SFY 2016
4b.	The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.	PIHP	First Quarter SFY 2016
5.	The percentage of Medicaid recipients having received PIHP managed services.	MDHHS	First Quarter SFY 2016
6.	The percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	MDHHS	First Quarter SFY 2016
8.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who are employed competitively.	MDHHS	SFY 2015
9.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who earn minimum wage or more from employment activities.	MDHHS	SFY 2015
10.	The percentage of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.	PIHP	First Quarter SFY 2016
13.	The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	MDHHS	SFY 2015
14.	The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	MDHHS	SFY 2015

Data Aggregation, Analysis, and How Conclusions Were Drawn

Based on all validation activities, HSAG determined results for each performance measure. As set forth in the CMS protocol, HSAG assigned a validation finding of *Report (R), Not Reported (NR),* or *No Benefit (NB)* for each performance measure. HSAG based each validation finding on the magnitude of errors detected for the measure's evaluation elements, not by the number of elements determined to be not compliant based on the review findings. Consequently, it was possible that an error for a single element resulted in a designation of *NR* because the impact of the error biased the reported performance measure by more than 5 percentage points. Conversely, it was also possible that several element errors had little impact on the reported rate and HSAG gave the indicator a designation of *R*.

After completing the validation process, HSAG prepared a report of the performance measure validation review findings, which included recommendations for each PIHP reviewed. HSAG forwarded these reports, which complied with 42 CFR 438.364, to MDHHS and the appropriate PIHPs.

To draw conclusions and make overall assessments about the **quality** and **timeliness** of and **access** to care provided by the PIHPs using the results of the performance measures (as described in Section 3), HSAG assigned each of the standards to one or more of the three domains, as depicted in Table 2-5.

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

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

	Indicator	Quality	Timeliness	Access
8.	The percentage of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who are employment competitively.	✓		
9.	The percentage of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who earned minimum wage or more from employment activities.	✓		
10.	The percentage of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.	✓		
13.	The percentage of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	✓		
14.	The percentage of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	✓		

Validation of Performance Improvement Projects

Objectives

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

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

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

For each PIHP, HSAG performed validation activities on one PIP. For the 2015–2016 validation cycle, all PIHPs submitted a continuing statewide PIP on integrating behavioral health and physical healthcare. HSAG provided technical assistance to the PIHPs as requested. The technical assistance sessions provided an opportunity for the PIHPs to ask questions and obtain assistance for conducting a successful PIP. The PIHPs had the opportunity to receive initial PIP validation scores (shown as *Submission* scores in Section 3 of this report), request additional technical assistance from HSAG, make corrections to PIP submissions, and resubmit the PIPs for second reviews. After the second validation, HSAG finalized the scores (shown as *Resubmission* scores in Section 3 of this report).

Technical Methods of Data Collection and Analysis

HSAG based the methodology it used to validate PIPs on CMS guidelines as outlined in the Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[2-2] Using this protocol, HSAG, in collaboration with MDHHS, 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.

[2-2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html. Accessed on: Feb 19, 2013.

HSAG, with MDHHS' input and approval, developed a PIP Validation Tool to ensure uniform validation of PIPs. Using this tool, HSAG evaluated each of the PIPs according to the CMS protocols. The CMS protocols identify 10 activities that should be validated for each PIP, although in some cases the PIP may not have progressed to the point where all of the activities can be validated.

These activities are:

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

Description of Data Obtained

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

Table 2-6—Description of PIHP Data Sources

Data Obtained	Time Period to Which the Data Applied
PIP Summary Form (completed by the PIHP)	SFY 2016

Data Aggregation, Analysis, and How Conclusions Were Drawn

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

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

The percentage score for all evaluation elements was calculated by dividing the number of elements (including critical elements) *Met* by the sum of evaluation elements *Met*, *Partially Met*, and *Not Met*. The percentage score for critical elements *Met* was calculated by dividing the number of critical elements *Met* by the sum of critical elements *Met*, *Partially Met*, and *Not Met*. The scoring methodology also included the *Not Applicable* designation for situations in which the evaluation element did not apply to the PIP. For example, in Activity V, if the PIP did not use sampling

techniques, HSAG would score the evaluation elements in Activity V as *Not Applicable*. HSAG used the *Not Assessed* scoring designation when the PIP had not progressed to the remaining activities in the CMS protocol. HSAG used a *Point of Clarification* when documentation for an evaluation element included the basic components to meet requirements for the evaluation element (as described in the narrative of the PIP), but enhanced documentation would demonstrate a stronger application of CMS protocols.

The validation status score was based on the percentage score and whether or not critical elements were *Met*, *Partially Met*, or *Not Met.* Due to the importance of critical elements, any critical element scored as *Not Met* would invalidate a PIP. Critical elements that were *Partially Met* and noncritical elements that were *Partially Met* or *Not Met* would not invalidate the PIP, but they would affect the overall percentage score (which indicates the percentage of the PIP's compliance with CMS' protocol for conducting PIPs).

The scoring methodology was designed to ensure that critical elements are a must-pass step. If at least one critical element was *Not Met*, the overall validation status was *Not Met*. HSAG's outcomes-focused validation methodology placed greater emphasis on outcomes. For the PIP to receive an overall *Met* validation status, the improvement must be statistically significant over the baseline across all study indicators. In addition, the methodology addressed the potential situation in which all critical elements were *Met* but suboptimal performance was observed for noncritical elements. The final outcome would be based on the overall percentage score.

HSAG assessed the implications of the study's findings on the likely validity and reliability of the results. All PIPs were scored as follows:

- *Met*: High confidence/confidence in reported PIP results. All critical evaluation elements were *Met*, and 80 to 100 percent of all evaluation elements were *Met* across all activities.
- *Partially Met*: Low confidence in reported PIP results. All critical evaluation elements were *Met*, and 60 to 79 percent of all evaluation elements were *Met* across all activities; or one or more critical evaluation elements were *Partially Met*.
- *Not Met*: All critical evaluation elements were *Met*, and less than 60 percent of all evaluation elements were *Met* across all activities; or one or more critical evaluation elements were *Not Met*.

After completing the validation review, HSAG documented the findings and recommendations for each validated PIP. HSAG forwarded these completed PIP Validation Tools to MDHHS and the appropriate PIHP.

The EQR activities related to PIPs were designed to evaluate the validity and reliability of the PIHP's processes in conducting the PIPs and to draw conclusions about the PIHP's performance in the domains of quality, timeliness, and access to care and services. The *Integrated Behavioral and Physical Health Care* PIP topic addressed CMS' requirements related to quality outcomes—specifically, quality and access to care and services. HSAG assigned the PIPs to the **quality** and **access** domains as depicted in Table 2-7.

Table 2-7—Assignment of PIPs to Performance Domains

Topic	Quality	Timeliness	Access
Integrated Behavioral and Physical Health Care	✓		✓

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

Introduction

This section of the report contains findings from the three 2015–2016 EQR activities—compliance monitoring, validation of performance measures, and validation of PIPs—for the 10 PIHPs. It includes a summary of each PIHP's strengths as well as recommendations for improvement, and a summary assessment related to the **quality** and **timeliness** of, and **access** to, care and services provided by the PIHP. The individual PIHP reports for each EQR activity contain a more detailed description of the results.

Compliance Monitoring

This section of the report presents the results of the 2015–2016 compliance monitoring reviews. These reviews evaluated the PIHPs' compliance with federal and State regulations and contractual requirements related to the standards listed in Table 3-1. HSAG assigned the compliance standards to the domains of **quality**, **timeliness**, and **access** to care as follows:

Table 3-1—Compliance Monitoring Standards[3-1]

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

[3-1] Standard XV—Disclosure of Ownership, Control, and Criminal Convictions was not related to any of the domains and was therefore not included in Table 3-1 or the summary assessments related to quality, timeliness, and access in the following PIHP sections.

Region 1—NorthCare Network

Compliance Monitoring Results

Table 3-2 below presents the results of the 2015–2016 compliance review of **NorthCare Network**, showing for each standard the number of elements that received a score of *Met*, *Substantially Met*, *Partially Met*, *Not Met*, or *NA*. The table also shows the compliance score for each standard and overall. The 2015–2016 External Quality Review Compliance Monitoring Report for **NorthCare Network** contains a more detailed description of the results.

Table 3-2—Summary of 2015–2016 Compliance Review Results for NorthCare Network

Standard		Total Applicable Elements	Number of Elements						2015–2016 Total Compliance Score
			Prior Year	Current Year					
			M	*M*	*SM*	*PM*	*NM*	*NA*	
I	QAPIP Plan and Structure	20	20	NO FOLLOW-UP REQUIRED					100%
II	Performance Measurement and Improvement	24	24	NO FOLLOW-UP REQUIRED					100%
III	Practice Guidelines	14	14	NO FOLLOW-UP REQUIRED					100%
IV	Staff Qualifications and Training	9	9	NO FOLLOW-UP REQUIRED					100%
V	Utilization Management	21	21	NO FOLLOW-UP REQUIRED					100%
VI	Customer Services	13	13	NO FOLLOW-UP REQUIRED					100%
VII	Enrollee Grievance Process	16	16	NO FOLLOW-UP REQUIRED					100%
VIII	Enrollee Rights and Protections	36	36	NO FOLLOW-UP REQUIRED					100%
IX	Subcontracts and Delegation	4	4	NO FOLLOW-UP REQUIRED					100%
X	Provider Network	13	13	NO FOLLOW-UP REQUIRED					100%
XI	Credentialing	6	6	NO FOLLOW-UP REQUIRED					100%
XII	Access and Availability	17	15	2	0	0	0	0	100%
XIII	Coordination of Care	7	7	NO FOLLOW-UP REQUIRED.					100%
XIV	Appeals	18	16	2	0	0	0	0	100%
XV	Disclosure of Ownership, Control, and Criminal Convictions	8	3	5	0	0	0	0	100%
	Overall Compliance	**226**	**217**	**9**	**0**	**0**	**0**	**0**	**100%**

Strengths

NorthCare Network received a 2015–2016 overall compliance score of 100 percent across all standards.

In the 2014–2015 compliance review, **NorthCare Network** demonstrated full compliance with all requirements for Standard I—QAPIP Plan and Structure, Standard II—Performance Measurement and Improvement, Standard III—Practice Guidelines, Standard IV—Staff Qualifications and Training, Standard V—Utilization Management, Standard VI—Customer Services, Standard VII—Enrollee Grievance Process, Standard VIII—Enrollee Rights and Protections, Standard IX—Subcontracts and Delegation, Standard X—Provider Network, Standard XI—Credentialing, and Standard XIII—Coordination of Care. Therefore, follow-up was not required for these standards.

In the 2015–2016 follow-up review, **NorthCare Network** showed strong performance. The PIHP implemented corrective actions to ensure timely access to ongoing services for developmentally disabled adults and timely follow-up care for children discharged from a psychiatric inpatient unit; improved its documentation of the appeals process; and strengthened policies and procedures for collecting and reporting of disclosures of ownership, control, and criminal convictions. **NorthCare Network** demonstrated full compliance with all elements addressed in the follow-up review for Standard XII—Access and Availability; Standard XIV—Appeals; and Standard XV—Disclosure of Ownership, Control, and Criminal Convictions.

Recommendations

The 2015–2016 follow-up review identified no continued opportunities for improvement as **NorthCare Network** achieved 100 percent compliance on all standards.

Summary Assessment Related to Quality, Timeliness, and Access

NorthCare Network demonstrated strong performance across the domains of **quality**, **timeliness**, and **access**. After the 2015–2016 follow-up review, **NorthCare Network** achieved 100 percent compliance on all standards across the domains.

Region 2—Northern Michigan Regional Entity

Compliance Monitoring Results

Table 3-3 below presents the results of the 2015–2016 compliance review of **Northern Michigan Regional Entity**, showing for each standard the number of elements that received a score of *Met*, *Substantially Met*, *Partially Met*, *Not Met*, or *NA*. The table also shows the compliance score for each standard and overall. The 2015–2016 External Quality Review Compliance Monitoring Report for **Northern Michigan Regional Entity** contains a more detailed description of the results.

Table 3-3—Summary of 2015–2016 Compliance Review Results for Northern Michigan Regional Entity

Standard		Total Applicable Elements	Number of Elements						2015–2016 Total Compliance Score
			Prior Year	Current Year					
			M	*M*	*SM*	*PM*	*NM*	*NA*	
I	QAPIP Plan and Structure	17	15	2	0	0	0	0	100%
II	Performance Measurement and Improvement	21	21	NO FOLLOW-UP REQUIRED					100%
III	Practice Guidelines	14	14	NO FOLLOW-UP REQUIRED					100%
IV	Staff Qualifications and Training	9	9	NO FOLLOW-UP REQUIRED					100%
V	Utilization Management	18	18	NO FOLLOW-UP REQUIRED					100%
VI	Customer Services	13	13	NO FOLLOW-UP REQUIRED					100%
VII	Enrollee Grievance Process	16	16	NO FOLLOW-UP REQUIRED					100%
VIII	Enrollee Rights and Protections	33	33	NO FOLLOW-UP REQUIRED					100%
IX	Subcontracts and Delegation	4	4	NO FOLLOW-UP REQUIRED					100%
X	Provider Network	13	13	NO FOLLOW-UP REQUIRED					100%
XI	Credentialing	6	6	NO FOLLOW-UP REQUIRED					100%
XII	Access and Availability	17	15	1	0	0	1	0	94%
XIII	Coordination of Care	4	4	NO FOLLOW-UP REQUIRED					100%
XIV	Appeals	18	18	NO FOLLOW-UP REQUIRED					100%
XV	Disclosure of Ownership, Control, and Criminal Convictions	8	1	7	0	0	0	0	100%
	Overall Compliance	**211**	**200**	**10**	**0**	**0**	**1**	**0**	**100%**

Strengths

Northern Michigan Regional Entity received a 2015–2016 overall compliance score of 100 percent across all standards.

In the 2014–2015 compliance review, **Northern Michigan Regional Entity** demonstrated full compliance with all requirements for Standard II—Performance Measurement and Improvement, Standard III—Practice Guidelines, Standard IV—Staff Qualifications and Training, Standard V—Utilization Management, Standard VI—Customer Services, Standard VII—Enrollee Grievance Process, Standard VIII—Enrollee Rights and Protections, Standard IX—Subcontracts and Delegation, Standard X—Provider Network, Standard XI—Credentialing, Standard XIII—Coordination of Care, and Standard XIV—Appeals. Therefore, follow-up was not required for these standards.

In the 2015–2016 follow-up review, **Northern Michigan Regional Entity** showed strong performance. The PIHP implemented corrective actions to produce and distribute an annual effectiveness review of its QAPIP; ensured timely access to ongoing services for developmentally disabled adults; and strengthened policies and procedures for collecting and reporting of disclosures of ownership, control, and criminal convictions. **Northern Michigan Regional Entity** demonstrated full compliance with all elements addressed in the follow-up review for Standard I—QAPIP Plan and Structure and Standard XV—Disclosure of Ownership, Control, and Criminal Convictions. For Standard XII—Access and Availability, the PIHP successfully addressed one of the two recommendations.

Recommendations

The 2015–2016 follow-up review identified one continued opportunity for improvement for **Northern Michigan Regional Entity** for Standard XII—Access and Availability. The PIHP should continue efforts to consistently meet the contractual performance standard for timely follow-up care for beneficiaries discharged from a detox unit.

Summary Assessment Related to Quality, Timeliness, and Access

Northern Michigan Regional Entity demonstrated strong performance across the domains of **quality**, **timeliness**, and **access**. After the 2015–2016 follow-up review, **Northern Michigan Regional Entity** achieved 100 percent compliance on all standards in the **quality** domain and four of the five standards in the **timeliness** and **access** domains.

Region 3—Lakeshore Regional Entity

Compliance Monitoring Results

Table 3-4 below presents the results of the 2015–2016 compliance review of **Lakeshore Regional Entity**, showing for each standard the number of elements that received a score of *Met*, *Substantially Met*, *Partially Met*, *Not Met*, or *NA*. The table also shows the compliance score for each standard and overall. The 2015–2016 External Quality Review Compliance Monitoring Report for **Lakeshore Regional Entity** contains a more detailed description of the results.

Table 3-4—Summary of 2015–2016 Compliance Review Results for Lakeshore Regional Entity

Standard		Total Applicable Elements	Number of Elements						2015–2016 Total Compliance Score
			Prior Year	Current Year					
			M	*M*	*SM*	*PM*	*NM*	*NA*	
I	QAPIP Plan and Structure	20	13	7	0	0	0	0	100%
II	Performance Measurement and Improvement	24	22	2	0	0	0	0	100%
III	Practice Guidelines	17	17	NO FOLLOW-UP REQUIRED					100%
IV	Staff Qualifications and Training	9	9	NO FOLLOW-UP REQUIRED					100%
V	Utilization Management	21	17	3	1	0	0	0	99%
VI	Customer Services	13	13	NO FOLLOW-UP REQUIRED					100%
VII	Enrollee Grievance Process	16	16	NO FOLLOW-UP REQUIRED					100%
VIII	Enrollee Rights and Protections	36	36	NO FOLLOW-UP REQUIRED					100%
IX	Subcontracts and Delegation	4	3	0	1	0	0	0	94%
X	Provider Network	13	12	0	0	1	0	0	96%
XI	Credentialing	6	5	1	0	0	0	0	100%
XII	Access and Availability	17	16	1	0	0	0	0	100%
XIII	Coordination of Care	7	7	NO FOLLOW-UP REQUIRED					100%
XIV	Appeals	18	17	0	0	0	0	1	100%
XV	Disclosure of Ownership, Control, and Criminal Convictions	8	4	0	0	0	4	0	50%
	Overall Compliance	**229**	**207**	**14**	**2**	**1**	**4**	**1**	**98%**

Strengths

Lakeshore Regional Entity received a 2015–2016 overall compliance score of 98 percent across all standards.

In the 2014–2015 compliance review, **Lakeshore Regional Entity** demonstrated full compliance with all requirements for Standard III—Practice Guidelines, Standard IV—Staff Qualifications and Training, Standard VI—Customer Services, Standard VII—Enrollee Grievance Process, Standard VIII—Enrollee Rights and Protections, and Standard XIII—Coordination of Care. Therefore, follow-up was not required for these standards.

In the 2015–2016 follow-up review, **Lakeshore Regional Entity** showed mixed performance. The PIHP implemented corrective actions to ensure compliance with the requirements for the QAPIP, including adequate administration, oversight, and monitoring of QAPI operations; production and distribution of an annual effectiveness review of the QAPIP; and active consumer participation in the QAPIP. The PIHP ensured that its providers collect and analyze data from the behavior treatment committees. **Lakeshore Regional Entity** provided a written report on the regional consumer satisfaction survey to its governing body and included survey information on its website. The PIHP strengthened its processes to evaluate medical necessity and review and approve services and demonstrated compliance with the requirements to maintain the right to approve, suspend, or terminate providers from participating in Medicaid-funded services. The PIHP met the contractual performance standard for timely access to ongoing services for beneficiaries with a substance use disorder and detailed the requirements for the delegated appeals function in the written agreements. **Lakeshore Regional Entity** achieved full compliance with all elements addressed in the follow-up review for Standard I—QAPIP Plan and Structure; Standard II—Performance Measurement and Improvement, Standard XI—Credentialing, Standard XII—Access and Availability, and Standard XIV—Appeals.

Recommendations

The 2015–2016 follow-up review identified continued opportunities for improvement for **Lakeshore Regional Entity** for Standard V—Utilization Management; Standard IX—Subcontracts and Delegation; Standard X—Provider Network; and Standard XV—Disclosure of Ownership, Control, and Criminal Convictions. The PIHP should continue efforts to ensure availability of appeal mechanisms for providers, address in its policies the requirement and process for evaluating the proposed subcontractor's ability to perform the activities to be delegated prior to entering into a contract, and monitor delegated subcontractors' compliance with the requirement to give affected providers written notice of the reason for its decision when a CMHSP declines to include individual providers or groups of providers in its network for any reason. **Lakeshore Regional Entity** should continue efforts to comply with all federal requirements for disclosures of ownership, control interest, or criminal convictions for offenses related to participation in federal healthcare programs.

Summary Assessment Related to Quality, Timeliness, and Access

Lakeshore Regional Entity demonstrated mixed performance across the domains of **quality**, **timeliness**, and **access**. After the 2015–2016 follow-up review, the PIHP demonstrated its strongest performance in the **quality** domain, achieving full compliance on 10 of the 12 standards. Performance in the **timeliness** and **access** domains was lower, with **Lakeshore Regional Entity** achieving full compliance on four of the five standards in the **timeliness** domain and three of the five standards in the **access** domain. Continued recommendations for improvement addressed all three domains.

Region 4—Southwest Michigan Behavioral Health

Compliance Monitoring Results

Table 3-5 below presents the results of the 2015–2016 compliance review of **Southwest Michigan Behavioral Health**, showing for each standard the number of elements that received a score of *Met*, *Substantially Met*, *Partially Met*, *Not Met*, or *NA*. The table also shows the compliance score for each standard and overall. The 2015–2016 External Quality Review Compliance Monitoring Report for **Southwest Michigan Behavioral Health** contains a more detailed description of the results.

Table 3-5—Summary of 2015–2016 Compliance Review Results for Southwest Michigan Behavioral Health

Standard		Total Applicable Elements	Number of Elements						2015–2016 Total Compliance Score
			Prior Year	Current Year					
			M	*M*	*SM*	*PM*	*NM*	*NA*	
I	QAPIP Plan and Structure	20	19	0	1	0	0	0	99%
II	Performance Measurement and Improvement	24	24	NO FOLLOW-UP REQUIRED					100%
III	Practice Guidelines	14	14	NO FOLLOW-UP REQUIRED					100%
IV	Staff Qualifications and Training	9	9	NO FOLLOW-UP REQUIRED					100%
V	Utilization Management	21	21	NO FOLLOW-UP REQUIRED					100%
VI	Customer Services	13	13	NO FOLLOW-UP REQUIRED					100%
VII	Enrollee Grievance Process	16	15	1	0	0	0	0	100%
VIII	Enrollee Rights and Protections	36	36	NO FOLLOW-UP REQUIRED					100%
IX	Subcontracts and Delegation	4	4	NO FOLLOW-UP REQUIRED					100%
X	Provider Network	13	12	1	0	0	0	0	100%
XI	Credentialing	6	6	NO FOLLOW-UP REQUIRED					100%
XII	Access and Availability	17	15	1	0	1	0	0	97%
XIII	Coordination of Care	7	6	1	0	0	0	0	100%
XIV	Appeals	18	15	2	1	0	0	0	99%
XV	Disclosure of Ownership, Control, and Criminal Convictions	8	4	3	0	1	0	0	94%
	Overall Compliance	**226**	**213**	**9**	**2**	**2**	**0**	**0**	**99%**

Strengths

Southwest Michigan Behavioral Health received a 2015–2016 overall compliance score of 99 percent across all standards.

In the 2014–2015 compliance review, **Southwest Michigan Behavioral Health** demonstrated full compliance with all requirements for Standard II—Performance Measurement and Improvement, Standard III—Practice Guidelines, Standard IV—Staff Qualifications and Training, Standard V—Utilization Management, Standard VI—Customer Services, Standard VIII—Enrollee Rights and Protections, Standard IX—Subcontracts and Delegation, and Standard XI—Credentialing. Therefore, follow-up was not required for these standards.

In the 2015–2016 follow-up review, **Southwest Michigan Behavioral Health** showed mixed performance. The PIHP implemented corrective actions and revised its processes for monitoring subcontractors' performance to address the full scope of delegated network management functions and include an assessment of compliance with the requirements for handling grievances. **Southwest Michigan Behavioral Health** ensured that it has a written, functioning coordination agreement for integration of physical and mental healthcare with each Medicaid health plan serving any part of the service area. The PIHP also met the contractual performance standard for timely access to ongoing services for developmentally disabled children, revised the appeal disposition letter to include the required information about beneficiaries' potential liability for the cost of continued benefits if the hearing decision upholds the PIHP's action, and modified the site review monitoring tool to include a validation of a sample of appeals. **Southwest Michigan Behavioral Health** demonstrated full compliance with all elements addressed in the follow-up review for Standard VII—Enrollee Grievance Process, Standard X—Provider Network, and Standard XIII—Coordination of Care.

Recommendations

The 2015–2016 follow-up review identified continued opportunities for improvement for **Southwest Michigan Behavioral Health** for Standard I—QAPIP Plan and Structure; Standard XII—Access and Availability; Standard XIV—Appeals; and Standard XV—Disclosure of Ownership, Control, and Criminal Convictions. The PIHP should ensure that CMHSPs collect and analyze all behavior treatment data as required, including the length of time of interventions used per person, and continue efforts to consistently meet the contractual performance standard for timely access to ongoing services for developmentally disabled adults. **Southwest Michigan Behavioral Health** should ensure that customer handbooks regionwide include correct information about the appeal process. The PIHP should continue efforts to ensure that it complies with all federal requirements for disclosures of ownership, control interest, or criminal convictions for offenses related to participation in federal healthcare programs.

Summary Assessment Related to Quality, Timeliness, and Access

Southwest Michigan Behavioral Health demonstrated mixed performance across the domains of **quality**, **timeliness**, and **access**. The PIHP demonstrated its strongest performance in the **quality** domain, achieving full compliance on 10 of the 12 standards. Performance in the **timeliness** and **access** domains was not as strong for **Southwest Michigan Behavioral Health**, with full compliance on three of the five standards in the **timeliness** domain and four of the five standards in the **access** domain. Continued recommendations for improvement addressed all three domains.

Region 5—Mid-State Health Network

Compliance Monitoring Results

Table 3-6 below presents the results of the 2015–2016 compliance review of **Mid-State Health Network**, showing for each standard the number of elements that received a score of *Met*, *Substantially Met*, *Partially Met*, *Not Met*, or *NA*. The table also shows the compliance score for each standard and overall. The 2015–2016 External Quality Review Compliance Monitoring Report for **Mid-State Health Network** contains a more detailed description of the results.

Table 3-6—Summary of 2015–2016 Compliance Review Results for Mid-State Health Network

Standard		Total Applicable Elements	Number of Elements						2015–2016 Total Compliance Score
			Prior Year	Current Year					
			M	*M*	*SM*	*PM*	*NM*	*NA*	
I	QAPIP Plan and Structure	20	20	NO FOLLOW-UP REQUIRED					100%
II	Performance Measurement and Improvement	24	24	NO FOLLOW-UP REQUIRED					100%
III	Practice Guidelines	17	17	NO FOLLOW-UP REQUIRED					100%
IV	Staff Qualifications and Training	9	9	NO FOLLOW-UP REQUIRED					100%
V	Utilization Management	21	21	NO FOLLOW-UP REQUIRED					100%
VI	Customer Services	13	13	NO FOLLOW-UP REQUIRED					100%
VII	Enrollee Grievance Process	16	16	NO FOLLOW-UP REQUIRED					100%
VIII	Enrollee Rights and Protections	36	36	NO FOLLOW-UP REQUIRED					100%
IX	Subcontracts and Delegation	4	3	1	0	0	0	0	100%
X	Provider Network	13	13	NO FOLLOW-UP REQUIRED					100%
XI	Credentialing	6	4	2	0	0	0	0	100%
XII	Access and Availability	17	17	NO FOLLOW-UP REQUIRED					100%
XIII	Coordination of Care	7	7	NO FOLLOW-UP REQUIRED					100%
XIV	Appeals	18	18	NO FOLLOW-UP REQUIRED					100%
XV	Disclosure of Ownership, Control, and Criminal Convictions	8	2	6	0	0	0	0	100%
	Overall Compliance	**229**	**220**	**9**	**0**	**0**	**0**	**0**	**100%**

Strengths

Mid-State Health Network received a 2015–2016 overall compliance score of 100 percent across all standards.

In the 2014–2015 compliance review, **Mid-State Health Network** demonstrated full compliance with all requirements for Standard I—QAPIP Plan and Structure, Standard II—Performance Measurement and Improvement, Standard III—Practice Guidelines, Standard IV—Staff Qualifications and Training, Standard V—Utilization Management, Standard VI—Customer Services, Standard VII—Enrollee Grievance Process, Standard VIII—Enrollee Rights and Protections, Standard X—Provider Network, Standard XII—Access and Availability, Standard XIII—Coordination of Care, and Standard XIV—Appeals. Therefore, follow-up was not required for these standards.

In the 2015–2016 follow-up review, **Mid-State Health Network** showed strong performance. The PIHP implemented corrective actions to include in its written agreements provisions for revoking delegation or imposing other sanctions if the subcontractor's performance of a delegated function is inadequate; implemented a policy and a process to ensure that the PIHP maintains responsibility for credentialing and recredentialing decisions as well as the actual right to approve, suspend, or terminate providers from participating in Medicaid-funded services; and strengthened policies and procedures for collecting and reporting of disclosures of ownership, control, and criminal convictions. **Mid-State Health Network** demonstrated full compliance with all elements addressed in the follow-up review for Standard IX—Subcontracts and Delegation; Standard XI—Credentialing; and Standard XV—Disclosure of Ownership, Control, and Criminal Convictions.

Recommendations

The 2015–2016 follow-up review identified no continued opportunities for improvement as **Mid-State Health Network** achieved 100 percent compliance on all standards.

Summary Assessment Related to Quality, Timeliness, and Access

Mid-State Health Network demonstrated strong performance across the domains of **quality**, **timeliness**, and **access**. After the 2015–2016 follow-up review, **Mid-State Health Network** achieved 100 percent compliance on all standards across the domains.

Region 6—CMH Partnership of Southeast Michigan

Compliance Monitoring Results

Table 3-7 below presents the results of the 2015–2016 compliance review of **CMH Partnership of Southeast Michigan**, showing for each standard the number of elements that received a score of *Met*, *Substantially Met*, *Partially Met*, *Not Met*, or *NA*. The table also shows the compliance score for each standard and overall. The 2015–2016 External Quality Review Compliance Monitoring Report for **CMH Partnership of Southeast Michigan** contains a more detailed description of the results.

Table 3-7—Summary of 2015–2016 Compliance Review Results for CMH Partnership of Southeast Michigan

Standard		Total Applicable Elements	Number of Elements						2015–2016 Total Compliance Score
			Prior Year	Current Year					
			M	*M*	*SM*	*PM*	*NM*	*NA*	
I	QAPIP Plan and Structure	20	20	NO FOLLOW-UP REQUIRED					100%
II	Performance Measurement and Improvement	24	24	NO FOLLOW-UP REQUIRED					100%
III	Practice Guidelines	14	14	NO FOLLOW-UP REQUIRED					100%
IV	Staff Qualifications and Training	9	9	NO FOLLOW-UP REQUIRED					100%
V	Utilization Management	21	21	NO FOLLOW-UP REQUIRED					100%
VI	Customer Services	13	13	NO FOLLOW-UP REQUIRED					100%
VII	Enrollee Grievance Process	16	15	1	0	0	0	0	100%
VIII	Enrollee Rights and Protections	36	36	NO FOLLOW-UP REQUIRED					100%
IX	Subcontracts and Delegation	4	4	NO FOLLOW-UP REQUIRED					100%
X	Provider Network	13	13	NO FOLLOW-UP REQUIRED					100%
XI	Credentialing	6	6	NO FOLLOW-UP REQUIRED					100%
XII	Access and Availability	17	16	0	0	1	0	0	97%
XIII	Coordination of Care	7	7	NO FOLLOW-UP REQUIRED					100%
XIV	Appeals	18	16	1	1	0	0	0	99%
XV	Disclosure of Ownership, Control, and Criminal Convictions	8	2	0	2	2	2	0	56%
	Overall Compliance	**226**	**216**	**2**	**3**	**3**	**2**	**0**	**98%**

Strengths

CMH Partnership of Southeast Michigan received a 2015–2016 overall compliance score of 98 percent across all standards.

In the 2014–2015 compliance review, **CMH Partnership of Southeast Michigan** demonstrated full compliance with all requirements for Standard I—QAPIP Plan and Structure, Standard II—Performance Measurement and Improvement, Standard III—Practice Guidelines, Standard IV—Staff Qualifications and Training, Standard V—Utilization Management, Standard VI—Customer Services, Standard VIII—Enrollee Rights and Protections, Standard IX—Subcontracts and Delegation, Standard X—Provider Network, Standard XI—Credentialing, and Standard XIII—Coordination of Care. Therefore, follow-up was not required for these standards.

CMH Partnership of Southeast Michigan implemented corrective actions to ensure that its policies specify the federal and State requirements for handling grievances, demonstrating full compliance with the element addressed in the follow-up review for Standard VII—Enrollee Grievance Process.

Recommendations

The 2015–2016 follow-up review identified continued opportunities for improvement for **CMH Partnership of Southeast Michigan** for Standard XII—Access and Availability; Standard XIV—Appeals; and Standard XV—Disclosure of Ownership, Control, and Criminal Convictions. The PIHP should continue efforts to consistently meet the contractual performance standards for timely follow-up care for beneficiaries discharged from a detoxification unit. The PIHP should finalize its delegated functions review tool and conduct the annual delegated function reviews of the CMHSPs to assess compliance with the requirements for the appeals process. **CMH Partnership of Southeast Michigan** should ensure that it complies with all federal requirements for disclosures of ownership, control interest, or criminal convictions for offenses related to participation in federal healthcare programs.

Summary Assessment Related to Quality, Timeliness, and Access

CMH Partnership of Southeast Michigan demonstrated strong performance across the domains of **quality**, **timeliness**, and **access**. The PIHP demonstrated its strongest performance in the **quality** domain, achieving full compliance on 11 of the 12 standards in the **quality** domain. Performance in the other two domains was not as strong, with full compliance on three of the five standards in the **timeliness** domain and four of the five standards in the **access** domain. Continued recommendations for improvement addressed all three domains.

Region 7—Detroit Wayne Mental Health Authority

Compliance Monitoring Results

Table 3-8 below presents the results of the 2015–2016 compliance review of **Detroit Wayne Mental Health Authority**, showing for each standard the number of elements that received a score of *Met*, *Substantially Met*, *Partially Met*, *Not Met*, or *NA*. The table also shows the compliance score for each standard and overall. The 2015–2016 External Quality Review Compliance Monitoring Report for **Detroit Wayne Mental Health Authority** contains a more detailed description of the results.

Table 3-8—Summary of 2015–2016 Compliance Review Results for Detroit Wayne Mental Health Authority

Standard		Total Applicable Elements	Number of Elements						2015–2016 Total Compliance Score
			Prior Year	Current Year					
			M	*M*	*SM*	*PM*	*NM*	*NA*	
I	QAPIP Plan and Structure	20	20	NO FOLLOW-UP REQUIRED					100%
II	Performance Measurement and Improvement	24	24	NO FOLLOW-UP REQUIRED					100%
III	Practice Guidelines	14	14	NO FOLLOW-UP REQUIRED					100%
IV	Staff Qualifications and Training	6	6	NO FOLLOW-UP REQUIRED					100%
V	Utilization Management	21	21	NO FOLLOW-UP REQUIRED					100%
VI	Customer Services	10	10	NO FOLLOW-UP REQUIRED					100%
VII	Enrollee Grievance Process	13	13	NO FOLLOW-UP REQUIRED					100%
VIII	Enrollee Rights and Protections	33	32	1	0	0	0	0	100%
IX	Subcontracts and Delegation	4	4	NO FOLLOW-UP REQUIRED					100%
X	Provider Network	13	13	NO FOLLOW-UP REQUIRED					100%
XI	Credentialing	6	6	NO FOLLOW-UP REQUIRED					100%
XII	Access and Availability	17	16	1	0	0	0	0	100%
XIII	Coordination of Care	4	4	NO FOLLOW-UP REQUIRED					100%
XIV	Appeals	15	15	NO FOLLOW-UP REQUIRED					100%
XV	Disclosure of Ownership, Control, and Criminal Convictions	8	4	4	0	0	0	0	100%
	Overall Compliance	**208**	**202**	**6**	**0**	**0**	**0**	**0**	**100%**

Strengths

Detroit Wayne Mental Health Authority received a 2015–2016 overall compliance score of 100 percent across all standards.

In the 2014–2015 compliance review, **Detroit Wayne Mental Health Authority** demonstrated full compliance with all requirements for Standard I—QAPIP Plan and Structure, Standard II—Performance Measurement and Improvement, Standard III—Practice Guidelines, Standard IV—Staff Qualifications and Training, Standard V—Utilization Management, Standard VI—Customer Services, Standard VII—Enrollee Grievance Process, Standard IX—Subcontracts and Delegation, Standard X—Provider Network, Standard XI—Credentialing, Standard XIII—Coordination of Care, and Standard XIV—Appeals. Therefore, follow-up was not required for these standards.

In the 2015–2016 follow-up review, **Detroit Wayne Mental Health Authority** showed strong performance. The PIHP implemented corrective actions and developed a process to inform beneficiaries of the estimated cost to the PIHP of each covered support and service received; ensured timely access to ongoing services for developmentally disabled adults; and strengthened policies and procedures for collecting and reporting of disclosures of ownership, control, and criminal convictions. **Detroit Wayne Mental Health Authority** demonstrated full compliance with all elements addressed in the follow-up review for Standard VIII—Enrollee Rights and Protections; Standard XII—Access and Availability; and Standard XV—Disclosure of Ownership, Control, and Criminal Convictions.

Recommendations

The 2015–2016 follow-up review identified no continued opportunities for improvement as **Detroit Wayne Mental Health Authority** achieved 100 percent compliance on all standards.

Summary Assessment Related to Quality, Timeliness, and Access

Detroit Wayne Mental Health Authority demonstrated strong performance across the domains of **quality**, **timeliness**, and **access**. The 2014–2015 recommendations for improvement addressed all three domains. After the 2015–2016 follow-up review, **Detroit Wayne Mental Health Authority** achieved 100 percent compliance on all standards across the domains of **quality**, **timeliness**, and **access**.

Region 8—Oakland County CMH Authority

Compliance Monitoring Results

Table 3-9 below presents the results of the 2015–2016 compliance review of **Oakland County CMH Authority**, showing for each standard the number of elements that received a score of *Met*, *Substantially Met*, *Partially Met*, *Not Met*, or *NA*. The table also shows the compliance score for each standard and overall. The 2015–2016 External Quality Review Compliance Monitoring Report for **Oakland County CMH Authority** contains a more detailed description of the results.

Table 3-9—Summary of 2015–2016 Compliance Review Results for Oakland County CMH Authority

Standard		Total Applicable Elements	Number of Elements						2015–2016 Total Compliance Score
			Prior Year	Current Year					
			M	*M*	*SM*	*PM*	*NM*	*NA*	
I	QAPIP Plan and Structure	20	18	2	0	0	0	0	100%
II	Performance Measurement and Improvement	24	24	NO FOLLOW-UP REQUIRED					100%
III	Practice Guidelines	14	14	NO FOLLOW-UP REQUIRED					100%
IV	Staff Qualifications and Training	9	9	NO FOLLOW-UP REQUIRED					100%
V	Utilization Management	21	21	NO FOLLOW-UP REQUIRED					100%
VI	Customer Services	10	10	NO FOLLOW-UP REQUIRED					100%
VII	Enrollee Grievance Process	13	12	1	0	0	0	0	100%
VIII	Enrollee Rights and Protections	36	36	NO FOLLOW-UP REQUIRED					100%
IX	Subcontracts and Delegation	4	4	NO FOLLOW-UP REQUIRED					100%
X	Provider Network	13	13	NO FOLLOW-UP REQUIRED					100%
XI	Credentialing	6	5	1	0	0	0	0	100%
XII	Access and Availability	17	16	1	0	0	0	0	100%
XIII	Coordination of Care	7	7	NO FOLLOW-UP REQUIRED					100%
XIV	Appeals	15	15	NO FOLLOW-UP REQUIRED					100%
XV	Disclosure of Ownership, Control, and Criminal Convictions	8	4	4	0	0	0	0	100%
	Overall Compliance	**217**	**208**	**9**	**0**	**0**	**0**	**0**	**100%**

Strengths

Oakland County CMH Authority received a 2015–2016 overall compliance score of 100 percent across all standards.

In the 2014–2015 compliance review, **Oakland County CMH Authority** demonstrated full compliance with all requirements for Standard II—Performance Measurement and Improvement, Standard III—Practice Guidelines, Standard IV—Staff Qualifications and Training, Standard V—Utilization Management, Standard VI—Customer Services, Standard VIII—Enrollee Rights and Protections, Standard IX—Subcontracts and Delegation, Standard X—Provider Network, Standard XIII—Coordination of Care, and Standard XIV—Appeals. Therefore, follow-up was not required for these standards.

In the 2015–2016 follow-up review, **Oakland County CMH Authority** showed strong performance. The PIHP implemented corrective actions and expanded the QAPIP plan to describe the structure, components, and processes more completely; demonstrated that providers collect all required data for the behavior treatment committee; and updated its due process policy to include the current version of the MDHHS Grievance and Appeal Technical Requirement. The PIHP revised its contract language to include provisions that it has the authority to review, approve, suspend, or terminate providers from participation in Medicaid-funded services in its network; met the performance standard for timely face-to-face assessments for children with a developmental disability; and strengthened policies and procedures for collecting and reporting of disclosures of ownership, control, and criminal convictions. **Oakland County CMH Authority** demonstrated full compliance with all elements addressed in the follow-up review for Standard I—QAPIP Plan and Structure; Standard VII—Enrollee Grievance Process; Standard XI—Credentialing; Standard XII—Access and Availability; and Standard XV—Disclosure of Ownership, Control, and Criminal Convictions.

Recommendations

The 2015–2016 follow-up review identified no continued opportunities for improvement as **Oakland County CMH Authority** achieved 100 percent compliance on all standards.

Summary Assessment Related to Quality, Timeliness, and Access

Oakland County CMH Authority demonstrated strong performance across the domains of **quality**, **timeliness**, and **access**. After the 2015–2016 follow-up review, **Oakland County CMH Authority** achieved 100 percent compliance on all standards across the domains of **quality**, **timeliness**, and **access**.

Region 9—Macomb County CMH Services

Compliance Monitoring Results

Table 3-10 below presents the results of the 2015–2016 compliance review of **Macomb County CMH Services**, showing for each standard the number of elements that received a score of *Met*, *Substantially Met*, *Partially Met*, *Not Met*, or *NA*. The table also shows the compliance score for each standard and overall. The 2015–2016 External Quality Review Compliance Monitoring Report for **Macomb County CMH Services** contains a more detailed description of the results.

Table 3-10—Summary of 2015–2016 Compliance Review Results for Macomb County CMH Services

Standard		Total Applicable Elements	Number of Elements						2015–2016 Total Compliance Score
			Prior Year	Current Year					
			M	*M*	*SM*	*PM*	*NM*	*NA*	
I	QAPIP Plan and Structure	17	17	NO FOLLOW-UP REQUIRED					100%
II	Performance Measurement and Improvement	21	21	NO FOLLOW-UP REQUIRED					100%
III	Practice Guidelines	14	14	NO FOLLOW-UP REQUIRED					100%
IV	Staff Qualifications and Training	9	9	NO FOLLOW-UP REQUIRED					100%
V	Utilization Management	21	21	NO FOLLOW-UP REQUIRED					100%
VI	Customer Services	10	10	NO FOLLOW-UP REQUIRED					100%
VII	Enrollee Grievance Process	13	13	NO FOLLOW-UP REQUIRED					100%
VIII	Enrollee Rights and Protections	33	33	NO FOLLOW-UP REQUIRED					100%
IX	Subcontracts and Delegation	4	4	NO FOLLOW-UP REQUIRED					100%
X	Provider Network	10	10	NO FOLLOW-UP REQUIRED					100%
XI	Credentialing	6	6	NO FOLLOW-UP REQUIRED					100%
XII	Access and Availability	17	16	0	0	1	0	0	97%
XIII	Coordination of Care	7	6	1	0	0	0	0	100%
XIV	Appeals	15	15	NO FOLLOW-UP REQUIRED					100%
XV	Disclosure of Ownership, Control, and Criminal Convictions	8	4	4	0	0	0	0	100%
	Overall Compliance	**205**	**199**	**5**	**0**	**1**	**0**	**0**	**100%**

Strengths

Macomb County CMH Services received a 2015–2016 overall compliance score of 100 percent across all standards.

In the 2014–2015 compliance review, **Macomb County CMH Services** demonstrated full compliance with all requirements for Standard I—QAPIP Plan and Structure, Standard II—Performance Measurement and Improvement, Standard III—Practice Guidelines, Standard IV—Staff Qualifications and Training, Standard V—Utilization Management, Standard VI—Customer Services, Standard VII—Enrollee Grievance Process, Standard VIII—Enrollee Rights and Protections, Standard IX—Subcontracts and Delegation, Standard X—Provider Network, Standard XI—Credentialing, and Standard XIV—Appeals. Therefore, follow-up was not required for these standards.

In the 2015–2016 follow-up review, **Macomb County CMH Services** showed strong performance. The PIHP implemented corrective actions to maintain current coordination agreements with all Medicaid health plans in its region and strengthened policies and procedures for collecting and reporting of disclosures of ownership, control, and criminal convictions. **Macomb County CMH Services** demonstrated full compliance with all elements addressed in the follow-up review for Standard XIII—Coordination of Care and Standard XV—Disclosure of Ownership, Control, and Criminal Convictions.

Recommendations

The 2015–2016 follow-up review identified one continued opportunity for improvement **Macomb County CMH Services**. The PIHP should continue efforts to consistently meet the contractual performance standard for timely access to ongoing services for developmentally disabled children.

Summary Assessment Related to Quality, Timeliness, and Access

Macomb County CMH Services demonstrated strong performance across the domains of **quality**, **timeliness**, and **access**. After the 2015–2016 follow-up review, **Macomb County CMH Services** achieved 100 percent compliance on all 12 standards in the **quality** domain and four of the five standards in the **timeliness** and **access** domains.

Region 10 PIHP

Compliance Monitoring Results

Table 3-11 below presents the results of the 2015–2016 compliance review of **Region 10 PIHP**, showing for each standard the number of elements that received a score of *Met*, *Substantially Met*, *Partially Met*, *Not Met*, or *NA*. The table also shows the compliance score for each standard and overall. The 2015–2016 External Quality Review Compliance Monitoring Report for **Region 10 PIHP** contains a more detailed description of the results.

Table 3-11—Summary of 2015–2016 Compliance Review Results for Region 10 PIHP

Standard		Total Applicable Elements	Number of Elements						2015–2016 Total Compliance Score
			Prior Year	Current Year					
			M	*M*	*SM*	*PM*	*NM*	*NA*	
I	QAPIP Plan and Structure	20	18	2	0	0	0	0	100%
II	Performance Measurement and Improvement	24	22	2	0	0	0	0	100%
III	Practice Guidelines	17	17	NO FOLLOW-UP REQUIRED					100%
IV	Staff Qualifications and Training	9	9	NO FOLLOW-UP REQUIRED					100%
V	Utilization Management	21	16	1	4	0	0	0	95%
VI	Customer Services	13	13	NO FOLLOW-UP REQUIRED					100%
VII	Enrollee Grievance Process	16	9	6	1	0	0	0	98%
VIII	Enrollee Rights and Protections	36	36	NO FOLLOW-UP REQUIRED					100%
IX	Subcontracts and Delegation	4	3	1	0	0	0	0	100%
X	Provider Network	13	11	2	0	0	0	0	100%
XI	Credentialing	6	5	1	0	0	0	0	100%
XII	Access and Availability	17	17	NO FOLLOW-UP REQUIRED					100%
XIII	Coordination of Care	7	7	NO FOLLOW-UP REQUIRED					100%
XIV	Appeals	18	15	2	0	0	0	1	100%
XV	Disclosure of Ownership, Control, and Criminal Convictions	8	3	5	0	0	0	0	100%
	Overall Compliance	**229**	**201**	**22**	**5**	**0**	**0**	**1**	**99%**

Strengths

Region 10 PIHP received a 2015–2016 overall compliance score of 99 percent across all standards.

In the 2014–2015 compliance review, **Region 10 PIHP** demonstrated full compliance with all requirements for Standard III—Practice Guidelines, Standard IV—Staff Qualifications and Training, Standard VI—Customer Services, Standard VIII—Enrollee Rights and Protections, Standard XII—Access and Availability, and Standard XIII—Coordination of Care. Therefore, follow-up was not required for these standards.

In the 2015–2016 follow-up review, **Region 10 PIHP** showed strong performance. The PIHP implemented corrective actions and increased PIHP staff resources in order to provide the necessary administration, oversight, and monitoring of QAPIP operations. **Region 10 PIHP** ensured that the collection and quarterly review of analyses included all required data from the behavior treatment committee and revised its process for the quarterly review and follow-up of sentinel events at the PIHP level. The PIHP also centralized the region's access system and implemented application of standardized medical necessity criteria through contract, policy, training, and centralized supervision of access staff. The PIHP revised its grievance policy to specify requirements for handling grievances per federal regulations and the MDHHS contract. **Region 10 PIHP** implemented its processes for review of and follow-up on provider network monitoring of delegated subcontractors and updated its policies to include the requirements to give written notice of the reason for declining a provider participation in the network and that the cost to the beneficiary for out-of-network services should not be greater than if services were furnished within the network. The PIHP implemented a process by which it retains the right to approve, suspend, or terminate providers from participation in Medicaid-funded services. **Region 10 PIHP** developed a region-wide appeal module to ensure that reports to the QAPIP include complete appeals data, revised its policies to address all requirements for the content of the notice of disposition, and strengthened policies and procedures for collecting and reporting of disclosures of ownership, control, and criminal convictions. **Region 10 PIHP** demonstrated full compliance with all elements addressed in the follow-up review for Standard I—QAPIP Plan and Structure, Standard II—Performance Measurement and Improvement, Standard IX—Subcontracts and Delegation, Standard X—Provider Network, Standard XI—Credentialing, Standard XIV—Appeals, and Standard XV—Disclosure of Ownership, Control, and Criminal Convictions.

Recommendations

The 2015–2016 follow-up review identified continued opportunities for improvement for **Region 10 PIHP** for Standard V—Utilization Management and Standard VII—Enrollee Grievance Process. The PIHP should develop a centralized utilization management (UM) program with a UM description and plan that include standardized procedures to define both the criteria to be used for decisions and the processes to review and authorize services; implement its strategic goal to centralize a regionwide UM system; and develop regionwide reports to track utilization of services, including under- and overutilization. **Region 10 PIHP** should implement processes for regular reporting of grievance data to the QAPIP.

Summary Assessment Related to Quality, Timeliness, and Access

Region 10 PIHP demonstrated strong performance across the domains of **quality**, **timeliness**, and **access**. The PIHP demonstrated its strongest performance in the **quality** domain, achieving full compliance on 11 of the 12 standards. Performance in the other two domains was not as strong, with full compliance on three of the five standards in the **timeliness** domain and four of the five standards in the **access** domain. Recommendations for improvement addressed primarily the **timeliness** domain.

Validation of Performance Measures

This section of the report presents the results for the validation of performance measures. The 2015–2016 validation of performance measures review included the same measures that were reported in 2014–2015.

The tables show validation findings and reported rates for each measure. The CMS Performance Measure Validation Protocol identifies three possible validation finding designations for performance indicators: *Report* (*R*), *Not Reported* (*NR*), and *No Benefit* (*NB*). Section 2 of this report provides a more detailed explanation of these indicator designations.

The validation review periods for the indicators were as follows: first quarter SFY 2016 for Indicators 1 through 6 and 10; and SFY 2015 for Indicators 8, 9, 13, and 14.

HSAG assigned performance measures to the domains of **quality**, **timeliness**, and **access**. Indicators addressing the **quality** of services provided by the PIHP included follow-up after discharge from a psychiatric inpatient or detox unit; 30-day readmission rates; the HSW rate; and the percentages of adults who were employed competitively, earned minimum wage or more, or lived in a private residence. The following indicators addressed the **timeliness** of and **access** to services: timely pre-admission screenings, face-to-face assessments, first service, and follow-up care after discharge. The penetration rate addressed the **access** domain.

Region 1—NorthCare Network

Findings

Table 3-12 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2016 Validation of Performance Measures Report for **NorthCare Network** includes additional details of the validation results.

Table 3-12—Performance Measure Results for NorthCare Network

	Indicator	Reported Rate		Indicator Designation
1.	The percentage of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children:	100%	*R*
		Adults:	99.55%	
2.	The percentage of new Medicaid beneficiaries during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service.	MI Children:	98.32%	*R*
		MI Adults:	99.30%	
		DD Children:	100%	
		DD Adults:	94.44%	
		Medicaid SA:	95.32%	
		Total:	96.99%	
3.	The percentage of new Medicaid beneficiaries during the quarter starting any needed ongoing service within 14 days of a non-emergent face-to-face assessment with a professional.	MI Children:	99.07%	*R*
		MI Adults:	95.10%	
		DD Children:	88.24%	
		DD Adults:	100%	
		Medicaid SA:	100%	
		Total:	98.56%	
4a.	The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.	Children:	100%	*R*
		Adults:	95.74%	
4b.	The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.	95.24%		*R*
5.	The percent of Medicaid recipients having received PIHP managed services.	7.87%		*R*
6.	The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	99.72%		*R*
8.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who are employed competitively.	MI Adults:	15.00%	*R*
		DD Adults:	5.99%	
		MI/DD Adults:	5.60%	

Table 3-12—Performance Measure Results for NorthCare Network

Indicator		Reported Rate		Indicator Designation
9.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.	MI Adults:	86.49%	*R*
		DD Adults:	33.57%	
		MI/DD Adults:	44.92%	
10.	The percentage of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.	Children:	0.00%	*R*
		Adults:	13.33%	
13.	The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	18.80%		*R*
14.	The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	49.06%		*R*

Strengths

NorthCare Network continued to use a team of professionals with extensive background and multiple years of experience related to performance indicator/quality improvement and Behavioral Health Treatment Episode Data Set (BH-TEDS) measures and data reporting. As a result of the robust data monitoring processes, the PIHP had no rejection files from the State for the current measurement period. **NorthCare Network** implemented various performance improvement projects and was able to increase several performance indicator rates that fell below the MDHHS standards during the previous reporting period. The PIHP's claims system was successfully enhanced from accepting International Statistical Classification of Diseases and Related Health Problems (ICD)-9 codes for claims with dates of service before October 1, 2015, to only accepting ICD-10 codes for claims with dates of service after that date. Claims (with dates of service on or after October 1, 2015) submitted with ICD-9 codes were denied and returned for correction.

Recommendations

NorthCare Network implemented all recommendations provided in the prior year and improved all processes and procedures. HSAG identified no additional recommendations based on the 2015–2016 findings.

Summary Assessment Related to Quality, Timeliness, and Access

NorthCare Network's indicators across the domains of **quality**, **timeliness**, and **access** received validation findings of *Report*, reflecting that the indicators were compliant with MDHHS specifications and that rates could be reported. The PIHP met all five contractually required performance standards related to the **quality** of services provided by the PIHP. For the remaining indicators in the **quality** domain, **NorthCare Network** demonstrated mostly above-average results. Rates for MI adults who were employed competitively or earned minimum wage were higher than the statewide rates, as was the rate for MI/DD adults earning minimum wage. The rates for DD and MI/DD adults who were employed competitively and the rate for DD adults earning minimum wage fell below the statewide rates. The rates for MI and DD adults who live in a private residence were higher than the statewide rates.

NorthCare Network met the contractually required performance standards for 15 of the 17 indicators related to **timeliness** of and **access** to services provided by the PIHP, with below-standard rates for timely face-to-face assessments for DD adults and access to ongoing services for DD children. The PIHP's penetration rate exceeded the statewide rate.

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

Region 2—Northern Michigan Regional Entity

Findings

Table 3-13 presents the results of the validation of performance measures. The State Fiscal Year 2016 Validation of Performance Measures Report for **Northern Michigan Regional Entity** includes additional details of the validation results.

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

Indicator		Reported Rate		Indicator Designation
1.	The percentage of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children:	97.97%	*R*
		Adults:	99.07%	
2.	The percentage of new Medicaid beneficiaries during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service.	MI Children:	99.38%	*R*
		MI Adults:	99.11%	
		DD Children:	100%	
		DD Adults:	100%	
		Medicaid SA:	95.82%	
		Total:	98.09%	
3.	The percentage of new Medicaid beneficiaries during the quarter starting any needed ongoing service within 14 days of a non-emergent face-to-face assessment with a professional.	MI Children:	95.81%	*R*
		MI Adults:	98.68%	
		DD Children:	93.75%	
		DD Adults:	90.48%	
		Medicaid SA:	95.71%	
		Total:	96.33%	
4a.	The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.	Children:	97.14%	*R*
		Adults:	95.87%	
4b.	The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.	95.12%		*R*
5.	The percent of Medicaid recipients having received PIHP managed services.	8.00%		*R*
6.	The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	99.37%		*R*
8.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who are employed competitively.	MI Adults:	12.90%	*R*
		DD Adults:	13.97%	
		MI/DD Adults:	13.18%	

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

Indicator		Reported Rate		Indicator Designation
9.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.	MI Adults:	77.27%	*R*
		DD Adults:	45.76%	
		MI/DD Adults:	56.27%	
10.	The percentage of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.	Children:	6.52%	*R*
		Adults:	10.93%	
13.	The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	25.04%		*R*
14.	The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	53.03%		*R*

Strengths

Northern Michigan Regional Entity underwent changes in staff, data systems, and internal processes during the last year. Several staffing changes added highly qualified new staff members with extensive background and experience in performance measure reporting.

Northern Michigan Regional Entity achieved improvement in some performance measures, including indicators with below-standard rates in the prior year. The PIHP implemented a new data system for three of the five affiliated CMHSPs, with the remaining two CMHSPs considering using this centralized system and process. The new system streamlined the process of receiving, controlling, and transferring claims and encounter data, leaving fewer possibilities for errors.

Recommendations

Northern Michigan Regional Entity noted several quality issues with the substance use disorder (SUD) encounter data files from its CX360 system for submission to the State. As the PIHP continues its process of moving to the new centralized system, HSAG recommended that all system and process changes be thoroughly documented for the next review period.

During the primary source verification process, HSAG identified that one record selected for Indicator 4 was incorrectly reported as numerator positive and recommended that the PIHP consider implementing a more stringent validation process to ensure accurate case reporting.

As the indicator calculations were performed by one staff member with no designated substitute, HSAG recommended that the PIHP consider cross training additional staff members to perform this function.

Summary Assessment Related to Quality, Timeliness, and Access

Northern Michigan Regional Entity's indicators across the domains of **quality**, **timeliness**, and **access** received validation findings of *Report*, reflecting that the indicators were compliant with MDHHS specifications and that rates could be reported. The PIHP met all five contractually

required performance standards related to the **quality** of services provided by the PIHP. For the remaining indicators in the **quality** domain, **Northern Michigan Regional Entity** demonstrated mostly above-average results. For indicators related to employment and minimum wage, only the rate for MI adults who were employed competitively fell below the statewide rate. The rates for MI and DD adults who live in a private residence exceeded the statewide averages.

Northern Michigan Regional Entity met the contractually required performance standards for 15 of the 17 indicators related to **timeliness** of and **access** to services provided by the PIHP, with below-standard rates for timely access to ongoing services for DD adults and children. The PIHP's penetration rate exceeded the statewide rate.

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

Region 3—Lakeshore Regional Entity

Findings

Table 3-14 presents the results of the validation of performance measures. The State Fiscal Year 2016 Validation of Performance Measures Report for **Lakeshore Regional Entity** includes additional details of the validation results.

Table 3-14—Performance Measure Results for Lakeshore Regional Entity

	Indicator	Reported Rate		Indicator Designation
1.	The percentage of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children:	98.34%	*R*
		Adults:	97.99%	
2.	The percentage of new Medicaid beneficiaries during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service.	MI Children:	99.59%	*R*
		MI Adults:	99.70%	
		DD Children:	100%	
		DD Adults:	100%	
		Medicaid SA:	100%	
		Total:	99.77%	
3.	The percentage of new Medicaid beneficiaries during the quarter starting any needed ongoing service within 14 days of a non-emergent face-to-face assessment with a professional.	MI Children:	97.26%	*R*
		MI Adults:	98.46%	
		DD Children:	94.29%	
		DD Adults:	94.74%	
		Medicaid SA:	97.40%	
		Total:	97.46%	
4a.	The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.	Children:	96.92%	*R*
		Adults:	97.86%	
4b.	The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.	98.73%		*R*
5.	The percent of Medicaid recipients having received PIHP managed services.	5.78%		*R*
6.	The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	97.35%		*R*
8.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who are employed competitively.	MI Adults:	13.01%	*R*
		DD Adults:	8.10%	
		MI/DD Adults:	8.28%	

Table 3-14—Performance Measure Results for Lakeshore Regional Entity

Indicator		Reported Rate		Indicator Designation
9.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.	MI Adults:	80.53%	*R*
		DD Adults:	34.65%	
		MI/DD Adults:	37.55%	
10.	The percentage of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.	Children:	7.32%	*R*
		Adults:	7.55%	
13.	The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	10.19%		*R*
14.	The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	39.10%		*R*

Strengths

Lakeshore Regional Entity experienced several staff changes during the last reporting period. All newly hired staff had extensive background working with behavioral health data as well as familiarity with performance indicator policies and procedures.

Lakeshore Regional Entity implemented several performance improvement projects and— for the current reporting period—improved rates for several performance indicators, including indicators with below-standard rates in the prior year. In addition, for the current reporting period—as a result of continuous monitoring of the timeliness and quality of all encounters prior to submission to the State—the encounter rejection rate was less than 2 percent of all submissions.

Recommendations

Lakeshore Regional Entity considered contracting with a new software vendor; therefore, HSAG recommended that the PIHP thoroughly document all system and process changes and testing procedures.

The reporting function at the PIHP level included several manual steps and was performed by one staff member. HSAG encouraged **Lakeshore Regional Entity** to consider cross training additional staff members to perform this function.

As part of the CMHSP oversight, **Lakeshore Regional Entity** developed an audit tool to ensure accuracy of the data received from the CMHSPs. Dual-eligible consumers cannot be included in the rate calculation for Indicators 4 and 10; therefore, HSAG advised the PIHP to consider adding additional validation steps to ensure that each CMHSP is in compliance with the requirement.

For the current measurement period, **Lakeshore Regional Entity** rates for DD children and adults for Indicator 3 fell below the minimum performance standard. HSAG recommended that the PIHP investigate the reasons behind this decline and explore options for rate improvement.

Summary Assessment Related to Quality, Timeliness, and Access

Lakeshore Regional Entity's indicators across the domains of **quality**, **timeliness**, and **access** received validation findings of *Report*, reflecting that the indicators were compliant with MDHHS specifications and that rates could be reported. The PIHP met all five contractually required performance standards related to the **quality** of services provided by the PIHP. For the remaining indicators in the **quality** domain, **Lakeshore Regional Entity** demonstrated mostly below-average results. The rates for MI and DD adults who were employed competitively were lower than the statewide rates. The rate for employed MI/DD adults exceeded the statewide rate. While the rate for MI adults who earned minimum wage was higher than the statewide rate, rates for DD and MI/DD minimum wage earners fell below the statewide scores. The rates for MI and DD adults who live in a private residence fell below the statewide averages.

Lakeshore Regional Entity met the contractually required performance standards for 15 of the 17 indicators related to **timeliness** of and **access** to services provided by the PIHP, with below-standard rates for timely access to ongoing services for DD adults and children. The PIHP's penetration rate was lower than the statewide rate.

Lakeshore Regional Entity met the minimum performance standard for 17 of the 19 indicators; achieved rates above the statewide average for two of the 10 indicators without a specified performance benchmark; and demonstrated mixed performance across the domains of **quality**, **timeliness**, and **access**.

Region 4—Southwest Michigan Behavioral Health

Findings

Table 3-15 presents the results of the validation of performance measures. The State Fiscal Year 2016 Validation of Performance Measures Report for **Southwest Michigan Behavioral Health** includes additional details of the validation results.

Table 3-15—Performance Measure Results for Southwest Michigan Behavioral Health

Indicator		Reported Rate		Indicator Designation
1.	The percentage of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children:	99.43%	*R*
		Adults:	99.54%	
2.	The percentage of new Medicaid beneficiaries during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service.	MI Children:	98.77%	*R*
		MI Adults:	98.58%	
		DD Children:	100%	
		DD Adults:	100%	
		Medicaid SA:	100%	
		Total:	98.87%	
3.	The percentage of new Medicaid beneficiaries during the quarter starting any needed ongoing service within 14 days of a non-emergent face-to-face assessment with a professional.	MI Children:	95.42%	*R*
		MI Adults:	97.39%	
		DD Children:	100%	
		DD Adults:	90.00%	
		Medicaid SA:	100%	
		Total:	97.35%	
4a.	The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.	Children:	100%	*R*
		Adults:	91.16%	
4b.	The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.	100%		*R*
5.	The percent of Medicaid recipients having received PIHP managed services.	7.01%		*R*
6.	The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	98.94%		*R*
8.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who are employed competitively.	MI Adults:	14.68%	*R*
		DD Adults:	7.92%	
		MI/DD Adults:	7.01%	

Table 3-15—Performance Measure Results for Southwest Michigan Behavioral Health

Indicator		Reported Rate		Indicator Designation
9.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.	MI Adults:	73.74%	*R*
		DD Adults:	42.86%	
		MI/DD Adults:	40.00%	
10.	The percentage of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.	Children:	6.98%	*R*
		Adults:	9.12%	
13.	The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	16.95%		*R*
14.	The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	49.46%		*R*

Strengths

Southwest Michigan Behavioral Health maintained a solid team with years of experience gained mostly by working for previous PIHPs. These staff members were familiar with all processes related to performance indicator and quality improvement measures as well as data reporting requirements. **Southwest Michigan Behavioral Health** followed the prior year's recommendations to ensure that all CMHSPs were operating the same version of the PIHP's data system, SmartCare. HSAG noted improvements in rates for performance measure indicators that fell below the MDHHS standards in 2015. **Southwest Michigan Behavioral Health** developed a dashboard that provided performance indicator results by CMHSP and provided an opportunity to research and implement performance improvement processes for any indicators that may have fallen below the set standard. As a result of the PIHP's strict monitoring and data validation processes, rejection files from the State for encounter batches were fewer than 1 percent for the current measurement year.

Southwest Michigan Behavioral Health's claims system was successfully enhanced from accepting ICD-9 codes for claims with dates of service before October 1, 2015, to only accepting ICD-10 codes for claims with dates of service on or after October 1, 2015. Claims (with dates of service on or after October 1, 2015) submitted with ICD-9 codes were denied and returned for correction.

Recommendations

HSAG provided suggestions to **Southwest Michigan Behavioral Health** regarding improvements to quality control activities for oversight of the CMHSPs. The PIHP should conduct primary source verification of the detail files to ensure that the CMHSPs report data accurately and encourage the CMHSPs to run frequent data submission reports in order to review and track reported rates.

In preparation for future primary source verification activities, **Southwest Michigan Behavioral Health** should create a snapshot of the summary and detail files submitted to the State.

For Indicator 2, the validation identified data integrity issues with the SUD data. HSAG recommended additional quality control activities to ensure validity of the data set.

Summary Assessment Related to Quality, Timeliness, and Access

Southwest Michigan Behavioral Health's indicators across the domains of **quality**, **timeliness**, and **access** received validation findings of *Report*, reflecting that the indicators were compliant with MDHHS specifications and that rates could be reported. The PIHP met four of the five contractually required performance standards related to the **quality** of services provided by the PIHP, falling below the standard for timely follow-up care for adults discharged from psychiatric inpatient units. For the remaining indicators in the **quality** domain, **Southwest Michigan Behavioral Health** demonstrated mixed results. The rate for MI adults who were employed competitively was higher than the statewide rate, while the rates for DD and MI/DD adults were lower. Rates for DD and MI/DD adults who earned minimum wage exceeded the statewide rates, while the rate for MI minimum wage earners fell below the statewide score. The rates for MI and DD adults who live in a private residence were higher than the statewide averages.

Southwest Michigan Behavioral Health met the contractually required performance standards for 15 of the 17 indicators related to **timeliness** of and **access** to services provided by the PIHP. Rates for timely access to ongoing services for DD adults and timely follow-up care for adults discharged from a psychiatric inpatient unit fell below the 95 percent thresholds. The PIHP's penetration rate was lower than the statewide rate.

Southwest Michigan Behavioral Health met the minimum performance standard for 17 of the 19 indicators; achieved rates above the statewide average for five of the 10 indicators without a specified performance benchmark; and demonstrated mixed performance across the domains of **quality**, **timeliness**, and **access**.

Region 5—Mid-State Health Network

Findings

Table 3-16 presents the results of the validation of performance measures. The State Fiscal Year 2016 Validation of Performance Measures Report for **Mid-State Health Network** includes additional details of the validation results.

Table 3-16—Performance Measure Results for Mid-State Health Network

	Indicator	Reported Rate		Indicator Designation
1.	The percentage of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children:	99.80%	*R*
		Adults:	99.72%	
2.	The percentage of new Medicaid beneficiaries during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service.	MI Children:	98.92%	*R*
		MI Adults:	99.78%	
		DD Children:	100%	
		DD Adults:	100%	
		Medicaid SA:	98.38%	
		Total:	99.10%	
3.	The percentage of new Medicaid beneficiaries during the quarter starting any needed ongoing service within 14 days of a non-emergent face-to-face assessment with a professional.	MI Children:	96.30%	*R*
		MI Adults:	97.69%	
		DD Children:	98.00%	
		DD Adults:	98.08%	
		Medicaid SA:	100%	
		Total:	98.40%	
4a.	The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.	Children:	97.53%	*R*
		Adults:	98.14%	
4b.	The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.	100%		*R*
5.	The percent of Medicaid recipients having received PIHP managed services.	7.28%		*R*
6.	The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	95.40%		*R*
8.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who are employed competitively.	MI Adults:	13.73%	*R*
		DD Adults:	8.33%	
		MI/DD Adults:	7.29%	

Table 3-16—Performance Measure Results for Mid-State Health Network

Indicator		Reported Rate		Indicator Designation
9.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.	MI Adults:	83.67%	*R*
		DD Adults:	33.45%	
		MI/DD Adults:	37.81%	
10.	The percentage of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.	Children:	6.31%	*R*
		Adults:	9.18%	
13.	The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	16.82%		*R*
14.	The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	45.91%		*R*

Strengths

Mid-State Health Network maintained a solid team with years of relevant experience gained mostly by working for previous PIHPs. Staff members were highly familiar with all processes related to performance indicator and quality improvement measures and data reporting requirements. The robust validation processes in place ensured that only complete and valid data were submitted to the State. As in the prior year, the PIHP demonstrated a strong commitment to the performance indicators and quality improvement data reporting.

Mid-State Health Network continued to manage data reporting for the SUD population. The PIHP hired several qualified staff members from former coordinating agencies in order to manage all functions, which included information technology, provider support, and SUD operations.

Many CMHSPs in the **Mid-State Health Network** experienced system changes in 2015. The CMHSPs had vendors that assisted in the transition from ICD-9 to ICD-10 codes.

Recommendations

Prior to calculating rates, **Mid-State Health Network** should—to ensure data integrity—perform additional primary source verification of sample cases of the data provided by the CMHSPs.

Summary Assessment Related to Quality, Timeliness, and Access

Mid-State Health Network's indicators across the domains of **quality**, **timeliness**, and **access** received validation findings of *Report*, reflecting that the indicators were compliant with MDHHS specifications and that rates could be reported. The PIHP met all five contractually required performance standards related to the **quality** of services provided by the PIHP. For the remaining indicators in the **quality** domain, **Mid-State Health Network** demonstrated mostly above-average results. The rate for MI adults who were employed competitively was higher than the statewide rate, while the rates for DD and MI/DD adults fell below. Rates for MI and MI/DD adults who earned minimum wage exceeded the statewide rates, while the rate for DD adults was lower than the

statewide rate. The rates for MI and DD adults who live in a private residence exceeded the statewide averages.

Mid-State Health Network met the contractually required performance standards for all 17 indicators related to **timeliness** of and **access** to services provided by the PIHP. The PIHP's penetration rate exceeded the statewide rate.

Mid-State Health Network met the minimum performance standard for all 19 indicators; achieved rates above the statewide average for seven of the 10 indicators without a specified performance benchmark; and demonstrated strong performance across the domains of **quality**, **timeliness**, and **access**.

Region 6—CMH Partnership of Southeast Michigan

Findings

Table 3-17 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2016 Validation of Performance Measures Report for **CMH Partnership of Southeast Michigan** includes additional details of the validation results.

Table 3-17—Performance Measure Results for CMH Partnership of Southeast Michigan

Indicator		Reported Rate		Indicator Designation
1.	The percentage of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children:	100%	*R*
		Adults:	99.81%	
2.	The percentage of new Medicaid beneficiaries during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service.	MI Children:	98.35%	*R*
		MI Adults:	96.59%	
		DD Children:	100%	
		DD Adults:	100%	
		Medicaid SA:	96.43%	
		Total:	96.98%	
3.	The percentage of new Medicaid beneficiaries during the quarter starting any needed ongoing service within 14 days of a non-emergent face-to-face assessment with a professional.	MI Children:	100%	*R*
		MI Adults:	100%	
		DD Children:	100%	
		DD Adults:	96.15%	
		Medicaid SA:	96.56%	
		Total:	97.60%	
4a.	The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.	Children:	96.55%	*R*
		Adults:	98.73%	
4b.	The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.	90.10%		*R*
5.	The percent of Medicaid recipients having received PIHP managed services.	7.46%		*R*
6.	The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	98.31%		*R*
8.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who are employed competitively.	MI Adults:	14.03%	*R*
		DD Adults:	10.22%	
		MI/DD Adults:	7.99%	

Table 3-17—Performance Measure Results for CMH Partnership of Southeast Michigan

Indicator		Reported Rate		Indicator Designation
9.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.	MI Adults:	76.05%	*R*
		DD Adults:	60.48%	
		MI/DD Adults:	66.67%	
10.	The percentage of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.	Children:	13.51%	*R*
		Adults:	13.11%	
13.	The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	24.70%		*R*
14.	The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	28.57%		*R*

Strengths

CMH Partnership of Southeast Michigan experienced several staff changes during the last reporting period. All newly hired staff had extensive background in behavioral health data as well as familiarity with performance indicator policies and procedures. The PIHP continued to work collaboratively with the affiliated CMHSPs and discussed any changes that would affect performance indicator reporting. As part of a robust validation process, the PIHP ensured that each error file received from the State was sent to the transactional system as part of claims/encounter verification process to avoid future duplication of the same error.

CMH Partnership of Southeast Michigan created user manuals ensuring that proper cross-training for all functions related to performance indicator data could be performed when needed. The PIHP ensured that each provider was able to run live reports of data to provide an opportunity to correct any error prior to the data being used for rate reporting. The PIHP created a dashboard to track the quality, timeliness, and accuracy of the data for Indicators 2, 3 and 4b submitted by the contracted SUD providers. This process ensured that the PIHP held all providers to the same standard.

Recommendations

During the rate validation process for **CMH Partnership of Southeast Michigan**, the auditor identified inconsistencies in the number of cases included in the calculation. HSAG recommended that **CMH Partnership of Southeast Michigan** create a consumer-level detail file for each quarter, with a snapshot of data used for rate calculation, to ensure that accurate records are validated for each performance indicator.

Due to difficulty locating information during primary source verification to support exceptions, HSAG recommended that a data field containing "offered appointment" be required and that the consumer's reason for declining an appointment be appropriately documented by each provider, ensuring data validity for reporting.

Even though HSAG was able to perform primary source verification on all selected cases, it was noted that record adjustments within the data system were not appropriately flagged. HSAG suggested that **CMH Partnership of Southeast Michigan** implement a process to ensure appropriate identification of any adjustments made to the records.

Rate improvement was noted for Indicator 4; however, since the rate for timely follow-up care after discharge from a detox unit was still below the MDHHS standard, HSAG recommended that **CMH Partnership of Southeast Michigan** continue efforts to increase the rate.

Summary Assessment Related to Quality, Timeliness, and Access

CMH Partnership of Southeast Michigan's indicators across the domains of **quality**, **timeliness**, and **access** received validation findings of *Report*, reflecting that the indicators were compliant with MDHHS specifications and that rates could be reported. The PIHP met four of the five contractually required performance standards related to the **quality** of services provided by the PIHP, falling below the 95 percent benchmark for timely follow-up care for beneficiaries discharged from a detoxification unit. For the remaining indicators in the **quality** domain, **CMH Partnership of Southeast Michigan** demonstrated mostly above-average results. The rates for MI, DD, and MI/DD adults who were employed competitively were higher than the statewide rates. Rates for DD and MI/DD adults who earned minimum wage exceeded the statewide rates, while the rate for MI adults fell below. The rate for MI adults who live in a private residence was lower than the statewide rate, while the rate for DD adults exceeded the statewide average.

CMH Partnership of Southeast Michigan met the contractually required performance standards for 16 of the 17 indicators related to **timeliness** of and **access** to services provided by the PIHP, with a below-standard rate for timely follow-up care for beneficiaries discharged from a detoxification unit. The PIHP's penetration rate exceeded the statewide rate.

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

Region 7—Detroit Wayne Mental Health Authority

Findings

Table 3-18 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2016 Validation of Performance Measures Report for **Detroit Wayne Mental Health Authority** includes additional details of the validation results.

Table 3-18—Performance Measure Results for Detroit Wayne Mental Health Authority

	Indicator	Reported Rate		Indicator Designation
1.	The percentage of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children:	—	*NR*
		Adults:	—	
2.	The percentage of new Medicaid beneficiaries during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service.	MI Children:	98.49%	*R*
		MI Adults:	97.19%	
		DD Children:	99.06%	
		DD Adults:	100%	
		Medicaid SA:	98.32%	
		Total:	98.19%	
3.	The percentage of new Medicaid beneficiaries during the quarter starting any needed ongoing service within 14 days of a non-emergent face-to-face assessment with a professional.	MI Children:	98.01%	*R*
		MI Adults:	96.20%	
		DD Children:	97.22%	
		DD Adults:	95.24%	
		Medicaid SA:	98.62%	
		Total:	97.78%	
4a.	The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.	Children:	100%	*R*
		Adults:	96.33%	
4b.	The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.	—		*NR*
5.	The percent of Medicaid recipients having received PIHP managed services.	7.41%		*R*
6.	The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	98.96%		*R*
8.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who are employed competitively.	MI Adults:	—	*NR*
		DD Adults:	—	
		MI/DD Adults:	—	

Table 3-18—Performance Measure Results for Detroit Wayne Mental Health Authority

Indicator		Reported Rate		Indicator Designation
9.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.	MI Adults:	—	*NR*
		DD Adults:	—	
		MI/DD Adults:	—	
10.	The percentage of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.	Children:	15.38%	*R*
		Adults:	17.05%	
13.	The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	—		*NR*
14.	The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	—		*NR*

Strengths

Detroit Wayne Mental Health Authority experienced several staff changes during the last reporting period. All newly hired staff had extensive background working with behavioral health data as well as familiarity with performance indicator policies and procedures. The PIHP implemented several quality improvement processes, including implementing a centralized process for the calculation of Indicator 1—which was previously performed by the Managers of Comprehensive Provider Networks (MCPNs)—to further ensure accuracy of the data used for performance indicator reporting.

Detroit Wayne Mental Health Authority developed the MI CARE Connect program, which created an integrated care model to ensure that various entities all have access to consumers' information. The PIHP implemented a standard monitoring tool to ensure that all participating MCPNs are held to the same standard.

Recommendations

Detroit Wayne Mental Health Authority should continue its process of integrating detailed data information for Indicators 1, 4a, and 10 from the MCPNs' system into the PIHP's system, for a tighter and more efficient data monitoring process.

Detroit Wayne Mental Health Authority did not meet the MDHHS standard for either population of Indicator 10. HSAG recommended that the PIHP investigate the reasons behind this decline and explore options for rate improvement. Additional crisis residential facilities could help to reduce the hospital recidivism rate for the next reporting period.

Detroit Wayne Mental Health Authority implemented a new process to collect and report demographic information. BH-TEDS rates showed a need for substantial rate increases; therefore, the PIHP should explore opportunities to improve rates for the next reporting period.

During the rate validation and primary source verification, HSAG found calculation processes to be in accordance with MDHHS codebook specifications, but assigned validation findings of *Not*

Reported to some indicators due to dates of service in the data file not matching the supporting documentation, data completeness issues resulting from lack of a proper validation process during data migration, or incomplete reporting of employment status and residential data.

Detroit Wayne Mental Health Authority should create a consumer-level detail file for each quarter, with the snapshot of data used for rate calculation, to ensure that accurate records are validated for each performance indicator. HSAG recommended that the PIHP consider providing additional training to its providers to ensure that the dates when appointments are offered are clearly documented in the data system and conduct primary source validation prior to—rather than after—calculating rates and submitting them to the State. **Detroit Wayne Mental Health Authority** should perform root cause analysis and develop a validation process ensuring data accuracy of rates for Indicator 1.

Summary Assessment Related to Quality, Timeliness, and Access

Detroit Wayne Mental Health Authority received validation findings of *Report* for Indicators 4a and 10 in the **quality** domain, reflecting that these indicators were compliant with MDHHS specifications and that rates could be reported. The remaining indicators in this domain were rated *Not Reported* due to data issues described above. The PIHP met the MDHHS standard for two of the four reported indicators related to the **quality** of services provided by the PIHP, exceeding the 15 percent benchmark for 30-day readmissions for adults and children. For the remaining indicators in the **quality** domain, **Detroit Wayne Mental Health Authority**'s rates could not be reported. Therefore, the PIHP's rates for competitive employment, minimum wage, or living in a private residence could not be compared to the respective statewide rates.

Detroit Wayne Mental Health Authority's indicators in the domains of **timeliness** and **access** received validation findings of *Report* for Indicators 2, 3, 4a, and 5 and findings of *Not Reported* for Indicators 1 and 4b. **Detroit Wayne Mental Health Authority** met the contractually required performance standards for all 14 reported indicators related to **timeliness** of and **access** to services provided by the PIHP. The PIHP's penetration rate was higher than the statewide rate.

Detroit Wayne Mental Health Authority met the minimum performance standard for 14 of the 16 reported indicators and demonstrated mixed performance across the domains of **quality**, **timeliness**, and **access**.

Region 8—Oakland County CMH Authority

Findings

Table 3-19 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2016 Validation of Performance Measures Report for **Oakland County CMH Authority** includes additional details of the validation results.

Table 3-19—Performance Measure Results for Oakland County CMH Authority

	Indicator	Reported Rate		Indicator Designation
1.	The percentage of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children:	—	*NR*
		Adults:	—	
2.	The percentage of new Medicaid beneficiaries during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service.	MI Children:	—	*NR*
		MI Adults:	—	
		DD Children:	—	
		DD Adults:	—	
		Medicaid SA:	—	
		Total:	—	
3.	The percentage of new Medicaid beneficiaries during the quarter starting any needed ongoing service within 14 days of a non-emergent face-to-face assessment with a professional.	MI Children:	100%	*R*
		MI Adults:	99.80%	
		DD Children:	100%	
		DD Adults:	100%	
		Medicaid SA:	99.58%	
		Total:	99.75%	
4a.	The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.	Children:	—	*NR*
		Adults:	—	
4b.	The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.	99.20%		*R*
5.	The percent of Medicaid recipients having received PIHP managed services.	7.80%		*R*
6.	The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	99.40%		*R*
8.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who are employed competitively.	MI Adults:	14.73%	*R*
		DD Adults:	14.16%	
		MI/DD Adults:	11.18%	

Table 3-19—Performance Measure Results for Oakland County CMH Authority

Indicator		Reported Rate		Indicator Designation
9.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.	MI Adults:	62.12%	*R*
		DD Adults:	40.64%	
		MI/DD Adults:	29.70%	
10.	The percentage of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.	Children:	0.00%	*R*
		Adults:	11.02%	
13.	The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	18.73%		*R*
14.	The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	34.46%		*R*

Strengths

Oakland County CMH Authority contracts with Peter Chang Enterprises (PCE) to create the electronic medical record (EMR), Oakland Data and Information Network (ODIN). The PIHP developed a process with PCE to have an alert sent to the primary provider when a patient is admitted, discharged, or transferred from an inpatient setting, providing an innovative solution to improve recidivism rates. The PIHP continued to use the iDashboards product and shared them with providers to make available updates on the status of data completeness. These tools highlighted fields that needed to be completed early in the process to ensure ample time to add information in ODIN, thus monitoring performance and ensuring data completeness.

Oakland County CMH Authority was prepared for the transition to ICD-10 and worked closely with PCE to ensure that providers had adequate direct mapping between ICD-9 and ICD-10 codes. This preparation allowed for a smooth transition and minimal data record issues.

Recommendations

Oakland County CMH Authority's primary source verification identified issues during the on-site audit for several performance indicators. For Indicator 1, HSAG reviewed the records and noted that the PIHP did not have sufficient processes in place to validate whether the consumer records could be identified as compliant, noncompliant, or exclusions. For Indicator 2, the data used to create member-specific reports included cases that did not meet the requirements for this indicator. For Indicator 4a, the programming logic did not select the accurate compliance timeline that would have verified that the consumer was seen for follow-up care within seven days of discharge from a psychiatric inpatient unit. Consequently, Indicators 1, 2, and 4a received validation findings of *Not Reported*.

Oakland County CMH Authority should implement the following recommendations to achieve compliance with MDHHS Codebook specifications: improve the process of generating member-specific lists for Indicators 1, 2, 3, 4, and 10 so that the PIHP can monitor and have a quality process in place to conduct verification; institute detailed quality control activities to validate data records prior to submission to the State to ensure data integrity; maintain a detailed tracking process

of every record changed by the provider or staff, including detailed information about what was changed and why; conduct thorough follow-up review of exception records to verify that the records are, in fact, exceptions; and update the programming logic for Indicator 2 to exclude any consumers who received services within the last 90 days.

Summary Assessment Related to Quality, Timeliness, and Access

Oakland County CMH Authority's indicators in the **quality** domain received validation findings of *Report* for Indicators 4b and 10, reflecting that these indicators were compliant with MDHHS specifications and that rates could be reported. However, Indicator 4a received a designation of *Not Reported* due to concerns with the programming logic. The PIHP met the contractually required performance standards related to the **quality** of services provided by the PIHP for the three reported rates. For the remaining indicators in the **quality** domain, **Oakland County CMH Authority** demonstrated mostly above-average results. The rates for MI, DD, and MI/DD adults who were employed competitively were higher than the statewide rates. The rates for MI and MI/DD adults who earned minimum wage fell below the statewide rates, while the rate for DD adults exceeded the statewide rate. The rate for DD adults who live in a private residence exceeded the statewide rate, while the rate for MI adults was lower.

Oakland County CMH Authority's indicators in the domains of **timeliness** and **access** received validation findings of *Report* for Indicators 3, 4b, and 5, reflecting that these indicators were compliant with MDHHS specifications and that rates could be reported. For Indicators 1, 2, and 4a the PIHP received a designation of *Not Reported*. **Oakland County CMH Authority** met the contractually required performance standards for all seven indicators with valid rates that addressed **timeliness** of and **access** to services provided by the PIHP. The PIHP's penetration rate exceeded the statewide rate.

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

Region 9—Macomb County CMH Services

Findings

Table 3-20 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2016 Validation of Performance Measures Report for **Macomb County CMH Services** includes additional details of the validation results.

Table 3-20—Performance Measure Results for Macomb County CMH Services

Indicator		Reported Rate		Indicator Designation
1.	The percentage of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children:	100%	*R*
		Adults:	100%	
2.	The percentage of new Medicaid beneficiaries during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service.	MI Children:	87.10%	*R*
		MI Adults:	95.26%	
		DD Children:	89.74%	
		DD Adults:	96.00%	
		Medicaid SA:	98.04%	
		Total:	96.12%	
3.	The percentage of new Medicaid beneficiaries during the quarter starting any needed ongoing service within 14 days of a non-emergent face-to-face assessment with a professional.	MI Children:	97.81%	*R*
		MI Adults:	94.65%	
		DD Children:	93.18%	
		DD Adults:	82.86%	
		Medicaid SA:	98.74%	
		Total:	97.00%	
4a.	The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.	Children:	98.31%	*R*
		Adults:	96.07%	
4b.	The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.	98.52%		*R*
5.	The percent of Medicaid recipients having received PIHP managed services.	5.56%		*R*
6.	The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	99.79%		*R*
8.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who are employed competitively.	MI Adults:	11.45%	*R*
		DD Adults:	5.08%	
		MI/DD Adults:	4.93%	

Table 3-20—Performance Measure Results for Macomb County CMH Services

Indicator		Reported Rate		Indicator Designation
9.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.	MI Adults:	80.93%	*R*
		DD Adults:	37.50%	
		MI/DD Adults:	29.60%	
10.	The percentage of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.	Children:	14.52%	*R*
		Adults:	19.31%	
13.	The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	13.52%		*R*
14.	The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	29.76%		*R*

Strengths

Macomb County CMH Services maintained a solid team of experienced professionals. The PIHP developed new strategies, including training and staff support, to improve data collection from providers. The urgent care behavioral health program for the community made an impact on resolving crisis situations and avoiding inpatient hospitalization.

Macomb County CMH Services' internal training process provided cross training for all functions to ensure a solid backup system.

Recommendations

To improve the quality of the data used for performance indicator calculations, **Macomb County CMH Services** should take the following steps: implement a hard edit in FOCUS, the PIHP's system for behavioral health data, to require an explanation for appointments requested outside the 14-day time period; ensure that all system changes are accurately documented, and continue to monitor these changes for data accuracy; document in the EMR results and date of the research if an exception is altered as a result of an investigative finding; conduct quarterly quality checks to ensure that all exceptions—or a significant sample of exceptions—are reviewed for data quality; and continue efforts to improve rates for the four reported indicators showing decreased rates.

HSAG noted that a new process was implemented to collect and report demographic information. **Macomb County CMH Services**' completion rates showed a need for substantial increase; therefore, the PIHP should explore opportunities for improvement for the next reporting period.

Summary Assessment Related to Quality, Timeliness, and Access

Macomb County CMH Services' indicators across the domains of **quality**, **timeliness**, and **access** received validation findings of *Report*, reflecting that the indicators were compliant with MDHHS specifications and that rates could be reported. The PIHP met four of the five contractually required performance standards related to the **quality** of services provided by the PIHP, exceeding the 15 percent benchmark for 30-day readmissions for adults. For the remaining indicators in the **quality**

domain, **Macomb County CMH Services** demonstrated mostly below-average results. The rates for MI, DD and MI/DD adults who were employed competitively were lower than the statewide rates. Rates for MI and DD adults who earned minimum wage were higher than the statewide rates, while the rate for MI/DD minimum wage earners was lower than the statewide score. The rates for MI and DD adults who live in a private residence fell below the statewide averages.

Macomb County CMH Services met the contractually required performance standards for 12 of the 17 indicators related to **timeliness** of and **access** to services provided by the PIHP, with below-standard rates for timely assessments for MI and DD children and timely first service for MI adults, DD children, and DD adults. The PIHP's penetration rate was lower than the statewide rate.

Macomb County CMH Services met the minimum performance standard for 13 of the 19 indicators; achieved rates above the statewide average for two of the 10 indicators without a specified performance benchmark; and demonstrated mixed performance across the domains of **quality**, **timeliness**, and **access**.

Region 10 PIHP

Findings

Table 3-21 presents the results of the validation of performance measures. The State Fiscal Year 2016 Validation of Performance Measures Report for **Region 10 PIHP** includes additional details of the validation results.

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

	Indicator	Reported Rate		Indicator Designation
1.	The percentage of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children:	100%	*R*
		Adults:	100%	
2.	The percentage of new Medicaid beneficiaries during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service.	MI Children:	—	*NR*
		MI Adults:	—	
		DD Children:	—	
		DD Adults:	—	
		Medicaid SA:	—	
		Total:	—	
3.	The percentage of new Medicaid beneficiaries during the quarter starting any needed ongoing service within 14 days of a non-emergent face-to-face assessment with a professional.	MI Children:	96.43%	*R*
		MI Adults:	98.93%	
		DD Children:	100%	
		DD Adults:	93.75%	
		Medicaid SA:	98.11%	
		Total:	97.90%	
4a.	The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.	Children:	100%	*R*
		Adults:	99.12%	
4b.	The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.	100%		*R*
5.	The percent of Medicaid recipients having received PIHP managed services.	7.37%		*R*
6.	The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	99.54%		*R*
8.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who are employed competitively.	MI Adults:	7.84%	*R*
		DD Adults:	5.32%	
		MI/DD Adults:	4.82%	

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

Indicator		Reported Rate	Indicator Designation
9.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.	MI Adults: 70.44% DD Adults: 15.89% MI/DD Adults: 20.47%	*R*
10.	The percentage of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.	Children: 9.28% Adults: 14.48%	*R*
13.	The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	9.26%	*R*
14.	The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	42.65%	*R*

Strengths

Region 10 PIHP experienced several staff changes during the last reporting period. All newly hired staff had extensive background working with behavioral health data as well as familiarity with performance indicator policies and procedures.

Region 10 PIHP developed an annual monitoring tool to assist in monitoring the CMHSPs' data completeness and data accuracy and to ensure that each CMHSP is being held to the contractual agreement set by the PIHP.

As a result of continuous monitoring of the timeliness and quality of all encounters, **Region 10 PIHP**'s rejection rate for encounter batches was under 1 percent for all submissions for the current reporting period.

Recommendations

Region 10 PIHP

For the current reporting period, the CMHSPs were responsible to calculate performance indicators and submit results to **Region 10 PIHP** in a summary file displaying denominator, numerator, and calculated rate for each indicator. HSAG recommended that, in addition to the summary files, the PIHP require that each affiliated CMHSP submit the consumer-level detail files for reconciliation purposes to further ensure the accuracy of each indicator's rate calculation.

During the primary source verification process, HSAG noted that one of **Region 10 PIHP**'s affiliate CMHSPs did not follow the MDHHS Codebook specifications when calculating Indicator 2. Therefore, HSAG assigned a designation of *Not Reported* for this indicator. HSAG recommended that, during regular monthly quality meetings, **Region 10 PIHP** and CMHSPs review the codebook specifications provided by MDHHS to ensure that all entities are in agreement regarding each indicator's requirement.

For Indicator 4b, HSAG recommended that a data field for "offered appointment" be required and that consumers' reasons for declining appointments be appropriately documented by each CMHSP, ensuring data validity for reporting.

HSAG suggested that **Region 10 PIHP** implement a primary source verification process for sample cases to ensure that each CMHSP is using accurate data for performance indicator reporting and encouraged the PIHP to continue to work with the State regarding the requirements for the BH-TEDS data submission.

Summary Assessment Related to Quality, Timeliness, and Access

Region 10 PIHP's indicators in the **quality** domain received validation findings of *Report*, reflecting that the indicators were compliant with MDHHS specifications and that rates could be reported. The PIHP met all five contractually required performance standards related to the **quality** of services provided by the PIHP. For the remaining indicators in the **quality** domain, **Region 10 PIHP** demonstrated mostly below-average results. The rates for MI, DD, and MI/DD adults who were employed competitively or earned minimum wage were lower than the statewide rates. The rate for MI adults who live in a private residence was higher than the statewide rate, while the rate for DD adults was lower.

Region 10 PIHP's indicators in the domains of **timeliness** and **access** received validation findings of *Report* for Indicators 1, 3, 4, and 5, reflecting that the indicators were compliant with MDHHS specifications and that rates could be reported. For Indicator 2, the PIHP received a designation of *Not Reported* due to one of the CMHSPs in the region not following MDHHS Codebook specifications. **Region 10 PIHP** met the contractually required performance standards for 10 of the 11 reported valid rates that addressed **timeliness** of and **access** to services provided by the PIHP, falling below the performance standard for timely access to ongoing services for DD adults. The PIHP's penetration rate exceeded the statewide rate.

Region 10 PIHP met the minimum performance standard for 12 of the 13 indicators with valid rates; achieved rates above the statewide average for three of the 10 indicators without a specified performance benchmark; and demonstrated mixed performance across the domains of **quality**, **timeliness**, and **access**.

Validation of Performance Improvement Projects

This section of the report presents the results of the validation of PIPs. For the 2015–2016 validation, the PIHPs continued with their selected topic related to the integration of physical and mental healthcare and presented their third-year submissions. The PIP topics addressed CMS' requirements related to the **quality** of and **access** to care and services provided by the PIHPs.

Region 1—NorthCare Network

Findings

For the 2015–2016 validation, **NorthCare Network** provided its third-year submission on this PIP topic: *Improving Medical Nutrition Therapy Services for Consumers with Self-Reported Obesity*.

Table 3-22 and Table 3-23 show **NorthCare Network**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2015–2016 PIP Validation Report for **NorthCare Network**.

Table 3-22—Performance Improvement Project Validation Results for NorthCare Network

Study Stage	Activity		Percentage of Applicable Elements		
			Met	*Partially Met*	*Not Met*
Design	I.	Appropriate Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Clearly Defined, Answerable Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Correctly Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Clearly Defined Study Indicator(s)	100% (3/3)	0% (0/3)	0% (0/3)
	V.	Valid Sampling Techniques	*Not Applicable*		
	VI.	Accurate/Complete Data Collection	100% (4/4)	0% (0/4)	0% (0/4)
Design Total			**100% (11/11)**	**0% (0/11)**	**0% (0/11)**
Implementation	VII.	Sufficient Data Analysis and Interpretation	100% (8/8)	0% (0/8)	0% (0/8)
	VIII.	Appropriate Improvement Strategies	100% (3/3)	0% (0/3)	0% (0/3)
Implementation Total			**100% (11/11)**	**0% (0/11)**	**0% (0/11)**
Outcomes	IX.	Real Improvement Achieved	75% (3/4)	0% (0/4)	25% (1/4)
	X.	Sustained Improvement Achieved	*Not Assessed*		
Outcomes Total			**75% (3/4)**	**0% (0/4)**	**25% (1/4)**
Percentage Score of Applicable Evaluation Elements *Met*			**96% (25/26)**		

Table 3-23—Performance Improvement Project Validation Scores for NorthCare Network

Type of Annual Review	Percentage Score of Evaluation Elements *Met*	Percentage Score of Critical Elements *Met*	Overall Validation Status
Submission	65%	75%	*Not Met*
Resubmission	96%	88%	*Not Met*

NorthCare Network submitted the Design, Implementation, and Outcomes stages of the PIP for the 2015–2016 validation. The initial submission received an overall *Not Met* validation status. **NorthCare Network** received technical assistance from HSAG, corrected the identified deficiencies, and resubmitted the PIP for a second review. However, as the remeasurement results did not show a statistically significant improvement over the baseline, the final overall validation status remained *Not Met*, with an overall score of 96 percent and a score of 88 percent for critical elements.

Strengths

The performance of this PIP suggests a thorough application of the PIP design, appropriate analysis of the results, and selection of appropriate interventions based on data mining and brainstorming. The PIHP plans to evaluate the implementation and effectiveness of the interventions through ongoing PIP workgroup meetings.

Recommendations

HSAG identified an opportunity for improvement in Activity IX—Real Improvement Achieved. **NorthCare Network** should continue efforts to achieve statistically significant improvement in the study indicator. The PIHP should evaluate the effectiveness of each intervention; make data-driven decisions about revising, continuing, or discontinuing existing interventions or implementing new ones; and include the results of this analysis in the next PIP submission.

HSAG identified *Points of Clarification* as opportunities for improvement in Activity VII—Sufficient Data Analysis and Interpretation and Activity VIII—Appropriate Improvement Strategies. **NorthCare Network** should provide the *p* value from its statistical testing results, revise its process map, and provide a brief summary of the data analysis findings.

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

NorthCare Network's PIP topic, *Improving Medical Nutrition Therapy Services for Consumers with Self-Reported Obesity*, addressed CMS' requirements related to quality outcomes—specifically, the **quality** and **accessibility** of care and services. The goal of the study is to increase the percentage of consumers with mental illness who indicate a medical diagnosis of obesity in the self-reported measures and receive medical nutrition therapy services from a primary care provider.

NorthCare Network identified barriers through data review and brainstorming. Barriers included lack of a systemwide process or template form to make a referral for medical nutrition therapy as

well as shortage of information available to staff about members in need of this service. **NorthCare Network**'s interventions included developing a standard operating procedure and a cover letter template for referrals and training staff members in the use of the electronic health record to identify members in need of medical nutrition services.

Table 3-24 below shows baseline and remeasurement results for **NorthCare Network**'s PIP study indicator:

Table 3-24—Performance Improvement Project Outcomes for NorthCare Network

PIP Study Indicator	Baseline Period	Remeasurement 1	Remeasurement 2	Sustained Improvement
The percentage of adults with mental illness who indicate a medical diagnosis of obesity in the self-reported measures and receive primary health services to address obesity/nutrition.	1.1%	1.8%		

For the 2015–2016 validation, **NorthCare Network** reported and interpreted its Remeasurement 1 data accurately. The study indicator demonstrated improvement, but it was not statistically significant and did not meet the Remeasurement 1 goal. **NorthCare Network**'s Remeasurement 1 rate was 1.8 percent, an increase of 0.7 percentage point over the baseline but 0.6 percentage point below the PIHP's goal of 2.4 percent. **NorthCare Network** plans to continue with the original interventions and implement additional interventions developed using appropriate quality improvement tools and which have the potential to have a positive impact on the study indicator outcomes.

As **NorthCare Network** progresses in the study, assessment of the impact of the PIP on the **quality** of and **access** to care and services will continue.

Region 2—Northern Michigan Regional Entity

Findings

For the 2015–2016 validation, **Northern Michigan Regional Entity** provided its third-year submission on this PIP topic: *Increasing Diabetic Screenings for Consumers with SMI Prescribed an Antipsychotic Medication*.

Table 3-25 and Table 3-26 show **Northern Michigan Regional Entity**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2015–2016 PIP Validation Report for **Northern Michigan Regional Entity**.

Table 3-25—Performance Improvement Project Validation Results for Northern Michigan Regional Entity

Study Stage	Activity		Percentage of Applicable Elements		
			Met	*Partially Met*	*Not Met*
Design	I.	Appropriate Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Clearly Defined, Answerable Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Correctly Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Clearly Defined Study Indicator(s)	100% (3/3)	0% (0/3)	0% (0/3)
	V.	Valid Sampling Techniques	*Not Applicable*		
	VI.	Accurate/Complete Data Collection	100% (4/4)	0% (0/4)	0% (0/4)
Design Total			**100% (11/11)**	**0% (0/11)**	**0% (0/11)**
Implementation	VII.	Sufficient Data Analysis and Interpretation	100% (8/8)	0% (0/8)	0% (0/8)
	VIII.	Appropriate Improvement Strategies	100% (3/3)	0% (0/3)	0% (0/3)
Implementation Total			**100% (11/11)**	**0% (0/11)**	**0% (0/11)**
Outcomes	IX.	Real Improvement Achieved	100% (4/4)	0% (0/4)	0% (0/4)
	X.	Sustained Improvement Achieved	*Not Assessed*		
Outcomes Total			**100% (4/4)**	**0% (0/4)**	**0% (0/4)**
Percentage Score of Applicable Evaluation Elements *Met*			**100% (26/26)**		

Table 3-26—Performance Improvement Project Validation Scores for Northern Michigan Regional Entity

Type of Annual Review	Percentage Score of Evaluation Elements *Met*	Percentage Score of Critical Elements *Met*	Overall Validation Status
Submission	100%	100%	*Met*
Resubmission	NA	NA	*NA*

Strengths

Northern Michigan Regional Entity submitted the Design, Implementation, and Outcomes stages of the PIP for the 2015–2016 validation. The PIHP did not resubmit the PIP after the initial submission as the PIP received a validation status of *Met*, with an overall score of 100 percent and a score of 100 percent for critical elements. Based on the validation of this PIP, HSAG's assessment determined high confidence in the results.

The performance of this PIP suggests a thorough application of the PIP design, appropriate analysis of the results, and implementation of system interventions related to barriers identified through quality improvement processes.

Recommendations

HSAG identified no opportunities for improvement in the annual PIP validation tool for **Northern Michigan Regional Entity**. The PIHP should continue to evaluate and monitor interventions to ensure sustained improvement is achieved.

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

Northern Michigan Regional Entity's PIP topic, *Increasing Diabetic Screenings for Consumers with SMI Prescribed an Antipsychotic Medication*, addressed CMS' requirements related to quality outcomes—specifically, the **quality** and **accessibility** of care and services. The goal of the study is to increase diabetes screenings for consumers with severe mental illness who were prescribed an antipsychotic medication.

Northern Michigan Regional Entity identified barriers by using data analysis, brainstorming, and the 5-Whys technique for root-cause analysis. The barriers included lack of laboratory orders for diabetic screenings, completion of screenings outside the recommended time frame, and consumer-level barriers. **Northern Michigan Regional Entity**'s interventions included education for staff members and consumers, distribution of quarterly data reports identifying anyone prescribed a second-generation antipsychotic medication for six months or more who does not have a claim for a completed diabetic screening, and an electronic health record with a system to alert staff when labs are due.

Table 3-27 below shows baseline and remeasurement results for **Northern Michigan Regional Entity**'s PIP study indicator:

Table 3-27—Performance Improvement Project Outcomes for Northern Michigan Regional Entity

PIP Study Indicator	Baseline Period	Remeasurement 1	Remeasurement 2	Sustained Improvement
The percentage of consumers 18 to 64 years of age with serious mental illness who were prescribed an antipsychotic medication by a CMH physician for six months or longer and received an HbA1c test or fasting blood sugar test during the measurement year.	63.2%	82.4%		

For the 2015–2016 validation, **Northern Michigan Regional Entity** reported and interpreted its Remeasurement 1 data accurately. The PIHP used appropriate quality improvement tools to conduct causal/barrier analysis and implemented interventions with the potential to have a positive impact on the study indicator outcomes.

Northern Michigan Regional Entity identified an error in the calculation of the baseline rate and revised the rate in the current-year PIP submission. The revised rate of 63.2 percent was 5 percentage points lower than originally reported. The Remeasurement 1 rate for the study indicator was 82.4 percent. This statistically significant improvement was 19.2 percentage points above the baseline and 10.1 percentage points above the PIHP's goal of 72.3 percent. The study indicator demonstrated a statistically significant improvement over the baseline, indicating that the interventions had a positive impact on the **quality** of and **access** to care and services provided by the PIHP. **Northern Michigan Regional Entity** should build on its momentum of improvement to ensure that it can sustain the improvement achieved.

As **Northern Michigan Regional Entity** progresses in the study, assessment of the impact of the PIP on the **quality** of and **access** to care and services will continue.

Region 3—Lakeshore Regional Entity

Findings

For the 2015–2016 validation, **Lakeshore Regional Entity** provided its third-year submission on this PIP topic: *Consumers Who Filled at Least One Prescription for a Second-Generation Antipsychotic Medication Who Receive an HbA1C, Lipid Panel, or Fasting Plasma Glucose*.

Table 3-28 and Table 3-29 show **Lakeshore Regional Entity**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2015–2016 PIP Validation Report for **Lakeshore Regional Entity**.

Table 3-28—Performance Improvement Project Validation Results for Lakeshore Regional Entity

Study Stage	Activity		Percentage of Applicable Elements		
			Met	*Partially Met*	*Not Met*
Design	I.	Appropriate Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Clearly Defined, Answerable Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Correctly Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Clearly Defined Study Indicator(s)	100% (3/3)	0% (0/3)	0% (0/3)
	V.	Valid Sampling Techniques	*Not Applicable*		
	VI.	Accurate/Complete Data Collection	100% (4/4)	0% (0/4)	0% (0/4)
Design Total			**100% (11/11)**	**0% (0/11)**	**0% (0/11)**
Implementation	VII.	Sufficient Data Analysis and Interpretation	100% (8/8)	0% (0/8)	0% (0/8)
	VIII.	Appropriate Improvement Strategies	100% (3/3)	0% (0/3)	0% (0/3)
Implementation Total			**100% (11/11)**	**0% (0/11)**	**0% (0/11)**
Outcomes	IX.	Real Improvement Achieved	100% (4/4)	0% (0/4)	0% (0/4)
	X.	Sustained Improvement Achieved	*Not Assessed*		
Outcomes Total			**100% (4/4)**	**0% (0/4)**	**0% (0/4)**
Percentage Score of Applicable Evaluation Elements *Met*			**100% (26/26)**		

Table 3-29—Performance Improvement Project Validation Scores for Lakeshore Regional Entity

Type of Annual Review	Percentage Score of Evaluation Elements *Met*	Percentage Score of Critical Elements *Met*	Overall Validation Status
Submission	92%	100%	*Met*
Resubmission	100%	100%	*Met*

Strengths

Lakeshore Regional Entity submitted the Design, Implementation, and Outcomes stages of the PIP for the 2015–2016 validation. While the initial submission received an overall *Met* validation status, the PIHP elected to resubmit the PIP for a second review. **Lakeshore Regional Entity** received technical assistance from HSAG and corrected the identified deficiencies. The final validation status remained *Met*, with an overall score of 100 percent and a score of 100 percent for critical elements. Based on the validation of this PIP, HSAG's assessment determined high confidence in the results.

The performance of this PIP suggests a thorough application of the PIP design, appropriate analysis of the results, and implementation of system interventions related to barriers identified through quality improvement processes.

Recommendations

HSAG identified *Points of Clarification* as opportunities for improvement in Activity VII—Sufficient Data Analysis and Interpretation and Activity VIII—Appropriate Improvement Strategies. **Lakeshore Regional Entity** should include a numeric percentage for the PIHP-specific Remeasurement 2 goal. The PIHP should detail barriers related to achievement of the study indicator outcomes as well as the corresponding interventions implemented during the Remeasurement 2 study period.

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

Lakeshore Regional Entity's PIP topic, *Consumers Who Filled at Least One Prescription for a Second-Generation Antipsychotic Medication Who Receive an HbA1C, Lipid Panel, or Fasting Plasma Glucose*, addressed CMS' requirements related to quality outcomes—specifically, the **quality** and **accessibility** of care and services. The goal of the study is to increase monitoring of consumers taking antipsychotic medications.

Lakeshore Regional Entity identified barriers through brainstorming and completing a fishbone diagram. The barriers included lack of awareness of medications' risks and uncertainty of whether or not providers were regularly prescribing labs for consumers taking a second-generation antipsychotic medication. In addition, the data vendor was not providing monthly PIP data in a timely manner. **Lakeshore Regional Entity**'s interventions included staff education and training as well as letters to providers to remind them of requirements for ordering lab work.

Table 3-30 below shows baseline and remeasurement results for **Lakeshore Regional Entity**'s PIP study indicator:

Table 3-30—Performance Improvement Project Outcomes for Lakeshore Regional Entity

PIP Study Indicator	Baseline Period	Remeasurement 1	Remeasurement 2	Sustained Improvement
The percentage of Medicaid eligible adults who filled a prescription for a second-generation antipsychotic medication and received lab work for an HbA1c, lipid panel, or fasting plasma glucose during the measurement period.	74.6%	76.8%		

For the 2015–2016 validation, **Lakeshore Regional Entity** submitted and analyzed baseline and Remeasurement 1 data. The PIHP used appropriate quality improvement tools to conduct causal/barrier analysis and implemented interventions with the potential to have a positive impact on the study indicator outcomes.

Lakeshore Regional Entity identified errors in the calculation of the baseline rate and consequently recalculated and revised the rate in the current-year PIP submission. The original baseline rate was 49.7 percent, and the revised baseline rate was 24.9 percentage points higher at 74.6 percent. The Remeasurement 1 rate for the study indicator was 76.8 percent, a statistically significant improvement of 2.2 percentage points above the baseline; however, the rate fell 3.2 percentage points below the PIHP's goal of 80 percent. The study indicator demonstrated a statistically significant improvement, indicating that the interventions had a positive impact on the **quality** of and **access** to care and services provided by the PIHP. **Lakeshore Regional Entity** should build on its momentum of improvement to ensure that it can sustain the improvement achieved.

As **Lakeshore Regional Entity** progresses in the study, assessment of the impact of the PIP on the **quality** of and **access** to care and services will continue.

Region 4—Southwest Michigan Behavioral Health

Findings

For the 2015–2016 validation, **Southwest Michigan Behavioral Health** provided its third-year submission on this PIP topic: *Improving Diabetes Treatment for Consumers with a Co-morbid Mental Health Condition.*

Table 3-31 and Table 3-32 show **Southwest Michigan Behavioral Health**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2015–2016 PIP Validation Report for **Southwest Michigan Behavioral Health**.

Table 3-31—Performance Improvement Project Validation Results for Southwest Michigan Behavioral Health

Study Stage	Activity		Percentage of Applicable Elements		
			Met	*Partially Met*	*Not Met*
Design	I.	Appropriate Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Clearly Defined, Answerable Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Correctly Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Clearly Defined Study Indicator(s)	100% (3/3)	0% (0/3)	0% (0/3)
	V.	Valid Sampling Techniques	*Not Applicable*		
	VI.	Accurate/Complete Data Collection	100% (4/4)	0% (0/4)	0% (0/4)
Design Total			**100% (11/11)**	**0% (0/11)**	**0% (0/11)**
Implementation	VII.	Sufficient Data Analysis and Interpretation	88% (7/8)	0% (0/8)	13% (1/8)
	VIII.	Appropriate Improvement Strategies	67% (2/3)	33% (1/3)	0% (0/3)
Implementation Total			**82% (9/11)**	**9% (1/11)**	**9% (1/11)**
Outcomes	IX.	Real Improvement Achieved	100% (4/4)	0% (0/4)	0% (0/4)
	X.	Sustained Improvement Achieved	*Not Assessed*		
Outcomes Total			**100% (4/4)**	**0% (0/4)**	**0% (0/4)**
Percentage Score of Applicable Evaluation Elements *Met*			**92% (24/26)**		

Table 3-32—Performance Improvement Project Validation Scores for Southwest Michigan Behavioral Health

Type of Annual Review	Percentage Score of Evaluation Elements *Met*	Percentage Score of Critical Elements *Met*	Overall Validation Status
Submission	92%	100%	*Met*
Resubmission	NA	NA	NA

Strengths

Southwest Michigan Behavioral Health submitted the Design, Implementation, and Outcomes stages of the PIP for the 2015–2016 validation. The PIP received a validation status of *Met* for the initial submission, with an overall score of 92 percent and a score of 100 percent for critical elements. The PIHP did not resubmit the PIP. Based on the validation of this PIP, HSAG's assessment determined high confidence in the results.

The performance of this PIP suggests a thorough application of the PIP design, appropriate analysis of the results, and implementation of system interventions related to barriers identified through quality improvement processes.

Recommendations

HSAG identified opportunities for improvement in Activity VII—Sufficient Data Analysis and Interpretation and Activity VIII— Appropriate Improvement Strategies. **Southwest Michigan Behavioral Health** should report any factors affecting the ability to compare results between measurement periods or indicate that no such factors exist. The PIHP should specify whether or not it evaluated each intervention for effectiveness and provide the results of that evaluation. **Southwest Michigan Behavioral Health** should address the *Points of Clarification* in Activity IV—Clearly Defined Study Indicator(s) and Activity VII— Sufficient Data Analysis and Interpretation and make a correction from *percent* to *percentage point* in all applicable instances throughout the PIP submission form.

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

Southwest Michigan Behavioral Health's PIP topic, *Improving Diabetes Treatment for Consumers with a Co-morbid Mental Health Condition*, addressed CMS' requirements related to quality outcomes—specifically the **quality** and **accessibility** of care and services. The goal of the study is to increase the percentage of consumers with diabetes who demonstrate having received treatment for that condition within the past 12 months.

Southwest Michigan Behavioral Health identified barriers by using a fishbone diagram. The barriers included lack of coordination between PIHP clinicians and medical providers, absence of goals in treatment plans to address diabetic conditions when applicable, inability to identify consumers with diabetes, and lack of information and training regarding the importance of care coordination and treatment for diabetes. **Southwest Michigan Behavioral Health**'s interventions

included offering education and training for providers and consumers, using a data analytics tool to verify consumers' diagnosis and treatment information, and coordinating care with primary care providers.

Table 3-33 below shows baseline and remeasurement results for **Southwest Michigan Behavioral Health**'s PIP study indicator:

Table 3-33—Performance Improvement Project Outcomes for Southwest Michigan Behavioral Health

PIP Study Indicator	Baseline Period	Remeasurement 1	Remeasurement 2	Sustained Improvement
Proportion of individuals who report having diabetes and demonstrate having been treated for the condition within the past twelve months.	52.3%	84.4%		

For the 2015–2016 validation, **Southwest Michigan Behavioral Health** reported and interpreted its first remeasurement data accurately. The PIHP used appropriate quality improvement tools to conduct causal/barrier analysis and implemented interventions with the potential to have a positive impact on the study indicator outcomes.

Southwest Michigan Behavioral Health's Remeasurement 1 rate for the study indicator was 84.4 percent. This rate demonstrated a statistically significant improvement of 32.1 percentage points above the baseline and was 22.1 percentage points above the PIHP's goal of 62.3 percent. The study indicator demonstrated statistically significant improvement, indicating that the interventions had a positive impact on the **quality** of and **access** to care and services provided by the PIHP. **Southwest Michigan Behavioral Health** should build on its momentum of improvement to ensure that it can sustain the improvement achieved.

As **Southwest Michigan Behavioral Health** progresses in the study, assessment of the impact of the PIP on the **quality** of and **access** to care and services will continue.

Region 5—Mid-State Health Network

Findings

For the 2015–2016 validation, **Mid-State Health Network** provided its third-year submission on this PIP topic: *Increasing Diabetes Screening for Consumers with Schizophrenia or Bipolar Disorder Prescribed Antipsychotic Medications*.

Table 3-34 and Table 3-35 show **Mid-State Health Network**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2015–2016 PIP Validation Report for **Mid-State Health Network**.

Table 3-34—Performance Improvement Project Validation Results for Mid-State Health Network

Study Stage	Activity		Percentage of Applicable Elements		
			Met	*Partially Met*	*Not Met*
Design	I.	Appropriate Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Clearly Defined, Answerable Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Correctly Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Clearly Defined Study Indicator(s)	100% (3/3)	0% (0/3)	0% (0/3)
	V.	Valid Sampling Techniques	*Not Applicable*		
	VI.	Accurate/Complete Data Collection	100% (4/4)	0% (0/4)	0% (0/4)
Design Total			**100% (11/11)**	**0% (0/11)**	**0% (0/11)**
Implementation	VII.	Sufficient Data Analysis and Interpretation	100% (8/8)	0% (0/8)	0% (0/8)
	VIII.	Appropriate Improvement Strategies	100% (4/4)	0% (0/4)	0% (0/4)
Implementation Total			**100% (12/12)**	**0% (0/12)**	**0% (0/12)**
Outcomes	IX.	Real Improvement Achieved	100% (4/4)	0% (0/4)	0% (0/4)
	X.	Sustained Improvement Achieved	*Not Assessed*		
Outcomes Total			**100% (4/4)**	**0% (0/4)**	**0% (0/4)**
Percentage Score of Applicable Evaluation Elements *Met*			**100% (27/27)**		

Table 3-35—Performance Improvement Project Validation Scores for Mid-State Health Network

Type of Annual Review	Percentage Score of Evaluation Elements *Met*	Percentage Score of Critical Elements *Met*	Overall Validation Status
Submission	89%	100%	*Met*
Resubmission	100%	100%	*Met*

Strengths

Mid-State Health Network submitted the Design, Implementation, and Outcomes stages of the PIP for the 2015–2016 validation. While the initial submission received an overall *Met* validation status, the PIHP elected to resubmit the PIP for a second review. **Mid-State Health Network** received technical assistance from HSAG and corrected the identified deficiencies. The final validation status remained *Met*, with an overall score of 100 percent and a score of 100 percent for critical elements. Based on the validation of this PIP, HSAG's assessment determined high confidence in the results.

The performance of this PIP suggests a thorough application of the PIP design, appropriate analysis of the results, and implementation of system interventions related to barriers identified through quality improvement processes.

Recommendations

HSAG identified no opportunities for improvement in the annual PIP validation tool for **Mid-State Health Network**. The PIHP should continue to evaluate and monitor interventions to ensure sustained improvement is achieved.

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

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

Mid-State Health Network identified barriers by using brainstorming and a fishbone diagram. The identified barriers included limited access to data on the completion of lab work, consumers' lack of awareness of the importance of regular primary care visits or benefit coverage for diabetes testing, availability of only a limited number of providers, and lack of coordination with primary care physicians. **Mid-State Health Network**'s interventions included a care alert report with real-time data for the diabetes screening key performance indicator, consumer education, and coordination of care with the consumer and primary care physician regarding diabetes testing.

Table 3-36 below shows baseline and remeasurement results for **Mid-State Health Network**'s PIP study indicator:

Table 3-36—Performance Improvement Project Outcomes for Mid-State Health Network

PIP Study Indicator	Baseline Period	Remeasurement 1	Remeasurement 2	Sustained Improvement
The proportion of the eligible population having at least one diabetes screening completed in the measurement year.	73.7%	77.5%		

For the 2015–2016 validation, **Mid-State Health Network** reported and interpreted its Remeasurement 1 data accurately. The PIHP used appropriate quality improvement tools to conduct causal/barrier analysis and implemented interventions with the potential to have a positive impact on the study indicator outcomes.

Mid-State Health Network identified an error in the calculation of the baseline rate and revised the rate in the current-year PIP submission from 85.7 percent to 73.7 percent. The Remeasurement 1 rate for the study indicator was 77.5 percent, or 3.8 percentage points above the baseline. The PIHP also met its Remeasurement 1 goal of 75 percent. The study indicator demonstrated a statistically significant improvement over the baseline, indicating that the interventions had a positive impact on the **quality** of and **access** to care and services provided by the PIHP. **Mid-State Health Network** should build on its momentum of improvement to ensure that it can sustain the improvement achieved.

As **Mid-State Health Network** progresses in the study, assessment of the impact of the PIP on the **quality** of and **access** to care and services will continue.

Region 6—CMH Partnership of Southeast Michigan

For the 2015–2016 validation, **CMH Partnership of Southeast Michigan** provided its third-year submission on this PIP topic: *Medication Labs*. Table 3-37 and Table 3-38 show **CMH Partnership of Southeast Michigan**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2015–2016 PIP Validation Report for **CMH Partnership of Southeast Michigan**.

Table 3-37—Performance Improvement Project Validation Results for CMH Partnership of Southeast Michigan

Study Stage	Activity		Percentage of Applicable Elements		
			Met	*Partially Met*	*Not Met*
Design	I.	Appropriate Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Clearly Defined, Answerable Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Correctly Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Clearly Defined Study Indicator(s)	100% (3/3)	0% (0/3)	0% (0/3)
	V.	Valid Sampling Techniques	*Not Applicable*		
	VI.	Accurate/Complete Data Collection	100% (4/4)	0% (0/4)	0% (0/4)
Design Total			**100% (11/11)**	**0% (0/11)**	**0% (0/11)**
Implementation	VII.	Sufficient Data Analysis and Interpretation	100% (8/8)	0% (0/8)	0% (0/8)
	VIII.	Appropriate Improvement Strategies	67% (2/3)	33% (1/3)	0% (0/3)
Implementation Total			**91% (10/11)**	**9% (1/11)**	**0% (0/11)**
Outcomes	IX.	Real Improvement Achieved	100% (4/4)	0% (0/4)	0% (0/4)
	X.	Sustained Improvement Achieved	*Not Assessed*		
Outcomes Total			**100% (4/4)**	**0% (0/4)**	**0% (0/4)**
Percentage Score of Applicable Evaluation Elements *Met*			**96% (25/26)**		

Table 3-38—Performance Improvement Project Validation Scores for CMH Partnership of Southeast Michigan

Type of Annual Review	Percentage Score of Evaluation Elements *Met*	Percentage Score of Critical Elements *Met*	Overall Validation Status
Submission	96%	100%	*Met*
Resubmission	NA	NA	*NA*

Strengths

CMH Partnership of Southeast Michigan submitted the Design, Implementation, and Outcomes stages of the PIP for the 2015–2016 validation. The PIP received a validation status of *Met*, with an overall score of 96 percent and a score of 100 percent for critical elements. The PIHP did not re-submit the PIP after the initial validation. Based on the validation of this PIP, HSAG's assessment determined high confidence in the results.

The performance of this PIP suggests a thorough application of the PIP design, appropriate analysis of the results, and implementation of system interventions related to barriers identified through quality improvement processes.

Recommendations

HSAG identified an opportunity for improvement in Activity VIII—Appropriate Improvement Strategies. **CMH Partnership of Southeast Michigan** should provide more details about the data reviewed monthly to evaluate the effectiveness of the interventions and provide the results of that evaluation.

HSAG identified *Points of Clarification* as opportunities for improvement in Activity VI—Accurate/Complete Data Collection, Activity VII— Sufficient Data Analysis and Interpretation, and Activity VIII— Appropriate Improvement Strategies: **CMH Partnership of Southeast Michigan** should include in its data analysis plan that—in addition to comparing the remeasurement results to the goal and the baseline—it will also compare study indicator results between the remeasurement periods, specify the percentage points or percent improvement shown over the baseline, indicate the Remeasurement 2 goal in the applicable tables, and include the barriers and interventions information in the Remeasurement 2 table.

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

CMH Partnership of Southeast Michigan's PIP topic, *Medication Labs*, addressed CMS' requirements related to quality outcomes—specifically, the **quality** and **accessibility** of care and services. The goal of the study is to increase the percentage of consumers taking antipsychotic medication who have lab values (including HbA1c or glucose, cholesterol, and triglycerides) entered in the electronic health record during the measurement year.

CMH Partnership of Southeast Michigan identified barriers by reviewing and discussing data. The barriers included consumer noncompliance with ordered blood draws; labs completed by external providers captured outside of the PIHP's data system; and lack of staff motivation, accountability, and communication regarding lab orders. **CMH Partnership of Southeast Michigan**'s interventions included on-site phlebotomists at various locations, data reports to drive staff responsibility and accountability, coordination-of-care letters to primary care physicians when medications are changed, staff education on entering labs in the electronic health record, and reminder calls to consumers.

Table 3-39 below shows baseline and remeasurement results for **CMH Partnership of Southeast Michigan**'s PIP study indicator.

Table 3-39—Performance Improvement Project Outcomes for CMH Partnership of Southeast Michigan

PIP Study Indicator	Baseline Period	Remeasurement 1	Remeasurement 2	Sustained Improvement
The percentage of Medicaid consumers prescribed antipsychotic medication that have all of the required lab values (HbA1c or glucose, HDL cholesterol, LDL cholesterol, total cholesterol, and triglycerides) in the electronic health record during the measurement period.	44.8%	51.0%		

For the 2015–2016 validation, **CMH Partnership of Southeast Michigan** reported and interpreted its first remeasurement data accurately. The PIHP used appropriate quality improvement tools to conduct causal/barrier analysis and implemented interventions with the potential to have a positive impact on the study indicator outcomes.

CMH Partnership of Southeast Michigan's Remeasurement 1 rate for the study indicator was 51.0 percent. This rate demonstrated a statistically significant improvement of 6.2 percentage points above the baseline and was 1.8 percentage points above the PIHP's goal of 49.2 percent. The study indicator demonstrated statistically significant improvement, indicating that the interventions had a positive impact on the **quality** of and **access** to care and services provided by the PIHP. **CMH Partnership of Southeast Michigan** should build on its momentum of improvement to ensure that it can sustain the improvement achieved.

As **CMH Partnership of Southeast Michigan** progresses in the study, assessment of the impact of the PIP on the **quality** of and **access** to care and services will continue.

Region 7—Detroit Wayne Mental Health Authority

Findings

For the 2015–2016 validation, **Detroit Wayne Mental Health Authority** provided its third-year submission on this PIP topic: *Improving Wellness Self-Management of SMI Consumers with Chronic Health Conditions*.

Table 3-40 and Table 3-41 show **Detroit Wayne Mental Health Authority**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2015–2016 PIP Validation Report for **Detroit Wayne Mental Health Authority**.

Table 3-40—Performance Improvement Project Validation Results for Detroit Wayne Mental Health Authority

Study Stage	Activity		Percentage of Applicable Elements		
			Met	*Partially Met*	*Not Met*
Design	I.	Appropriate Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Clearly Defined, Answerable Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Correctly Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Clearly Defined Study Indicator(s)	100% (3/3)	0% (0/3)	0% (0/3)
	V.	Valid Sampling Techniques	*Not Applicable*		
	VI.	Accurate/Complete Data Collection	100% (4/4)	0% (0/4)	0% (0/4)
Design Total			**100% (11/11)**	**0% (0/11)**	**0% (0/11)**
Implementation	VII.	Sufficient Data Analysis and Interpretation	100% (8/8)	0% (0/8)	0% (0/8)
	VIII.	Appropriate Improvement Strategies	100% (3/3)	0% (0/3)	0% (0/3)
Implementation Total			**100% (11/11)**	**0% (0/11)**	**0% (0/11)**
Outcomes	IX.	Real Improvement Achieved	100% (4/4)	0% (0/4)	0% (0/4)
	X.	Sustained Improvement Achieved	*Not Assessed*		
Outcomes Total			**100% (4/4)**	**0% (0/4)**	**0% (0/4)**
Percentage Score of Applicable Evaluation Elements *Met*			**100% (26/26)**		

Table 3-41—Performance Improvement Project Validation Scores for Detroit Wayne Mental Health Authority

Type of Annual Review	Percentage Score of Evaluation Elements *Met*	Percentage Score of Critical Elements *Met*	Overall Validation Status
Submission	96%	100%	*Met*
Resubmission	100%	100%	*Met*

Strengths

Detroit Wayne Mental Health Authority submitted the Design, Implementation, and Outcomes stages of the PIP for the 2015–2016 validation. While the initial submission received an overall *Met* validation status, the PIHP elected to resubmit the PIP for a second review. **Detroit Wayne Mental Health Authority** received technical assistance from HSAG and corrected the identified deficiencies. The final validation status remained *Met*, with an overall score of 100 percent and a score of 100 percent for critical elements. Based on the validation of this PIP, HSAG's assessment determined high confidence in the results.

The performance of this PIP suggests a thorough application of the PIP design, appropriate analysis of the results, and implementation of system interventions related to barriers identified through quality improvement processes.

Recommendations

HSAG identified *Points of Clarification* as opportunities for improvement in Activity VII—Sufficient Data Analysis and Interpretation and Activity VIII—Appropriate Improvement Strategies: **Detroit Wayne Mental Health Authority** should clarify which consumers are to be included in the denominator, revise the stated increase over the baseline from *percent* to *percentage points*, include the Remeasurement 2 goal in the results table, determine the Remeasurement 3 goal after collecting the Remeasurement 2 results, and include the actual barriers and intervention titles in the Activity VIII table.

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

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

Detroit Wayne Mental Health Authority identified barriers by completing a fishbone analysis. The barriers included coding issues, lack of peers trained to facilitate evidence-based wellness workshops, and consumers' inability to attend workshops due to lack of transportation. **Detroit Wayne Mental Health Authority**'s interventions included a coding manual for providers, training of additional peer support specialists, notifications to peers and providers about evidence-based

wellness trainings, and provision of bus tickets to consumers for transportation to and from wellness self-management workshops.

Table 3-42 below shows baseline and remeasurement results for **Detroit Wayne Mental Health Authority**'s PIP study indicator:

Table 3-42—Performance Improvement Project Outcomes for Detroit Wayne Mental Health Authority

PIP Study Indicator	Baseline Period	Remeasurement 1	Remeasurement 2	Sustained Improvement
The percentage of adult SMI consumers with at least one chronic health condition who completed a wellness self-management workshop during the measurement year.	1.3%	2.7%		

For the 2015–2016 validation, **Detroit Wayne Mental Health Authority** reported and interpreted its first remeasurement data accurately. The PIHP used appropriate quality improvement tools to conduct causal/barrier analysis and implemented interventions with the potential to have a positive impact on the study indicator outcomes.

Detroit Wayne Mental Health Authority's Remeasurement 1 rate for the study indicator was 2.7 percent. This rate demonstrated a statistically significant improvement of 1.4 percentage points above the baseline and was 0.1 percentage point above the PIHP's goal of 2.6 percent. The study indicator demonstrated statistically significant improvement, indicating that the interventions had a positive impact on the **quality** of and **access** to care and services provided by the PIHP. **Detroit Wayne Mental Health Authority** should continue to monitor the identified barriers and develop additional interventions to build on its momentum of improvement to sustain the improvement achieved.

As **Detroit Wayne Mental Health Authority** progresses in the study, assessment of the impact of the PIP on the **quality** of and **access** to care and services will continue.

Region 8—Oakland County CMH Authority

Findings

For the 2015–2016 validation, **Oakland County CMH Authority** provided its third-year submission on this PIP topic: *Increasing the Proportion of Medicaid Eligible Adults with Mental Illness and Diabetes Who Have Their Diabetes Addressed in Their Current Individual Plan of Service*.

Table 3-43 and Table 3-44 show **Oakland County CMH Authority**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2015–2016 PIP Validation Report for **Oakland County CMH Authority**.

Table 3-43—Performance Improvement Project Validation Results for Oakland County CMH Authority

Study Stage	Activity		Percentage of Applicable Elements		
			Met	*Partially Met*	*Not Met*
Design	I.	Appropriate Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Clearly Defined, Answerable Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Correctly Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Clearly Defined Study Indicator(s)	100% (3/3)	0% (0/3)	0% (0/3)
	V.	Valid Sampling Techniques	*Not Applicable*		
	VI.	Accurate/Complete Data Collection	100% (4/4)	0% (0/4)	0% (0/4)
Design Total			**100% (11/11)**	**0% (0/11)**	**0% (0/11)**
Implementation	VII.	Sufficient Data Analysis and Interpretation	100% (8/8)	0% (0/8)	0% (0/8)
	VIII.	Appropriate Improvement Strategies	100% (3/3)	0% (0/3)	0% (0/3)
Implementation Total			**100% (11/11)**	**0% (0/11)**	**0% (0/11)**
Outcomes	IX.	Real Improvement Achieved	100% (4/4)	0% (0/4)	0% (0/4)
	X.	Sustained Improvement Achieved	*Not Assessed*		
Outcomes Total			**100% (4/4)**	**0% (0/4)**	**0% (0/4)**
Percentage Score of Applicable Evaluation Elements *Met*			**100% (26/26)**		

Table 3-44—Performance Improvement Project Validation Scores for Oakland County CMH Authority

Type of Annual Review	Percentage Score of Evaluation Elements *Met*	Percentage Score of Critical Elements *Met*	Overall Validation Status
Submission	100%	100%	*Met*
Resubmission	NA	NA	*NA*

Strengths

Oakland County CMH Authority submitted the Design, Implementation, and Outcomes stages of the PIP for the 2015–2016 validation. The PIHP did not resubmit the PIP after the initial submission as the PIP received a validation status of *Met,* with an overall score of 100 percent and a score of 100 percent for critical elements. Based on the validation of this PIP, HSAG's assessment determined high confidence in the results.

The performance of this PIP suggests a thorough application of the PIP design, appropriate analysis of the results, and implementation of system interventions related to barriers identified through quality improvement processes.

Recommendations

HSAG identified *Points of Clarification* as opportunities for improvement in Activity VII—Sufficient Data Analysis and Interpretation and Activity VIII—Appropriate Improvement Strategies. **Oakland County CMH Authority** should specify the improvement over the baseline rate as percentage points or percent, document the Remeasurement 2 goal in the Activity VII results table, and list the barrier and intervention titles in the Remeasurement 2 interventions table.

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

Oakland County CMH Authority's PIP topic, *Increasing the Proportion of Medicaid Eligible Adults with Mental Illness and Diabetes Who Have Their Diabetes Addressed in Their Current Individual Plan of Service,* addressed CMS' requirements related to quality outcomes—specifically, the **quality** and **accessibility** of care and services. The goal of the study is to increase the percentage of Medicaid eligible adults, with mental illness and diabetes, who have their diabetes addressed (i.e., have a goal or objective related to their diabetes) in their current individual plan of service).

Oakland County CMH Authority identified barriers by using data mining and analysis of process-level data from the PIHP's centralized data system. The primary barrier was that— at the time of development or review of the treatment plan—the person responsible for documenting the individual plan of service did not always have accurate information regarding the consumer's chronic health condition of diabetes. **Oakland County CMH Authority**'s interventions included

providing information on consumers with a diagnosis of diabetes to the persons responsible for the plans of service and sending aggregated project data to the health plan network.

Table 3-45 below shows baseline and remeasurement results for **Oakland County CMH Authority**'s PIP study indicator:

Table 3-45—Performance Improvement Project Outcomes for Oakland County CMH Authority

PIP Study Indicator	Baseline Period	Remeasurement 1	Remeasurement 2	Sustained Improvement
The proportion of Medicaid eligible adults with mental illness and diabetes receiving services from the PIHP who have their diabetes addressed in their current Plan of Service.	34.0%	48.6%		

For the 2015–2016 validation, **Oakland County CMH Authority** reported and interpreted its first remeasurement data accurately. The PIHP used appropriate quality improvement tools to conduct causal/barrier analysis and implemented interventions with the potential to have a positive impact on the study indicator outcomes.

Oakland County CMH Authority's Remeasurement 1 rate for the study indicator was 48.6 percent. This rate demonstrated a statistically significant improvement of 14.6 percentage points above the baseline and was 10.5 percentage points above the PIHP's goal of 38.1 percent. The study indicator demonstrated statistically significant improvement, indicating that the interventions had a positive impact on the **quality** of and **access** to care and services provided by the PIHP. **Oakland County CMH Authority** should build on its momentum of improvement to ensure that it can sustain the improvement achieved.

As **Oakland County CMH Authority** progresses in the study, assessment of the impact of the PIP on the **quality** of and **access** to care and services will continue.

Region 9—Macomb County CMH Services

Findings

For the 2015–2016 validation, **Macomb County CMH Services** provided its third-year submission on this PIP topic: *Increasing Metabolic Syndrome Screening for Adults with Severe Mental Illness*.

Table 3-46 and Table 3-47 show **Macomb County CMH Services**' scores based on HSAG's PIP evaluation. For additional details, refer to the 2015–2016 PIP Validation Report for **Macomb County CMH Services**.

Table 3-46—Performance Improvement Project Validation Results for Macomb County CMH Services

Study Stage	Activity		Percentage of Applicable Elements		
			Met	*Partially Met*	*Not Met*
Design	I.	Appropriate Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Clearly Defined, Answerable Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Correctly Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Clearly Defined Study Indicator(s)	100% (3/3)	0% (0/3)	0% (0/3)
	V.	Valid Sampling Techniques	*Not Applicable*		
	VI.	Accurate/Complete Data Collection	83% (5/6)	0% (0/6)	17% (1/6)
Design Total			**92% (12/13)**	**0% (0/13)**	**8% (1/13)**
Implementation	VII.	Sufficient Data Analysis and Interpretation	88% (7/8)	13% (1/8)	0% (0/8)
	VIII.	Appropriate Improvement Strategies	33% (1/3)	67% (2/3)	0% (0/3)
Implementation Total			**73% (8/11)**	**27% (3/11)**	**0% (0/11)**
Outcomes	IX.	Real Improvement Achieved	100% (4/4)	0% (0/4)	0% (0/4)
	X.	Sustained Improvement Achieved	*Not Assessed*		
Outcomes Total			**100% (4/4)**	**0% (0/4)**	**0% (0/4)**
Percentage Score of Applicable Evaluation Elements *Met*			**86% (24/28)**		

Table 3-47—Performance Improvement Project Validation Scores for Macomb County CMH Services

Type of Annual Review	Percentage Score of Evaluation Elements *Met*	Percentage Score of Critical Elements *Met*	Overall Validation Status
Submission	86%	67%	*Not Met*
Resubmission	NA	NA	*NA*

Strengths

Macomb County CMH Services submitted the Design, Implementation, and Outcomes stages of the PIP for the 2015–2016 validation. The PIP received a validation status of *Not Met* for its initial PIP submission, with an overall score of 86 percent and a score of 67 percent for critical elements. However, the PIHP chose not to resubmit the PIP to improve the scores.

The performance of this PIP suggests a thorough application of the PIP design and selection of appropriate interventions based on data analysis.

Recommendations

HSAG identified opportunities for improvement in Activity VI— Accurate/Complete Data Collection, Activity VII— Sufficient Data Analysis and Interpretation, and Activity VIII—Appropriate Improvement Strategies. **Macomb County CMH Services** should include its manual data collection tool with the next PIP resubmission; specify the Remeasurement 1 and Remeasurement 2 time periods—actual numeric percent goals for both Remeasurement 1 and Remeasurement 2 and statistical testing results with the *p* value for Remeasurement 1; perform a causal/barrier analysis every year to identify relevant barriers and interventions, and include the completed tools with the PIP submission; include barriers and corresponding interventions being implemented or continued during Remeasurement 2 in the Activity VIII table; and detail any interventions discontinued and the rationale for doing so. **Macomb County CMH Services** should provide results of the evaluation for each intervention in the PIP.

HSAG identified *Points of Clarification* as opportunities for improvement in Activity IV— Clearly Defined Study Indicator(s), Activity VI—Accurate/Complete Data Collection, Activity VII—Sufficient Data Analysis and Interpretation and Activity VIII—Appropriate Improvement Strategies. **Macomb County CMH Services** should correct its Remeasurement 1 and Remeasurement 2 goals, include the current ISCAT in the next PIP submission, move the interpretation of Remeasurement 1 data to the correct section heading, and specify percentage points or percentage of improvement shown over the baseline. For comparability of data across measurement periods, **Macomb County CMH Services** should recalculate and analyze Remeasurement 1 data including correct lab codes or report the impact of not including missing codes.

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

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

Macomb County CMH Services identified barriers by developing a committee and analyzing consumer data. The barriers included providers' and consumers' lack of knowledge about the possible adverse impact of second-generation atypical antipsychotic medications, insufficient ongoing monitoring of labs ordered, and inconsistent documentation of lab orders in the electronic medical record. **Macomb County CMH Services**' interventions included a quality forum with handouts about metabolic syndrome and implementation of an integrated health portal to assist in the development and monitoring of health goals.

Table 3-48 below shows baseline and remeasurement results for **Macomb County CMH Services**' PIP study indicator:

Table 3-48—Performance Improvement Project Outcomes for Macomb County CMH Services

PIP Study Indicator	Baseline Period	Remeasurement 1	Remeasurement 2	Sustained Improvement
The percentage of consumers who are prescribed atypical second-generation antipsychotic medication and are also monitored for metabolic syndrome by having at least one of the Adult Treatment Panel III measures completed during the measurement period.	41.0%	54.9%		

For the 2015–2016 validation, **Macomb County CMH Services** reported and interpreted its first remeasurement data accurately. The PIHP used appropriate quality improvement tools to conduct causal/barrier analysis and implemented interventions with the potential to have a positive impact on the study indicator outcomes.

Macomb County CMH Services' Remeasurement 1 rate for the study indicator was 54.9 percent. This rate demonstrated a statistically significant improvement of 13.9 percentage points above the baseline. The documentation provided was unclear regarding the Remeasurement 1 goal set by the PIHP, and HSAG could not evaluate whether or not the PIHP met its Remeasurement 1 goal.

The **Macomb County CMH Services** PIP received a *Not Met* validation status due to inaccurate results and inadequate documentation in the PIP submission form. However, the PIHP demonstrated statistically significant improvement in the study indicator results, indicating that the interventions had a positive impact on the **quality** of and **access** to care and services provided by

the PIHP. **Macomb County CMH Services** should build on its momentum of improvement to ensure that it can sustain the improvement achieved.

As **Macomb County CMH Services** progresses in the study, assessment of the impact of the PIP on the **quality** of and **access** to care and services will continue.

Region 10 PIHP

Findings

For the 2015–2016 validation, **Region 10 PIHP** provided its third-year submission on this PIP topic: *Behavioral and Physical Health Care Integration.*

Table 3-49 and Table 3-50 show **Region 10 PIHP**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2015–2016 PIP Validation Report for **Region 10 PIHP**.

Table 3-49—Performance Improvement Project Validation Results for Region 10 PIHP

Study Stage	Activity		Percentage of Applicable Elements		
			Met	*Partially Met*	*Not Met*
Design	I.	Appropriate Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Clearly Defined, Answerable Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Correctly Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Clearly Defined Study Indicator(s)	100% (3/3)	0% (0/3)	0% (0/3)
	V.	Valid Sampling Techniques	*Not Applicable*		
	VI.	Accurate/Complete Data Collection	100% (4/4)	0% (0/4)	0% (0/4)
Design Total			**100% (11/11)**	**0% (0/11)**	**0% (0/11)**
Implementation	VII.	Sufficient Data Analysis and Interpretation	100% (8/8)	0% (0/8)	0% (0/8)
	VIII.	Appropriate Improvement Strategies	100% (2/2)	0% (0/2)	0% (0/2)
Implementation Total			**100% 10/10**	**0% 0/10**	**0% 0/10**
Outcomes	IX.	Real Improvement Achieved	67% (2/3)	0% (0/3)	33% (1/3)
	X.	Sustained Improvement Achieved	*Not Assessed*		
Outcomes Total			**67% (2/3)**	**0% (0/3)**	**33% (1/3)**
Percentage Score of Applicable Evaluation Elements *Met*			**96% (23/24)**		

Table 3-50—Performance Improvement Project Validation Scores for Region 10 PIHP

Type of Annual Review	Percentage Score of Evaluation Elements *Met*	Percentage Score of Critical Elements *Met*	Overall Validation Status
Submission	81%	63%	*Not Met*
Resubmission	96%	88%	*Not Met*

Strengths

Region 10 PIHP submitted the Design, Implementation, and Outcomes stages of the PIP for the 2015–2016 validation. The initial submission received an overall *Not Met* validation status. **Region 10 PIHP** received technical assistance from HSAG, corrected the identified deficiencies, and resubmitted the PIP for a second review. However, as the remeasurement results did not show a statistically significant improvement over the baseline, the final overall validation status remained *Not Met*, with an overall score of 96 percent and a score of 88 percent for critical elements.

The performance of this PIP suggests a thorough application of the PIP design and selection of appropriate interventions based on data mining and root cause analysis.

Recommendations

HSAG identified an opportunity for improvement in Activity IX—Real Improvement Achieved. **Region 10 PIHP** should continue efforts to achieve statistically significant improvement in the study indicator. The PIHP should address the *Points of Clarification* in Activity IV—Clearly Defined Study Indicator(s) and indicate the Remeasurement 2 goal in this activity. Additionally, HSAG recommended that **Region 10 PIHP** continue to work to solve data issues and implement interventions to improve its study indicator results.

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

Region 10 PIHP's PIP topic, *Behavioral and Physical Health Care Integration,* addressed CMS' requirements related to quality outcomes—specifically, the **quality** and **accessibility** of care and services. The goal of the study is to increase the percentage of consumers identified as having cardiovascular risk factors who had an encounter for a medical service to treat the condition.

Region 10 PIHP identified barriers by completing a root cause analysis. The barriers included care managers' limited knowledge of—and reluctance to address—physical health issues with consumers as well as consumer-level barriers, including lack of engagement and follow-through with primary care. **Region 10 PIHP**'s interventions included developing staff training resources on cardiovascular risk, a cardiovascular checklist to monitor conditions and interventions, and materials for consumer education explaining cardiovascular risks and how to address them; conducting meetings with individual consumers to focus on the need to access medical services; adding a primary care referral form and/or consent to coordinate care into every consumer's electronic health record; and developing at least one health-related goal for every consumer.

Table 3-51 below shows baseline and remeasurement results for **Region 10 PIHP**'s PIP study indicator:

Table 3-51—Performance Improvement Project Outcomes for Region 10 PIHP

PIP Study Indicator	Baseline Period	Remeasurement 1	Remeasurement 2	Sustained Improvement
The proportion of SMI adult Medicaid consumers identified with select cardio- vascular risk conditions that had at least one reported encounter to the State's data warehouse for a medical service to treat a cardiovascular condition.	27.2%	29.9%		

For the 2015–2016 validation, **Region 10 PIHP** reported and interpreted its baseline and Remeasurement 1 data. The PIHP used appropriate quality improvement tools to conduct causal/barrier analysis and implemented in Remeasurement 2 interventions with the potential to have a positive impact on the study indicator outcomes.

Region 10 PIHP identified an error in the calculation of the baseline rate and revised the baseline rate in the current-year PIP submission. The revised rate of 27.2 percent was 5.2 percentage points higher than originally reported. The study indicator demonstrated improvement, but it was not statistically significant and did not meet the Remeasurement 1 goal. **Region 10 PIHP**'s Remeasurement 1 rate was 29.9 percent, an increase of 2.7 percentage points over the baseline but 2.1 percentage points below the PIHP's goal of 32 percent. The PIHP indicated numerous difficulties in procuring accurate and timely baseline data in order to perform a root cause analysis and implement PIP-related interventions during Remeasurement 1. **Region 10 PIHP** should continue efforts to resolve data issues and implement interventions aiming to improve member care and impact the **quality** of and **access** to care and services provided by the PIHP.

As **Region 10 PIHP** progresses in the study, assessment of the impact of the PIP on the **quality** of and **access** to care and services will continue.

4. Assessment of PIHP Follow-Up on Prior Recommendations

Introduction

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

The 2015–2016 follow-up compliance monitoring reviews addressed the PIHPs' compliance with requirements that had received scores of less than *Met* in the prior review cycle. This section presents a summary of the PIHPs' progress in addressing recommendations identified in the 2014–2015 review of compliance standards.

The validation of performance measures assessed the PIHPs' processes related to the reporting of performance indicator data and oversight of subcontractors' performance indicator reporting activities. This section presents each PIHP's status of addressing recommendations identified in the 2014–2015 validation cycle.

For the 2015–2016 validation, the PIHPs continued their PIPs related to integration of physical and mental healthcare. This section presents an assessment of the PIHPs' follow-up on recommendations from the 2014–2015 validation cycle.

Region 1—NorthCare Network

Compliance Monitoring

Table 4-1 shows the results for **NorthCare Network** from the 2014–2015 compliance monitoring review and the 2015–2016 assessment of the PIHP's follow-up on HSAG's recommendations.

Table 4-1—Compliance Following Initial and Follow-Up Reviews

Standard		Full Compliance		One or More Remaining Corrective Action(s)
		Achieved at Initial Review	Achieved After Follow-Up	
I	QAPIP Plan and Structure	✓		
II	Performance Measurement and Improvement	✓		
III	Practice Guidelines	✓		
IV	Staff Qualifications and Training	✓		
V	Utilization Management	✓		
VI	Customer Services	✓		
VII	Enrollee Grievance Process	✓		
VIII	Enrollee Rights and Protections	✓		
IX	Subcontracts and Delegation	✓		
X	Provider Network	✓		
XI	Credentialing	✓		
XII	Access and Availability		✓	
XIII	Coordination of Care	✓		
XIV	Appeals		✓	
XV	Disclosure of Ownership, Control, and Criminal Convictions		✓	

The 2014–2015 compliance monitoring review resulted in recommendations for improvement for the following standards: Standard XII—Access and Availability; Standard XIV—Appeals; and Standard XV—Disclosure of Ownership, Control, and Criminal Convictions. The PIHP addressed recommendations through corrective actions and implemented improvements. As determined in the 2015–2016 review, **NorthCare Network** successfully addressed all prior recommendations and achieved full compliance on all standards.

Validation of Performance Measures

Based on recommendations made last year during the performance validation audit, **NorthCare Network** ensured that the submitted ISCAT reflected current and accurate information. The PIHP provided a report to its CMHSPs to review their own performance indicator results and compare results to the other CMHSPs in the region. All systems-related changes were adequately documented.

NorthCare Network increased its rates on performance indicators that fell below the standard last year to exceed the performance standard in the current validation cycle.

Validation of Performance Improvement Projects

The 2014–2015 validation of performance improvement projects for **NorthCare Network** identified a *Point of Clarification* as an opportunity for improvement in Activity VIII—Implement Intervention and Improvement Strategies. In its 2015–2016 PIP submission, the PIHP included an updated process map; however, the map detailed the PIP project rather than the steps toward achieving improvement in the study indicator. **NorthCare Network** did not fully address the prior recommendation.

Region 2—Northern Michigan Regional Entity

Compliance Monitoring

Table 4-2 shows the results for **Northern Michigan Regional Entity** from the 2014–2015 compliance monitoring review and the 2015–2016 assessment of the PIHP's follow-up on HSAG's recommendations.

Table 4-2—Compliance Following Initial and Follow-Up Reviews

Standard		Full Compliance		One or More Remaining Corrective Action(s)
		Achieved at Initial Review	Achieved After Follow-Up	
I	QAPIP Plan and Structure		✓	
II	Performance Measurement and Improvement	✓		
III	Practice Guidelines	✓		
IV	Staff Qualifications and Training	✓		
V	Utilization Management	✓		
VI	Customer Services	✓		
VII	Enrollee Grievance Process	✓		
VIII	Enrollee Rights and Protections	✓		
IX	Subcontracts and Delegation	✓		
X	Provider Network	✓		
XI	Credentialing	✓		
XII	Access and Availability			✓
XIII	Coordination of Care	✓		
XIV	Appeals	✓		
XV	Disclosure of Ownership, Control, and Criminal Convictions		✓	

The 2014–2015 compliance monitoring review resulted in recommendations for improvement for the following standards: Standard I—QAPIP Plan and Structure; Standard XII—Access and Availability; and Standard XV—Disclosure of Ownership, Control, and Criminal Convictions. The PIHP addressed recommendations through corrective actions and implemented improvements. As determined in the 2015–2016 review, **Northern Michigan Regional Entity** successfully addressed the prior recommendations for the QAPIP Plan and Structure and Disclosure of Ownership, Control, and Criminal Convictions standards but received one continued recommendation for the Access and Availability standard. The PIHP achieved full compliance on 14 of the 15 standards.

Validation of Performance Measures

Northern Michigan Regional Entity addressed last year's recommendation to ensure that the submitted ISCAT reflected current and accurate information. The PIHP continued to have difficulty generating encounter data files from its CX360 system. **Northern Michigan Regional Entity** implemented a new data system to eliminate the data concerns.

To ensure that only accurate information was used for performance indicator calculation, **Northern Michigan Regional Entity** implemented additional data quality checks in the form of primary source verification.

Northern Michigan Regional Entity showed improvement in the rates for performance indicators that fell below the minimum performance standard last year.

Validation of Performance Improvement Projects

The 2014–2015 validation of performance improvement projects for **Northern Michigan Regional Entity** identified a *Point of Clarification* as an opportunity for improvement in Activity VIII—Implement Intervention and Improvement Strategies. In its 2015–2016 PIP submission, the PIHP completed a causal/barrier analysis and used improvement strategies related to the causes/barriers identified through data analysis and a quality improvement process. **Northern Michigan Regional Entity** successfully addressed the prior recommendation.

Region 3—Lakeshore Regional Entity

Compliance Monitoring

Table 4-3 shows the results for **Lakeshore Regional Entity** from the 2014–2015 compliance monitoring review and the 2015–2016 assessment of the PIHP's follow-up on HSAG's recommendations.

Table 4-3—Compliance Following Initial and Follow-Up Reviews

Standard		Full Compliance		One or More Remaining Corrective Action(s)
		Achieved at Initial Review	Achieved After Follow-Up	
I	QAPIP Plan and Structure		✓	
II	Performance Measurement and Improvement		✓	
III	Practice Guidelines	✓		
IV	Staff Qualifications and Training	✓		
V	Utilization Management			✓
VI	Customer Services	✓		
VII	Enrollee Grievance Process	✓		
VIII	Enrollee Rights and Protections	✓		
IX	Subcontracts and Delegation			✓
X	Provider Network			✓
XI	Credentialing		✓	
XII	Access and Availability		✓	
XIII	Coordination of Care	✓		
XIV	Appeals		✓	
XV	Disclosure of Ownership, Control, and Criminal Convictions			✓

The 2014–2015 compliance monitoring review resulted in recommendations for improvement for the following standards: Standard I—QAPIP Plan and Structure; Standard II—Performance Measurement and Improvement; Standard V—Utilization Management; Standard IX—Subcontracts and Delegation; Standard X—Provider Network; Standard XI—Credentialing; Standard XII—Access and Availability; Standard XIV—Appeals; and Standard XV—Disclosure of Ownership, Control, and Criminal Convictions. The PIHP addressed recommendations through corrective actions and implemented improvements. As determined in the 2015–2016 review, **Lakeshore Regional Entity** successfully addressed the prior recommendations for the QAPIP Plan and Structure, Performance Measurement and Improvement, Credentialing, Access and Availability, and Appeals standards. However, the PIHP received continued recommendations for the Utilization Management; Subcontracts and Delegation; Provider Network; and Disclosure of Ownership,

Control, and Criminal Convictions standards. The PIHP achieved full compliance on 11 of the 15 standards.

Validation of Performance Measures

Based on recommendations made last year during the performance validation audit, **Lakeshore Regional Entity** implemented a validation process for its SUD data. As a result, rejection files received from the State were few. The PIHP created a summary report with information on each CMHSP's performance and errors and made this report available to all affiliates for performance monitoring.

Lakeshore Regional Entity showed improvement in indicator rates that fell below the minimum performance standard in the prior year, achieving current-year rates well above the standard.

Validation of Performance Improvement Projects

The 2014–2015 validation of performance improvement projects for **Lakeshore Regional Entity** identified no opportunities for improvement.

Region 4—Southwest Michigan Behavioral Health

Compliance Monitoring

Table 4-4 shows the results for **Southwest Michigan Behavioral Health** from the 2014–2015 compliance monitoring review and the 2015–2016 assessment of the PIHP's follow-up on HSAG's recommendations.

Table 4-4—Compliance Following Initial and Follow-Up Reviews

Standard		Full Compliance		One or More Remaining Corrective Action(s)
		Achieved at Initial Review	Achieved After Follow-Up	
I	QAPIP Plan and Structure			✓
II	Performance Measurement and Improvement	✓		
III	Practice Guidelines	✓		
IV	Staff Qualifications and Training	✓		
V	Utilization Management	✓		
VI	Customer Services	✓		
VII	Enrollee Grievance Process		✓	
VIII	Enrollee Rights and Protections	✓		
IX	Subcontracts and Delegation	✓		
X	Provider Network		✓	
XI	Credentialing	✓		
XII	Access and Availability			✓
XIII	Coordination of Care		✓	
XIV	Appeals			✓
XV	Disclosure of Ownership, Control, and Criminal Convictions			✓

The 2014–2015 compliance monitoring review resulted in recommendations for improvement for the following standards: Standard I—QAPIP Plan and Structure; Standard VII—Enrollee Grievance Process; Standard X—Provider Network; Standard XII—Access and Availability; Standard XIII—Coordination of Care; Standard XIV—Appeals; and Standard XV—Disclosure of Ownership, Control, and Criminal Convictions. The PIHP addressed recommendations through corrective actions and implemented improvements. As determined in the 2015–2016 review, **Southwest Michigan Behavioral Health** successfully addressed the prior recommendations for the Enrollee Grievance Process, Provider Network, and Coordination of Care standards. However, the PIHP received continued recommendations for the QAPIP Plan and Structure; Access and Availability; Appeals; and Disclosure of Ownership, Control, and Criminal Convictions standards. The PIHP achieved full compliance on 11 of the 15 standards.

Validation of Performance Measures

Based on recommendations made last year during the performance validation audit, **Southwest Michigan Behavioral Health** ensured that all CMHSPs were operating the same version of the SmartCare system. With the exception of one population, **Southwest Michigan Behavioral Health** improved its rates for Indicator 3.

Validation of Performance Improvement Projects

The 2014–2015 validation of performance improvement projects for **Southwest Michigan Behavioral Health** identified no opportunities for improvement.

Region 5—Mid-State Health Network

Compliance Monitoring

Table 4-5 shows the results for **Mid-State Health Network** from the 2014–2015 compliance monitoring review and the 2015–2016 assessment of the PIHP's follow-up on HSAG's recommendations.

Table 4-5—Compliance Following Initial and Follow-Up Reviews

Standard		Full Compliance		One or More Remaining Corrective Action(s)
		Achieved at Initial Review	Achieved After Follow-Up	
I	QAPIP Plan and Structure	✓		
II	Performance Measurement and Improvement	✓		
III	Practice Guidelines	✓		
IV	Staff Qualifications	✓		
V	Utilization Management	✓		
VI	Customer Services	✓		
VII	Enrollee Grievance Process	✓		
VIII	Enrollee Rights and Protections	✓		
IX	Subcontracts and Delegation		✓	
X	Provider Network	✓		
XI	Credentialing		✓	
XII	Access and Availability	✓		
XIII	Coordination of Care	✓		
XIV	Appeals	✓		
XV	Disclosure of Ownership, Control, and Criminal Convictions		✓	

The 2014–2015 compliance monitoring review resulted in recommendations for improvement for the following standards: Standard IX—Subcontracts and Delegation; Standard XI—Credentialing; and Standard XV—Disclosure of Ownership, Control, and Criminal Convictions. The PIHP addressed recommendations through corrective actions and implemented improvements. As determined in the 2015–2016 review, **Mid-State Health Network** successfully addressed all prior recommendations and achieved full compliance on all standards.

Validation of Performance Measures

Mid-State Health Network implemented all recommendations provided in the prior year. Based on last year's recommendation, the PIHP ensured that the ISCAT documentation included only information relevant to the PIHP's functions. In addition, **Mid-State Health Network** continued to work closely with the State to resolve existing issues.

Validation of Performance Improvement Projects

The 2014–2015 validation of performance improvement projects for **Mid-State Health Network** identified no opportunities for improvement.

Region 6—CMH Partnership of Southeast Michigan

Compliance Monitoring

Table 4-6 shows the results for **CMH Partnership of Southeast Michigan** from the 2014–2015 compliance monitoring review and the 2015–2016 assessment of the PIHP's follow-up on HSAG's recommendations.

Table 4-6—Compliance Following Initial and Follow-Up Reviews

Standard		Full Compliance		One or More Remaining Corrective Action(s)
		Achieved at Initial Review	Achieved After Follow-Up	
I	QAPIP Plan and Structure	✓		
II	Performance Measurement and Improvement	✓		
III	Practice Guidelines	✓		
IV	Staff Qualifications	✓		
V	Utilization Management	✓		
VI	Customer Services	✓		
VII	Enrollee Grievance Process		✓	
VIII	Enrollee Rights and Protections	✓		
IX	Subcontracts and Delegation	✓		
X	Provider Network	✓		
XI	Credentialing	✓		
XII	Access and Availability			✓
XIII	Coordination of Care	✓		
XIV	Appeals			✓
XV	Disclosure of Ownership, Control, and Criminal Convictions			✓

The 2014–2015 compliance monitoring review resulted in recommendations for improvement for the following standards: Standard VII—Enrollee Grievance Process; Standard XII—Access and Availability; Standard XIV—Appeals; and Standard XV—Disclosure of Ownership, Control, and Criminal Convictions. The PIHP addressed recommendations through corrective actions and implemented improvements. As determined in the 2015–2016 review, **CMH Partnership of Southeast Michigan** successfully addressed the prior recommendations for the Enrollee Grievance Process standard. However, the PIHP received continued recommendations for the Access and Availability; Appeals; and Disclosure of Ownership, Control, and Criminal Convictions standards. The PIHP achieved full compliance on 12 of the 15 standards.

Validation of Performance Measures

Based on recommendations made last year during the performance validation audit, **CMH Partnership of Southeast Michigan** implemented a requirement that affiliate CMHSPs submit a corrective action plan within 30 days when a performance indicator rate does not meet the minimum performance standard for one quarter.

The PIHP and its contracted vendor, PCE, performed indicator rate calculation separately and compared results for added quality control. For the current reporting period, **CMH Partnership of Southeast Michigan** ensured that consumers' initial calls for service requests were counted accurately by all CMHSPs.

CMH Partnership of Southeast Michigan implemented a process for primary source verification to ensure that each CMHSP identified cases appropriately for performance indicator reporting.

Validation of Performance Improvement Projects

The 2014–2015 validation of performance improvement projects for **CMH Partnership of Southeast Michigan** identified a *Point of Clarification* as an opportunity for improvement in Activity VII—Analyze and Interpret Study Results. In its 2015–2016 PIP submission, the PIHP presented results in a clear, accurate, and easily understood format. **CMH Partnership of Southeast Michigan** successfully addressed the prior recommendation.

Region 7—Detroit Wayne Mental Health Authority

Compliance Monitoring

Table 4-7 shows the results for **Detroit Wayne Mental Health Authority** from the 2014–2015 compliance monitoring review and the 2015–2016 assessment of the PIHP's follow-up on HSAG's recommendations.

Table 4-7—Compliance Following Initial and Follow-Up Reviews

Standard		Full Compliance		One or More Remaining Corrective Action(s)
		Achieved at Initial Review	Achieved After Follow-Up	
I	QAPIP Plan and Structure	✓		
II	Performance Measurement and Improvement	✓		
III	Practice Guidelines	✓		
IV	Staff Qualifications	✓		
V	Utilization Management	✓		
VI	Customer Services	✓		
VII	Enrollee Grievance Process	✓		
VIII	Enrollee Rights and Protections		✓	
IX	Subcontracts and Delegation	✓		
X	Provider Network	✓		
XI	Credentialing	✓		
XII	Access and Availability		✓	
XIII	Coordination of Care	✓		
XIV	Appeals	✓		
XV	Disclosure of Ownership, Control, and Criminal Convictions		✓	

The 2014–2015 compliance monitoring review resulted in recommendations for improvement for the following standards: Standard VIII—Enrollee Rights and Protections; Standard XII—Access and Availability; and Standard XV—Disclosure of Ownership, Control, and Criminal Convictions. The PIHP addressed recommendations through corrective actions and implemented improvements. As determined in the 2015–2016 review, **Detroit Wayne Mental Health Authority** successfully addressed all prior recommendations and achieved full compliance on all standards.

Validation of Performance Measures

Detroit Wayne Mental Health Authority implemented a crisis care plan in an effort to improve hospital recidivism rates. This process was implemented in March 2016; therefore, rate improvement will not be expected until the next reporting period.

Validation of Performance Improvement Projects

The 2014–2015 validation of performance improvement projects for **Detroit Wayne Mental Health Authority** identified no opportunities for improvement.

Region 8—Oakland County CMH Authority

Compliance Monitoring

Table 4-8 shows the results for **Oakland County CMH Authority** from the 2014–2015 compliance monitoring review and the 2015–2016 assessment of the PIHP's follow-up on HSAG's recommendations.

Table 4-8—Compliance Following Initial and Follow-Up Reviews

Standard		Full Compliance		One or More Remaining Corrective Action(s)
		Achieved at Initial Review	Achieved After Follow-Up	
I	QAPIP Plan and Structure		✓	
II	Performance Measurement and Improvement	✓		
III	Practice Guidelines	✓		
IV	Staff Qualifications	✓		
V	Utilization Management	✓		
VI	Customer Services	✓		
VII	Enrollee Grievance Process		✓	
VIII	Enrollee Rights and Protections	✓		
IX	Subcontracts and Delegation	✓		
X	Provider Network	✓		
XI	Credentialing		✓	
XII	Access and Availability		✓	
XIII	Coordination of Care	✓		
XIV	Appeals	✓		
XV	Disclosure of Ownership, Control, and Criminal Convictions		✓	

The 2014–2015 compliance monitoring review resulted in recommendations for improvement for the following standards: Standard I—QAPIP Plan and Structure; Standard VII—Enrollee Grievance Process; Standard XI—Credentialing; Standard XII—Access and Availability; and Standard XV—Disclosure of Ownership, Control, and Criminal Convictions. The PIHP addressed recommendations through corrective actions and implemented improvements. As determined in the 2015–2016 review, **Oakland County CMH Authority** successfully addressed all prior recommendations and achieved full compliance on all standards.

Validation of Performance Measures

Based on recommendations made last year during the performance validation audit, **Oakland County CMH Authority** initiated actions to improve the method used to generate and verify performance indicator data. For Performance Indicators 2, 3, 4, and 10, the PIHP created an automated report which was divided by provider to expedite the record review process. **Oakland County CMH Authority** transitioned from performing manual calculation to automating the calculation process for Performance Indicators 4 and 10. However, no improvements were made to calculation methods for Performance Indicators 1, 2, and 4a.

Validation of Performance Improvement Projects

The 2014–2015 validation of performance improvement projects for **Oakland County CMH Authority** identified no opportunities for improvement.

Region 9—Macomb County CMH Services

Compliance Monitoring

Table 4-9 shows the results for **Macomb County CMH Services** from the 2014–2015 compliance monitoring review and the 2015–2016 assessment of the PIHP's follow-up on HSAG's recommendations.

Table 4-9—Compliance Following Initial and Follow-Up Reviews

Standard		Full Compliance		One or More Remaining Corrective Action(s)
		Achieved at Initial Review	Achieved After Follow-Up	
I	QAPIP Plan and Structure	✓		
II	Performance Measurement and Improvement	✓		
III	Practice Guidelines	✓		
IV	Staff Qualifications	✓		
V	Utilization Management	✓		
VI	Customer Services	✓		
VII	Enrollee Grievance Process	✓		
VIII	Enrollee Rights and Protections	✓		
IX	Subcontracts and Delegation	✓		
X	Provider Network	✓		
XI	Credentialing	✓		
XII	Access and Availability			✓
XIII	Coordination of Care		✓	
XIV	Appeals	✓		
XV	Disclosure of Ownership, Control, and Criminal Convictions		✓	

The 2014–2015 compliance monitoring review resulted in recommendations for improvement for the following standards: Standard XII—Access and Availability; Standard XIII—Coordination of Care; and Standard XV—Disclosure of Ownership, Control, and Criminal Convictions. The PIHP addressed recommendations through corrective actions and implemented improvements. As determined in the 2015–2016 review, **Macomb County CMH Services** successfully addressed the prior recommendations for the Coordination of Care and Disclosure of Ownership, Control, and Criminal Convictions standards. However, the PIHP received a continued recommendation for the Access and Availability standard. The PIHP achieved full compliance on 14 of the 15 standards.

Validation of Performance Measures

Macomb County CMH Services worked with one of its contracted agencies, Macomb-Oakland Regional Center (MORC), to provide education and training to providers to ensure that all electronic medical records are completed accurately. **Macomb County CMH Services** conducted frequent meetings to ensure that quality improvement continued to be a priority. While some recommendations from the 2014–2015 audit continued through 2016, the PIHP continued to work closely with its vendor, PCE, to implement additional system edits in FOCUS.

Validation of Performance Improvement Projects

The 2014–2015 validation of performance improvement projects for **Macomb County CMH Services** identified no opportunities for improvement.

Region 10 PIHP

Compliance Monitoring

Table 4-10 shows the results for **Region 10 PIHP** from the 2014–2015 compliance monitoring review and the 2015–2016 assessment of the PIHP's follow-up on HSAG's recommendations.

Table 4-10—Compliance Following Initial and Follow-Up Reviews

Standard		Full Compliance		One or More Remaining Corrective Action(s)
		Achieved at Initial Review	Achieved After Follow-Up	
I	QAPIP Plan and Structure		✓	
II	Performance Measurement and Improvement		✓	
III	Practice Guidelines	✓		
IV	Staff Qualifications	✓		
V	Utilization Management			✓
VI	Customer Services	✓		
VII	Enrollee Grievance Process			✓
VIII	Enrollee Rights and Protections	✓		
IX	Subcontracts and Delegation		✓	
X	Provider Network		✓	
XI	Credentialing		✓	
XII	Access and Availability	✓		
XIII	Coordination of Care	✓		
XIV	Appeals		✓	
XV	Disclosure of Ownership, Control, and Criminal Convictions		✓	

The 2014–2015 compliance monitoring review resulted in recommendations for improvement for the following standards: Standard I—QAPIP Plan and Structure; Standard II—Performance Measurement and Improvement; Standard V—Utilization Management; Standard VII—Enrollee Grievance Process; Standard IX—Subcontracts and Delegation; Standard X—Provider Network; Standard XI—Credentialing; Standard XIV—Appeals; and Standard XV—Disclosure of Ownership, Control, and Criminal Convictions. The PIHP addressed recommendations through corrective actions and implemented improvements. As determined in the 2015–2016 review, **Region 10 PIHP** successfully addressed the prior recommendations for the QAPIP Plan and Structure; Performance Measurement and Improvement; Subcontracts and Delegation; Provider Network; Credentialing; Appeals; and Disclosure of Ownership, Control, and Criminal Convictions standards. However, the PIHP received continued recommendations for the Access and Availability and Utilization Management standards. The PIHP achieved full compliance on 13 of the 15 standards.

Validation of Performance Measures

Based on recommendations made last year during the performance validation audit, **Region 10 PIHP** hired several staff members with extensive background as well as familiarity with behavioral health data, performance indicators, policies, and procedures. In addition, most employees that the PIHP leased from various CMHSPs during the prior year transitioned into direct-hire PIHP staff members.

Validation of Performance Improvement Projects

The 2014–2015 validation of performance improvement projects for **Region 10 PIHP** identified *Points of Clarification* as opportunities for improvement in Activity IV—Select the Study Indicator(s), Activity VI—Reliably Collect Data, and Activity VIII—Implement Intervention and Improvement Strategies. In its 2015–2016 PIP submission, the PIHP described its data analysis plan with all necessary components but did not specify the actual percentage goal for Remeasurement 1. **Region 10 PIHP** completed the first two steps in Activity VIII but did not implement interventions in time to determine whether or not they were successful. **Region 10 PIHP** partially addressed the prior recommendations.

Appendix A. Summary Tables of External Quality Review Activity Results

Introduction

This section of the report presents prior and current-year results for the compliance monitoring standards, the validation of performance measures, and the validation of PIPs.

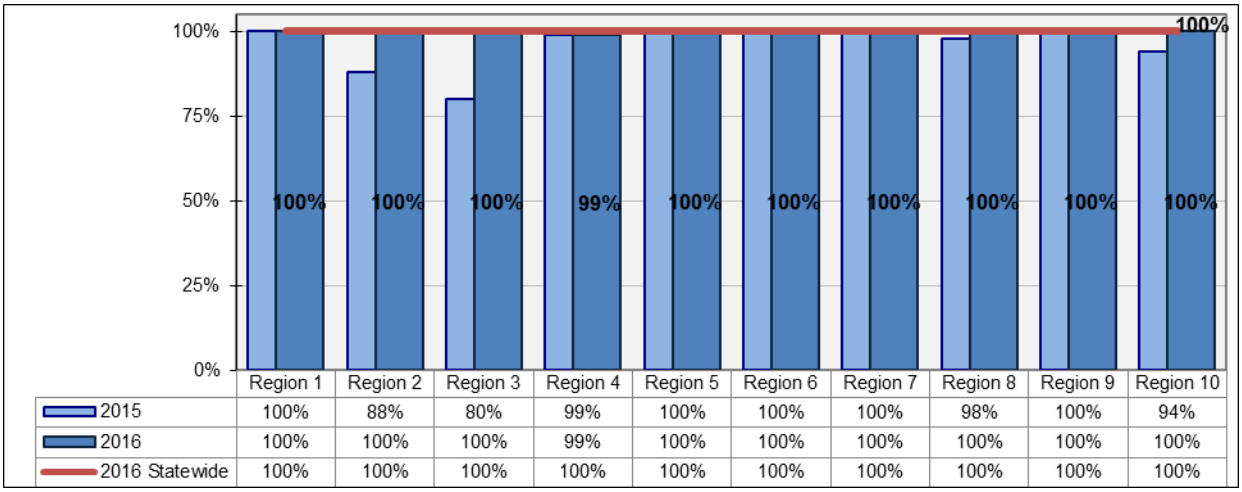
Results for Compliance Monitoring

The following tables and graphs present for each of the 15 standards reviewed PIHP-level results for the 2014–2015 full compliance monitoring reviews, the 2015–2016 follow-up compliance monitoring review scores, and the 2016 statewide scores.

Compliance Monitoring Standards

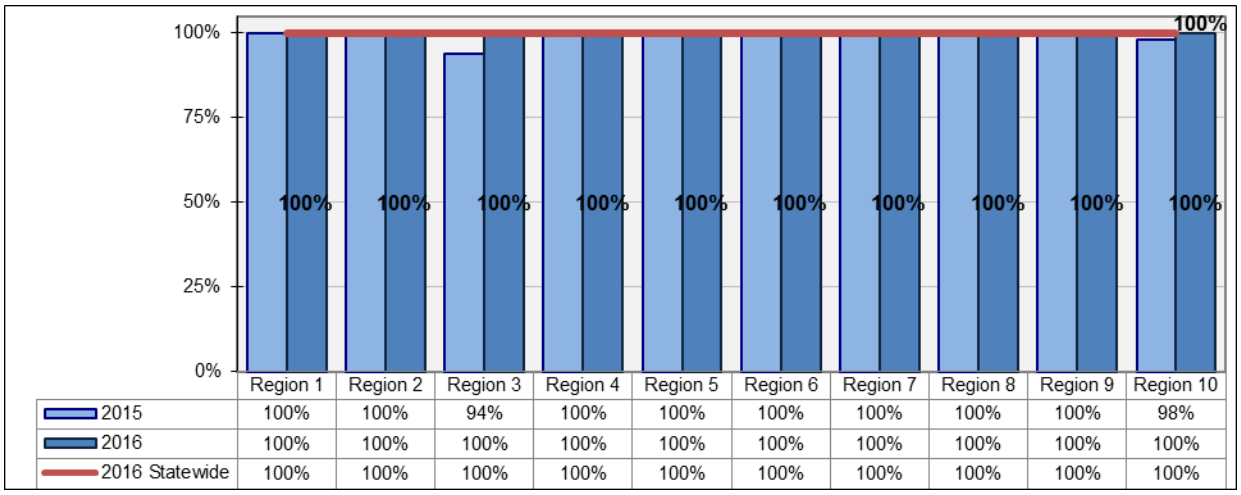
Figure A-1 through Figure A-15 present 2015–2016 statewide and PIHP-level compliance scores as well as prior-year scores for each of the 15 compliance monitoring standards.

Figure A-1—Standard I: QAPIP



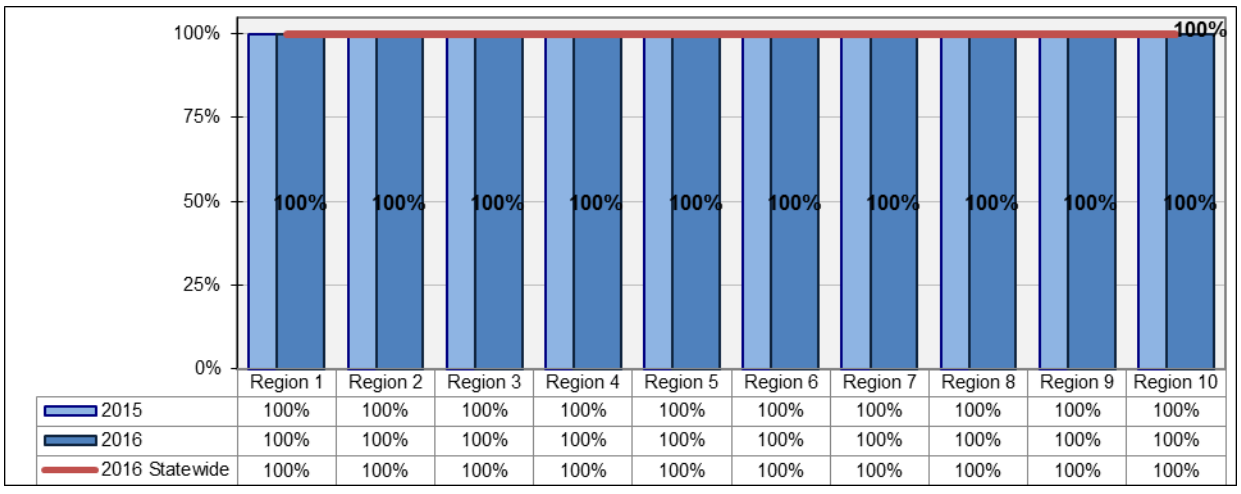
	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9	Region 10
2015	100%	88%	80%	99%	100%	100%	100%	98%	100%	94%
2016	100%	100%	100%	99%	100%	100%	100%	100%	100%	100%
2016 Statewide	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

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



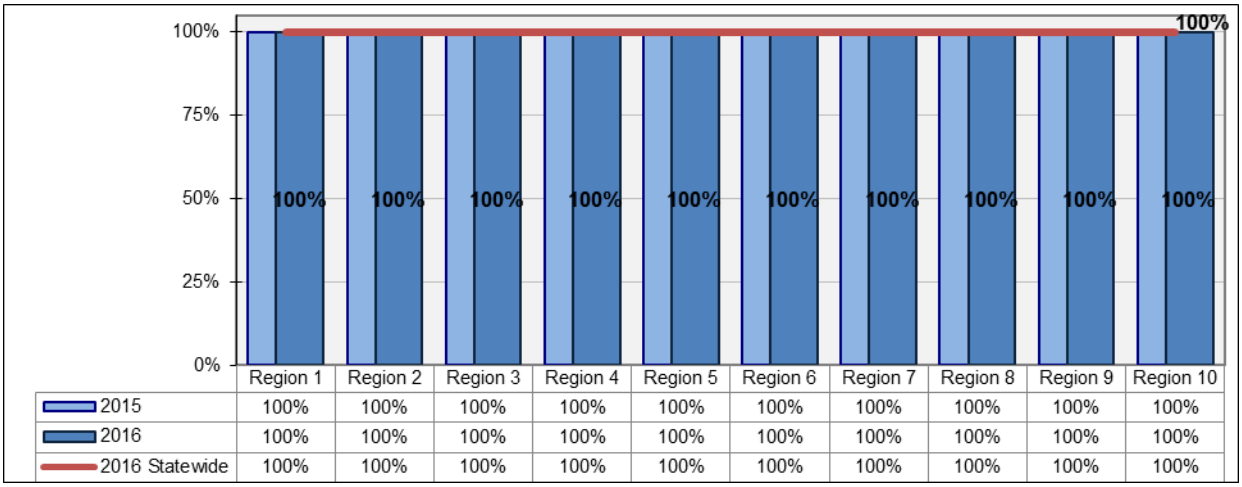
	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9	Region 10
2015	100%	100%	94%	100%	100%	100%	100%	100%	100%	98%
2016	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
2016 Statewide	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Figure A-3—Standard III: Practice Guidelines



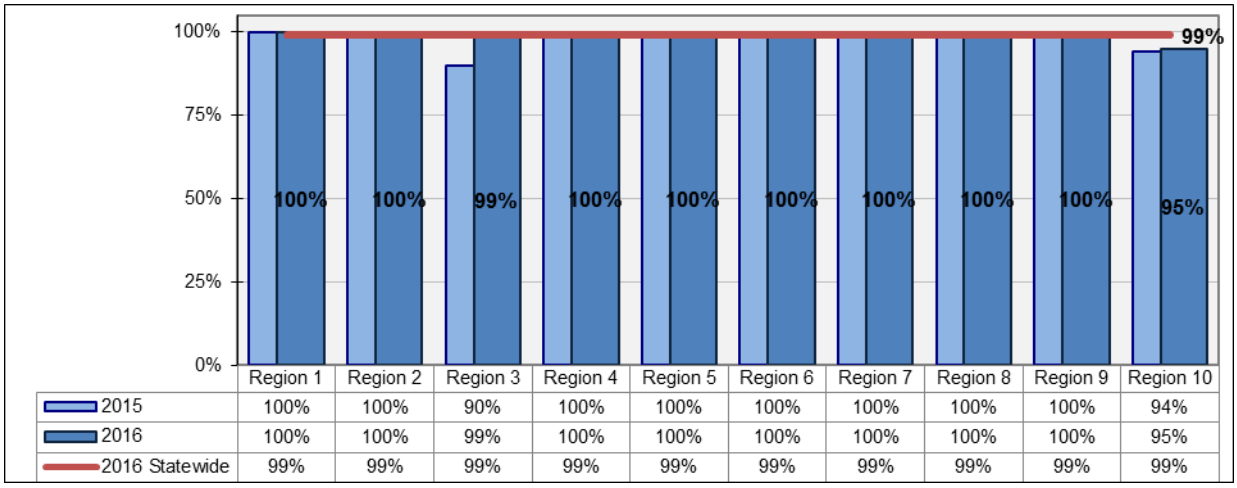
	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9	Region 10
2015	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
2016	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
2016 Statewide	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

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



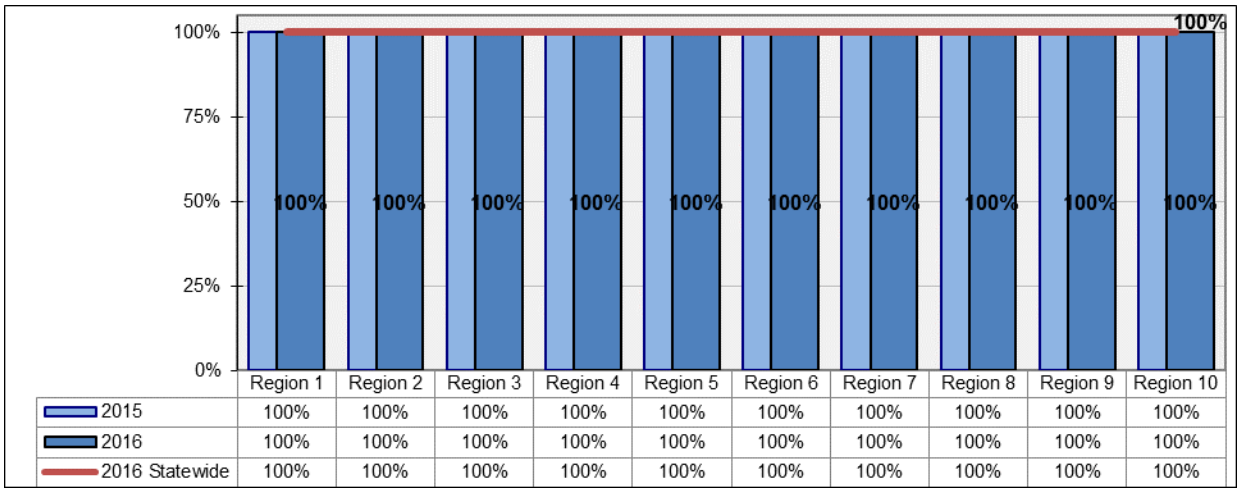
	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9	Region 10
2015	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
2016	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
2016 Statewide	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Figure A-5—Standard V: Utilization Management



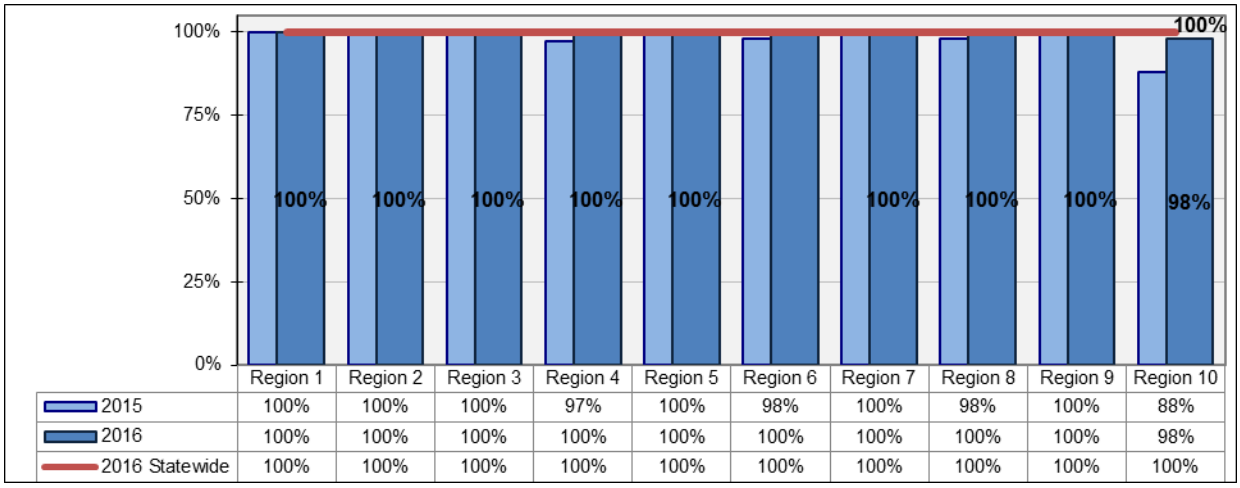
	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9	Region 10
2015	100%	100%	90%	100%	100%	100%	100%	100%	100%	94%
2016	100%	100%	99%	100%	100%	100%	100%	100%	100%	95%
2016 Statewide	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%

Figure A-6—Standard VI: Customer Services



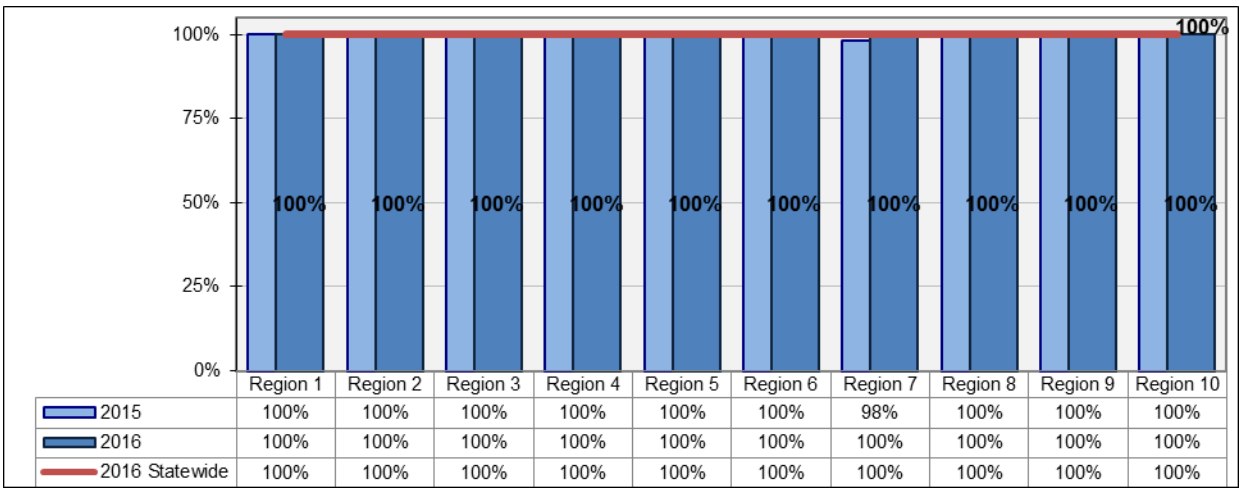
	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9	Region 10
2015	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
2016	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
2016 Statewide	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Figure A-7—Standard VII: Enrollee Grievance Process



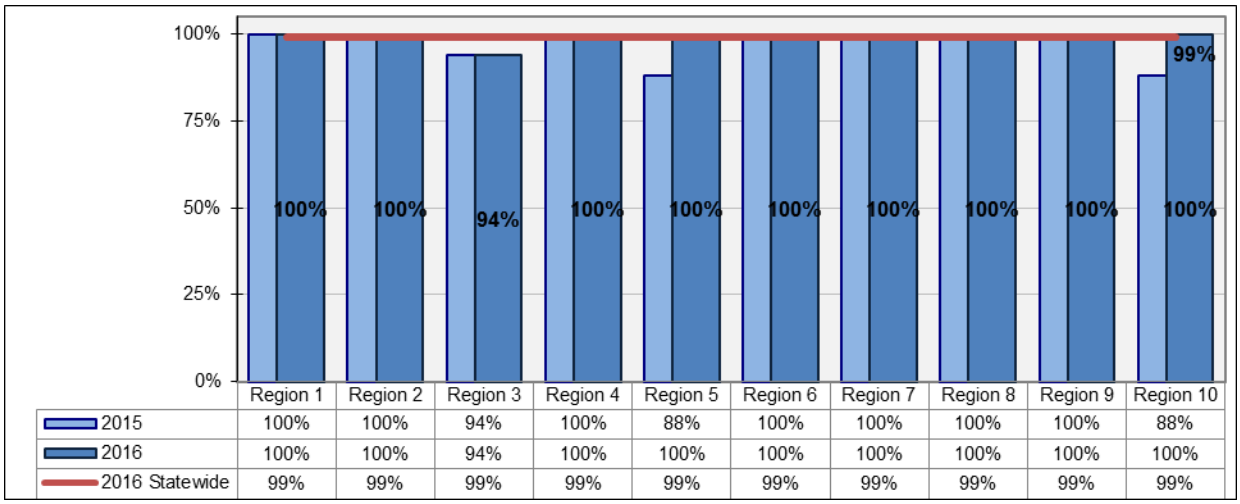
	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9	Region 10
2015	100%	100%	100%	97%	100%	98%	100%	98%	100%	88%
2016	100%	100%	100%	100%	100%	100%	100%	100%	100%	98%
2016 Statewide	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

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



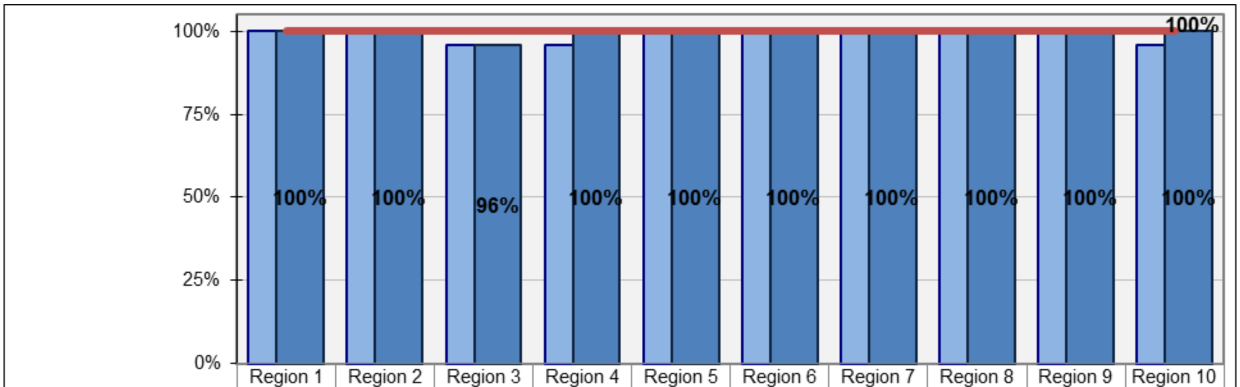
	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9	Region 10
2015	100%	100%	100%	100%	100%	100%	98%	100%	100%	100%
2016	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
2016 Statewide	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Figure A-9—Standard IX: Subcontracts and Delegation



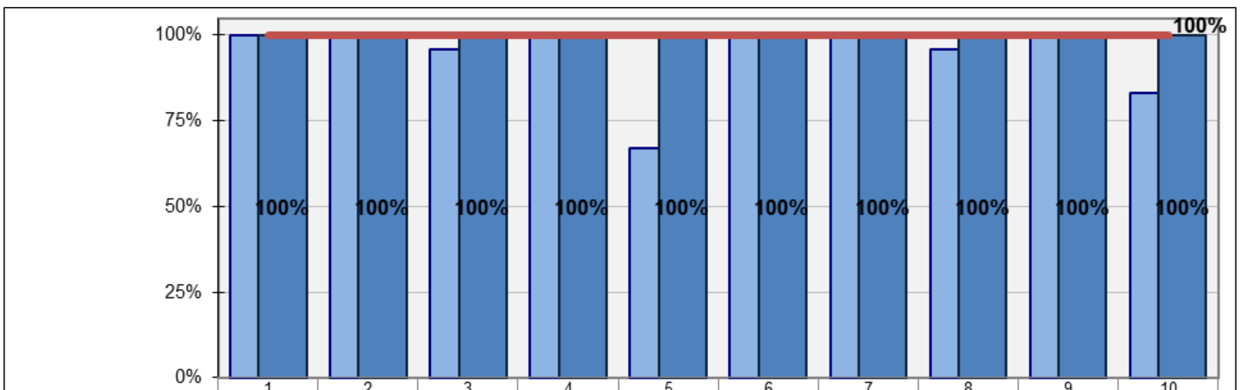
	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9	Region 10
2015	100%	100%	94%	100%	88%	100%	100%	100%	100%	88%
2016	100%	100%	94%	100%	100%	100%	100%	100%	100%	100%
2016 Statewide	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%

Figure A-10—Standard X: Provider Network



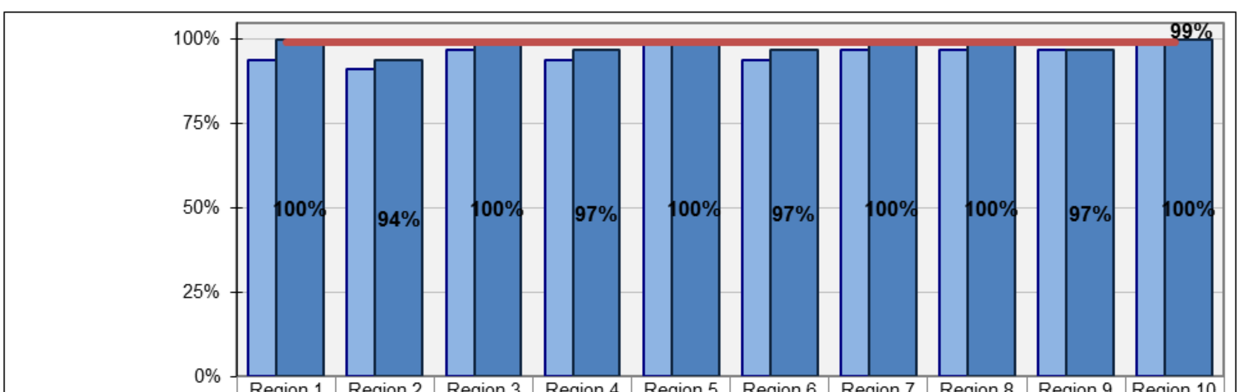
	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9	Region 10
2015	100%	100%	96%	96%	100%	100%	100%	100%	100%	96%
2016	100%	100%	96%	100%	100%	100%	100%	100%	100%	100%
2016 Statewide	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Figure A-11—Standard XI: Credentialing



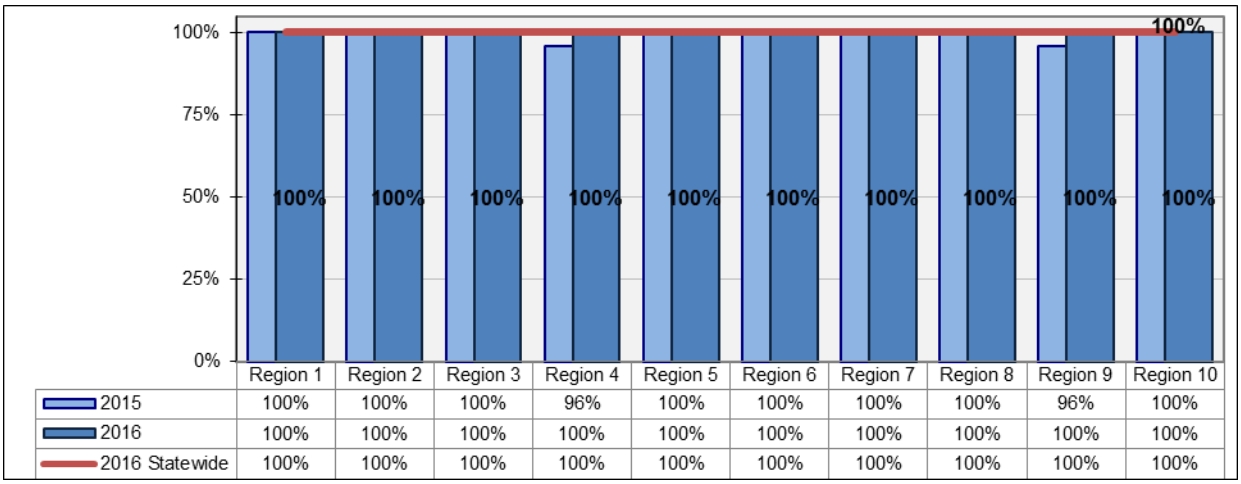
	1	2	3	4	5	6	7	8	9	10
2015	100%	100%	96%	100%	67%	100%	100%	96%	100%	83%
2016	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
2016 Statewide	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Figure A-12—Standard XII: Access and Availability



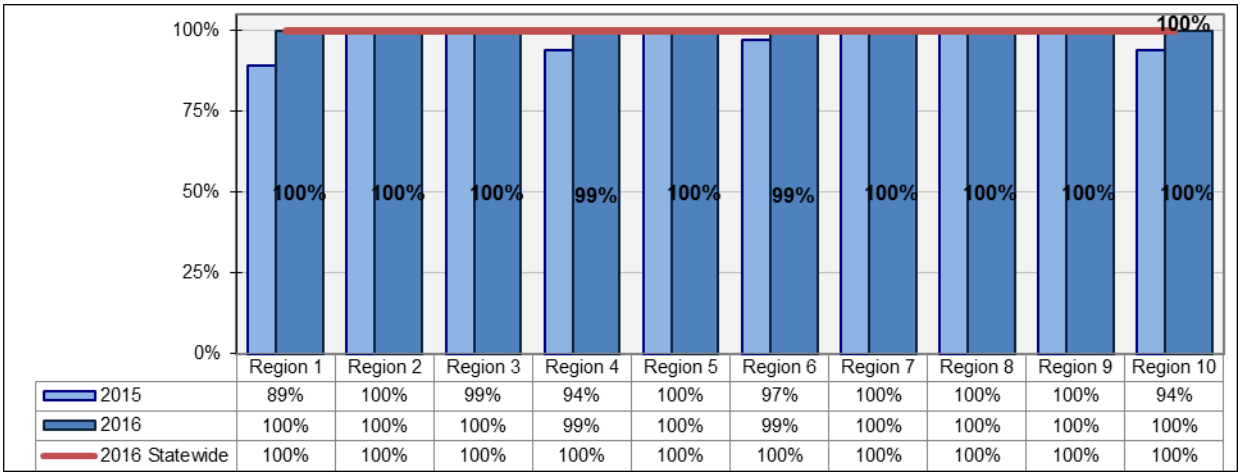
	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9	Region 10
2015	94%	91%	97%	94%	100%	94%	97%	97%	97%	100%
2016	100%	94%	100%	97%	100%	97%	100%	100%	97%	100%
2016 Statewide	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%

Figure A-13—Standard XIII: Coordination of Care



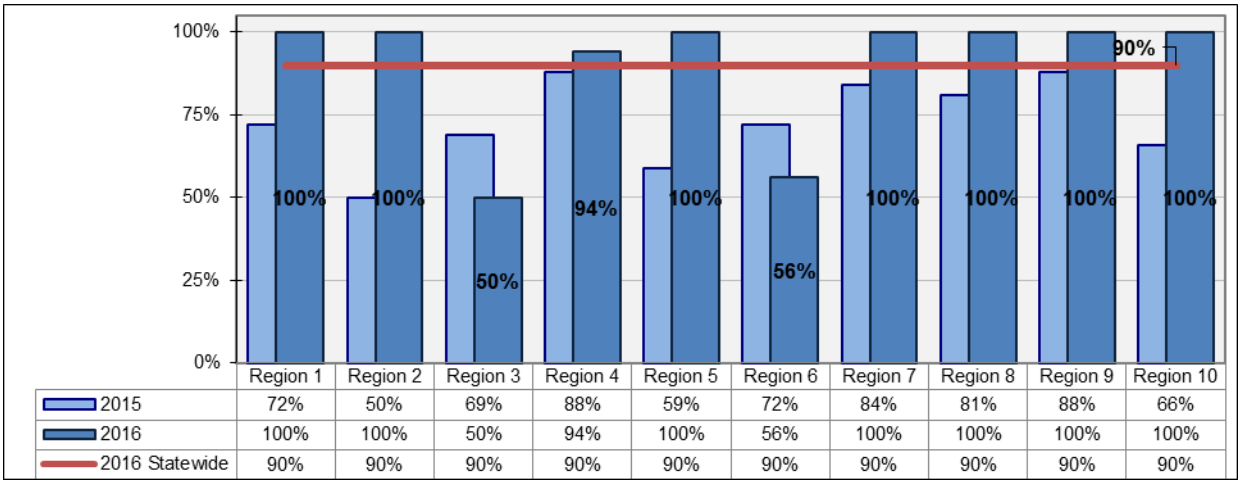
	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9	Region 10
2015	100%	100%	100%	96%	100%	100%	100%	100%	96%	100%
2016	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
2016 Statewide	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Figure A-14—Standard XIV: Appeals



	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9	Region 10
2015	89%	100%	99%	94%	100%	97%	100%	100%	100%	94%
2016	100%	100%	100%	99%	100%	99%	100%	100%	100%	100%
2016 Statewide	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Figure A-15—Standard XV: Disclosure of Ownership, Control, and Criminal Convictions



	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9	Region 10
2015	72%	50%	69%	88%	59%	72%	84%	81%	88%	66%
2016	100%	100%	50%	94%	100%	56%	100%	100%	100%	100%
2016 Statewide	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%

PIHP Compliance

Table A-1 presents the results from the 2014–2015 initial (P) and 2015–2016 follow-up (C) compliance reviews for each PIHP and statewide.

Table A-1—Summary of PIHP Compliance Monitoring Scores (Percentage of Compliance) Comparison of Prior-Year (2014–2015) and Current-Year (2015–2016) Scores

PIHP	Review Period	I. QAPIP Plan and Structure	II. Performance Measurement and Improvement	III. Practice Guidelines	IV. Staff Qualifications and Training	V. Utilization Management	VI. Customer Services	VII. Enrollee Grievance Process	VIII. Enrollee Rights and Protections	IX. Subcontracts and Delegation	X. Provider Network	XI. Credentialing	XII. Access and Availability	XIII. Coordination of Care	XIV. Appeals	XV. Disclosure of Ownership	Overall
Region 1—NorthCare	P	100	100	100	100	100	100	100	100	100	100	100	94	100	89	72	98
	C	NA[1]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	100	NA	100	100	100
Region 2—Northern MI	P	88	100	100	100	100	100	100	100	100	100	100	91	100	100	50	97
	C	100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	94	NA	NA	100	100
Region 3—Lakeshore	P	80	94	100	100	90	100	100	100	94	96	96	97	100	99	69	95
	C	100	100	NA	NA	99	NA	NA	NA	94	96	100	100	NA	100	50	98
Region 4—Southwest MI	P	99	100	100	100	100	100	97	100	100	96	100	94	96	94	88	98
	C	99	NA	NA	NA	NA	NA	100	NA	NA	100	NA	97	100	99	94	99
Region 5—Mid-State	P	100	100	100	100	100	100	100	100	88	100	67	100	100	100	59	97
	C	NA	NA	NA	NA	NA	NA	NA	NA	100	NA	100	NA	NA	NA	100	100
Region 6—CMHPSM	P	100	100	100	100	100	100	98	100	100	100	100	94	100	97	72	98
	C	NA	NA	NA	NA	NA	NA	100	NA	NA	NA	NA	97	NA	99	56	98
Region 7—Detroit	P	100	100	100	100	100	100	100	98	100	100	100	97	100	100	84	99
	C	NA	NA	NA	NA	NA	NA	NA	100	NA	NA	NA	100	NA	NA	100	100
Region 8—Oakland	P	98	100	100	100	100	100	98	100	100	100	96	97	100	100	81	99
	C	100	NA	NA	NA	NA	NA	100	NA	NA	NA	100	100	NA	NA	100	100
Region 9—Macomb	P	100	100	100	100	100	100	100	100	100	100	100	97	96	100	88	99
	C	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	97	100	NA	100	100
Region 10 PIHP	P	94	98	100	100	94	100	88	100	88	96	83	100	100	94	66	95
	C	100	100	NA	NA	95	NA	98	NA	100	100	100	NA	NA	100	100	99
Statewide Score	P	96	99	100	100	98	100	98	100	97	99	94	96	99	97	73	97
	C	100	100	100	100	99	100	100	100	99	100	100	99	100	100	90	99

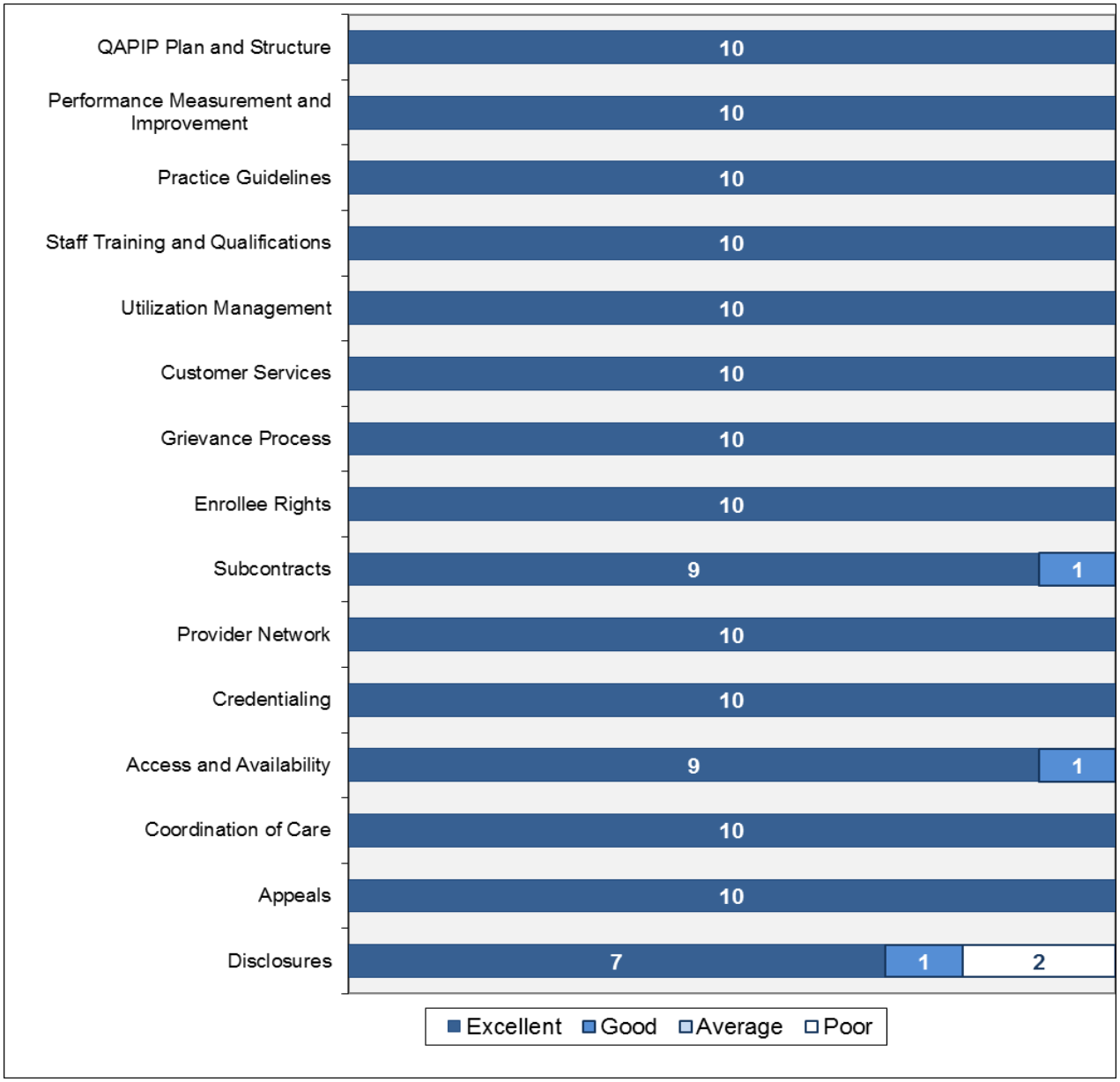
[1] NA denotes that the standard was not included in the follow-up review as the PIHP had achieved 100 percent compliance in the initial review of that standard.

PIHP Compliance Scores

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

Figure A-16 presents the number of PIHPs receiving *Excellent/Good/Average/Poor* 2015–2016 compliance scores for each of the 15 standards.

Figure A-16—Number of PIHPs Receiving *Excellent/Good/Average/Poor* Compliance Scores



Results for Validation of Performance Measures

Table A-2 shows a two-year comparison of the overall statewide PIHP compliance with the MDHHS Codebook specifications for performance indicators validated by HSAG.

Table A-2—Degree of Compliance for Performance Measures

Indicator		Percentage of PIHPs					
		Report		*Not Reported*		*No Benefit*	
		2014 – 2015	2015 – 2016	2014 – 2015	2015 – 2016	2014 – 2015	2015 – 2016
1.	The percentage of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	100%	80%	0%	20%	0%	0%
2.	The percentage of new Medicaid beneficiaries during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service.	80%	80%	20%	20%	0%	0%
3.	The percentage of new Medicaid beneficiaries during the quarter starting any needed ongoing service within 14 days of a non-emergent face-to-face assessment with a professional.	90%	100%	10%	0%	0%	0%
4a.	The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.	100%	90%	0%	10%	0%	0%
4b.	The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.	100%	90%	0%	10%	0%	0%
5.	The percent of Medicaid recipients having received PIHP managed services.	100%	100%	0%	0%	0%	0%
6.	The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	100%	100%	0%	0%	0%	0%
8.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who are employed competitively.	100%	90%	0%	10%	0%	0%
9.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.	100%	90%	0%	10%	0%	0%
10.	The percentage of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.	90%	100%	10%	0%	0%	0%
13.	The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	100%	90%	0%	10%	0%	0%
14.	The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	100%	90%	0%	10%	0%	0%

Table A-3 presents the 2014–2015 and 2015–2016 statewide results for the validated performance indicators.

Table A-3—Statewide Performance Measure Rates

Indicator			Reported Rate	
			2014–2015	2015–2016
1.	The percentage of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children	98.91%	99.48%
		Adults	98.76%	99.51%
2.	The percentage of new Medicaid beneficiaries during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service.	MI Children	98.73%	98.63%
		MI Adults	99.12%	98.79%
		DD Children	98.95%	98.67%
		DD Adults	99.34%	99.40%
		Medicaid SA	98.91%	98.01%
		Total	98.95%	98.45%
3.	The percentage of new Medicaid beneficiaries during the quarter starting any needed ongoing service within 14 days of a non-emergent face-to-face assessment with a professional.	MI Children	97.22%	97.22%
		MI Adults	97.57%	97.70%
		DD Children	98.45%	96.48%
		DD Adults	97.88%	94.05%
		Medicaid SA	99.45%	98.54%
		Total	98.27%	97.87%
4a.	The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.	Children	98.34%	98.86%
		Adults	97.77%	96.72%
4b.	The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.		92.69%	98.18%
5.	The percent of Medicaid recipients having received PIHP managed services.		7.47%	7.09%
6.	The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.		97.89%	98.26%
8.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who are employed competitively.	MI Adults	9.56%	13.17%
		DD Adults	7.63%	9.18%
		MI/DD Adults	7.60%	7.76%
9.	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.	Adults With MI	75.48%	76.86%
		Adults With DD	32.99%	36.95%
		Adults With MI/DD	36.30%	37.59%

Table A-3—Statewide Performance Measure Rates				
Indicator			Reported Rate	
			2014–2015	2015–2016
10.	The percentage of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.	Children	8.59%	10.61%
		Adults	13.49%	13.05%
13.	The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).		18.72%	16.66%
14.	The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).		37.94%	42.29%

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

**Table A-4—PIHP Performance Measure Results (Percentage Scores)
Comparison of Prior-Year (2014–2015) and Current-Year (2015–2016) Rates**

PIHP		1. Timeliness/ Inpatient Screening		2. Timeliness/Face-To-Face Assessment						3. Timeliness/First Service						4. Continuity of Care		
		Children	Adults	MI—Children	MI—Adults	DD—Children	DD—Adults	Medicaid SA	Total	MI—Children	MI—Adults	DD—Children	DD—Adults	Medicaid SA	Total	Follow-Up Care—Children	Follow-Up Care—Adults	Follow-Up Care—Detox
Region 1—NorthCare	P	97.73	99.53	96.49	98.64	100	100	97.93	97.93	94.95	94.79	100	80.00	100	97.09	93.75	87.50	100
	C	100	99.55	98.32	99.30	100	94.44	95.32	96.99	99.07	95.10	88.24	100	100	98.56	100	95.74	95.24
Region 2—Northern MI	P	98.63	100	99.66	99.80	100	100	96.06	98.11	98.03	99.16	100	100	100	99.36	96.55	92.91	43.66
	C	97.97	99.07	99.38	99.11	100	100	95.82	98.09	95.81	98.68	93.75	90.48	95.71	96.33	97.14	95.87	95.12
Region 3—Lakeshore	P	94.50	96.18	99.08	98.97	100	100	99.75	99.35	97.29	98.03	100	100	96.48	97.40	96.36	98.18	95.00
	C	98.34	97.99	99.59	99.70	100	100	100	99.77	97.26	98.46	94.29	94.74	97.40	97.46	96.92	97.86	98.73
Region 4—Southwest	P	99.47	100	98.26	99.18	100	100	100	99.07	94.16	93.63	96.30	92.59	100	95.26	100	98.62	100
	C	99.43	99.54	98.77	98.58	100	100	100	98.87	95.42	97.39	100	90.00	100	97.35	100	91.16	100
Region 5—Mid-State	P	99.02	99.25	99.33	99.74	100	98.39	98.74	99.27	95.43	97.09	100	100	99.35	97.73	95.61	97.66	98.25
	C	99.80	99.72	98.92	99.78	100	100	98.38	99.10	96.30	97.69	98.00	98.08	100	98.40	97.53	98.14	100
Region 6—CMHPSM	P	100	100	95.00	99.50	87.50	100	96.36	97.22	99.03	99.04	100	100	96.49	98.69	97.30	97.62	78.95
	C	100	99.81	98.35	96.59	100	100	96.43	96.98	100	100	100	96.15	96.56	97.60	96.55	98.73	90.10
Region 7—Detroit	P	99.20	97.08	98.87	97.65	98.95	98.48	100	98.93	99.04	98.56	96.91	98.33	100	99.12	100	98.37	100
	C	NR	NR	98.49	97.19	99.06	100	98.32	98.19	98.01	96.20	97.22	95.24	98.62	97.78	100	96.33	NR

**Table A-4—PIHP Performance Measure Results (Percentage Scores)
Comparison of Prior-Year (2014–2015) and Current-Year (2015–2016) Rates**

PIHP		1. Timeliness/ Inpatient Screening		2. Timeliness/Face-To-Face Assessment						3. Timeliness/First Service						4. Continuity of Care		
		Children	Adults	MI—Children	MI—Adults	DD—Children	DD—Adults	Medicaid SA	Total	MI—Children	MI—Adults	DD—Children	DD—Adults	Medicaid SA	Total	Follow-Up Care—Children	Follow-Up Care—Adults	Follow-Up Care—Detox
Region 8—Oakland	P	99.14	98.59	NR	NR	NR	NR	NR	NR	99.34	99.80	100	100	99.81	99.75	96.43	96.37	100
	C	NR	NR	NR	NR	NR	NR	NR	NR	100	99.80	100	100	99.58	99.75	NR	NR	99.20
Region 9—Macomb	P	100	100	96.72	100	94.74	100	99.85	99.54	98.36	99.19	95.83	100	100	99.65	100	99.15	99.51
	C	100	100	87.10	95.26	89.74	96.00	98.04	96.12	97.81	94.65	93.18	82.86	98.74	97.00	98.31	96.07	98.52
Region 10 PIHP	P	100	99.74	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	100	99.39	99.49
	C	100	100	NR	NR	NR	NR	NR	NR	96.34	98.93	100	93.75	98.11	97.90	100	99.12	100

Note: NR indicates that the rate could not be reported, as detailed in Section 3 of this report.

Table A-5—PIHP Performance Measure Results (Percentage Scores) Comparison of Prior-Year (2014–2015) and Current-Year (2015–2016) Rates													
PIHP		5.	6.	8. Outcomes—Competitive Employment			9. Outcomes—Minimum Wage			10. Outcomes—Inpatient Recidivism		13/14. Outcomes—Private Residence	
		Penetration Rate	HSW Rate	MI—Adults	DD—Adults	MI/DD Adults	MI—Adults	DD—Adults	MI/DD Adults	Children	Adults	DD—Adults	MI— Adults
Region 1—NorthCare	P	8.07	97.83	13.55	5.91	5.21	85.98	32.42	40.12	11.11	10.71	18.82	51.38
	C	7.87	99.72	15.00	5.99	5.60	86.49	33.57	44.92	0.00	13.33	18.80	49.06
Region 2—Northern MI	P	8.51	96.40	10.77	14.25	13.25	83.13	45.19	60.84	0.00	11.63	23.29	53.23
	C	8.00	99.37	12.90	13.97	13.18	77.27	45.76	56.27	6.52	10.93	25.04	53.03
Region 3—Lakeshore	P	5.80	98.26	10.70	8.79	9.21	82.66	30.69	35.34	2.78	15.13	11.16	42.15
	C	5.78	97.35	13.01	8.10	8.28	80.53	34.65	37.55	7.32	7.55	10.19	39.10
Region 4—Southwest MI	P	7.75	98.38	10.01	8.68	6.28	74.40	46.11	38.35	4.08	8.73	17.28	51.17
	C	7.01	98.94	14.68	7.92	7.01	73.74	42.86	40.00	6.98	9.12	16.95	49.46
Region 5— Mid-State	P	7.78	97.81	10.97	8.91	7.36	80.79	33.14	36.74	8.55	11.25	17.44	49.13
	C	7.28	95.40	13.73	8.33	7.29	83.67	33.45	37.81	6.31	9.18	16.82	45.91
Region 6—CMHPSM	P	7.60	97.56	12.29	9.36	7.07	78.49	56.62	63.89	13.51	10.40	27.37	29.09
	C	7.46	98.31	14.03	10.22	7.99	76.05	60.48	66.67	13.51	13.11	24.70	28.57
Region 7—Detroit	P	7.87	97.90	7.19	4.10	5.24	71.70	26.35	40.23	12.50	15.86	22.09	26.21
	C	7.41	98.96	NR	NR	NR	NR	NR	NR	15.38	17.05	NR	NR
Region 8—Oakland	P	8.95	98.61	13.06	13.14	11.36	62.06	40.55	29.96	NR	NR	18.62	35.64
	C	7.80	99.40	14.73	14.16	11.18	62.12	40.64	29.70	0.00	11.02	18.73	34.46
Region 9—Macomb	P	5.96	97.57	9.68	4.75	4.23	77.24	35.58	26.83	9.09	16.16	14.30	32.39
	C	5.56	99.79	11.45	5.08	4.93	80.93	37.50	29.60	14.52	19.31	13.52	29.76
Region 10 PIHP	P	6.72	98.52	6.82	5.10	4.02	71.09	14.52	15.74	4.76	11.20	10.37	44.94
	C	7.37	99.54	7.84	5.32	4.82	70.44	15.89	20.47	9.28	14.48	9.26	42.65

Note: NR indicates that the rate could not be reported, as detailed in Section 3 of this report.

Results for Validation of Performance Improvement Projects

Table A-6 presents a two-year comparison of the PIHPs' PIP validation status.

Table A-6—Comparison of PIHPs' PIP Validation Status		
Validation Status	Number of PIPs	
	2014–2015	2015–2016
Met	10	7
Partially Met	0	0
Not Met	0	3

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

Table A-7—Summary of Data From Validation of Performance Improvement Projects					
Validation Activity		Number of PIPs Meeting All Evaluation Elements/ Number Reviewed		Number of PIPs Meeting All Critical Elements/ Number Reviewed	
		2014–2015	2015–2016	2014–2015	2015–2016
I.	Appropriate Study Topic	10/10	10/10	10/10	10/10
II.	Clearly Defined, Answerable Study Question(s)	10/10	10/10	10/10	10/10
III.	Correctly Identified Study Population	10/10	10/10	10/10	10/10
IV.	Clearly Defined Indicator(s)	10/10	10/10	10/10	10/10
V.	Valid Sampling Techniques*	*NA*	*NA*	*NA*	*NA*
VI.	Accurate/Complete Data Collection**	10/10	9/10	10/10	0/10
VII.	Sufficient Data Analysis and Interpretation	10/10	8/10	10/10	9/10
VIII.	Appropriate Improvement Strategies	9/9	7/10	9/9	9/10
IX.	Real Improvement Achieved	Not Assessed	8/10	Not Assessed	8/10
X.	Sustained Improvement Achieved	Not Assessed	Not Assessed	*No Critical Elements*	*No Critical Elements*

*In 2014–2015 and 2015–2016, HSAG scored all elements for Activity V *Not Applicable (NA)* for all PIPs.
** In 2015–2016, HSAG scored the critical element in Activity VI as *NA* for nine of the 10 PIPs.

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

Table A-8—Comparison of PIHP PIP Validation Scores						
PIHP	Percent of All Evaluation Elements *Met*		Percent of Critical Elements *Met*		Validation Status	
	2014–2015	2015–2016	2014–2015	2015–2016	2014–2015	2015–2016
	Activities I–VIII	Activities I–IX	Activities I–VIII	Activities I–IX	Activities I–VIII	Activities I–IX
Region 1—NorthCare	100	96	100	88	*Met*	*Not Met*
Region 2—Northern MI	100	100	100	100	*Met*	*Met*
Region 3—Lakeshore	100	100	100	100	*Met*	*Met*
Region 4—Southwest MI	100	92	100	100	*Met*	*Met*
Region 5—Mid-State	100	100	100	100	*Met*	*Met*
Region 6—CMHPSM	100	96	100	100	*Met*	*Met*
Region 7—Detroit	100	100	100	100	*Met*	*Met*
Region 8—Oakland	100	100	100	100	*Met*	*Met*
Region 9—Macomb	100	86	100	67	*Met*	*Not Met*
Region 10 PIHP*	100	96	100	88	*Met*	*Not Met*
*Please note that for the 2014–2015 validation, Region 10 PIHP's PIP was validated for Activities I through VII only.						