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2008–2009 External Quality Review Technical Report

for

Prepaid Inpatient Health Plans

December 2009

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HSAG HEALTH SERVICES ADVISORY GROUP

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ACKNOWLEDGMENTS AND COPYRIGHTS

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1. Executive Summary

Purpose of Report

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

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

Scope of EQR Activities Conducted

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

- **Compliance monitoring:** The 2008–2009 evaluation was designed to determine the PIHPs' compliance with their contract and with State and federal regulations through review of performance in 14 compliance standards: Quality Assessment and Performance Improvement Program (QAPIP) Plan and Structure, Performance Measurement and Improvement, Practice Guidelines, Staff Qualifications and Training, Utilization Management, Customer Services, Enrollee Grievance Process, Enrollee Rights and Protections, Subcontracts and Delegation, Provider Network, Credentialing, Access and Availability, Coordination of Care, and Appeals.
- **Validation of performance measures:** HSAG validated each of the performance measures identified by MDCH to evaluate the accuracy of the performance measures reported by or on behalf of a PIHP. The validation also determined the extent to which Medicaid-specific performance measures calculated by a PIHP followed specifications established by MDCH.
- **Validation of performance improvement projects (PIPs):** For each PIHP, HSAG reviewed one PIP to ensure that the PIHP designed, conducted, and reported on the project in a methodologically sound manner, allowing real improvements in care and giving confidence in the reported improvements.

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

Definitions

The BBA states that "each contract with a Medicaid managed care organization must provide for an annual external independent review conducted by a qualified independent entity of the quality outcomes and timeliness of, and access to, the items and services for which the organization is responsible."[1-1] 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

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

desired health outcomes of its recipients through its structural and operational characteristics and through provision of health services that are consistent with current professional knowledge."[1-2]

Timeliness

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

Access

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

Findings

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

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

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

Quality

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

Table 1-1—Measures Assessing Quality

Measure			Statewide Score	PIHP Low Score	PIHP High Score
Compliance Monitoring Standards					
Standard I.	QAPIP Plan and Structure		97%	81%	100%
Standard II.	Performance Measurement/Improvement		99%	96%	100%
Standard III.	Practice Guidelines		100%	96%	100%
Standard IV.	Staff Qualifications and Training		99%	83%	100%
Standard VI.	Customer Services		99%	93%	100%
Standard VII.	Enrollee Grievance Process		93%	73%	100%
Standard VIII.	Enrollee Rights and Protections		99%	97%	100%
Standard IX.	Subcontracts and Delegation		100%	100%	100%
Standard X.	Provider Network		100%	98%	100%
Standard XI.	Credentialing		100%	96%	100%
Standard XIII.	Coordination of Care		100%	100%	100%
Standard XIV.	Appeals		95%	77%	100%
Performance Measure Indicators					
Indicator 4a:	Follow-Up Care	Children	97%	62%	100%
		Adults	96%	92%	100%
Indicator 4b:	Follow-Up Care After Detox		96%	54%	100%
Indicator 8:	HSW Rate		82%	12%	98%
Indicator 10:	Competitive Employment	Adults With MI	10%	6%	15%
		Adults With DD	11%	2%	22%
Indicator 11:	Earning Minimum Wage	Adults With MI	79%	49%	93%
		Adults With DD	29%	7%	89%
Indicator 12†:	Readmission Rate	Children	8%	29%	0%
		Adults	12%	22%	4%
Indicator 13*:	Recipient Rights Complaints				
Indicator 14*:	Sentinel Events				
Performance Improvement Projects					
		All evaluation elements *Met*	73%	38%	100%
		Critical elements *Met*	75%	30%	100%

†Lower rates are better for this measure.
*Rates were not available for reporting.
MI =mental illness
DD =developmental disabilities

PIHP performance on the compliance monitoring standards in the domain of **quality** continued to be a statewide strength. For five of the standards—Practice Guidelines, Subcontracts and Delegation, Provider Network, Credentialing, and Coordination of Care—the statewide score was 100 percent. Other statewide scores in the **quality** domain were also high, with most PIHPs achieving full compliance. Enrollee Grievance Process and Appeals showed lower statewide rates and fewer PIHPs that achieved full compliance. More than half of the recommendations related to the **quality** domain addressed these two standards.

The EQR activities related to the validation of PIPs addressed the validity and reliability of the PIHPs' processes for conducting valid PIPs. Therefore, for the purposes of the EQR technical report, HSAG assigned all PIPs to the **quality** domain. MDCH mandated a new study topic for the 2008–2009 PIPs, *Improving the Penetration Rates for Children*. For this validation cycle, HSAG validated Steps I through VIII; however, two studies did not complete Step VII. Only 4 of the 18 PIHPs received a validation status of *Met* for this new PIP. The findings indicated that for this first validation cycle of this study, few PIHPs designed, conducted, and reported their project in a methodologically sound manner, allowing real improvements in care and giving confidence in the reported results.

The PIHPs' results for performance measures related to **quality** of care and services reflected strong and improved performance. Six of the eight indicators received validation ratings of *Fully Compliant* across all PIHPs. Indicators 10 and 11 (Competitive Employment and Earning Minimum Wage) received validation ratings of *Fully Compliant* for 15 of the 18 PIHPs. Three PIHPs received a validation status of *Substantially Compliant* due to low data completeness for the employment and/or minimum wage data, resulting in understated rates for these measures. Statewide rates for the performance measures related to **quality** of care and services exceeded the minimum performance standard set by MDCH for all indicators in this domain. Statewide rates for the following indicators continued to be above the 95 percent benchmark: Indicator 4a, addressing follow-up care for children discharged from a psychiatric inpatient unit; Indicator 4b, addressing follow-up care after discharge from a detoxification (detox) unit; and the 30-day readmission rates to an inpatient psychiatric unit for children and adults (Indicator 12). The statewide rate for Indicator 4a, related to timely follow-up care for adults after discharge from a psychiatric inpatient unit, which did not meet the minimum performance standard in 2007–2008, increased to exceed the MDCH benchmark in 2008–2009. The number of PIHPs that met all performance standards in the **quality** domain increased from eight to nine. Rates for two measures (Indicator 13: Recipient Rights Complaints and Indicator 14: Sentinel Events) were not available for reporting, and the three remaining indicators related to **quality** of care (Indicators 8, 10, and 11, addressing the HSW rate, competitive employment, and minimum wage earners, respectively) did not have a performance standard set by MDCH. Statewide rates for competitive employment and minimum wage earners increased this year, most markedly for beneficiaries with a mental illness who earned at least minimum wage (from 45 percent in 2007–2008 to 79 percent for this validation cycle).

Timeliness

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

Table 1-2—Measures Assessing Timeliness					
Measure			Statewide Score	PIHP Low Score	PIHP High Score
Compliance Monitoring Standards					
Standard II.	Performance Measurement/Improvement		99%	96%	100%
Standard V.	Utilization Management		97%	80%	100%
Standard VII.	Enrollee Grievance Process		93%	73%	100%
Standard XII.	Access and Availability		90%	59%	100%
Standard XIV.	Appeals		95%	77%	100%
Performance Measure Indicators					
Indicator 1:	Preadmission Screenings	Children	99%	96%	100%
		Adults	98%	93%	100%
Indicator 2:	Face-to-Face Assessments		96%	82%	100%
Indicator 3:	Initiation of Ongoing Service		96%	85%	100%
Indicator 4a:	Follow-Up Care	Children	97%	62%	100%
		Adults	96%	92%	100%
Indicator 4b:	Follow-Up Care After Detox		96%	54%	100%

Statewide performance on compliance monitoring standards in the **timeliness** domain was strong, with scores ranging from a low of 90 percent for Access and Availability to a high of 99 percent for Performance Measurement and Improvement. However, the five compliance monitoring standards assessing **timeliness** of care and services provided by the PIHPs included the four lowest statewide scores. While several PIHPs achieved 100 percent compliance with requirements related to these standards, about three-fourths of all recommendations identified in the 2008–2009 reviews addressed this domain, indicating statewide opportunities for improvement.

Timeliness, as addressed by the validation of performance measures, reflected a statewide strength, with all of the seven measures related to **timeliness** of care and services achieving statewide averages that exceeded the minimum performance level as specified by MDCH. The statewide rates for Indicators 1, 2, 3, and 4, addressing timely preadmission screenings for children and adults, timely face-to-face assessments with a professional, and follow-up care for beneficiaries discharged from a psychiatric inpatient or detox unit, respectively, were above the 95 percent benchmark. The number of PIHPs that met all minimum performance standards in the **timeliness** domain increased from 8 to 12. The PIHPs demonstrated compliance with technical requirements and specifications in their collection and reporting of performance indicators. All of the 18 PIHPs, including the two PIHPs with 2007–2008 designations of *Substantially Compliant* for Indicator 1: Preadmission Screenings, received validation scores of *Fully Compliant* for all indicators related to **timeliness** of care and services for this validation cycle.

Access

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

Table 1-3—Measures Assessing Access					
Measure			Statewide Score	PIHP Low Score	PIHP High Score
Compliance Monitoring Standards					
Standard V.	Utilization Management		97%	80%	100%
Standard VI.	Customer Services		99%	93%	100%
Standard X.	Provider Network		100%	98%	100%
Standard XII.	Access and Availability		90%	59%	100%
Standard XIII.	Coordination of Care		100%	100%	100%
Performance Measure Indicators					
Indicator 1:	Preadmission Screenings	Children	99%	96%	100%
		Adults	98%	93%	100%
Indicator 2:	Face-to-Face Assessments		96%	82%	100%
Indicator 3:	Initiation of Ongoing Service		96%	85%	100%
Indicator 4a:	Follow-Up Care	Children	97%	62%	100%
		Adults	96%	92%	100%
Indicator 4b:	Follow-Up Care After Detox		96%	54%	100%
Indicator 5:	Penetration Rate		9%	7%	12%

Overall, PIHP performance on the compliance monitoring standards in the domain of **access** continued to indicate another statewide strength. Statewide scores for the five **access**-related standards ranged from a low of 90 percent for the Access and Availability standard to a high of 100 percent for the Provider Network and Coordination of Care standards. Except for the Access and Availability standard, most PIHPs achieved full compliance on the standards assessing **access** to care and services.

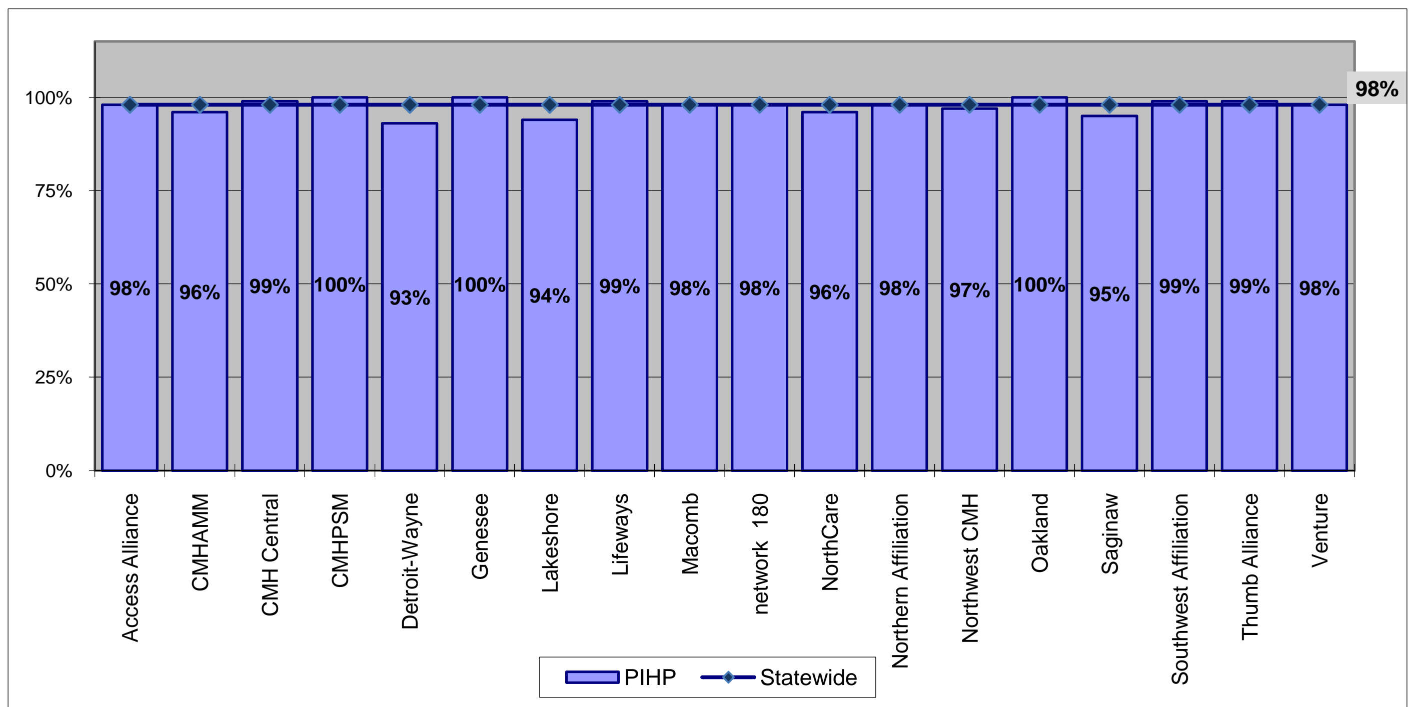
Access, as assessed by the validation of performance measures, indicated a statewide strength. Statewide rates exceeded the minimum performance standard for all indicators. Twelve of the 18 PIHPs met all minimum performance standards in the **access** domain. Rates for timely follow-up care for adults after discharge from a psychiatric inpatient unit improved from below the minimum performance standard to 96 percent, exceeding the MDCH benchmark in 2008–2009. For all six indicators related to **access** to care and services, all PIHPs received a validation score of *Fully Compliant*, including the one PIHP that had previously received a score of *Not Valid* for Indicator 5: Penetration Rate. The statewide penetration rate increased from 6 percent in 2007–2008 to 9 percent for the current validation cycle.

Findings for the 2008–2009 Compliance Monitoring Reviews

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

The overall compliance rating across all standards for the 18 PIHPs was 98 percent, with individual PIHP scores ranging from 93 percent to 100 percent. Scores ranging from 95 percent to 100 percent were rated *Excellent*, scores ranging from 85 percent to 94 percent were rated *Good*, scores ranging from 75 percent to 84 percent were rated *Average*, and scores of 74 percent and lower were rated *Poor*. Figure 1-1 displays PIHP scores for overall compliance across all compliance monitoring standards. Sixteen PIHPs performed at an overall *Excellent* level, with three PIHPs receiving overall compliance scores of 100 percent. Two PIHPs were rated *Good*. None of the PIHPs performed at the *Average* or *Poor* level.

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



PIHPs demonstrated high levels of compliance with federal and contractual requirements in all areas assessed. The PIHPs' performance was strongest in the areas of Subcontracts and Delegation and Coordination of Care, with all 18 PIHPs receiving a compliance score of 100 percent.

Other areas where all PIHPs performed at the *Excellent* level included Performance Measurement and Improvement, Practice Guidelines, Enrollee Rights and Protections, Provider Network, and Credentialing. While almost all PIHPs achieved full compliance in these areas, there were a few recommendations related to the performance improvement process, the adoption process for practice guidelines, requirements for providing beneficiaries with general information, evaluation of the delivery network, and the PIHP's credentialing policy. None of these recommendations applied to more than two or three PIHPs.

Customer Services, Staff Qualifications and Training, and QAPIP Plan and Structure, were also areas of strong performance, with 17, 16, and 15 PIHPs, respectively, receiving scores in the *Excellent* range. The PIHPs demonstrated that they had written QAPIP descriptions and adequate organizational structures to support their QAPIPs. Customer services units provided required information to beneficiaries, facilitated access to services, and assisted beneficiaries in the grievances and appeals processes. The PIHPs demonstrated compliance with requirements for staff training and ensuring that employed and contracted staff members have appropriate qualifications. The most frequent recommendations for improvement in these three standards addressed the review of data from the behavior treatment committees and PIHPs' handbooks that did not include all required elements specified in the MDCH contract attachment.

On the Appeals standard, 14 PIHPs performed at the *Excellent* level, 1 PIHP performed at the *Good* level, and 3 PIHPs performed at the *Average* level. While most PIHPs demonstrated compliance with contract requirements related to processing and responding to beneficiary appeals of a PIHP's decision to deny, reduce, suspend, or terminate services, there were opportunities for improvement across the majority of elements on this standard. Many recommendations addressed requirements for the content and timeliness of the notice of disposition.

PIHPs demonstrated strong performance on the Enrollee Grievance Process standard. Nine PIHPs performed at the *Excellent* level, eight PIHPs performed at the *Good* level, and one PIHP performed at the *Poor* level. Overall, PIHPs had grievance processes in place and provided required information about the grievance process to beneficiaries and subcontractors. Most recommendations in this area addressed the process of handling grievances, primarily the content of the written disposition notice.

For the Access and Availability standard, the PIHPs continued to demonstrate mixed performance. Eight PIHPs performed in the *Excellent* range, with five PIHPs receiving scores of 100 percent compliance. Seven PIHPs received scores in the *Good* range, two PIHPs performed at the *Average* level, and one PIHP received a score in the *Poor* range. All PIHPs met the requirements for regular reporting of performance indicator data to MDCH and oversight of subcontractors to ensure that providers meet State standards for timely access to care and services. Most recommendations in this area focused on continued efforts to improve performance on the access standard for initiation of ongoing services within 14 days of a nonemergent assessment with a professional.

Table 1-4 presents the PIHPs' 2008–2009 compliance monitoring scores (percentage of compliance) on the 14 standards reviewed as well as an overall compliance score across all standards.

Table 1-4—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	Overall
Access Alliance	100	100	100	100	95	100	98	98	100	100	100	88	100	100	98
CMHAMM	81	99	96	92	100	98	94	100	100	98	100	100	100	83	96
CMH Central	100	100	100	100	100	98	96	100	100	100	100	100	100	97	99
CMHPSM	99	100	100	100	100	100	96	100	100	100	100	100	100	98	100
Detroit-Wayne	99	100	100	100	93	95	87	100	100	100	100	59	100	77	93
Genesee	100	100	100	100	100	100	98	100	100	100	100	97	100	100	100
Lakeshore	83	96	100	100	80	98	85	98	100	100	100	88	100	98	94
LifeWays	100	100	100	100	100	100	92	99	100	100	100	100	100	92	99
Macomb	100	100	100	100	100	93	98	100	100	100	100	82	100	97	98
network180	100	100	100	100	100	100	90	100	100	100	96	85	100	98	98
NorthCare	100	99	98	100	100	100	92	97	100	100	100	85	100	83	96
Northern Affiliation	100	100	100	100	89	100	92	100	100	100	100	97	100	98	98
Northwest CMH	94	100	100	83	93	98	96	100	100	100	100	88	100	98	97
Oakland	100	100	100	100	100	100	100	99	100	100	100	100	100	100	100
Saginaw	96	100	100	100	95	100	73	98	100	100	100	76	100	95	95
Southwest Affiliation	99	100	100	100	100	100	98	100	100	100	100	91	100	95	99
Thumb Alliance	100	98	100	100	100	100	92	100	100	100	100	97	100	97	99
Venture	97	98	100	100	97	100	100	100	100	100	100	91	100	95	98
Statewide Score	**97**	**99**	**100**	**99**	**97**	**99**	**93**	**99**	**100**	**100**	**100**	**90**	**100**	**95**	**98**

Note: Shaded cells show PIHP performance below the statewide score.

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

Findings for the 2008–2009 Validation of Performance Measures

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

HSAG assessed 12 performance indicators for each PIHP for compliance with technical requirements, specifications, and construction. HSAG scored the performance measures as *Fully Compliant* (the PIHP followed the specifications without any deviation), *Substantially Compliant* (some deviation was noted, but the reported rate was not significantly biased), or *Not Valid* (significant deviation from the specifications that resulted in a +/- bias of greater than 5 percent in the final reported rate). The 18 PIHPs calculated and reported a total of 216 performance measures. Table 1-5 presents the results.

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

Validation Finding	Performance Indicators	
	Number	Percent
Fully Compliant	210	97%
Substantially Compliant	6	3%
Not Valid	0	0%
Total	**216**	**100%**

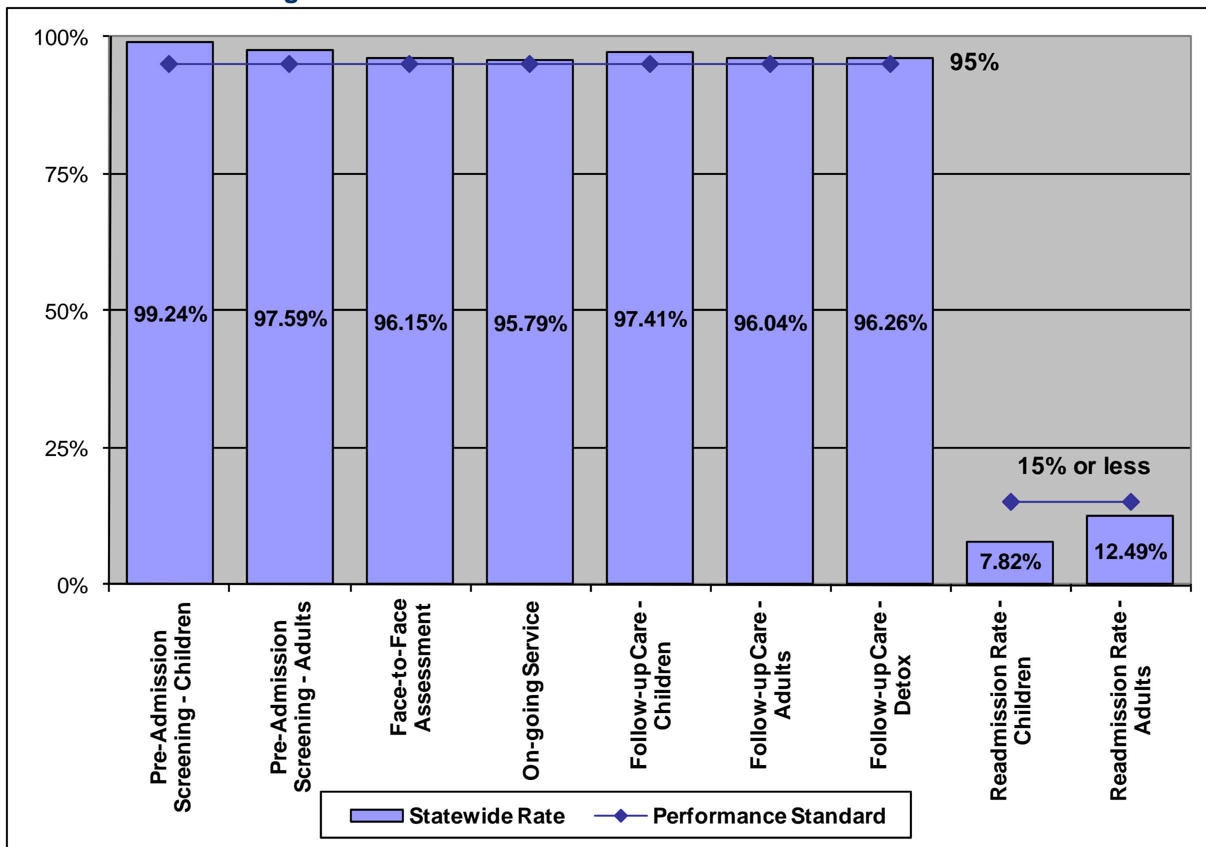
Table 1-6 shows overall PIHP compliance with the MDCH code book specifications for each of the 12 performance indicators validated by HSAG. All but 2 of the 12 measures were *Fully Compliant* for all 18 PIHPs. Three PIHPs received a score of *Substantially Compliant* on Indicators 10 and 11. The PIHPs that had previously received scores of *Substantially Compliant* for Indicator 1 or *Not Valid* for Indicator 5 brought their processes for the calculation of these indicators into full compliance.

The PIHPs continued to demonstrate a strong commitment to the performance indicator reporting process and the quality and integrity of their quality improvement (QI) data. Several PIHPs transitioned to new information systems that offered more automated reporting capabilities and enhanced data collection processes. The PIHPs' oversight of their affiliates and coordinating agencies (CAs), including regular audits or assessments of data completeness and requirements for corrective actions to address any deficiencies, represented another statewide strength. Best practices were noted in methods to improve data accuracy and completeness; continued enhancements to analytic tools, such as the "info-mart;" automation of performance indicator reporting processes; online performance indicator reporting functions; and staff training and manuals. Recommendations for improvement addressed documentation of the transition to new information systems, formalizing processes related to QI data quality and claims or encounter submissions, and continued automation of performance indicator reporting. The PIHPs should continue to increase the proportion of claims submitted electronically and enhance existing or institute new validation processes. Most PIHPs should continue efforts to improve the completeness of their QI data files, particularly for the minimum wage data element.

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

Overall, statewide performance met the MDCH-established minimum performance standards for all indicators, as shown in Figure 1-2. Statewide rates were calculated by summing the number of cases that met the requirements of the indicator across all PIHPs (e.g., the total number of adults for all 18 PIHPs who received a timely follow-up service) and dividing this number by the number of applicable cases across all PIHPs (e.g., the total number of adults for all 18 PIHPs who were discharged from a psychiatric inpatient facility). MDCH did not specify a standard for Indicators 5, 8, 10, and 11. While HSAG validated Indicators 13 and 14, rates for PIHP performance on these indicators were not available for reporting.

Figure 1-2—Statewide Rates for Performance Measures



Continued strong or improved performance resulted in statewide rates that exceeded the MDCH benchmark for all measures. Performance on the indicators related to follow-up care after discharge continued to improve. In 2006–2007, the statewide rates for the three performance measures related to follow-up care after discharge fell below the standard of 95 percent. In 2007–2008, only the rate for follow-up care for adults discharged from a psychiatric inpatient unit remained below the benchmark. In 2008–2009, all three measures for follow-up care exceeded the 95 percent minimum performance level set by MDCH. Indicator 1, Preadmission Screenings, continued to show the highest statewide rate (99.24 percent for children) and was the only indicator for which all 18 PIHPs met the MDCH performance standard.

Table 1-7 displays the 2008–2009 PIHP results for the validated performance indicators. Most indicators (Indicators 1 through 5, 8, and 12) were reported and validated for the first quarter of the state fiscal year (SFY) 2009, which began October 1, 2008 and ended December 31, 2008. Indicators 10 and 11 were reported and validated for SFY 2008.

Table 1-7—PIHP Performance Measure Results—Percentage Scores

PIHP	1. Pre-Admission Screening		2. Initial Assessment Within 14 Days	3. Initiate Ongoing Service Within 14 Days	4. Follow-Up Care			5. Penetration Rate	8. HSW Rate	10. Competitive Employment		11. Earning Minimum Wage		12. 30-Day Readmission Rate	
	Children	Adults			Psychiatric—Children	Psychiatric—Adults	Detox			Adults With Mental Illness	Adults With Developmental Disabilities	Adults With Mental Illness	Adults With Developmental Disabilities	Children	Adults
Access Alliance	98.65	98.72	98.25	98.90	96.55	98.18	94.12	10.34	96.05	12.34	14.23	82.96	40.23	6.25	10.45
CMHAMM	100	97.36	98.65	98.08	93.75	92.00	100	8.43	96.29	12.31	13.45	85.00	48.46	0.00	10.53
CMH Central	100	98.13	99.46	98.17	100	100	100	11.69	96.20	12.92	14.34	93.28	28.85	0.00	9.09
CMHPSM	100	100	98.59	100	100	100	97.37	7.72	82.23	12.15	17.54	81.82	68.85	28.95	8.75
Detroit-Wayne	99.30	92.90	81.64	89.96	96.97	92.15	100	8.89	12.25	8.99	2.29	90.54	6.92	2.43	13.37
Genesee	98.98	99.68	98.92	97.19	100	98.44	100	8.46	91.03	5.71	4.82	78.60	20.28	11.11	9.01
Lakeshore	97.44	100	98.39	96.56	100	100	100	7.38	98.24	9.59	14.90	71.90	37.42	0.00	6.45
LifeWays	100	100	97.80	98.80	100	100	100	9.01	93.33	11.34	13.33	81.75	75.00	15.00	15.87
Macomb	100	98.68	99.55	99.26	100	97.64	98.04	10.46	97.98	11.31	10.48	56.12	25.89	10.94	14.65
network180	97.62	96.83	98.52	84.57	100	97.41	100	7.43	91.76	10.64	17.82	72.65	50.00	0.00	8.59
NorthCare	100	100	97.49	98.07	100	96.43	100	8.82	97.00	14.72	11.85	74.42	43.06	8.70	11.90
Northern Affiliation	100	97.81	98.37	98.27	100	97.92	100	10.71	95.23	11.93	21.91	77.00	53.70	6.90	14.08
Northwest CMH	97.44	99.18	99.17	98.47	100	97.67	100	11.88	93.37	13.58	17.07	92.25	88.96	5.00	8.62
Oakland	99.07	98.51	99.76	98.44	97.78	96.15	100	9.70	98.27	9.31	20.46	67.83	26.43	13.51	13.75
Saginaw	100	100	98.36	93.38	61.54	93.18	54.17	7.16	95.73	9.01	13.04	49.23	19.63	12.50	22.45
Southwest Alliance	100	100	94.54	99.15	92.31	96.67	90.91	9.06	93.58	9.62	15.15	85.77	60.94	0.00	5.56
Thumb Alliance	100	100	99.47	99.14	100	97.33	100	10.53	96.60	10.79	5.55	53.26	14.15	15.00	18.37
Venture	95.65	99.38	99.10	96.72	100	100	100	10.01	92.88	13.24	13.63	64.85	36.57	18.18	4.48
Statewide Rate	**99.24**	**97.59**	**96.15**	**95.79**	**97.41**	**96.04**	**96.26**	**9.13**	**81.93**	**10.48**	**11.41**	**79.36**	**28.66**	**7.82**	**12.49**
MDCH Standard	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	NA	NA	NA	NA	NA	NA	≤15%	≤15%

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

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.

Findings for the 2008–2009 Validation of Performance Improvement Projects

For each PIHP, HSAG validated one PIP based on CMS' protocol. MDCH mandated a new study topic, improving penetration rates for children, in 2008–2009 for all PIHPs.

Table 1-8 presents a summary of the PIPs' validation status results. Most PIPs received a *Not Met* validation status. For 2008–2009, the number of PIPs that received a validation status of *Met* decreased to only 4 PIPs from 13 in 2007–2008.

Table 1-8—PIHPs' PIP Validation Status

Validation Status	Number of PIHPs
Met	4
Partially Met	4
Not Met	10

Table 1-9 presents a statewide summary of the PIHPs' PIP validation results for each of the CMS PIP protocol activities. HSAG validated Steps I through VI and Step VIII for all 18 PIPs. For two PIPs, Step VII was not validated because the PIHPs had not yet completed this activity. All or almost all of the PIPs *Met* all critical and noncritical evaluation elements for Steps II and III. For two steps, HSAG assigned ratings of *NA* for all PIPs: for all elements in Step V, as the studies did not use sampling, and for the critical element in Step VI, as the studies did not use a manual data collection tool. No PIP had progressed to collecting remeasurement data; therefore, Steps IX and X were not assessed in this validation cycle.

Table 1-9—Summary of Data From Validation of Performance Improvement Projects

Validation Step		Number of PIPs Meeting All Evaluation Elements/ Number Reviewed	Number of PIPs Meeting All Critical Elements/ Number Reviewed
I.	Review the Selected Study Topic(s)	6/18	8/18
II.	Review the Study Question(s)	18/18	18/18
III.	Review the Selected Study Indicator(s)	15/18	16/18
IV.	Review the Identified Study Population	11/18	12/18
V.	Review Sampling Methods	18/18*	18/18*
VI.	Review Data Collection Procedures	7/18	18/18*
VII.	Assess Improvement Strategies	11/16	11/16
VIII.	Review Data Analysis and Study Results	2/18	5/18
IX.	Assess for Real Improvement	0/0	NA
X.	Assess for Sustained Improvement	0/0	NA

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

Overall, the PIHPs demonstrated compliance with CMS PIP protocol requirements in the areas of the study questions, study indicators, study population, and planning of improvement strategies. For two-thirds of the PIPs, HSAG identified opportunities for improvement related to the study topic, primarily to provide additional information about selection of the topic and to address the eligible

population, inclusion of members with special health care needs, and the potential effects of the study. About one-third of the PIPs included a complete description of collection procedures. While all or almost all PIPs identified the data sources, provided a timeline for baseline and remeasurement data collection, and included an estimated degree of data completeness, several studies did not identify the data elements to be collected, define a systematic process for data collection, or detail steps in the production of the indicators. Almost all PIPs included an incomplete data analysis plan or failed to include an interpretation of findings.

Table 1-10 presents the PIHP results of the 2008–2009 PIP validation.

Table 1-10—PIHPs' PIP Validation Results			
PIHP	**% of All Elements *Met***	**% of All Critical Elements *Met***	**Validation Status**
Access Alliance	92%	90%	*Partially Met*
CMHAMM	38%	30%	*Not Met*
CMH Central	96%	100%	*Met*
CMHPSM	100%	100%	*Met*
Detroit-Wayne	62%	70%	*Partially Met*
Genesee	75%	89%	*Not Met*
Lakeshore	58%	70%	*Not Met*
LifeWays	62%	50%	*Not Met*
Macomb	79%	78%	*Not Met*
network180	58%	60%	*Not Met*
NorthCare	69%	60%	*Not Met*
Northern Affiliation	73%	80%	*Not Met*
Northwest CMH	69%	70%	*Not Met*
Oakland	81%	70%	*Partially Met*
Saginaw	48%	50%	*Not Met*
Southwest Affiliation	85%	100%	*Met*
Thumb Alliance	85%	90%	*Partially Met*
Venture	92%	100%	*Met*

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

Conclusions

Findings from the 2008–2009 EQR activities reflected continued improvement in the **quality** and **timeliness** of and **access** to care and services provided by the PIHPs. Across all three EQR activities, the PIHPs demonstrated strong performance and high levels of compliance with federal, State, and contractual requirements related to the provision of care to beneficiaries.

Results from the compliance monitoring review reflected continued high levels of compliance across all standards, as reflected in the high statewide scores and the large number of PIHPs that received scores of *Met* on the elements assessed. The PIHPs continued to build on the improvements implemented as a result of the previous reviews of these standards. The findings indicated that overall, the PIHPs demonstrated compliance with the federal and State requirements addressed in this review cycle.

For the new PIP, the PIHPs demonstrated lower levels of compliance with the requirements of the CMS PIP protocol than in prior years, resulting in few valid PIPs that gave confidence in the reported results and could achieve real improvements in care. Most PIPs will require revisions to ensure that reported results are credible.

The results from the validation of performance measures showed that the PIHPs continued to improve on their processes to collect and report valid performance indicator data. The performance measure rates continued to improve over previous years' results, and for this validation cycle, all statewide rates met the minimum performance standard.

Introduction

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

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

Compliance Monitoring Reviews

Objectives

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

The 2008–2009 compliance monitoring reviews evaluated the PIHPs' compliance with federal and State regulations and with contractual requirements related to the following standards:

- Standard I. QAPIP Plan and Structure
- Standard 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. Recipient 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

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

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

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

Technical Methods of Data Collection

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

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

- **Pre-Review Activities:** In addition to scheduling the compliance review and developing the review agenda, HSAG conducted the key pre-review activity of requesting and reviewing various documents submitted by the PIHPs: the *Desk Audit Form* describing a PIHP's structure, processes, and operational practices related to the areas assessed; the comprehensive EQR compliance review tool—*Documentation Request and Evaluation Tool*— that was adapted from CMS protocols; and PIHP documents (policies, member materials, subcontracts, etc.) to demonstrate compliance with each requirement in the tool. The focus of the desk review was to identify compliance with the BBA and MDCH contractual rules and regulations.
- HSAG developed record review tools for the review of utilization management (UM) denials, grievances, and beneficiary appeals. HSAG requested audit samples based on data files supplied by each PIHP. These files included logs of UM denials, grievances, and beneficiary appeals for the period of January 1, 2008, through September 30, 2008. From each of these logs HSAG selected random samples of files for review.
- **Compliance Monitoring Reviews:** The 2008–2009 compliance monitoring reviews were conducted either via telephone conference calls between key PIHP staff members and the HSAG review team or as a two-day site visit (for PIHPs that scored 100 percent after follow-up on fewer than 12 of the 15 standards reviewed in prior years). The on-site reviews included an entrance conference, document and record reviews using the HSAG compliance monitoring and record review tools, and interviews with key PIHP staff. During the exit conference at the conclusion of the on-site reviews, the HSAG review team provided a summary of preliminary findings and recommendations. Telephonic reviews lasted several hours over two consecutive afternoons and included an opening statement to detail the review process and objectives,

followed by discussions with key PIHP staff to evaluate the degree of compliance for each of the standards, a discussion of findings from the record reviews, and a closing statement.

- **Compliance Monitoring Report:** After completing the review, analysis, and scoring of the information obtained from the desk audit and the on-site or telephonic reviews, HSAG prepared a detailed report of the compliance monitoring review findings and recommendations for each PIHP.
- Based on the findings, each PIHP that did not receive a score of *Met* for all elements was required to submit a performance improvement plan to MDCH for any standard element that was not fully compliant. HSAG provided each PIHP with a template for the corrective action plan.

Description of Data Obtained

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

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

Interviews with PIHP staff (e.g., PIHP leadership, customer services staff, network management staff, etc.) provided additional information.

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

Table 2-1—Description of PIHP Data Sources

Data Obtained	Time Period to Which the Data Applied
Desk Review Documentation	State Fiscal Year (SFY) 2008 to Date of Review
Record Reviews	January 1, 2008, to September 30, 2008
Information From Interviews Conducted	SFY 2008 to Date of Review

Data Aggregation, Analysis, and How Conclusions Were Drawn

Reviewers used the compliance monitoring and appeal record review tools to document findings regarding PIHP compliance with the standards. Results of the record reviews were incorporated into the scoring of the related elements. 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 MDCH. MDCH provided data directly to HSAG for the first and second quarters of FY 2007–2008.

HSAG evaluated and scored each element addressed in the compliance monitoring review as *Met (M), Substantially Met (SM), Partially Met (PM), Not Met (NM)*, or *Not Applicable (NA),* except that *Substantially Met* was not applicable to the Access and Availability standard. The overall score for each of the 14 standards was determined by totaling the number of *Met* (value: 1 point) and the number of *Substantially Met* (0.75 points), *Partially Met* (0.50 points), *Not Met* (0.00 points), and *Not Applicable* (0.00 points) elements, then dividing the summed score by the total number of applicable elements for that standard. Using the same methodology, HSAG determined the overall score across all standards for each PIHP and the statewide scores, summing the values of the ratings and dividing that sum by the total number of applicable elements.

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

Table 2-2—Assignment of Standards to Performance Domains

Standard		Quality	Timelines	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	✓	✓	

Validation of Performance Measures

Objectives

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

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

HSAG validated a set of 12 performance indicators developed by MDCH and selected for validation. Each PIHP collected and reported 7 of these indicators on a quarterly basis, with the remaining 5 calculated by MDCH.

Technical Methods of Data Collection and Analysis

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

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

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

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

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

Description of Data Obtained

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

- **Information Systems Capabilities Assessment Tool (ISCAT).** HSAG received this tool from each PIHP. The completed ISCATs provided HSAG with background information on MDCH's and the PIHPs' policies, processes, and data in preparation for the on-site validation activities.
- **Source Code (Programming Language) for Performance Measures.** HSAG obtained this source code from each PIHP (if applicable) and MDCH. HSAG used the code to determine compliance with the performance measure definitions.
- **Previous Performance Measure Reports.** HSAG obtained these reports from each PIHP and reviewed the reports to assess trending patterns and rate reasonability.
- **Supporting Documentation.** This documentation provided additional information needed by HSAG reviewers to complete the validation process, including performance measure definitions, file layouts, system flow diagrams, system log files, policies and procedures, data collection process descriptions, and file consolidations or extracts.
- **Current Performance Measure Results.** HSAG obtained the calculated results from MDCH and each of the PIHPs.

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

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

Table 2-3—Description of Data Sources

Data Obtained	Time Period to Which the Data Applied
ISCAT (From PIHPs)	SFY 2008
Source Code (Programming Language) for Performance Measures (From MDCH)	SFY 2008
Previous Performance Measure Reports (From PIHPs)	SFY 2008
Performance Measure Reports (From PIHPs and MDCH)	First Quarter of SFY 2009
Supporting Documentation (From PIHPs and MDCH)	First Quarter of SFY 2009
On-site Interviews and Demonstrations (From PIHPs and MDCH)	First Quarter of SFY 2009

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

Table 2-4—List of Performance Indicators for PIHPs

	Indicator	Calculation by:	Validation Review Period
1.	Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	PIHP	First Quarter SFY 2009
2.	Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	PIHP	First Quarter SFY 2009
3.	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional.	PIHP	First Quarter SFY 2009
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	PIHP	First Quarter SFY 2009
4b.	Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	PIHP	First Quarter SFY 2009
5.	Percentage of Medicaid recipients having received PIHP-managed services (penetration rate).	MDCH	First Quarter SFY 2009
8.	Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination (HSW rate).	MDCH	First Quarter SFY 2009

Table 2-4—List of Performance Indicators for PIHPs			
Indicator		Calculation by:	Validation Review Period
10.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who are employed competitively.	MDCH	SFY 2008
11.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who earned minimum wage or more from any employment activities.	MDCH	SFY 2008
12.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	PIHP	First Quarter SFY 2009
13.	Annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by the PIHPs.	MDCH	SFY 2008
14.	Number of sentinel events during the six-month period per 1,000 Medicaid beneficiaries served, by the following populations: adults with mental illness, children with mental illness, persons with developmental disabilities not on the HSW, persons on the HSW, and persons with substance abuse disorder.	PIHP	Last Half of SFY 2008

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

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

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

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

	Indicator	Quality	Timeliness	Access
1.	Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.		✓	✓
2.	Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.		✓	✓
3.	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional.		✓	✓
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	✓	✓	✓
4b.	Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	✓	✓	✓
5.	Percentage of Medicaid recipients having received PIHP-managed services (penetration rate).			✓
8.	Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination (HSW rate).	✓		
10.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who are employed competitively.	✓		
11.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who earned minimum wage or more from any employment activities.	✓		
12.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	✓		
13.	Annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by the PIHPs.	✓		
14.	Number of sentinel events during the six-month period per 1,000 Medicaid beneficiaries served, by the following populations: adults with mental illness, children with mental illness, persons with developmental disabilities not on the HSW, persons on the HSW, and persons with substance abuse disorder.	✓		

Validation of Performance Improvement Projects

Objectives

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

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

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

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

Technical Methods of Data Collection and Analysis

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

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

- Step I. Review the Selected Study Topic(s)
- Step II. Review the Study Question(s)
- Step III. Review the Selected Study Indicator(s)
- Step IV. Review the Identified Study Population
- Step V. Review Sampling Methods
- Step VI. Review Data Collection Procedures
- Step VII. Assess the Health Plan's Improvement Strategies

- Step VIII. Review Data Analysis and the Interpretation of Study Results
- Step IX. Assess for Real Improvement
- Step X. Assess for Sustained Improvement

Description of Data Obtained

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

Table 2-6—Description of PIHP Data Sources	
Data Obtained	**Time Period to Which the Data Applied**
PIP Summary Form (completed by the PIHP)	SFY 2009

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

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

The scoring methodology was designed to ensure that critical elements are a must-pass step. If at least one critical element was *Not Met*, the overall validation status was *Not Met*. In addition, the methodology addressed the potential situation in which all critical elements were *Met*, but suboptimal performance was observed for noncritical elements. The final outcome would be based on the overall percentage score.

All PIPs were scored as follows:

- *Met*: All critical elements were *Met* and 80 percent to 100 percent of all evaluation elements were *Met* across all activities.
- *Partially Met*: All critical elements were *Met* and 60 percent to 79 percent of all evaluation elements were *Met* across all activities, or one or more critical element(s) were *Partially Met* and the percentage score for all elements across all activities was 60 percent or more.
- *Not Met*: All critical elements were *Met* and less than 60 percent of all evaluation elements were *Met* across all activities or one or more critical element(s) were *Not Met*.

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

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

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

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

Table 2-7—Assignment of PIPs to Performance Domains

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

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

Introduction

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

Compliance Monitoring

This section of the report presents the results of the 2008–2009 compliance monitoring reviews. These reviews evaluated the PIHPs' compliance with federal and State regulations and contractual requirements related to the following standards: QAPIP Plan and Structure, Performance Measurement and Improvement, Practice Guidelines, Staff Qualifications and Training, Utilization Management, Customer Services, Enrollee Grievance Process, Enrollee Rights and Protections, Subcontracts and Delegation, Provider Network, Credentialing, Access and Availability, Coordination of Care, and Appeals.

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

Table 3-1—Standards				
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	✓	✓	

Access Alliance of Michigan

Overall Compliance Monitoring Results

Table 3-2 presents the results from the 2008–2009 compliance monitoring review, showing the number of elements for each of the standards that received a score of *Met*, *Substantially Met*, *Partially Met, Not Met*, or *NA*. The table also shows compliance scores for each of the standards and an overall compliance score across all standards. The 2008–2009 External Quality Review Compliance Monitoring Report for **Access Alliance of Michigan** contains a more detailed description of the results.

Table 3-2—Summary of Scores for the Standards *for* Access Alliance of Michigan

Standard	Standard Name	Number of Elements					Compliance Score
		M	*SM*	*PM*	*NM*	*NA*	
I	QAPIP Plan and Structure	18	0	0	0	0	100%
II	Performance Measurement	21	0	0	0	0	100%
III	Practice Guidelines	14	0	0	0	0	100%
IV	Staff Qualifications	6	0	0	0	0	100%
V	Utilization Management	18	0	0	1	0	95%
VI	Customer Services	11	0	0	0	0	100%
VII	Enrollee Grievance Process	12	1	0	0	0	98%
VIII	Enrollee Rights and Protections	29	2	0	0	2	98%
IX	Subcontracts and Delegation	7	0	0	0	0	100%
X	Provider Network	12	0	0	0	0	100%
XI	Credentialing	25	0	0	0	0	100%
XII	Access and Availability	13		4	0	0	88%
XIII	Coordination of Care	3	0	0	0	0	100%
XIV	Appeals	15	0	0	0	0	100%
						Overall Compliance	98%

Strengths

Access Alliance of Michigan received an overall compliance score of 98 percent across all standards. The PIHP achieved 100 percent compliance on 10 of the 14 standards: QAPIP Plan and Structure, Performance Measurement, Practice Guidelines, Staff Qualifications, Customer Services, Subcontracts and Delegation, Provider Network, Credentialing, Coordination of Care, and Appeals. **Access Alliance of Michigan** also demonstrated strong performance on the standards of Utilization Management, Enrollee Grievance Process, and Enrollee Rights and Protections.

Recommendations

Recommendations for improving **Access Alliance of Michigan**'s performance addressed Utilization Management, Enrollee Grievance Process, Enrollee Rights and Protections, and Access and Availability. The PIHP should ensure compliance with all requirements related to the utilization management review and enrollee grievance procedures and complete implementation of the revised policy addressing the notice of terminated providers. **Access Alliance of Michigan** should continue its efforts to meet the minimum performance standard for access to ongoing services and follow-up care after discharge from a psychiatric inpatient unit.

Summary Assessment Related to Quality, Timeliness, and Access

Access Alliance of Michigan demonstrated strong performance across the three domains of **quality**, **timeliness**, and **access**. The PIHP demonstrated its strongest performance in the **quality** domain, achieving full compliance on 10 of the 12 standards. Performance in the **access** domain was also strong, with full compliance on 3 of the 5 standards in this domain. All recommendations for improvement related to the **timeliness** domain, where the PIHP achieved full compliance on 2 of the 5 standards.

CMH Affiliation of Mid-Michigan

Overall Compliance Monitoring Results

Table 3-3 presents the results from the 2008–2009 compliance monitoring review, showing the number of elements for each of the standards that received a score of *Met*, *Substantially Met*, *Partially Met, Not Met*, or *NA*. The table also shows compliance scores for each of the standards and an overall compliance score across all standards. The 2008–2009 External Quality Review Compliance Monitoring Report for **CMH Affiliation of Mid-Michigan** contains a more detailed description of the results.

Table 3-3—Summary of Scores for the Standards *for* CMH Affiliation of Mid-Michigan

Standard	Standard Name	Number of Elements					Compliance Score
		M	*SM*	*PM*	*NM*	*NA*	
I	QAPIP Plan and Structure	14	0	1	3	0	81%
II	Performance Measurement	20	1	0	0	0	99%
III	Practice Guidelines	12	2	0	0	0	96%
IV	Staff Qualifications	5	0	1	0	0	92%
V	Utilization Management	19	0	0	0	0	100%
VI	Customer Services	10	1	0	0	0	98%
VII	Enrollee Grievance Process	10	3	0	0	0	94%
VIII	Enrollee Rights and Protections	31	0	0	0	2	100%
IX	Subcontracts and Delegation	6	0	0	0	1	100%
X	Provider Network	10	1	0	0	1	98%
XI	Credentialing	23	0	0	0	2	100%
XII	Access and Availability	17		0	0	0	100%
XIII	Coordination of Care	3	0	0	0	0	100%
XIV	Appeals	10	2	2	1	0	83%
		Overall Compliance					96%

Strengths

CMH Affiliation of Mid-Michigan received an overall compliance score of 96 percent across all standards. The PIHP achieved 100 percent compliance on 6 of the 14 standards: Utilization Management, Enrollee Rights and Protections, Subcontracts and Delegation, Credentialing, Access and Availability, and Coordination of Care. **CMH Affiliation of Mid-Michigan** also demonstrated strong performance on the standards of Performance Measurement, Practice Guidelines, Customer Services, and Provider Network.

Recommendations

Recommendations for improving **CMH Affiliation of Mid-Michigan**'s performance addressed the areas of the QAPIP, Performance Measurement, Practice Guidelines, Staff Qualifications, Customer Services, Enrollee Grievance Process, Provider Network, and Appeals. Opportunities for improvement related to changes to the PIHP's QAPIP, additional information in the customer handbook, and the PIHP's annual assessment of the adequacy of its provider network. The PIHP should also ensure compliance with all requirements related to the enrollee grievance and appeals processes.

Summary Assessment Related to Quality, Timeliness, and Access

CMH Affiliation of Mid-Michigan demonstrated its strongest performance in the domain of **access**, achieving full compliance on 3 of the 5 standards in this domain. Performance in the **timeliness** domain was not as strong, with full compliance on 2 of the 5 standards in the domain. Most recommendations for improvement addressed the **quality** domain, where the PIHP achieved full compliance on 4 of the 12 standards.

CMH for Central Michigan

Overall Compliance Monitoring Results

Table 3-4 presents the results from the 2008–2009 compliance monitoring review, showing the number of elements for each of the standards that received a score of *Met*, *Substantially Met*, *Partially Met, Not Met*, or *NA*. The table also shows compliance scores for each of the standards and an overall compliance score across all standards. The 2008–2009 External Quality Review Compliance Monitoring Report for **CMH for Central Michigan** contains a more detailed description of the results.

Table 3-4—Summary of Scores for the Standards *for* CMH for Central Michigan

Standard	Standard Name	Number of Elements					Compliance Score
		M	*SM*	*PM*	*NM*	*NA*	
I	QAPIP Plan and Structure	18	0	0	0	0	100%
II	Performance Measurement	21	0	0	0	0	100%
III	Practice Guidelines	14	0	0	0	0	100%
IV	Staff Qualifications	6	0	0	0	0	100%
V	Utilization Management	18	0	0	0	1	100%
VI	Customer Services	10	1	0	0	0	98%
VII	Enrollee Grievance Process	11	2	0	0	0	96%
VIII	Enrollee Rights and Protections	31	0	0	0	2	100%
IX	Subcontracts and Delegation	7	0	0	0	0	100%
X	Provider Network	12	0	0	0	0	100%
XI	Credentialing	25	0	0	0	0	100%
XII	Access and Availability	17		0	0	0	100%
XIII	Coordination of Care	3	0	0	0	0	100%
XIV	Appeals	14	0	1	0	0	97%
		Overall Compliance					99%

Strengths

CMH for Central Michigan received an overall compliance score of 99 percent across all standards. The PIHP achieved 100 percent compliance on 11 of the 14 standards: QAPIP Plan and Structure, Performance Measurement, Practice Guidelines, Staff Qualifications, Utilization Management, Enrollee Rights and Protections, Subcontracts and Delegation, Provider Network, Credentialing, Access and Availability, and Coordination of Care. **CMH for Central Michigan** also demonstrated strong performance on the standards of Customer Services, Enrollee Grievance Process, and Appeals.

Recommendations

Recommendations for improving **CMH for Central Michigan**'s performance addressed the areas of Customer Services, Enrollee Grievance Process, and Appeals. The PIHP should finalize the distribution of the revised Customer Services Handbook and ensure compliance with all requirements related to the delegation of the grievance and appeal processes.

Summary Assessment Related to Quality, Timeliness, and Access

CMH for Central Michigan demonstrated strong performance across the three domains of **quality**, **timeliness**, and **access.** In the **access** domain, the PIHP achieved full compliance on 4 of the 5 standards, with one recommendation for improvement. In the **quality** domain, the PIHP received scores of 100 percent compliance on 9 of the 12 standards. All four opportunities for improvement related to this domain. Performance in the **timeliness** domain was also strong, with full compliance on 3 of the 5 standards.

CMH Partnership of Southeastern Michigan

Overall Compliance Monitoring Results

Table 3-5 presents the results from the 2008–2009 compliance monitoring review, showing the number of elements for each of the standards that received a score of *Met*, *Substantially Met*, *Partially Met, Not Met*, or *NA*. The table also shows compliance scores for each of the standards and an overall compliance score across all standards. The 2008–2009 External Quality Review Compliance Monitoring Report for **CMH Partnership of Southeastern Michigan** contains a more detailed description of the results.

Table 3-5—Summary of Scores for the Standards *for* CMH Partnership of Southeastern Michigan

Standard	Standard Name	Number of Elements					Compliance Score
		M	*SM*	*PM*	*NM*	*NA*	
I	QAPIP Plan and Structure	17	1	0	0	0	99%
II	Performance Measurement	21	0	0	0	0	100%
III	Practice Guidelines	14	0	0	0	0	100%
IV	Staff Qualifications	6	0	0	0	0	100%
V	Utilization Management	19	0	0	0	0	100%
VI	Customer Services	11	0	0	0	0	100%
VII	Enrollee Grievance Process	11	2	0	0	0	96%
VIII	Enrollee Rights and Protections	31	0	0	0	2	100%
IX	Subcontracts and Delegation	7	0	0	0	0	100%
X	Provider Network	12	0	0	0	0	100%
XI	Credentialing	24	0	0	0	1	100%
XII	Access and Availability	17		0	0	0	100%
XIII	Coordination of Care	3	0	0	0	0	100%
XIV	Appeals	14	1	0	0	0	98%
		Overall Compliance					100%

Strengths

CMH Partnership of Southeastern Michigan received an overall compliance score of 100 percent across all standards. The PIHP achieved 100 percent compliance on 11 of the 14 standards: Performance Measurement, Practice Guidelines, Staff Qualifications, Utilization Management, Customer Services, Enrollee Rights and Protections, Subcontracts and Delegation, Provider Network, Credentialing, Access and Availability, and Coordination of Care. **CMH Partnership of Southeastern Michigan** also demonstrated strong performance on the standards of QAPIP Plan and Structure, Enrollee Grievance Process, and Appeals.

Recommendations

Recommendations for improving **CMH Partnership of Southeast Michigan**'s performance addressed the areas of the QAPIP, Enrollee Grievance Process, and Appeals. The PIHP should ensure that the QAPIP reviews analyses of data from the Behavior Treatment Review Committee quarterly and complies with all requirements related to the handling of grievances and beneficiary appeals.

Summary Assessment Related to Quality, Timeliness, and Access

CMH Partnership of Southeast Michigan demonstrated excellent performance across the three domains of **quality**, **timeliness**, and **access.** The PIHP demonstrated its strongest performance in the **access** domain, with full compliance on all 5 standards. In the **quality** domain, the PIHP received scores of 100 percent compliance on 9 of the 12 standards. All four opportunities for improvement related to this domain. Performance in the **timeliness** domain was also strong, with full compliance on 3 of the 5 standards.

Detroit-Wayne County CMH Agency

Overall Compliance Monitoring Results

Table 3-6 presents the results from the 2008–2009 compliance monitoring review, showing the number of elements for each of the standards that received a score of *Met*, *Substantially Met*, *Partially Met, Not Met*, or *NA*. The table also shows compliance scores for each of the standards and an overall compliance score across all standards. The 2008–2009 External Quality Review Compliance Monitoring Report for **Detroit-Wayne County CMH Agency** contains a more detailed description of the results.

Table 3-6—Summary of Scores for the Standards *for* Detroit-Wayne County CMH Agency

Standard	Standard Name	Number of Elements					Compliance Score
		M	*SM*	*PM*	*NM*	*NA*	
I	QAPIP Plan and Structure	17	1	0	0	0	99%
II	Performance Measurement	21	0	0	0	0	100%
III	Practice Guidelines	14	0	0	0	0	100%
IV	Staff Qualifications	6	0	0	0	0	100%
V	Utilization Management	16	1	2	0	0	93%
VI	Customer Services	9	2	0	0	0	95%
VII	Enrollee Grievance Process	7	5	1	0	0	87%
VIII	Enrollee Rights and Protections	31	0	0	0	2	100%
IX	Subcontracts and Delegation	6	0	0	0	1	100%
X	Provider Network	12	0	0	0	0	100%
XI	Credentialing	25	0	0	0	0	100%
XII	Access and Availability	7		6	4	0	59%
XIII	Coordination of Care	3	0	0	0	0	100%
XIV	Appeals	11	0	1	3	0	77%
		Overall Compliance					93%

Strengths

Detroit-Wayne County CMH Agency received an overall compliance score of 93 percent across all standards. The PIHP achieved 100 percent compliance on 8 of the 14 standards: Performance Measurement, Practice Guidelines, Staff Qualifications, Enrollee Rights and Protections, Subcontracts and Delegation, Provider Network, Credentialing, and Coordination of Care. **Detroit-Wayne County CMH Agency** also demonstrated strong performance on the standards of QAPIP Plan and Structure and Customer Services.

Recommendations

Recommendations for improving **Detroit-Wayne County CMH Agency**'s performance addressed the QAPIP Plan and Structure, Utilization Management, Customer Services, Enrollee Grievance Process, Access and Availability, and Appeals. The PIHP should ensure quarterly review of data from the behavior treatment committee and compliance with requirements related to the customer services telephone line and handbook. **Detroit-Wayne County CMH Agency** should continue efforts to meet the minimum performance standards for the access to care measures. The PIHP should implement corrective actions to ensure that its policies, procedures, and processes for utilization management, grievances, and beneficiary appeals are fully compliant with all contractual requirements.

Summary Assessment Related to Quality, Timeliness, and Access

Detroit-Wayne County CMH Agency demonstrated its strongest performance in the domain of **quality**, with full compliance on 8 of the 12 standards. In the **access** domain, the PIHP received scores of 100 percent on 2 of the 5 standards. The **timeliness** domain had the lowest performance, with full compliance on 1 of the 5 standards. Almost all opportunities for improvement related to this domain.

Genesee County CMH

Overall Compliance Monitoring Results

Table 3-7 presents the results from the 2008–2009 compliance monitoring review, showing the number of elements for each of the standards that received a score of *Met*, *Substantially Met*, *Partially Met, Not Met*, or *NA*. The table also shows compliance scores for each of the standards and an overall compliance score across all standards. The 2008–2009 External Quality Review Compliance Monitoring Report for **Genesee County CMH** contains a more detailed description of the results.

Table 3-7—Summary of Scores for the Standards *for* Genesee County CMH

Standard	Standard Name	Number of Elements					Compliance Score
		M	*SM*	*PM*	*NM*	*NA*	
I	QAPIP Plan and Structure	18	0	0	0	0	100%
II	Performance Measurement	21	0	0	0	0	100%
III	Practice Guidelines	14	0	0	0	0	100%
IV	Staff Qualifications	6	0	0	0	0	100%
V	Utilization Management	19	0	0	0	0	100%
VI	Customer Services	11	0	0	0	0	100%
VII	Enrollee Grievance Process	12	1	0	0	0	98%
VIII	Enrollee Rights and Protections	31	0	0	0	2	100%
IX	Subcontracts and Delegation	7	0	0	0	0	100%
X	Provider Network	12	0	0	0	0	100%
XI	Credentialing	24	0	0	0	1	100%
XII	Access and Availability	16		1	0	0	97%
XIII	Coordination of Care	3	0	0	0	0	100%
XIV	Appeals	15	0	0	0	0	100%
		Overall Compliance					100%

Strengths

Genesee County CMH received an overall compliance score of 100 percent across all standards. The PIHP achieved 100 percent compliance on 12 of the 14 standards: QAPIP Plan and Structure, Performance Measurement, Practice Guidelines, Staff Qualifications, Utilization Management, Customer Services, Enrollee Rights and Protections, Subcontracts and Delegation, Provider Network, Credentialing, Coordination of Care, and Appeals. **Genesee County CMH** also demonstrated strong performance on the standards of Enrollee Grievance Process and Access and Availability.

Recommendations

Recommendations for improving **Genesee County CMH**'s performance addressed the areas of the Enrollee Grievance Process and Access and Availability. The PIHP should ensure compliance with all requirements related to handling of grievances and continue efforts to meet the minimum performance standard for access to ongoing services for beneficiaries with a substance use disorder.

Summary Assessment Related to Quality, Timeliness, and Access

Genesee County CMH demonstrated excellent performance across the three domains of **quality**, **timeliness**, and **access.** The PIHP achieved 100 percent compliance on 11 of the 12 standards in the **quality** domain and 4 of the 5 standards in the **access** domain. In the **timeliness** domain, **Genesee County CMH** demonstrated full compliance on 3 of the 5 standards. Both recommendations for improvement addressed this domain.

Lakeshore Behavioral Health Alliance

Overall Compliance Monitoring Results

Table 3-8 presents the results from the 2008–2009 compliance monitoring review, showing the number of elements for each of the standards that received a score of *Met*, *Substantially Met*, *Partially Met, Not Met*, or *NA*. The table also shows compliance scores for each of the standards and an overall compliance score across all standards. The 2008–2009 External Quality Review Compliance Monitoring Report for **Lakeshore Behavioral Health Alliance** contains a more detailed description of the results.

Table 3-8—Summary of Scores for the Standards *for* Lakeshore Behavioral Health Alliance

Standard	Standard Name	Number of Elements					Compliance Score
		M	*SM*	*PM*	*NM*	*NA*	
I	QAPIP Plan and Structure	12	4	0	2	0	83%
II	Performance Measurement	18	3	0	0	0	96%
III	Practice Guidelines	14	0	0	0	0	100%
IV	Staff Qualifications	6	0	0	0	0	100%
V	Utilization Management	4	15	0	0	0	80%
VI	Customer Services	10	1	0	0	0	98%
VII	Enrollee Grievance Process	10	0	2	1	0	85%
VIII	Enrollee Rights and Protections	30	0	1	0	2	98%
IX	Subcontracts and Delegation	7	0	0	0	0	100%
X	Provider Network	12	0	0	0	0	100%
XI	Credentialing	24	0	0	0	1	100%
XII	Access and Availability	13		4	0	0	88%
XIII	Coordination of Care	3	0	0	0	0	100%
XIV	Appeals	13	1	0	0	1	98%
		Overall Compliance					**94%**

Strengths

Lakeshore Behavioral Health Alliance received an overall compliance score of 94 percent across all standards. The PIHP achieved 100 percent compliance on 6 of the 14 standards: Practice Guidelines, Staff Qualifications, Subcontracts and Delegation, Provider Network, Credentialing, and Coordination of Care. **Lakeshore Behavioral Health Alliance** also demonstrated strong performance on the standards of Performance Measurement, Customer Services, Enrollee Rights and Protections, and Appeals.

Recommendations

Recommendations for improving **Lakeshore Behavioral Health Alliance**'s performance addressed the areas of the QAPIP, Performance Measurement, Utilization Management, Customer Services, Enrollee Grievance Process, Enrollee Rights and Protections, Access and Availability, and Appeals. The PIHP should ensure that it complies with all requirements related to the QAPIP, the customer handbook, and enrollee information, and continue efforts to meet the minimum performance standards for timely face-to-face assessments and access to ongoing services. The PIHP should implement corrective actions to ensure that its policies, procedures, and processes for utilization management, grievances, and beneficiary appeals are fully compliant with all contractual requirements.

Summary Assessment Related to Quality, Timeliness, and Access

Lakeshore Behavioral Health Alliance demonstrated mixed performance across the three domains of **quality**, **timeliness**, and **access**. The PIHP's strongest performance was in the **quality** domain, with 6 of the 12 standards in full compliance. Performance in the **access** domain was not as strong, with scores of 100 percent compliance on 2 of the 5 standards. The **timeliness** domain had the lowest performance, with none of the 5 standards in full compliance. The majority of opportunities for improvement addressed this domain.

LifeWays

Overall Compliance Monitoring Results

Table 3-9 presents the results from the 2008–2009 compliance monitoring review, showing the number of elements for each of the standards that received a score of *Met*, *Substantially Met*, *Partially Met, Not Met*, or *NA*. The table also shows compliance scores for each of the standards and an overall compliance score across all standards. The 2008–2009 External Quality Review Compliance Monitoring Report for **LifeWays** contains a more detailed description of the results.

Table 3-9—Summary of Scores for the Standards *for* LifeWays

Standard	Standard Name	Number of Elements					Compliance Score
		M	*SM*	*PM*	*NM*	*NA*	
I	QAPIP Plan and Structure	18	0	0	0	0	100%
II	Performance Measurement	21	0	0	0	0	100%
III	Practice Guidelines	14	0	0	0	0	100%
IV	Staff Qualifications	6	0	0	0	0	100%
V	Utilization Management	19	0	0	0	0	100%
VI	Customer Services	11	0	0	0	0	100%
VII	Enrollee Grievance Process	10	2	1	0	0	92%
VIII	Enrollee Rights and Protections	30	1	0	0	2	99%
IX	Subcontracts and Delegation	7	0	0	0	0	100%
X	Provider Network	12	0	0	0	0	100%
XI	Credentialing	25	0	0	0	0	100%
XII	Access and Availability	17		0	0	0	100%
XIII	Coordination of Care	3	0	0	0	0	100%
XIV	Appeals	12	1	2	0	0	92%
		Overall Compliance					**99%**

Strengths

LifeWays received an overall compliance score of 99 percent across all standards. The PIHP achieved 100 percent compliance on 11 of the 14 standards: QAPIP Plan and Structure, Performance Measurement, Practice Guidelines, Staff Qualifications, Utilization Management, Customer Services, Subcontracts and Delegation, Provider Network, Credentialing, Access and Availability, and Coordination of Care. **LifeWays** also demonstrated strong performance on the standard of Enrollee Rights and Protections.

Recommendations

Recommendations for improving **LifeWay**'s performance addressed the areas of Enrollee Grievance Process, Enrollee Rights and Protections, and Appeals. The PIHP should implement corrective actions to conduct regular monitoring of subcontractors' grievances and appeals processes and ensure that its policies, procedures, and processes related to grievances and beneficiary appeals are fully compliant with all contractual requirements.

Summary Assessment Related to Quality, Timeliness, and Access

LifeWays demonstrated strong performance across the three domains of **quality**, **timeliness**, and **access**. The PIHP's strongest performance was in the **access** domain, with all 5 standards in full compliance. In the **timeliness** domain, the PIHP received scores of 100 percent compliance on 3 of the 5 standards. All opportunities for improvement addressed the **quality** domain, where the PIHP achieved full compliance on 9 of the 12 standards.

Macomb County CMH Services

Overall Compliance Monitoring Results

Table 3-10 presents the results from the 2008–2009 compliance monitoring review, showing the number of elements for each of the standards that received a score of *Met*, *Substantially Met*, *Partially Met, Not Met*, or *NA*. The table also shows compliance scores for each of the standards and an overall compliance score across all standards. The 2008–2009 External Quality Review Compliance Monitoring Report for **Macomb County CMH Services** contains a more detailed description of the results.

Table 3-10—Summary of Scores for the Standards *for* Macomb County CMH Services

Standard	Standard Name	Number of Elements					Compliance Score
		M	*SM*	*PM*	*NM*	*NA*	
I	QAPIP Plan and Structure	18	0	0	0	0	100%
II	Performance Measurement	21	0	0	0	0	100%
III	Practice Guidelines	10	0	0	0	4	100%
IV	Staff Qualifications	6	0	0	0	0	100%
V	Utilization Management	19	0	0	0	0	100%
VI	Customer Services	8	3	0	0	0	93%
VII	Enrollee Grievance Process	12	1	0	0	0	98%
VIII	Enrollee Rights and Protections	31	0	0	0	2	100%
IX	Subcontracts and Delegation	7	0	0	0	0	100%
X	Provider Network	12	0	0	0	0	100%
XI	Credentialing	25	0	0	0	0	100%
XII	Access and Availability	13		2	2	0	82%
XIII	Coordination of Care	3	0	0	0	0	100%
XIV	Appeals	14	0	1	0	0	97%
		Overall Compliance					98%

Strengths

Macomb County CMH Services received an overall compliance score of 98 percent across all standards. The PIHP achieved 100 percent compliance on 10 of the 14 standards: QAPIP Plan and Structure, Performance Measurement, Practice Guidelines, Staff Qualifications, Utilization Management, Enrollee Rights and Protections, Subcontracts and Delegation, Provider Network, Credentialing, and Coordination of Care. **Macomb County CMH Services** also demonstrated strong performance on the standards of the Enrollee Grievance Process and Appeals.

Recommendations

Recommendations for improving **Macomb County CMH Service**'s performance addressed the areas of Customer Services, Enrollee Grievance Process, Access and Availability, and Appeals. The PIHP should implement corrective actions to ensure that the customer services unit provides all required information and that handling of grievances and beneficiary appeals complies with all requirements. The PIHP should continue efforts to meet the minimum performance standard for access to ongoing services.

Summary Assessment Related to Quality, Timeliness, and Access

Macomb County CMH Services demonstrated strong performance across the three domains of **quality**, **timeliness**, and **access**. The PIHP's strongest performance was in the **quality** domain, with 9 of the 12 standards in full compliance. In the **access** domain, the PIHP received scores of 100 percent on 3 of the 5 standards. Performance in the **timeliness** domain was lower, with 2 of the 5 standards in full compliance. Opportunities for improvement existed across all three domains.

network180

Overall Compliance Monitoring Results

Table 3-11 presents the results from the 2008–2009 compliance monitoring review, showing the number of elements for each of the standards that received a score of *Met*, *Substantially Met*, *Partially Met, Not Met*, or *NA*. The table also shows compliance scores for each of the standards and an overall compliance score across all standards. The 2008–2009 External Quality Review Compliance Monitoring Report for **network180** contains a more detailed description of the results.

Table 3-11—Summary of Scores for the Standards *for* network180

Standard	Standard Name	Number of Elements					Compliance Score
		M	*SM*	*PM*	*NM*	*NA*	
I	QAPIP Plan and Structure	18	0	0	0	0	100%
II	Performance Measurement	21	0	0	0	0	100%
III	Practice Guidelines	10	0	0	0	4	100%
IV	Staff Qualifications	6	0	0	0	0	100%
V	Utilization Management	19	0	0	0	0	100%
VI	Customer Services	11	0	0	0	0	100%
VII	Enrollee Grievance Process	10	1	2	0	0	90%
VIII	Enrollee Rights and Protections	31	0	0	0	2	100%
IX	Subcontracts and Delegation	7	0	0	0	0	100%
X	Provider Network	12	0	0	0	0	100%
XI	Credentialing	22	0	2	0	1	96%
XII	Access and Availability	14		1	2	0	85%
XIII	Coordination of Care	3	0	0	0	0	100%
XIV	Appeals	14	1	0	0	0	98%
		Overall Compliance					98%

Strengths

network180 received an overall compliance score of 98 percent across all standards. The PIHP achieved 100 percent compliance on 10 of the 14 standards: QAPIP Plan and Structure, Performance Measurement, Practice Guidelines, Staff Qualifications, Utilization Management, Customer Services, Enrollee Rights and Protections, Subcontracts and Delegation, Provider Network and Coordination of Care. **network180** also demonstrated strong performance on the standards of Credentialing and Appeals.

Recommendations

Recommendations for improving **network180**'s performance addressed the areas of Enrollee Grievance Process, Credentialing, Access and Availability, and Appeals. The PIHP should implement corrective actions to ensure that its credentialing policy includes all required provisions and continue efforts to meet the minimum performance standard for access to ongoing services and follow-up care after discharge from a detox unit. The PIHP's policies, procedures, and processes for grievances and beneficiary appeals should be fully compliant with all contractual requirements.

Summary Assessment Related to Quality, Timeliness, and Access

network180 demonstrated strong performance across the three domains of **quality**, **timeliness**, and **access**. The PIHP's strongest performance was in the **access** domain, with 4 of the 5 standards in full compliance. Results for the **quality** domain were also strong, with scores of 100 percent compliance for 9 of the 12 standards. In the **timeliness** domain, 2 of the 5 standards were in full compliance. Almost all recommendations for improvement addressed this domain.

NorthCare

Overall Compliance Monitoring Results

Table 3-12 presents the results from the 2008–2009 compliance monitoring review, showing the number of elements for each of the standards that received a score of *Met*, *Substantially Met*, *Partially Met, Not Met*, or *NA*. The table also shows compliance scores for each of the standards and an overall compliance score across all standards. The 2008–2009 External Quality Review Compliance Monitoring Report for **NorthCare** contains a more detailed description of the results.

Table 3-12—Summary of Scores for the Standards *for* NorthCare

Standard	Standard Name	Number of Elements					Compliance Score
		M	*SM*	*PM*	*NM*	*NA*	
I	QAPIP Plan and Structure	18	0	0	0	0	100%
II	Performance Measurement	20	1	0	0	0	99%
III	Practice Guidelines	13	1	0	0	0	98%
IV	Staff Qualifications	6	0	0	0	0	100%
V	Utilization Management	19	0	0	0	0	100%
VI	Customer Services	11	0	0	0	0	100%
VII	Enrollee Grievance Process	11	0	2	0	0	92%
VIII	Enrollee Rights and Protections	29	0	2	0	2	97%
IX	Subcontracts and Delegation	7	0	0	0	0	100%
X	Provider Network	12	0	0	0	0	100%
XI	Credentialing	25	0	0	0	0	100%
XII	Access and Availability	13		3	1	0	85%
XIII	Coordination of Care	3	0	0	0	0	100%
XIV	Appeals	12	0	1	2	0	83%
		Overall Compliance					96%

Strengths

NorthCare received an overall compliance score of 96 percent across all standards. The PIHP achieved 100 percent compliance on 8 of the 14 standards: QAPIP Plan and Structure, Staff Qualifications, Utilization Management, Customer Services, Subcontracts and Delegation, Provider Network, Credentialing, and Coordination of Care. **NorthCare** also demonstrated strong performance on the standards of Performance Measurement, Practice Guidelines, and Enrollee Rights and Protections.

Recommendations

Recommendations for improving **NorthCare**'s performance addressed the areas of Performance Measurement, Practice Guidelines, Enrollee Grievance Process, Enrollee Rights and Protections, Access and Availability, and Appeals. The PIHP should revise its sentinel events policy, implement its goal to establish a practice guideline plan, and ensure that beneficiaries are informed of their right to request and obtain information about enrollee rights and protections. The PIHP should ensure that the processes for handling grievances and beneficiary appeals meet all contractual requirements and continue efforts to meet the minimum performance standard for access to face-to-face assessments and ongoing services.

Summary Assessment Related to Quality, Timeliness, and Access

NorthCare demonstrated mixed performance across the three domains of **quality**, **timeliness**, and **access**. The PIHP's strongest performance was in the **access** domain, with 4 of the 5 standards in full compliance. In the quality domain, the PIHP received scores of 100 percent compliance on 7 of the 12 standards. PIHP performance in the **timeliness** domain was much lower, with 1 of the 5 standards in full compliance. Most opportunities for improvement related to this domain.

Northern Affiliation

Overall Compliance Monitoring Results

Table 3-13 presents the results from the 2008–2009 compliance monitoring review, showing the number of elements for each of the standards that received a score of *Met*, *Substantially Met*, *Partially Met, Not Met*, or *NA*. The table also shows compliance scores for each of the standards and an overall compliance score across all standards. The 2008–2009 External Quality Review Compliance Monitoring Report for **Northern Affiliation** contains a more detailed description of the results.

Table 3-13—Summary of Scores for the Standards *for* Northern Affiliation

Standard	Standard Name	Number of Elements					Compliance Score
		M	*SM*	*PM*	*NM*	*NA*	
I	QAPIP Plan and Structure	18	0	0	0	0	100%
II	Performance Measurement	21	0	0	0	0	100%
III	Practice Guidelines	10	0	0	0	4	100%
IV	Staff Qualifications	6	0	0	0	0	100%
V	Utilization Management	17	0	0	2	0	89%
VI	Customer Services	11	0	0	0	0	100%
VII	Enrollee Grievance Process	11	0	2	0	0	92%
VIII	Enrollee Rights and Protections	31	0	0	0	0	100%
IX	Subcontracts and Delegation	7	0	0	0	0	100%
X	Provider Network	12	0	0	0	0	100%
XI	Credentialing	25	0	0	0	0	100%
XII	Access and Availability	16		1	0	0	97%
XIII	Coordination of Care	3	0	0	0	0	100%
XIV	Appeals	14	1	0	0	0	98%
		Overall Compliance					98%

Strengths

Northern Affiliation received an overall compliance score of 98 percent across all standards. The PIHP achieved 100 percent compliance on 10 of the 14 standards: QAPIP Plan and Structure, Performance Measurement, Practice Guidelines, Staff Qualifications, Customer Services, Enrollee Rights and Protections, Subcontracts and Delegation, Provider Network, Credentialing, and Coordination of Care. **Northern Affiliation** also demonstrated strong performance on the standards of Access and Availability and Appeals.

Recommendations

Recommendations for improving **Northern Affiliation**'s performance addressed the areas of Utilization Management, Enrollee Grievance Process, Access and Availability, and Appeals. The PIHP should implement corrective actions to ensure that its processes for utilization management, grievances, and beneficiary appeals comply with all contractual requirements and continue its efforts to ensure timely access to ongoing services for adults with a developmental disability.

Summary Assessment Related to Quality, Timeliness, and Access

Northern Affiliation demonstrated mixed performance across the three domains of **quality**, **timeliness**, and **access**. The PIHP's strongest performance was in the **quality** domain, achieving full compliance on 10 of the 12 standards. In the **access** domain, the PIHP received compliance scores of 100 percent for 3 of the 5 standards. Performance in the **timeliness** domain was lower, with 1 of the 5 standards in full compliance. All opportunities for improvement related to this domain.

Northwest CMH Affiliation

Overall Compliance Monitoring Results

Table 3-14 presents the results from the 2008–2009 compliance monitoring review, showing the number of elements for each of the standards that received a score of *Met*, *Substantially Met*, *Partially Met, Not Met*, or *NA*. The table also shows compliance scores for each of the standards and an overall compliance score across all standards. The 2008–2009 External Quality Review Compliance Monitoring Report for **Northwest CMH Affiliation** contains a more detailed description of the results.

Table 3-14—Summary of Scores for the Standards *for* Northwest CMH Affiliation

Standard	Standard Name	Number of Elements					Compliance Score
		M	*SM*	*PM*	*NM*	*NA*	
I	QAPIP Plan and Structure	17	0	0	1	0	94%
II	Performance Measurement	21	0	0	0	0	100%
III	Practice Guidelines	14	0	0	0	0	100%
IV	Staff Qualifications	4	0	2	0	0	83%
V	Utilization Management	16	1	2	0	0	93%
VI	Customer Services	10	1	0	0	0	98%
VII	Enrollee Grievance Process	12	0	1	0	0	96%
VIII	Enrollee Rights and Protections	31	0	0	0	2	100%
IX	Subcontracts and Delegation	7	0	0	0	0	100%
X	Provider Network	12	0	0	0	0	100%
XI	Credentialing	23	0	0	0	2	100%
XII	Access and Availability	13		4	0	0	88%
XIII	Coordination of Care	3	0	0	0	0	100%
XIV	Appeals	14	1	0	0	0	98%
		Overall Compliance					97%

Strengths

Northwest CMH Affiliation received an overall compliance score of 97 percent across all standards. The PIHP achieved 100 percent compliance on 7 of the 14 standards: Performance Measurement, Practice Guidelines, Enrollee Rights and Protections, Subcontracts and Delegation, Provider Network, Credentialing, and Coordination of Care. **Northwest CMH Affiliation** also demonstrated strong performance on the standards of Customer Services, Enrollee Grievance Process, and Appeals.

Recommendations

Recommendations for improving **Northwest CMH Affiliation**'s performance addressed the areas of QAPIP Plan and Structure, Staff Qualifications, Utilization Management, Customer Services, Enrollee Grievance Process, Access and Availability, and Appeals. The PIHP should ensure quarterly review of data analyses from the behavior treatment committee, revise the QAPIP to address staff training, and add teletype (TTY) telephone numbers or telephone relay information for some of the affiliates to the member handbook. The PIHP should ensure that its procedures for utilization management and handling of grievances meet all requirements. **Northwest CMH Affiliation** should continue efforts to meet the minimum performance standard for access to face-to-face assessments, ongoing services, and follow-up care, and ensure regular reporting of appeals data from all delegated subcontractors.

Summary Assessment Related to Quality, Timeliness, and Access

Northwest CMH Affiliation demonstrated mixed performance across the three domains of **quality**, **timeliness**, and **access**. The PIHP's strongest performance was in the **quality** domain, with 7 of the 12 standards in full compliance. In the **access** domain, the PIHP received scores of 100 percent compliance on 2 of the 5 standards. Performance in the timeliness domain was lowest, with full compliance on 1 of the 5 standards. Most opportunities for improvement related to this domain.

Oakland County CMH Authority

Overall Compliance Monitoring Results

Table 3-15 presents the results from the 2008–2009 compliance monitoring review, showing the number of elements for each of the standards that received a score of *Met*, *Substantially Met*, *Partially Met, Not Met*, or *NA*. The table also shows compliance scores for each of the standards and an overall compliance score across all standards. The 2008–2009 External Quality Review Compliance Monitoring Report for **Oakland County CMH Authority** contains a more detailed description of the results.

Table 3-15—Summary of Scores for the Standards *for* Oakland County CMH Authority

Standard	Standard Name	Number of Elements					Compliance Score
		M	*SM*	*PM*	*NM*	*NA*	
I	QAPIP Plan and Structure	18	0	0	0	0	100%
II	Performance Measurement	21	0	0	0	0	100%
III	Practice Guidelines	14	0	0	0	0	100%
IV	Staff Qualifications	6	0	0	0	0	100%
V	Utilization Management	19	0	0	0	0	100%
VI	Customer Services	11	0	0	0	0	100%
VII	Enrollee Grievance Process	13	0	0	0	0	100%
VIII	Enrollee Rights and Protections	31	1	0	0	1	99%
IX	Subcontracts and Delegation	7	0	0	0	0	100%
X	Provider Network	12	0	0	0	0	100%
XI	Credentialing	23	0	0	0	2	100%
XII	Access and Availability	17		0	0	0	100%
XIII	Coordination of Care	3	0	0	0	0	100%
XIV	Appeals	15	0	0	0	0	100%
						Overall Compliance	100%

Strengths

Oakland County CMH Authority received an overall compliance score of 100 percent across all standards. The PIHP achieved 100 percent compliance on 13 of the 14 standards: QAPIP Plan and Structure, Performance Measurement, Practice Guidelines, Staff Qualifications, Utilization Management, Customer Services, Enrollee Grievance Process, Subcontracts and Delegation, Provider Network, Credentialing, Access and Availability, Coordination of Care, and Appeals. **Oakland County CMH Authority** also demonstrated strong performance on the standard of Enrollee Rights and Protections.

Recommendations

Recommendations for improving **Oakland County CMH Authority**'s performance related to the area of Enrollee Rights and Protections. The PIHP should ensure that beneficiaries receive all required information about the State fair hearing process within a reasonable time after enrollment.

Summary Assessment Related to Quality, Timeliness, and Access

Oakland County CMH Authority demonstrated exceptional performance across the three domains of **quality**, **timeliness**, and **access**. The PIHP achieved full compliance on all 5 standards in the **timeliness** domain and all 5 standards in the **access** domain. In the **quality** domain, the PIHP achieved 100 percent compliance on 11 of the 12 standards, with one opportunity for improvement identified in this domain.

Saginaw County CMH Authority

Overall Compliance Monitoring Results

Table 3-16 presents the results from the 2008–2009 compliance monitoring review, showing the number of elements for each of the standards that received a score of *Met*, *Substantially Met*, *Partially Met, Not Met*, or *NA*. The table also shows compliance scores for each of the standards and an overall compliance score across all standards. The 2008–2009 External Quality Review Compliance Monitoring Report for **Saginaw County CMH Authority** contains a more detailed description of the results.

Table 3-16—Summary of Scores for the Standards *for* Saginaw County CMH Authority

Standard	Standard Name	Number of Elements					Compliance Score
		M	*SM*	*PM*	*NM*	*NA*	
I	QAPIP Plan and Structure	15	3	0	0	0	96%
II	Performance Measurement	21	0	0	0	0	100%
III	Practice Guidelines	14	0	0	0	0	100%
IV	Staff Qualifications	6	0	0	0	0	100%
V	Utilization Management	18	0	0	1	0	95%
VI	Customer Services	11	0	0	0	0	100%
VII	Enrollee Grievance Process	8	0	3	2	0	73%
VIII	Enrollee Rights and Protections	29	1	1	0	2	98%
IX	Subcontracts and Delegation	7	0	0	0	0	100%
X	Provider Network	12	0	0	0	0	100%
XI	Credentialing	25	0	0	0	0	100%
XII	Access and Availability	12		2	3	0	76%
XIII	Coordination of Care	3	0	0	0	0	100%
XIV	Appeals	13	1	1	0	0	95%
						Overall Compliance	95%

Strengths

Saginaw County CMH Authority received an overall compliance score of 95 percent across all standards. The PIHP achieved 100 percent compliance on 8 of the 14 standards: Performance Measurement, Practice Guidelines, Staff Qualifications, Customer Services, Subcontracts and Delegation, Provider Network, Credentialing, and Coordination of Care. **Saginaw County CMH Authority** also demonstrated strong performance on the standards of the QAPIP Plan and Structure, Utilization Management, Enrollee Rights and Protections, and Appeals.

Recommendations

Recommendations for improving **Saginaw County CMH Authority**'s performance addressed the areas of QAPIP Plan and Structure, Utilization Management, Enrollee Grievance Process, Enrollee Rights and Protections, Access and Availability, and Appeals. The PIHP should implement corrective actions to ensure that it meets all requirements related to the QAPIP and providing enrollee information. **Saginaw County CMH Authority** should ensure that its grievances and appeals processes meet all contractual requirements and continue efforts to meet the minimum performance standard for access to ongoing services and follow-up care after discharge from a psychiatric inpatient or detox unit.

Summary Assessment Related to Quality, Timeliness, and Access

Saginaw County CMH Authority demonstrated mixed performance across the three domains of **quality**, **timeliness**, and **access**. The PIHP's strongest performance was in the **quality** domain, with full compliance on 8 of the 12 standards. In the **access** domain, the PIHP received scores of 100 percent compliance on 3 of the 5 standards. The PIHP's lowest performance was in the **timeliness** domain, with 1 of the 5 standards in full compliance. Opportunities for improvement existed across all three domains.

Southwest Affiliation

Overall Compliance Monitoring Results

Table 3-17 presents the results from the 2008–2009 compliance monitoring review, showing the number of elements for each of the standards that received a score of *Met*, *Substantially Met*, *Partially Met, Not Met*, or *NA*. The table also shows compliance scores for each of the standards and an overall compliance score across all standards. The 2008–2009 External Quality Review Compliance Monitoring Report for **Southwest Affiliation** contains a more detailed description of the results.

Table 3-17—Summary of Scores for the Standards *for* Southwest Affiliation

Standard	Standard Name	Number of Elements					Compliance Score
		M	*SM*	*PM*	*NM*	*NA*	
I	QAPIP Plan and Structure	17	1	0	0	0	99%
II	Performance Measurement	21	0	0	0	0	100%
III	Practice Guidelines	14	0	0	0	0	100%
IV	Staff Qualifications	6	0	0	0	0	100%
V	Utilization Management	19	0	0	0	0	100%
VI	Customer Services	11	0	0	0	0	100%
VII	Enrollee Grievance Process	12	1	0	0	0	98%
VIII	Enrollee Rights and Protections	31	0	0	0	2	100%
IX	Subcontracts and Delegation	7	0	0	0	0	100%
X	Provider Network	12	0	0	0	0	100%
XI	Credentialing	24	0	0	0	1	100%
XII	Access and Availability	15		1	1	0	91%
XIII	Coordination of Care	3	0	0	0	0	100%
XIV	Appeals	13	1	1	0	0	95%
		Overall Compliance					99%

Strengths

Southwest Affiliation received an overall compliance score of 99 percent across all standards. The PIHP achieved 100 percent compliance on 10 of the 14 standards: Performance Measurement, Practice Guidelines, Staff Qualifications, Utilization Management, Customer Services, Enrollee Rights and Protections, Subcontracts and Delegation, Provider Network, Credentialing, and Coordination of Care. **Southwest Affiliation** also demonstrated strong performance on the standards of QAPIP Plan and Structure, Enrollee Grievance Process, and Appeals.

Recommendations

Recommendations for improving **Southwest Affiliation**'s performance addressed the areas of the QAPIP Plan and Structure, Enrollee Grievance Process, Access and Availability, and Appeals. The PIHP should ensure quarterly review of data from the behavior treatment committee. **Southwest Affiliation** should implement corrective actions to ensure that its process for handling grievances and appeals procedures meet all contractual requirements and continue efforts to meet the minimum performance standard for access to ongoing services and follow-up care after discharge from a detox unit.

Summary Assessment Related to Quality, Timeliness, and Access

Southwest Affiliation demonstrated strong performance across the three domains of **quality**, **timeliness**, and **access**. The PIHP's strongest performance was in the **access** domain, with 4 of the 5 standards in full compliance. In the **quality** domain, the PIHP received scores of 100 percent compliance on 9 of the 12 standards. All opportunities for improvement related to the **timeliness** domain, where the PIHP achieved full compliance on 2 of the 5 standards.

Thumb Alliance PIHP

Overall Compliance Monitoring Results

Table 3-18 presents the results from the 2008–2009 compliance monitoring review, showing the number of elements for each of the standards that received a score of *Met*, *Substantially Met*, *Partially Met, Not Met*, or *NA*. The table also shows compliance scores for each of the standards and an overall compliance score across all standards. The 2008–2009 External Quality Review Compliance Monitoring Report for **Thumb Alliance PIHP** contains a more detailed description of the results.

Table 3-18—Summary of Scores for the Standards *for* Thumb Alliance PIHP

Standard	Standard Name	Number of Elements					Compliance Score
		M	*SM*	*PM*	*NM*	*NA*	
I	QAPIP Plan and Structure	18	0	0	0	0	100%
II	Performance Measurement	20	0	1	0	0	98%
III	Practice Guidelines	14	0	0	0	0	100%
IV	Staff Qualifications	6	0	0	0	0	100%
V	Utilization Management	19	0	0	0	0	100%
VI	Customer Services	11	0	0	0	0	100%
VII	Enrollee Grievance Process	12	0	0	1	0	92%
VIII	Enrollee Rights and Protections	31	0	0	0	2	100%
IX	Subcontracts and Delegation	7	0	0	0	0	100%
X	Provider Network	12	0	0	0	0	100%
XI	Credentialing	24	0	0	0	1	100%
XII	Access and Availability	16		1	0	0	97%
XIII	Coordination of Care	3	0	0	0	0	100%
XIV	Appeals	14	0	1	0	0	97%
						Overall Compliance	**99%**

Strengths

Thumb Alliance PIHP received an overall compliance score of 99 percent across all standards. The PIHP achieved 100 percent compliance on 10 of the 14 standards: QAPIP Plan and Structure, Practice Guidelines, Staff Qualifications, Utilization Management, Customer Services, Enrollee Rights and Protections, Subcontracts and Delegation, Provider Network, Credentialing, and Coordination of Care. **Thumb Alliance PIHP** also demonstrated strong performance on the standards of Performance Measurement, Access and Availability, and Appeals.

Recommendations

Recommendations for improving **Thumb Alliance PIHP**'s performance addressed the areas of Performance Measurement, Enrollee Grievance Process, Access and Availability, and Appeals. The PIHP should ensure that staff involved in the review of sentinel events has the appropriate credentials and that notices of disposition for grievances and appeals meet contractual requirements. The PIHP should continue efforts to meet the minimum performance standard for follow-up care after discharge from a detox unit.

Summary Assessment Related to Quality, Timeliness, and Access

Thumb Alliance PIHP demonstrated strong performance across the three domains of **quality**, **timeliness**, and **access.** The PIHP's strongest performance was in the **access** domain, with 4 of the 5 standards in full compliance. In the **quality** domain, the PIHP received scores of 100 percent compliance on 9 of the 12 standards. All recommendations for improvement related to the **timeliness** domain, where 1 of the 5 standards was in full compliance.

Venture Behavioral Health

Overall Compliance Monitoring Results

Table 3-19 presents the results from the 2008–2009 compliance monitoring review, showing the number of elements for each of the standards that received a score of *Met*, *Substantially Met*, *Partially Met, Not Met*, or *NA*. The table also shows compliance scores for each of the standards and an overall compliance score across all standards. The 2008–2009 External Quality Review Compliance Monitoring Report for **Venture Behavioral Health** contains a more detailed description of the results.

Table 3-19—Summary of Scores for the Standards *for* Venture Behavioral Health							
Standard	Standard Name	Number of Elements					Compliance Score
		M	*SM*	*PM*	*NM*	*NA*	
I	QAPIP Plan and Structure	17	0	1	0	0	97%
II	Performance Measurement	20	0	1	0	0	98%
III	Practice Guidelines	10	0	0	0	4	100%
IV	Staff Qualifications	6	0	0	0	0	100%
V	Utilization Management	18	0	1	0	0	97%
VI	Customer Services	11	0	0	0	0	100%
VII	Enrollee Grievance Process	13	0	0	0	0	100%
VIII	Enrollee Rights and Protections	31	0	0	0	2	100%
IX	Subcontracts and Delegation	7	0	0	0	0	100%
X	Provider Network	12	0	0	0	0	100%
XI	Credentialing	24	0	0	0	1	100%
XII	Access and Availability	15		1	1	0	91%
XIII	Coordination of Care	3	0	0	0	0	100%
XIV	Appeals	13	1	1	0	0	95%
		Overall Compliance					98%

Strengths

Venture Behavioral Health received an overall compliance score of 98 percent across all standards. The PIHP achieved 100 percent compliance on 9 of the 14 standards: Practice Guidelines, Staff Qualifications, Customer Services, Enrollee Grievance Process, Enrollee Rights and Protections, Subcontracts and Delegation, Provider Network, Credentialing, and Coordination of Care. **Venture Behavioral Health** also demonstrated strong performance on the standards of the QAPIP Plan and Structure, Performance Measurement, Utilization Management, and Appeals.

Recommendations

Recommendations for improving **Venture Behavioral Health**'s performance related to the areas of QAPIP Plan and Structure, Performance Measurement, Utilization Management, Access and Availability, and Appeals. The PIHP should ensure regular review of data from the behavior management committee and that staff involved in the review of sentinel events has the appropriate credentials. **Venture Behavioral Health** should take corrective action by implementing enhanced monitoring of affiliates' utilization management processes and ensuring that beneficiary appeals are handled in accordance with contractual requirements. The PIHP should continue efforts to meet the minimum performance standard for access to ongoing services.

Summary Assessment Related to Quality, Timeliness, and Access

Venture Behavioral Health demonstrated mixed performance across the three domains of **quality**, **timeliness**, and **access**. The PIHP's strongest performance was in the **quality** domain, with 9 of the 12 standards in full compliance. In the **access** domain, the PIHP received scores of 100 percent compliance on 3 of the 5 standards. Most recommendations for improvement related to the **timeliness** domain, where 1 of the 5 standards was in full compliance.

Validation of Performance Measures

This section of the report presents the results for the validation of performance measures and shows audit designations and reported rates. The 2008–2009 validation of performance measures included Indicators 13 and 14; however, MDCH and the PIHPs agreed to report the validation results only and not the actual rates for the measures due to the sensitive nature of the indicators.

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, the percentages of adults who were employed competitively or earned minimum wage or more, and the number of substantiated recipient rights complaints and sentinel events (validation status only for these two measures). The following indicators addressed the **timeliness** of and **access** to services: timely pre-admission screenings, initial assessments, ongoing services, and follow-up care after discharge. The penetration rate addressed the **access** domain.

Access Alliance of Michigan

Findings

Table 3-20 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2009 Validation of Performance Measures Report for **Access Alliance of Michigan** includes additional details of the validation results.

Table 3-20—2008–2009 Performance Measure Results
***for* Access Alliance of Michigan**

	Indicator	Reported Rate	Audit Designation
1.	Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children: 98.65% Adults: 98.72%	*Fully Compliant*
2.	Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	98.25%	*Fully Compliant*
3.	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional.	98.90%	*Fully Compliant*
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children: 96.55% Adults: 98.18%	*Fully Compliant*
4b.	Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	94.12%	*Fully Compliant*
5.	Percentage of Medicaid recipients having received PIHP-managed services (penetration rate).	10.34%	*Fully Compliant*
8.	Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination (HSW rate).	96.05%	*Fully Compliant*
10.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who are employed competitively.	MI Adults: 12.34% DD Adults: 14.23%	*Fully Compliant*
11.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who earned minimum wage or more from any employment activities.	MI Adults: 82.96% DD Adults: 40.23%	*Fully Compliant*
12.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children: 6.25% Adults: 10.45%	*Fully Compliant*
13.	Annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by the PIHPs.		*Fully Compliant*
14.	Number of sentinel events during the six-month period per 1,000 Medicaid beneficiaries served, by the following populations: adults with mental illness, children with mental illness, persons with developmental disabilities not on the HSW, persons on the HSW, and persons with substance abuse disorder.		*Fully Compliant*

Strengths

Access Alliance of Michigan's strengths included the use of a single data center for all affiliates and the PIHP data mart, which facilitated data aggregation and accuracy; a positive, collaborative approach to data accuracy; and an exceptional process for QI data completeness. Having the primary source verification of performance indicators as part of the annual affiliate audits was a best practice.

Recommendations

Access Alliance of Michigan should consider a more formal process of evaluating and reporting claims/encounter volume for its affiliates and key providers. The PIHP should develop formal policies for paper claims data entry and a process for formal reporting of audit results.

Summary Assessment Related to Quality, Timeliness, and Access

Access Alliance of Michigan's performance indicators related to **quality** were *Fully Compliant* with MDCH specifications. The PIHP met four of the five contractually required performance standards related to the **quality** of services provided by the PIHP. For the remaining indicators in the **quality** domain, **Access Alliance of Michigan** demonstrated the following results: the PIHP's HSW rate exceeded the statewide rate. The rates for MI and DD adults who were employed competitively or earned minimum wage were above the statewide rates. Performance indicators related to **timeliness** of and **access** to services were *Fully Compliant* with MDCH specifications. The PIHP met the contractually required performance standards for six of the seven performance measures related to **timeliness** of and **access** to services provided by the PIHP. **Access Alliance of Michigan**'s penetration rate exceeded the statewide rate. **Access Alliance of Michigan** demonstrated strong performance across all three domains of **quality**, **timeliness**, and **access** and met the minimum performance standard for a total of eight of the nine indicators.

CMH Affiliation of Mid-Michigan

Findings

Table 3-21 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2009 Validation of Performance Measures Report for **CMH Affiliation of Mid-Michigan** includes additional details of the validation results.

Table 3-21—2008–2009 Performance Measure Results *for* CMH Affiliation of Mid-Michigan

	Indicator	Reported Rate	Audit Designation
1.	Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children: 100% Adults: 97.36%	*Fully Compliant*
2.	Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	98.65%	*Fully Compliant*
3.	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional.	98.08%	*Fully Compliant*
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children: 93.75% Adults: 92.00%	*Fully Compliant*
4b.	Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	100%	*Fully Compliant*
5.	Percentage of Medicaid recipients having received PIHP-managed services (penetration rate).	8.43%	*Fully Compliant*
8.	Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination (HSW rate).	96.29%	*Fully Compliant*
10.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who are employed competitively.	MI Adults: 12.31% DD Adults: 13.45%	*Fully Compliant*
11.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who earned minimum wage or more from any employment activities.	MI Adults: 85.00% DD Adults: 48.46%	*Fully Compliant*
12.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children: 0.00% Adults: 10.53%	*Fully Compliant*
13.	Annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by the PIHPs.		*Fully Compliant*
14.	Number of sentinel events during the six-month period per 1,000 Medicaid beneficiaries served, by the following populations: adults with mental illness, children with mental illness, persons with developmental disabilities not on the HSW, persons on the HSW, and persons with substance abuse disorder.		*Fully Compliant*

Strengths

CMH Affiliation of Mid-Michigan's oversight of affiliate data remained a best practice. The PIHP required corrective actions from its subcontracted community mental health services programs (CMHSPs) and CAs to ensure accuracy and completeness of the QI and performance indicator data. The PIHP implemented the recommendation from last year's audit and increased the number of cases reviewed for the performance indicator audit from 4 cases to 8–10 cases.

Recommendations

CMH Affiliation of Mid-Michigan should follow up on any outstanding corrective action plans from its affiliates to ensure that all items have been addressed and resolved. The PIHP should consider more formal documentation of its criteria related to the timeliness of corrected encounters and continue to follow up with the CA regarding its data system restraints and calculation of the timeliness indicators.

Summary Assessment Related to Quality, Timeliness, and Access

CMH Affiliation of Mid-Michigan's performance indicators related to **quality** were *Fully Compliant* with MDCH specifications. The PIHP met three of the five contractually required performance standards related to the **quality** of services provided by the PIHP. For the remaining indicators in the **quality** domain, **CMH Affiliation of Mid-Michigan** achieved the following results: the PIHP's HSW rate exceeded the statewide rate. The rates for MI and DD adults who were employed competitively or earned minimum wage were higher than the statewide rates. Performance indicators related to **timeliness** of and **access** to services were *Fully Compliant* with MDCH specifications. **CMH Affiliation of Mid-Michigan** met the contractually required performance standards for five of the seven performance measures related to **timeliness** of and **access** to services provided by the PIHP. The PIHP's penetration rate fell below the statewide rate. **CMH Affiliation of Mid-Michigan** demonstrated strong performance across all three domains of **quality**, **timeliness**, and **access** and met the minimum performance standard for a total of seven of the nine indicators.

CMH for Central Michigan

Findings

Table 3-22 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2009 Validation of Performance Measures Report for **CMH for Central Michigan** includes additional details of the validation results.

Table 3-22—2008–2009 Performance Measure Results *for* CMH for Central Michigan			
Indicator		**Reported Rate**	**Audit Designation**
1.	Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children: 100% Adults: 98.13%	*Fully Compliant*
2.	Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	99.46%	*Fully Compliant*
3.	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional.	98.17%	*Fully Compliant*
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children: 100% Adults: 100%	*Fully Compliant*
4b.	Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	100%	*Fully Compliant*
5.	Percentage of Medicaid recipients having received PIHP-managed services (penetration rate).	11.69%	*Fully Compliant*
8.	Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination (HSW rate).	96.20%	*Fully Compliant*
10.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who are employed competitively.	MI Adults: 12.92% DD Adults: 14.34%	*Substantially Compliant*
11.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who earned minimum wage or more from any employment activities.	MI Adults: 93.28% DD Adults: 28.85%	*Substantially Compliant*
12.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children: 0.00% Adults: 9.09%	*Fully Compliant*
13.	Annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by the PIHPs.		*Fully Compliant*
14.	Number of sentinel events during the six-month period per 1,000 Medicaid beneficiaries served, by the following populations: adults with mental illness, children with mental illness, persons with developmental disabilities not on the HSW, persons on the HSW, and persons with substance abuse disorder.		*Fully Compliant*

Strengths

CMH for Central Michigan conducted monthly verification of the completeness of selected QI data items and provided e-mail reminders to providers. An increasing number of providers entered their own data directly into the PIHP's software application electronically, ensuring the accuracy of the data. The PIHP's online Active Caseload report gave providers a real-time assessment of the completeness of selected data items.

Recommendations

CMH for Central Michigan should address the low percentage of minimum wage data in the QI file. The PIHP should consider a more aggregate approach to the assessment of QI data completeness, integrating that assessment into the office managers' and data integrity meetings, and consider adding all QI indicators to the data verification report, associated e-mails, and clinician screens.

Summary Assessment Related to Quality, Timeliness, and Access

CMH for Central Michigan's performance indicators related to **quality** were *Fully Compliant* with MDCH specifications, except for Indicators 10 and 11, which received a designation of *Substantially Compliant*. Completeness of minimum wage data was far below the required 95 percent threshold, resulting in an understated rate for these measures. The PIHP met all contractually required performance standards related to the **quality** of services provided by the PIHP. For the remaining indicators in the **quality** domain, **CMH for Central Michigan** demonstrated the following results: the PIHP's HSW rate exceeded the statewide rate. The rates for MI and DD adults who were employed competitively or earned minimum wage were equal to or higher than the statewide rates. Performance indicators related to **timeliness** of and **access** to services were *Fully Compliant* with MDCH specifications, including Indicator 1, which received a designation of *Substantially Compliant* last year. **CMH for Central Michigan** met the contractually required performance standards for all performance measures related to **timeliness** of and **access** to services provided by the PIHP. The PIHP's penetration rate exceeded the statewide rate. **CMH for Central Michigan** demonstrated exceptional performance across all three domains of **quality**, **timeliness**, and **access** and continued to meet the minimum performance standard for all nine indicators.

CMH Partnership of Southeastern Michigan

Findings

Table 3-23 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2009 Validation of Performance Measures Report for **CMH Partnership of Southeastern Michigan** includes additional details of the validation results.

Table 3-23—2008–2009 Performance Measure Results *for* CMH Partnership of Southeastern Michigan

	Indicator	Reported Rate	Audit Designation
1.	Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children: 100% Adults: 100%	*Fully Compliant*
2.	Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	98.59%	*Fully Compliant*
3.	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional.	100%	*Fully Compliant*
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children: 100% Adults: 100%	*Fully Compliant*
4b.	Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	97.37%	*Fully Compliant*
5.	Percentage of Medicaid recipients having received PIHP-managed services (penetration rate).	7.72%	*Fully Compliant*
8.	Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination (HSW rate).	82.23%	*Fully Compliant*
10.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who are employed competitively.	MI Adults: 12.15% DD Adults: 17.54%	*Fully Compliant*
11.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who earned minimum wage or more from any employment activities.	MI Adults: 81.82% DD Adults: 68.85%	*Fully Compliant*
12.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children: 28.95% Adults: 8.75%	*Fully Compliant*
13.	Annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by the PIHPs.		*Fully Compliant*
14.	Number of sentinel events during the six-month period per 1,000 Medicaid beneficiaries served, by the following populations: adults with mental illness, children with mental illness, persons with developmental disabilities not on the HSW, persons on the HSW, and persons with substance abuse disorder.		*Fully Compliant*

Strengths

CMH Partnership of Southeastern Michigan continued to demonstrate a strong commitment to data integrity, data quality, and the performance indicator reporting process. The PIHP implemented data integrity checks to give the system user the ability to see missing data elements as well as an automated incident report module to reduce paper processes.

Recommendations

CMH Partnership of Southeastern Michigan should consider means to easily track exceptions until the new appointment module is implemented. The PIHP should explore ways to use the new incident report module to tie into sentinel event identification. **CMH Partnership of Southeastern Michigan** should also continue close monitoring of its providers.

Summary Assessment Related to Quality, Timeliness, and Access

CMH Partnership of Southeastern Michigan's performance indicators related to **quality** were *Fully Compliant* with MDCH specifications. The PIHP met four of the five contractually required performance standards related to the **quality** of services provided by the PIHP. For the remaining indicators in the **quality** domain, **CMH Partnership of Southeastern Michigan** demonstrated the following results: the PIHP's HSW rate equaled the statewide rate. The rates for MI and DD adults who were employed competitively or earned minimum wage were higher than the statewide rates. Performance indicators related to **timeliness** of and **access** to services were *Fully Compliant* with MDCH specifications. **CMH Partnership of Southeastern Michigan** met the contractually required performance standards for all performance measures related to **timeliness** of and **access** to services provided by the PIHP. The PIHP's penetration rate fell below the statewide rate. **CMH Partnership of Southeastern Michigan** demonstrated strong performance across all three domains of **quality**, **timeliness**, and **access** and met the minimum performance standard for a total of eight of the nine indicators.

Detroit-Wayne County CMH Agency

Findings

Table 3-24 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2009 Validation of Performance Measures Report for **Detroit-Wayne County CMH Agency** includes additional details of the validation results.

Table 3-24—2008–2009 Performance Measure Results *for* Detroit-Wayne County CMH Agency

	Indicator	Reported Rate	Audit Designation
1.	Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children: 99.30%	*Fully Compliant*
		Adults: 92.90%	
2.	Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	81.64%	*Fully Compliant*
3.	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional.	89.96%	*Fully Compliant*
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children: 96.97%	*Fully Compliant*
		Adults: 92.15%	
4b.	Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	100%	*Fully Compliant*
5.	Percentage of Medicaid recipients having received PIHP-managed services (penetration rate).	8.89%	*Fully Compliant*
8.	Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination (HSW rate).	12.25%	*Fully Compliant*
10.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who are employed competitively.	MI Adults: 8.99%	*Substantially Compliant*
		DD Adults: 2.29%	
11.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who earned minimum wage or more from any employment activities.	MI Adults: 90.54%	*Substantially Compliant*
		DD Adults: 6.92%	
12.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children: 2.43%	*Fully Compliant*
		Adults: 13.37%	
13.	Annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by the PIHPs.		*Fully Compliant*
14.	Number of sentinel events during the six-month period per 1,000 Medicaid beneficiaries served, by the following populations: adults with mental illness, children with mental illness, persons with developmental disabilities not on the HSW, persons on the HSW, and persons with substance abuse disorder.		*Fully Compliant*

Strengths

Detroit-Wayne County CMH Agency implemented initiatives around its "System Transformation" project that targeted data processes and service delivery. The PIHP initiated aggressive efforts to improve the completeness of its QI data. The PIHP's process for tracking sentinel events and recipient rights issues was detailed and well documented, ensuring that all potential events are monitored throughout the reporting process.

Recommendations

Detroit-Wayne County CMH Agency should continue its efforts to improve the completeness of its QI data—specifically, minimum wage and employment—and develop quality initiatives to address any identified barriers. **Detroit-Wayne County CMH Agency** should document the transition process to the Peter Chang Enterprises (PCE) system and update existing policies, procedures, and process-flow documents.

Summary Assessment Related to Quality, Timeliness, and Access

Detroit-Wayne County CMH Agency's performance indicators related to **quality** were *Fully Compliant* with MDCH specifications except for Indicators 10 and 11, which received a designation of *Substantially Compliant*. Completeness of employment status and minimum wage data was far below the required 95 percent threshold, resulting in an understated rate for these measures. The PIHP met four of the five contractually required performance standards related to the **quality** of services provided by the PIHP. For the remaining indicators in the **quality** domain, **Detroit-Wayne County CMH Agency** demonstrated the following results: the PIHP's HSW rate fell significantly below the statewide rate. The rates for MI and DD adults who were employed competitively and the rate of DD adults who earned minimum wage were lower than the statewide rates. The rate of MI adults who earned minimum wage exceeded the statewide rate. Performance indicators related to **timeliness** of and **access** to services were *Fully Compliant* with MDCH specifications. **Detroit-Wayne County CMH Agency** met the contractually required performance standards for three of the seven performance measures related to **timeliness** of and **access** to services provided by the PIHP. The PIHP's penetration rate equaled the statewide rate. The PIHP met the minimum performance standard for five of the nine indicators. While **Detroit-Wayne County CMH Agency** demonstrated improved performance on several measures across the domains of **quality**, **timeliness**, and **access**, and met the minimum performance standard for a total of five of the nine indicators, opportunities for improvement remained in all three domains.

Genesee County CMH

Findings

Table 3-25 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2009 Validation of Performance Measures Report for **Genesee County CMH** includes additional details of the validation results.

Table 3-25—2008–2009 Performance Measure Results *for* Genesee County CMH			
Indicator		Reported Rate	Audit Designation
1.	Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children: 98.98% Adults: 99.68%	*Fully Compliant*
2.	Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	98.92%	*Fully Compliant*
3.	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional.	97.19%	*Fully Compliant*
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children: 100% Adults: 98.44%	*Fully Compliant*
4b.	Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	100%	*Fully Compliant*
5.	Percentage of Medicaid recipients having received PIHP-managed services (penetration rate).	8.46%	*Fully Compliant*
8.	Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination (HSW rate).	91.03%	*Fully Compliant*
10.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who are employed competitively.	MI Adults: 5.71% DD Adults: 4.82%	*Fully Compliant*
11.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who earned minimum wage or more from any employment activities.	MI Adults: 78.60% DD Adults: 20.28%	*Fully Compliant*
12.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children: 11.11% Adults: 9.01%	*Fully Compliant*
13.	Annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by the PIHPs.		*Fully Compliant*
14.	Number of sentinel events during the six-month period per 1,000 Medicaid beneficiaries served, by the following populations: adults with mental illness, children with mental illness, persons with developmental disabilities not on the HSW, persons on the HSW, and persons with substance abuse disorder.		*Fully Compliant*

Strengths

Genesee County CMH ensured data completeness and accuracy through full integration of the CAs and the data certification committee, which oversees data quality and integrity for reporting purposes. The PIHP proactively prepared for the transition to a new information system with meetings, trainings, and testing prior to the go-live date, thus addressing concerns of data loss during the conversion.

Recommendations

Genesee County CMH should consider formalizing a claims audit process for the paper claims entered manually. The PIHP should consider changing the soft edits built into the system that alert providers of invalid code entry, but allow providers to override the edits to hard edits, minimizing claim rejection. **Genesee County CMH** should continue to document the conversion process and consider reinstituting a validation process for the appointment process.

Summary Assessment Related to Quality, Timeliness, and Access

Genesee County CMH's performance indicators related to **quality** were *Fully Compliant* with MDCH specifications. The PIHP met all contractually required performance standards related to the **quality** of services provided by the PIHP. For the remaining indicators in the **quality** domain, **Genesee County CMH** demonstrated the following results: the PIHP's HSW rate exceeded the statewide rate. The rate for MI and DD adults who were employed competitively and the rate of DD adults who earned minimum wage were lower than the statewide rates, while the rate of MI adults who earned minimum wage equaled the statewide rate. Performance indicators related to **timeliness** of and **access** to services were *Fully Compliant* with MDCH specifications. **Genesee County CMH** met the contractually required performance standards for all performance measures related to **timeliness** of and **access** to services provided by the PIHP. The PIHP's penetration rate fell below the statewide rate. **Genesee County CMH** demonstrated exceptional performance across all three domains of **quality**, **timeliness**, and **access** and continued to meet the minimum performance standard for all nine indicators.

Lakeshore Behavioral Health Alliance

Findings

Table 3-26 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2009 Validation of Performance Measures Report for **Lakeshore Behavioral Health Alliance** includes additional details of the validation results.

Table 3-26—2008–2009 Performance Measure Results *for* Lakeshore Behavioral Health Alliance

	Indicator	Reported Rate	Audit Designation
1.	Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children: 97.44%	*Fully Compliant*
		Adults: 100%	
2.	Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	98.39%	*Fully Compliant*
3.	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional.	96.56%	*Fully Compliant*
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children: 100%	*Fully Compliant*
		Adults: 100%	
4b.	Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	100%	*Fully Compliant*
5.	Percentage of Medicaid recipients having received PIHP-managed services (penetration rate).	7.38%	*Fully Compliant*
8.	Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination (HSW rate).	98.24%	*Fully Compliant*
10.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who are employed competitively.	MI Adults: 9.59%	*Fully Compliant*
		DD Adults: 14.90%	
11.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who earned minimum wage or more from any employment activities.	MI Adults: 71.90%	*Fully Compliant*
		DD Adults: 37.42%	
12.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children: 0.00%	*Fully Compliant*
		Adults: 6.45%	
13.	Annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by the PIHPs.		*Fully Compliant*
14.	Number of sentinel events during the six-month period per 1,000 Medicaid beneficiaries served, by the following populations: adults with mental illness, children with mental illness, persons with developmental disabilities not on the HSW, persons on the HSW, and persons with substance abuse disorder.		*Fully Compliant*

Strengths

Lakeshore Behavioral Health Alliance implemented recommendations from the prior year's audit and successfully generated encounter data extraction from the Avatar system, resulting in a reportable penetration rate. The PIHP demonstrated commitment to the performance indicator process, collaborating to ensure uniform interpretation of indicator specifications across the PIHP. **Lakeshore Behavioral Health Alliance** provided good oversight of the CA. The PIHP's Medicaid verification audit and electronic submission of encounter data facilitated accurate and complete data reporting.

Recommendations

Lakeshore Behavioral Health Alliance should continue to work with one of its subcontractors to assist in automating performance indicator reporting. The PIHP should investigate reasons for the low completeness of minimum wage QI data. The PIHP should also implement a plan of correction to address the process of collecting this data element to comply with the MDCH threshold of 95 percent completeness.

Summary Assessment Related to Quality, Timeliness, and Access

Lakeshore Behavioral Health Alliance's performance indicators related to **quality** were *Fully Compliant* with MDCH specifications. The PIHP met all contractually required performance standards related to the **quality** of services provided by the PIHP. For the remaining indicators in the **quality** domain, **Lakeshore Behavioral Health Alliance** achieved the following results: the PIHP's HSW rate exceeded the statewide rate. The rates for MI and DD adults who were employed competitively and DD adults who earned minimum wage were equal to or higher than the statewide rates. The rate for MI adults who earned minimum wage fell below the statewide rate. Performance indicators related to **timeliness** of and **access** to services were *Fully Compliant* with MDCH specifications, including Indicators 1 and 5, which received designations of *Substantially Compliant* and *Not Valid*, respectively, in the prior audit. **Lakeshore Behavioral Health Alliance** met the contractually required performance standards for all performance measures related to **timeliness** of and **access** to services provided by the PIHP. The PIHP's penetration rate fell below the statewide rate. **Lakeshore Behavioral Health Alliance** demonstrated exceptional performance across all three domains of **quality**, **timeliness**, and **access** and improved its results to meet the minimum performance standard for all nine indicators.

LifeWays

Findings

Table 3-27 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2009 Validation of Performance Measures Report for **LifeWays** includes additional details of the validation results.

Table 3-27—2008–2009 Performance Measure Results *for* LifeWays

	Indicator	Reported Rate	Audit Designation
1.	Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children: 100% Adults: 100%	*Fully Compliant*
2.	Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	97.80%	*Fully Compliant*
3.	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional.	98.80%	*Fully Compliant*
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children: 100% Adults: 100%	*Fully Compliant*
4b.	Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	100%	*Fully Compliant*
5.	Percentage of Medicaid recipients having received PIHP-managed services (penetration rate).	9.01%	*Fully Compliant*
8.	Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination (HSW rate).	93.33%	*Fully Compliant*
10.	Percentage of adults with mental illness and the percent of adults with developmental disabilities served by the PIHPs who are employed competitively.	MI Adults: 11.34% DD Adults: 13.33%	*Fully Compliant*
11.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who earned minimum wage or more from any employment activities.	MI Adults: 81.75% DD Adults: 75.00%	*Fully Compliant*
12.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children: 15.00% Adults: 15.87%	*Fully Compliant*
13.	Annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by the PIHPs.		*Fully Compliant*
14.	Number of sentinel events during the six-month period per 1,000 Medicaid beneficiaries served, by the following populations: adults with mental illness, children with mental illness, persons with developmental disabilities not on the HSW, persons on the HSW, and persons with substance abuse disorder.		*Fully Compliant*

Strengths

LifeWays ensured accurate claims data through authorization requirements for all services and the subsequent use of the authorization information to verify all claims. Staff involved in performance measure data collection and calculation demonstrated a high level of collaboration across functional areas. The PIHP implemented the recommendations from the last audit, demonstrating a commitment to continuous quality improvement.

Recommendations

LifeWays should consider an alternate means of collecting QI data. The PIHP should consider adding a review phase to the monthly QI data exceptions process to ensure more complete data prior to submission to MDCH and explore creative methods to ensure that providers complete all QI data.

Summary Assessment Related to Quality, Timeliness, and Access

LifeWays' performance indicators related to **quality** were *Fully Compliant* with MDCH specifications. The PIHP met four of the five contractually required performance standards related to the **quality** of services provided by the PIHP. For the remaining indicators in the **quality** domain, **LifeWays** achieved the following results: the PIHP's HSW rate exceeded the statewide rate. The rate for MI and DD adults who were employed competitively or earned minimum wage were higher than the statewide rates. Performance indicators related to **timeliness** of and **access** to services were *Fully Compliant* with MDCH specifications. **LifeWays** met the contractually required performance standards for all performance measures related to **timeliness** of and **access** to services provided by the PIHP. The PIHP's penetration rate equaled the statewide rate. **LifeWays** demonstrated strong performance across all three domains of **quality**, **timeliness**, and **access** and met the minimum performance standard for a total of eight of the nine indicators.

Macomb County CMH Services

Findings

Table 3-28 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2009 Validation of Performance Measures Report for **Macomb County CMH Services** includes additional details of the validation results.

Table 3-28—2008–2009 Performance Measure Results
***for* Macomb County CMH Services**

	Indicator	Reported Rate	Audit Designation
1.	Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children: 100% Adults: 98.68%	*Fully Compliant*
2.	Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	99.55%	*Fully Compliant*
3.	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional.	99.26%	*Fully Compliant*
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children: 100% Adults: 97.64%	*Fully Compliant*
4b.	Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	98.04%	*Fully Compliant*
5.	Percentage of Medicaid recipients having received PIHP-managed services (penetration rate).	10.46%	*Fully Compliant*
8.	Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination (HSW rate).	97.98%	*Fully Compliant*
10.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who are employed competitively.	MI Adults: 11.31% DD Adults: 10.48%	*Fully Compliant*
11.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who earned minimum wage or more from any employment activities.	MI Adults: 56.12% DD Adults: 25.89%	*Fully Compliant*
12.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children: 10.94% Adults: 14.65%	*Fully Compliant*
13.	Annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by the PIHPs.		*Fully Compliant*
14.	Number of sentinel events during the six-month period per 1,000 Medicaid beneficiaries served, by the following populations: adults with mental illness, children with mental illness, persons with developmental disabilities not on the HSW, persons on the HSW, and persons with substance abuse disorder.		*Fully Compliant*

Strengths

Macomb County CMH Services used an integrated data system (FOCUS), thus facilitating accurate and complete data for performance measure reporting. The PIHP demonstrated positive oversight of CA data as well as a proactive approach to complete QI and performance indicator data. **Macomb County CMH Services** required corrective action plans from providers not meeting standards. The annual audit of claims and encounters performed by an outside entity enhanced the assessment of data accuracy and completeness.

Recommendations

Macomb County CMH Services should continue its efforts to automate the process for assessing the completeness of QI data. The PIHP should continue with the integration of CA data into the FOCUS system and consider systematic identification of valid exceptions in the system to facilitate the automation of summary reports.

Summary Assessment Related to Quality, Timeliness, and Access

Macomb County CMH Services' performance indicators related to **quality** were *Fully Compliant* with MDCH specifications. The PIHP met all contractually required performance standards related to the **quality** of services provided by the PIHP. For the remaining indicators in the **quality** domain, **Macomb County CMH Services** achieved the following results: the PIHP's HSW rate exceeded the statewide rate. The rate for MI adults who were employed competitively exceeded the statewide rate. The rates for DD adults who were employed competitively and the rates of MI and DD adults who earned minimum wage were below the statewide rates. Performance indicators related to **timeliness** of and **access** to services were *Fully Compliant* with MDCH specifications. **Macomb County CMH Services** met the contractually required performance standards for all performance measures related to **timeliness** of and **access** to services provided by the PIHP. The PIHP's penetration rate exceeded the statewide rate. **Macomb County CMH Services** demonstrated exceptional performance across all three domains of **quality**, **timeliness**, and **access** and improved its results to meet the minimum performance standard for all nine indicators.

network180

Findings

Table 3-29 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2009 Validation of Performance Measures Report for **network180** includes additional details of the validation results.

Table 3-29—2008–2009 Performance Measure Results *for* network180

	Indicator	Reported Rate	Audit Designation
1.	Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children: 97.62% Adults: 96.83%	*Fully Compliant*
2.	Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	98.52%	*Fully Compliant*
3.	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional.	84.57%	*Fully Compliant*
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children: 100% Adults: 97.41%	*Fully Compliant*
4b.	Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	100%	*Fully Compliant*
5.	Percentage of Medicaid recipients having received PIHP-managed services (penetration rate).	7.43%	*Fully Compliant*
8.	Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination (HSW rate).	91.76%	*Fully Compliant*
10.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who are employed competitively.	MI Adults: 10.64% DD Adults: 17.82%	*Fully Compliant*
11.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who earned minimum wage or more from any employment activities.	MI Adults: 72.65% DD Adults: 50.00%	*Fully Compliant*
12.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children: 0.00% Adults: 8.59%	*Fully Compliant*
13.	Annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by the PIHPs.		*Fully Compliant*
14.	Number of sentinel events during the six-month period per 1,000 Medicaid beneficiaries served, by the following populations: adults with mental illness, children with mental illness, persons with developmental disabilities not on the HSW, persons on the HSW, and persons with substance abuse disorder.		*Fully Compliant*

Strengths

network180 improved the timeliness of encounter data submissions, fully automated the recipient rights reporting function, and proactively identified ways to improve data quality and accuracy. The PIHP continued efforts to increase fee-for-service payment arrangements for different programs. The rates for timeliness indicators for the DD population improved as a result of changes to the appointment scheduling process.

Recommendations

network180 should consider an assessment of the completeness of current data and develop a written plan for improvement. The PIHP should consider allowing providers to access components of the electronic client record to facilitate the performance indicator reporting process. **network180** should continue its efforts to fully automate the process for encounter file submissions and continue close monitoring of encounter submissions by providers who have difficulty meeting timeliness requirements.

Summary Assessment Related to Quality, Timeliness, and Access

network180's performance indicators related to **quality** were *Fully Compliant* with MDCH specifications. The PIHP met all contractually required performance standards related to the **quality** of services provided by the PIHP. For the remaining indicators in the **quality** domain, **network180** demonstrated the following results: the PIHP's HSW rate exceeded the statewide rate. The rates for MI and DD adults who were employed competitively and the rate for DD adults who earned minimum wage were higher than the statewide rates, while the rate of MI adults who earned minimum wage fell below the statewide rate. Performance indicators related to **timeliness** of and **access** to services were *Fully Compliant* with MDCH specifications. **network180** met the contractually required performance standards for six of the seven performance measures related to **timeliness** of and **access** to services provided by the PIHP. The PIHP's penetration rate was lower than the statewide rate. **network180** demonstrated strong performance and met the minimum performance standard for a total of eight of the nine indicators.

NorthCare

Findings

Table 3-30 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2009 Validation of Performance Measures Report for **NorthCare** includes additional details of the validation results.

Table 3-30—2008–2009 Performance Measure Results
***for* NorthCare**

	Indicator	Reported Rate	Audit Designation
1.	Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children: 100% Adults: 100%	*Fully Compliant*
2.	Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	97.49%	*Fully Compliant*
3.	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional.	98.07%	*Fully Compliant*
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children: 100% Adults: 96.43%	*Fully Compliant*
4b.	Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	100%	*Fully Compliant*
5.	Percentage of Medicaid recipients having received PIHP-managed services (penetration rate).	8.82%	*Fully Compliant*
8.	Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination (HSW rate).	97.00%	*Fully Compliant*
10.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who are employed competitively.	MI Adults: 14.72% DD Adults: 11.85%	*Fully Compliant*
11.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who earned minimum wage or more from any employment activities.	MI Adults: 74.42% DD Adults: 43.06%	*Fully Compliant*
12.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children: 8.70% Adults: 11.90%	*Fully Compliant*
13.	Annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by the PIHPs.		*Fully Compliant*
14.	Number of sentinel events during the six-month period per 1,000 Medicaid beneficiaries served, by the following populations: adults with mental illness, children with mental illness, persons with developmental disabilities not on the HSW, persons on the HSW, and persons with substance abuse disorder.		*Fully Compliant*

Strengths

NorthCare's implementation of a centralized access center minimized the potential for duplicates in the system. The PIHP successfully completed the migration of one of its community mental health center (CMHC) boards to the new information system, with no loss of data. **NorthCare** plans to implement this new system, which offers enhanced reporting capabilities, across the PIHP. **NorthCare** demonstrated good tracking and trending processes for encounter submissions and a proactive approach to improving performance indicator rates.

Recommendations

NorthCare should continue to monitor the CMHC boards' processes for manual data entry until the new system is fully implemented. For CA data, the PIHP should continue its close monitoring of the data collection and reporting processes and implement communication loops between the new substance abuse data system and **NorthCare**.

Summary Assessment Related to Quality, Timeliness, and Access

NorthCare's performance indicators related to **quality** were *Fully Compliant* with MDCH specifications. The PIHP met all contractually required performance standards related to the **quality** of services provided by the PIHP. For the remaining indicators in the **quality** domain, **NorthCare** demonstrated the following results: the PIHP's HSW rate exceeded the statewide rate. The rates for MI and DD adults who were employed competitively and the rate of DD adults who earned minimum wage were above the statewide rates, while the rate of MI adults earning minimum wage fell below the statewide rate. Performance indicators related to **timeliness** of and **access** to services were *Fully Compliant* with MDCH specifications. **NorthCare** met the contractually required performance standards for all performance measures related to **timeliness** of and **access** to services provided by the PIHP. The PIHP's penetration rate equaled the statewide rate. **NorthCare** demonstrated exceptional performance across all three domains of **quality**, **timeliness**, and **access** and improved its results to meet the minimum performance standard for all nine indicators.

Northern Affiliation

Findings

Table 3-31 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2009 Validation of Performance Measures Report for **Northern Affiliation** includes additional details of the validation results.

Table 3-31—2008–2009 Performance Measure Results *for* Northern Affiliation

	Indicator	Reported Rate	Audit Designation
1.	Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children: 100% Adults: 97.81%	*Fully Compliant*
2.	Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	98.37%	*Fully Compliant*
3.	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional.	98.27%	*Fully Compliant*
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children: 100% Adults: 97.92%	*Fully Compliant*
4b.	Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	100%	*Fully Compliant*
5.	Percentage of Medicaid recipients having received PIHP-managed services (penetration rate).	10.71%	*Fully Compliant*
8.	Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination (HSW rate).	95.23%	*Fully Compliant*
10.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who are employed competitively.	MI Adults: 11.93% DD Adults: 21.91%	*Fully Compliant*
11.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who earned minimum wage or more from any employment activities.	MI Adults: 77.00% DD Adults: 53.70%	*Fully Compliant*
12.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children: 6.90% Adults: 14.08%	*Fully Compliant*
13.	Annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by the PIHPs.		*Fully Compliant*
14.	Number of sentinel events during the six-month period per 1,000 Medicaid beneficiaries served, by the following populations: adults with mental illness, children with mental illness, persons with developmental disabilities not on the HSW, persons on the HSW, and persons with substance abuse disorder.		*Fully Compliant*

Strengths

Northern Affiliation implemented a detailed data analysis report and worked collaboratively with its affiliates to ensure accurate and complete performance indicator data. The PIHP explored ways to improve data accuracy and completeness, resulting in industry best practices. The use of a common system across the PIHP ensured comparable and complete data.

Recommendations

Northern Affiliation should consider implementing more frequent audits of claims data entry, incorporating the audits into an existing process to minimize the administrative burden. The PIHP should consider updating the coding rules document and continue efforts to improve data quality through the development of a core set of metrics used across different departments.

Summary Assessment Related to Quality, Timeliness, and Access

Northern Affiliation's performance indicators related to **quality** were *Fully Compliant* with MDCH specifications. The PIHP met all contractually required performance standards related to the **quality** of services provided by the PIHP. For the remaining indicators in the **quality** domain, **Northern Affiliation** achieved the following results: the PIHP's HSW rate exceeded the statewide rate. The rates for MI and DD adults who were employed competitively and the rate of DD adults who earned minimum wage were higher than the statewide rates. The rate of MI adults who earned minimum wage fell below the statewide rate. Performance indicators related to **timeliness** of and **access** to services were *Fully Compliant* with MDCH specifications. **Northern Affiliation** met the contractually required performance standards for all performance measures related to **timeliness** of and **access** to services provided by the PIHP. The PIHP's penetration rate exceeded the statewide rate. **Northern Affiliation** demonstrated exceptional performance across all three domains of **quality**, **timeliness**, and **access** and continued to meet the minimum performance standard for all nine indicators.

Northwest CMH Affiliation

Findings

Table 3-32 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2009 Validation of Performance Measures Report for **Northwest CMH Affiliation** includes additional details of the validation results.

Table 3-32—2008–2009 Performance Measure Results *for* Northwest CMH Affiliation

	Indicator	Reported Rate	Audit Designation
1.	Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children: 97.44% Adults: 99.18%	*Fully Compliant*
2.	Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	99.17%	*Fully Compliant*
3.	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional.	98.47%	*Fully Compliant*
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children: 100% Adults: 97.67%	*Fully Compliant*
4b.	Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	100%	*Fully Compliant*
5.	Percentage of Medicaid recipients having received PIHP-managed services (penetration rate).	11.88%	*Fully Compliant*
8.	Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination (HSW rate).	93.37%	*Fully Compliant*
10.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who are employed competitively.	MI Adults: 13.58% DD Adults: 17.07%	*Fully Compliant*
11.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who earned minimum wage or more from any employment activities.	MI Adults: 92.25% DD Adults: 88.96%	*Fully Compliant*
12.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children: 5.00% Adults: 8.62%	*Fully Compliant*
13.	Annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by the PIHPs.		*Fully Compliant*
14.	Number of sentinel events during the six-month period per 1,000 Medicaid beneficiaries served, by the following populations: adults with mental illness, children with mental illness, persons with developmental disabilities not on the HSW, persons on the HSW, and persons with substance abuse disorder.		*Fully Compliant*

Strengths

Northwest CMH Affiliation demonstrated a collaborative approach to complete and comparable data collection and performance indicator reporting through the use of a consistent file format, data storage on a single server, development of a data assumptions document, and cross-training of staff members. The PIHP developed systematic edits for service codes based on provider type and increased the automation of data collection processes to facilitate accurate and complete data. **Northwest CMH Affiliation** provided strong oversight through the quality improvement committee.

Recommendations

Northwest CMH Affiliation should continue its efforts to automate performance measure calculations and cross-train PIHP staff members. The PIHP should consider a more formal evaluation and reporting of data completeness and add the review of QI data to the agenda of the PIHP QI committee.

Summary Assessment Related to Quality, Timeliness, and Access

Northwest CMH Affiliation's performance indicators related to **quality** were *Fully Compliant* with MDCH specifications. The PIHP met all contractually required performance standards related to the **quality** of services provided by the PIHP. For the remaining indicators in the **quality** domain, **Northwest CMH Affiliation** demonstrated the following results: the PIHP's HSW rate exceeded the statewide rate. The rates for MI and DD adults who were employed competitively and the rates of MI and DD adults who earned minimum wage were higher than the statewide rates. Performance indicators related to **timeliness** of and **access** to services were *Fully Compliant* with MDCH specifications. **Northwest CMH Affiliation** met the contractually required performance standards for all performance measures related to **timeliness** of and **access** to services provided by the PIHP. The PIHP's penetration rate exceeded the statewide rate. **Northwest CMH Affiliation** demonstrated exceptional performance across all three domains of **quality**, **timeliness**, and **access** and improved its results to meet the minimum performance standard for all nine indicators.

Oakland County CMH Authority

Findings

Table 3-33 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2009 Validation of Performance Measures Report for **Oakland County CMH Authority** includes additional details of the validation results.

Table 3-33—2008–2009 Performance Measure Results *for* Oakland County CMH Authority

	Indicator	Reported Rate	Audit Designation
1.	Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children: 99.07% Adults: 98.51%	*Fully Compliant*
2.	Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	99.76%	*Fully Compliant*
3.	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional.	98.44%	*Fully Compliant*
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children: 97.78% Adults: 96.15%	*Fully Compliant*
4b.	Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	100%	*Fully Compliant*
5.	Percentage of Medicaid recipients having received PIHP-managed services (Penetration rate).	9.70%	*Fully Compliant*
8.	Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination (HSW rate).	98.27%	*Fully Compliant*
10.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who are employed competitively.	MI Adults: 9.31% DD Adults: 20.46%	*Fully Compliant*
11.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who earned minimum wage or more from any employment activities.	MI Adults: 67.83% DD Adults: 26.43%	*Fully Compliant*
12.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children: 13.51% Adults: 13.75%	*Fully Compliant*
13.	Annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by the PIHPs.		*Fully Compliant*
14.	Number of sentinel events during the six-month period per 1,000 Medicaid beneficiaries served, by the following populations: adults with mental illness, children with mental illness, persons with developmental disabilities not on the HSW, persons on the HSW, and persons with substance abuse disorder.		*Fully Compliant*

Strengths

Oakland County CMH Authority's use of a single vendor for provider and PIHP systems enhanced the comparability and validity of the data. The extensive data accuracy and completeness reports and analysis continued to be at the forefront of the industry. The information system's "info-mart" and its continued enhancements remained an industry best practice as an analytic tool. The PIHP provided several examples of the collaborative use and discussion of its analytical reporting.

Recommendations

Oakland County CMH Authority should continue the centralization project, including the completion of the electronic medical record project and the use of a single system for all providers and the PIHP. **Oakland County CMH Authority** is encouraged to automate the performance indicator calculation process and to include reporting of all the performance indicators in the info-mart.

Summary Assessment Related to Quality, Timeliness, and Access

Oakland County CMH Authority's performance indicators related to **quality** were *Fully Compliant* with MDCH specifications. The PIHP met all contractually required performance standards related to the **quality** of services provided by the PIHP. For the remaining indicators in the **quality** domain, **Oakland County CMH Authority** achieved the following results: the PIHP's HSW rate exceeded the statewide rate. The rates for MI adults who were employed competitively and the rates of MI and DD adults who earned minimum wage were lower than the statewide rates, while the rate of DD adults who were employed competitively exceeded the statewide rate. Performance indicators related to **timeliness** of and **access** to services were *Fully Compliant* with MDCH specifications. **Oakland County CMH Authority** met the contractually required performance standards for all performance measures related to **timeliness** of and **access** to services provided by the PIHP. The PIHP's penetration rate exceeded the statewide rate. **Oakland County CMH Authority** demonstrated exceptional performance across all three domains of **quality**, **timeliness**, and **access** and continued to meet the minimum performance standard for all nine indicators.

Saginaw County CMH Authority

Findings

Table 3-34 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2009 Validation of Performance Measures Report for **Saginaw County CMH Authority** includes additional details of the validation results.

Table 3-34—2008–2009 Performance Measure Results
***for* Saginaw County CMH Authority**

	Indicator	Reported Rate	Audit Designation
1.	Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children: 100% Adults: 100%	*Fully Compliant*
2.	Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	98.36%	*Fully Compliant*
3.	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional.	93.38%	*Fully Compliant*
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children: 61.54% Adults: 93.18%	*Fully Compliant*
4b.	Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	54.17%	*Fully Compliant*
5.	Percentage of Medicaid recipients having received PIHP-managed services (penetration rate).	7.16%	*Fully Compliant*
8.	Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination (HSW rate).	95.73%	*Fully Compliant*
10.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who are employed competitively.	MI Adults: 9.01% DD Adults: 13.04%	*Fully Compliant*
11.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who earned minimum wage or more from any employment activities.	MI Adults: 49.23% DD Adults: 19.63%	*Fully Compliant*
12.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children: 12.50% Adults: 22.45%	*Fully Compliant*
13.	Annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by the PIHPs.		*Fully Compliant*
14.	Number of sentinel events during the six-month period per 1,000 Medicaid beneficiaries served, by the following populations: adults with mental illness, children with mental illness, persons with developmental disabilities not on the HSW, persons on the HSW, and persons with substance abuse disorder.		*Fully Compliant*

Strengths

Saginaw County CMH Authority used a fully integrated information system that ensured data accuracy and completeness. A high proportion of electronic data entries enhanced the accuracy of the data. The PIHP conducted very thorough and rigorous data validation and integrated the CA's data into the PIHP's information system. **Saginaw County CMH Authority**'s increased automation of the performance indicator reporting process and associated clean-up programs and activities were a best practice.

Recommendations

Saginaw County CMH Authority should continue to update the data system to meet its current business practice and move forward with the Integrity Environment initiative to further facilitate data verification activities. The PIHP should consider a programmatic process for the verification of completeness of direct provider data as well as a more global assessment of QI data completeness.

Summary Assessment Related to Quality, Timeliness, and Access

Saginaw County CMH Authority's performance indicators related to **quality** were *Fully Compliant* with MDCH specifications. The PIHP met one of the five contractually required performance standards related to the **quality** of services provided by the PIHP. For the remaining indicators in the **quality** domain, **Saginaw County CMH Authority** demonstrated the following results: the PIHP's HSW rate exceeded the statewide rate. The rates for MI adults who were employed competitively and the rates of MI and DD adults who earned minimum wage were lower than the statewide rates, while the rate of DD adults who were employed competitively exceeded the statewide rate. Performance indicators related to **timeliness** of and **access** to services were *Fully Compliant* with MDCH specifications. **Saginaw County CMH Authority** met the contractually required performance standards for three of the seven performance measures related to **timeliness** of and **access** to services provided by the PIHP. The PIHP's penetration rate was lower than the statewide rate. While **Saginaw County CMH Authority** demonstrated strong performance on several measures across the domains of **quality**, **timeliness**, and **access**, and met the minimum performance standard for a total of four of the nine indicators, opportunities for improvement remained in all three domains.

Southwest Affiliation

Findings

Table 3-35 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2009 Validation of Performance Measures Report for **Southwest Affiliation** includes additional details of the validation results.

Table 3-35—2008–2009 Performance Measure Results *for* Southwest Affiliation

	Indicator	Reported Rate	Audit Designation
1.	Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children: 100% Adults: 100%	*Fully Compliant*
2.	Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	94.54%	*Fully Compliant*
3.	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional.	99.15%	*Fully Compliant*
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children: 92.31% Adults: 96.67%	*Fully Compliant*
4b.	Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	90.91%	*Fully Compliant*
5.	Percentage of Medicaid recipients having received PIHP-managed services (penetration rate).	9.06%	*Fully Compliant*
8.	Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination (HSW rate).	93.58%	*Fully Compliant*
10.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who are employed competitively.	MI Adults: 9.62% DD Adults: 15.15%	*Fully Compliant*
11.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who earned minimum wage or more from any employment activities.	MI Adults: 85.77% DD Adults: 60.94%	*Fully Compliant*
12.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children: 0.00% Adults: 5.56%	*Fully Compliant*
13.	Annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by the PIHPs.		*Fully Compliant*
14.	Number of sentinel events during the six-month period per 1,000 Medicaid beneficiaries served, by the following populations: adults with mental illness, children with mental illness, persons with developmental disabilities not on the HSW, persons on the HSW, and persons with substance abuse disorder.		*Fully Compliant*

Strengths

Southwest Affiliation demonstrated a collaborative approach to accurate performance measure reporting. The PIHP assessed data completeness through regular review of trending reports for several metrics and conducted claims/provider audits to ensure accurate claims and encounter data. Electronic submission of data facilitated the verification process.

Recommendations

Southwest Affiliation should increase the validation of performance measure data through exception reporting and audits of numerator positives. The PIHP should also increase the validation of QI data through exception reporting or other means. The PIHP should document the transition to the new data system in detail.

Summary Assessment Related to Quality, Timeliness, and Access

Southwest Affiliation's performance indicators related to **quality** were *Fully Compliant* with MDCH specifications. The PIHP met three of the five contractually required performance standards related to the **quality** of services provided by the PIHP. For the remaining indicators in the **quality** domain, **Southwest Affiliation** achieved the following results: the PIHP's HSW rate exceeded the statewide rate. The rates for DD adults who were employed competitively and the rates for MI and DD adults who earned minimum wage were higher than the statewide rates. The rate for MI adults who were employed competitively equaled the statewide rate. Performance indicators related to **timeliness** of and **access** to services were *Fully Compliant* with MDCH specifications. **Southwest Affiliation** met the contractually required performance standards for four of the seven performance measures related to **timeliness** of and **access** to services provided by the PIHP. The PIHP's penetration rate equaled the statewide rate. **Southwest Affiliation** demonstrated strong performance across all three domains of **quality**, **timeliness**, and **access** and met the minimum performance standard for a total of six of the nine indicators.

Thumb Alliance PIHP

Findings

Table 3-36 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2009 Validation of Performance Measures Report for **Thumb Alliance PIHP** includes additional details of the validation results.

Table 3-36—2008–2009 Performance Measure Results *for* Thumb Alliance PIHP

	Indicator	Reported Rate	Audit Designation
1.	Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children: 100% Adults: 100%	*Fully Compliant*
2.	Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	99.47%	*Fully Compliant*
3.	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional.	99.14%	*Fully Compliant*
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children: 100% Adults: 97.33%	*Fully Compliant*
4b.	Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	100%	*Fully Compliant*
5.	Percentage of Medicaid recipients having received PIHP-managed services (penetration rate).	10.53%	*Fully Compliant*
8.	Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination (HSW rate).	96.60%	*Fully Compliant*
10.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who are employed competitively.	MI Adults: 10.79% DD Adults: 5.55%	*Fully Compliant*
11.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who earned minimum wage or more from any employment activities.	MI Adults: 53.26% DD Adults: 14.15%	*Fully Compliant*
12.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children: 15.00% Adults: 18.37%	*Fully Compliant*
13.	Annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by the PIHPs.		*Fully Compliant*
14.	Number of sentinel events during the six-month period per 1,000 Medicaid beneficiaries served, by the following populations: adults with mental illness, children with mental illness, persons with developmental disabilities not on the HSW, persons on the HSW, and persons with substance abuse disorder.		*Fully Compliant*

Strengths

Thumb Alliance PIHP's PIHP-wide, fully integrated system, along with the requirement for authorization of all services, ensured the completeness and accuracy of the data. The PIHP conducted a systematic annual evaluation of data completeness to ensure complete data for performance indicator reporting. **Thumb Alliance PIHP**'s training classes in combination with a large number of "how-to" guides were a best practice to facilitate data accuracy and service data completeness.

Recommendations

Thumb Alliance PIHP should proceed with the planned implementation of the scheduler application to enhance data cohesiveness and accuracy, and continue with increased oversight of CA data. The PIHP should continue exploring new methodologies to assess real-time completeness of QI data. **Thumb Alliance PIHP** should continue efforts to increase inpatient providers' use of the data system instead of paper claims.

Summary Assessment Related to Quality, Timeliness, and Access

Thumb Alliance PIHP's performance indicators related to **quality** were *Fully Compliant* with MDCH specifications. The PIHP met four of the five contractually required performance standards related to the **quality** of services provided by the PIHP. For the remaining indicators in the **quality** domain, **Thumb Alliance PIHP** demonstrated the following results: the PIHP's HSW rate exceeded the statewide rate. The rate for MI adults who were employed competitively was higher than the statewide rate, while the rate for DD adults who were employed competitively and the rates of MI and DD adults who earned minimum wage were lower than the statewide rates. Performance indicators related to **timeliness** of and **access** to services were *Fully Compliant* with MDCH specifications. **Thumb Alliance PIHP** met the contractually required performance standards for all performance measures related to **timeliness** of and **access** to services provided by the PIHP. The PIHP's penetration rate exceeded the statewide rate. **Thumb Alliance PIHP** demonstrated strong performance across all three domains of **quality**, **timeliness**, and **access** and met the minimum performance standard for a total of eight of the nine indicators.

Venture Behavioral Health

Findings

Table 3-37 presents the results of the validation of performance measures and the reported rates. The State Fiscal Year 2009 Validation of Performance Measures Report for **Venture Behavioral Health** includes additional details of the validation results.

Table 3-37—2008–2009 Performance Measure Results *for* Venture Behavioral Health

	Indicator	Reported Rate	Audit Designation
1.	Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	Children: 95.65% Adults: 99.38%	*Fully Compliant*
2.	Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	99.10%	*Fully Compliant*
3.	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional.	96.72%	*Fully Compliant*
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	Children: 100% Adults: 100%	*Fully Compliant*
4b.	Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	100%	*Fully Compliant*
5.	Percentage of Medicaid recipients having received PIHP-managed services (penetration rate).	10.01%	*Fully Compliant*
8.	Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination (HSW rate).	92.88%	*Fully Compliant*
10.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who are employed competitively.	MI Adults: 13.24% DD Adults: 13.63%	*Substantially Compliant*
11.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who earned minimum wage or more from any employment activities.	MI Adults: 64.85% DD Adults: 36.57%	*Substantially Compliant*
12.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	Children: 18.18% Adults: 4.48%	*Fully Compliant*
13.	Annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by the PIHPs.		*Fully Compliant*
14.	Number of sentinel events during the six-month period per 1,000 Medicaid beneficiaries served, by the following populations: adults with mental illness, children with mental illness, persons with developmental disabilities not on the HSW, persons on the HSW, and persons with substance abuse disorder.		*Fully Compliant*

Strengths

Venture Behavioral Health's data system allowed multiple points of entry for service data, facilitating aggregation and comparability of the data. The PIHP demonstrated a strong collaborative relationship with the system vendor, resulting in quick implementation of system changes to support PIHP business practices. The online performance indicator report function, with drill-down capabilities, exception reporting, and a tie to the exceptions database, was an industry best practice.

Recommendations

Venture Behavioral Health should implement a process to audit paper claims to ensure the services entered are those that were provided. The PIHP should pursue a change in the online screening form to capture additional information about clinical availability. **Venture Behavioral Health** should continue its efforts to increase the proportion of claims submitted electronically and continue the assessment of data completeness.

Summary Assessment Related to Quality, Timeliness, and Access

Venture Behavioral Health's performance indicators related to **quality** were *Fully Compliant* with MDCH specifications, except for Indicators 10 and 11, which received a designation of *Substantially Compliant*. Completeness of the minimum wage data was far below the required 95 percent threshold, resulting in an understated rate for these measures. The PIHP met four of the five contractually required performance standards related to the **quality** of services provided by the PIHP. For the remaining indicators in the **quality** domain, **Venture Behavioral Health** demonstrated the following results: the PIHP's HSW rate exceeded the statewide rate. The rate for MI and DD adults who were employed competitively and the rate of DD adults who earned minimum wage were higher than the statewide rate, while the rate for MI adults who earned minimum wage was lower than the statewide rates. Performance indicators related to **timeliness** of and **access** to services were *Fully Compliant* with MDCH specifications. **Venture Behavioral Health** met the contractually required performance standards for seven of the eight performance measures related to **timeliness** of and **access** to services provided by the PIHP. The PIHP's penetration rate exceeded the statewide rate. **Venture Behavioral Health** demonstrated strong performance across all three domains of **quality**, **timeliness**, and **access** and met the minimum performance standard for eight of the nine indicators.

Validation of Performance Improvement Projects

This section of the report presents the results of the validation of PIPs. For the 2008–2009 validation, MDCH selected a new mandatory study topic: improving the penetration rates for children. All PIHPs submitted their PIP on the new study topic, but differed in how far they progressed in the implementation. The validation of PIPs addresses the validity and reliability of the PIHP's processes for conducting valid PIPs. Therefore, for the purposes of the EQR technical report, HSAG assigned all PIPs to the **quality** domain.

Access Alliance of Michigan

Findings

Table 3-38 and Table 3-39 show **Access Alliance of Michigan**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2008–2009 PIP Validation Report for **Access Alliance of Michigan**. Validation of Steps I through VIII resulted in a validation status of *Partially Met,* with an overall score of 92 percent and a score of 90 percent for critical elements. Based on the validation of this PIP, HSAG's assessment determined low confidence in the results.

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

		All Evaluation Elements (Including Critical Elements)					Critical Elements				
Review Step		Total	*M*	*PM*	*NM*	*NA*	Total	*M*	*PM*	*NM*	*NA*
I.	Review the Selected Study Topic(s)	6	5	0	0	1	1	1	0	0	0
II.	Review the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III.	Review the Selected Study Indicator(s)	7	4	0	0	3	3	3	0	0	0
IV.	Review the Identified Study Population	3	3	0	0	0	2	2	0	0	0
V.	Review Sampling Methods	6	0	0	0	6	1	0	0	0	1
VI.	Review Data Collection Procedures	11	6	0	0	5	1	0	0	0	1
VII.	Assess Improvement Strategies	4	2	0	0	2	1	1	0	0	0
VIII.	Review Data Analysis and Study Results	9	2	1	1	5	2	0	1	0	1
IX.	Assess for Real Improvement	4	Not Assessed				No Critical Elements				
X.	Assess for Sustained Improvement	1	Not Assessed				No Critical Elements				
Totals for All Steps		**53**	**24**	**1**	**1**	**22**	**13**	**9**	**1**	**0**	**3**

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

Percentage Score of Evaluation Elements *Met*	**92%**
Percentage Score of Critical Elements *Met*	**90%**
Validation Status	***Partially Met***

Strengths

Access Alliance of Michigan demonstrated strength in its study design and implementation with scores of *Met* for all applicable evaluation elements in Steps I through VII.

Recommendations

The data analysis plan should include how the rates are calculated and compared to goals. HSAG recommended using a Chi-square or z test instead of the reported two-tailed t test to determine whether the improvement was statistically significant.

For the steps related to the study topic, study indicators, improvement strategies, and data analysis and interpretation of study results, HSAG identified additional *Points of Clarification* to strengthen the study.

Summary Assessment Related to Quality, Timeliness, and Access

Access Alliance of Michigan implemented several interventions to improve services to children with a serious emotional disorder, a developmental disability, or both a serious emotional disorder and a developmental disability. The PIHP had not yet advanced to collecting remeasurement data. As **Access Alliance of Michigan** progresses in the study, assessment of the impact of the PIP on the **quality** of care and services will continue.

CMH Affiliation of Mid-Michigan

Findings

Table 3-40 and Table 3-41 show **CMH Affiliation of Mid-Michigan**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2008–2009 PIP Validation Report for **CMH Affiliation of Mid-Michigan**. Validation of Steps I through VIII resulted in a validation status of *Not Met,* with an overall score of 38 percent and a score of 30 percent for critical elements. Based on the validation of this PIP, HSAG's assessment determined that the reported PIP results were not credible.

Table 3-40—PIP Validation Scores
for **CMH Affiliation of Mid-Michigan**

		All Evaluation Elements (Including Critical Elements)					Critical Elements				
Review Step		Total	*M*	*PM*	*NM*	*NA*	Total	*M*	*PM*	*NM*	*NA*
I.	Review the Selected Study Topic(s)	6	1	1	3	1	1	0	0	1	0
II.	Review the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III.	Review the Selected Study Indicator(s)	7	1	2	1	3	3	1	1	1	0
IV.	Review the Identified Study Population	3	1	2	0	0	2	0	2	0	0
V.	Review Sampling Methods	6	0	0	0	6	1	0	0	0	1
VI.	Review Data Collection Procedures	11	4	1	1	5	1	0	0	0	1
VII.	Assess Improvement Strategies	4	1	1	0	2	1	0	1	0	0
VIII.	Review Data Analysis and Study Results	9	0	1	3	5	2	0	1	0	1
IX.	Assess for Real Improvement	4	Not Assessed				No Critical Elements				
X.	Assess for Sustained Improvement	1	Not Assessed				No Critical Elements				
Totals for All Activities		**53**	**10**	**8**	**8**	**22**	**13**	**3**	**5**	**2**	**3**

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

Percentage Score of Evaluation Elements *Met*	**38%**
Percentage Score of Critical Elements *Met*	**30%**
Validation Status	***Not Met***

Strengths

CMH Affiliation of Mid-Michigan's study topic addressed a broad spectrum of care and services. The study questions were answerable and stated the study problem in simple terms. The process for collecting data was defined and systematic, and the interventions included system changes that were likely to induce permanent change.

Recommendations

HSAG made several recommendations to provide additional information about the study topic, study indicators, study population, and data collection procedures. In future submissions, **CMH Affiliation of Mid-Michigan** should also include a discussion about the quality improvement process used to identify causes and barriers, statistical tests that will be used to compare measurements, and interpretation of findings for each measurement period. The PIHP should identify factors that threaten the validity of this study and provide results for each study indicator.

For the steps related to the study population and the data collection procedures, HSAG identified additional *Points of Clarification* to strengthen the study.

Summary Assessment Related to Quality, Timeliness, and Access

CMH Affiliation of Mid-Michigan developed the study to improve services to children with a serious emotional disorder, a developmental disability, or both a serious emotional disorder and a developmental disability. The PIHP had not yet advanced to collecting remeasurement data. As **CMH Affiliation of Mid-Michigan** progresses in the study, assessment of the impact of the PIP on the **quality** of care and services will continue.

CMH for Central Michigan

Findings

Table 3-42 and Table 3-43 show **CMH for Central Michigan**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2007–2008 PIP Validation Report for **CMH for Central Michigan**. Validation of Steps I through VIII resulted in a validation status of *Met,* with an overall score of 96 percent and a score of 100 percent for critical elements. Based on the validation of this PIP, HSAG's assessment determined high confidence in the results.

Table 3-42—PIP Validation Scores *for* CMH for Central Michigan

Review Step		All Evaluation Elements (Including Critical Elements)					Critical Elements				
		Total	*M*	*PM*	*NM*	*NA*	Total	*M*	*PM*	*NM*	*NA*
I.	Review the Selected Study Topic(s)	6	5	0	0	1	1	1	0	0	0
II.	Review the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III.	Review the Selected Study Indicator(s)	7	4	0	0	3	3	3	0	0	0
IV.	Review the Identified Study Population	3	3	0	0	0	2	2	0	0	0
V.	Review Sampling Methods	6	0	0	0	6	1	0	0	0	1
VI.	Review Data Collection Procedures	11	6	0	0	5	1	0	0	0	1
VII.	Assess Improvement Strategies	4	2	0	0	2	1	1	0	0	0
VIII.	Review Data Analysis and Study Results	9	3	1	0	5	2	1	0	0	1
IX.	Assess for Real Improvement	4	Not Assessed				No Critical Elements				
X.	Assess for Sustained Improvement	1	Not Assessed								
Totals for All Activities		**53**	**25**	**1**	**0**	**22**	**13**	**10**	**0**	**0**	**3**

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

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

Strengths

CMH for Central Michigan demonstrated strength in its study design and implementation with scores of *Met* for all applicable evaluation elements in Steps I through VII.

Recommendations

CMH for Central Michigan should include in future reports an interpretation of the baseline and remeasurement results, including a narrative description of the rates and a comparison of the results to goals and additional measurement periods.

For the steps related to the study indicators and the data collection procedures, HSAG identified additional *Points of Clarification* to strengthen the study.

Summary Assessment Related to Quality, Timeliness, and Access

CMH for Central Michigan implemented several interventions to improve services to children with a serious emotional disorder, a developmental disability, or both a serious emotional disorder and a developmental disability. The PIHP had not yet advanced to collecting remeasurement data. As **CMH for Central Michigan** progresses in the study, assessment of the impact of the PIP on the **quality** of care and services will continue.

CMH Partnership of Southeastern Michigan

Findings

Table 3-44 and Table 3-45 show **CMH Partnership of Southeastern Michigan**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2008–2009 PIP Validation Report for **CMH Partnership of Southeastern Michigan**. Validation of Activities I through IX resulted in a validation status of *Met,* with an overall score of 100 percent and a score of 100 percent for critical elements. Based on the validation of this PIP, HSAG's assessment determined high confidence in the results.

Table 3-44—PIP Validation Scores *for* CMH Partnership of Southeastern Michigan

Review Step		All Evaluation Elements (Including Critical Elements)					Critical Elements				
		Total	*M*	*PM*	*NM*	*NA*	Total	*M*	*PM*	*NM*	*NA*
I.	Review the Selected Study Topic(s)	6	5	0	0	1	1	1	0	0	0
II.	Review the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III.	Review the Selected Study Indicator(s)	7	4	0	0	3	3	3	0	0	0
IV.	Review the Identified Study Population	3	3	0	0	0	2	2	0	0	0
V.	Review Sampling Methods	6	0	0	0	6	1	0	0	0	1
VI.	Review Data Collection Procedures	11	6	0	0	5	1	0	0	0	1
VII.	Assess Improvement Strategies	4	2	0	0	2	1	1	0	0	0
VIII.	Review Data Analysis and Study Results	9	4	0	0	5	2	1	0	0	1
IX.	Assess for Real Improvement	4	Not Assessed				No Critical Elements				
X.	Assess for Sustained Improvement	1	Not Assessed				No Critical Elements				
Totals for All Activities		**53**	**26**	**0**	**0**	**22**	**13**	**10**	**0**	**0**	**3**

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

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

Strengths

CMH Partnership of Southeastern Michigan demonstrated strength in its study design and implementation with scores of *Met* for all applicable evaluation elements in Steps I through VII.

Recommendations

There were no opportunities for improvement identified during this validation cycle. For the steps related to the study topic, the study indicators, data collection procedures, and data analysis and interpretation of study results, HSAG identified *Points of Clarification* to strengthen the study.

Summary Assessment Related to Quality, Timeliness, and Access

CMH Partnership of Southeastern Michigan implemented several interventions to improve services to children with a serious emotional disorder, a developmental disability, or both a serious emotional disorder and a developmental disability. The PIHP had not yet advanced to collecting remeasurement data. As **CMH Partnership of Southeastern Michigan** progresses in the study, assessment of the impact of the PIP on the **quality** of care and services will continue.

Detroit-Wayne County CMH Agency

Findings

Table 3-46 and Table 3-47 show **Detroit-Wayne County CMH Agency**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2008–2009 PIP Validation Report for **Detroit-Wayne County CMH Agency**. Validation of Steps I through VIII resulted in a validation status of *Partially Met,* with an overall score of 62 percent and a score of 70 percent for critical elements. Based on the validation of this PIP, HSAG's assessment determined low confidence in the results.

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

		All Evaluation Elements (Including Critical Elements)					Critical Elements				
Review Step		Total	*M*	*PM*	*NM*	*NA*	Total	*M*	*PM*	*NM*	*NA*
I.	Review the Selected Study Topic(s)	6	2	1	2	1	1	1	0	0	0
II.	Review the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III.	Review the Selected Study Indicator(s)	7	4	0	0	3	3	3	0	0	0
IV.	Review the Identified Study Population	3	0	2	1	0	2	0	2	0	0
V.	Review Sampling Methods	6	0	0	0	6	1	0	0	0	1
VI.	Review Data Collection Procedures	11	5	1	0	5	1	0	0	0	1
VII.	Assess Improvement Strategies	4	2	0	0	2	1	1	0	0	0
VIII.	Review Data Analysis and Study Results	9	1	2	1	5	2	0	1	0	1
IX.	Assess for Real Improvement	4	Not Assessed				No Critical Elements				
X.	Assess for Sustained Improvement	1	Not Assessed				No Critical Elements				
Totals for All Activities		**53**	**16**	**6**	**4**	**22**	**13**	**7**	**3**	**0**	**3**

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

Percentage Score of Evaluation Elements *Met*	**62%**
Percentage Score of Critical Elements *Met*	**70%**
Validation Status	***Partially Met***

Strengths

Detroit-Wayne County CMH Agency's study topic addressed a broad spectrum of care and services. The study questions were answerable, stating the problem to be studied in simple terms. The study indicators were well-defined, objective, and measurable. The PIHP defined a systematic process for collecting data. The PIP submission included interventions related to causes/barriers identified through a quality improvement process and included system changes likely to induce permanent change.

Recommendations

HSAG made several recommendations to provide additional information about the study topic, study population, and data collection procedures. In future submissions, **Detroit-Wayne County CMH Agency**'s data analysis plan should also address how rates will be calculated and include comparisons to benchmarks and goals. HSAG recommended using a Chi-square or *z* test for proportions to determine whether any improvement was statistically significant. Future submissions should include an interpretation of the findings for each measurement period and ensure that the PIHP calculated all rates accurately.

For the steps related to the study indicators, sampling methods, and improvement strategies, HSAG identified additional *Points of Clarification* to strengthen the study.

Summary Assessment Related to Quality, Timeliness, and Access

Detroit-Wayne County CMH Agency reported plans to implement several interventions to improve services to children with a serious emotional disorder, a developmental disability, or both a serious emotional disorder and a developmental disability. The PIHP had not yet advanced to collecting remeasurement data. As **Detroit-Wayne County CMH Agency** progresses in the study, the assessment of the impact of the PIP on the **quality** of care and services will continue.

Genesee County CMH

Findings

Table 3-48 and Table 3-49 show **Genesee County CMH**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2008–2009 PIP Validation Report for **Genesee County CMH**. Validation of Steps I through VIII resulted in a validation status of *Not Met,* with an overall score of 75 percent and a score of 89 percent for critical elements. Based on the validation of this PIP, HSAG's assessment determined that the reported PIP results were not credible.

Table 3-48—PIP Validation Scores *for* Genesee County CMH

		All Evaluation Elements (Including Critical Elements)					Critical Elements				
Review Step		Total	*M*	*PM*	*NM*	*NA*	Total	*M*	*PM*	*NM*	*NA*
I.	Review the Selected Study Topic(s)	6	2	0	3	1	1	0	0	1	0
II.	Review the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III.	Review the Selected Study Indicator(s)	7	4	0	0	3	3	3	0	0	0
IV.	Review the Identified Study Population	3	2	1	0	0	2	2	0	0	0
V.	Review Sampling Methods	6	0	0	0	6	1	0	0	0	1
VI.	Review Data Collection Procedures	11	4	0	2	5	1	0	0	0	1
VII.	Assess Improvement Strategies	4	2	0	0	2	1	1	0	0	0
VIII.	Review Data Analysis and Study Results	9	2	0	0	7	2	0	0	0	2
IX.	Assess for Real Improvement	4	Not Assessed				No Critical Elements				
X.	Assess for Sustained Improvement	1	Not Assessed				No Critical Elements				
Totals for All Activities		**53**	**18**	**1**	**5**	**24**	**13**	**8**	**0**	**1**	**4**

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

Percentage Score of Evaluation Elements *Met*	**75%**
Percentage Score of Critical Elements *Met*	**89%**
Validation Status	***Not Met***

Strengths

Genesee County CMH's study topic addressed a broad spectrum of care and services. The study questions were answerable and stated the problem to be studied in simple terms. The study indicators were well-defined, objective, and measurable. The PIHP accurately defined the study population, and the interventions included system changes likely to induce permanent change.

Recommendations

HSAG made several recommendations to provide additional information about the study topic and study population. In future submissions, **Genesee County CMH**'s data collection procedures should include a description of the systematic process for collecting data, an administrative data collection algorithm, a data flow chart, or a narrative description that outlines all of the steps in the production of the study indicators.

For the steps related to the study topic, study questions, study indicators, study population, data collection procedures, and improvement strategies, HSAG identified *Points of Clarification* to strengthen the study.

Summary Assessment Related to Quality, Timeliness, and Access

Genesee County CMH implemented several interventions to improve services to children with a serious emotional disorder, a developmental disability, or both a serious emotional disorder and a developmental disability. The PIHP had not yet advanced to collecting remeasurement data. As **Genesee County CMH** progresses in the study, the assessment of the impact of the PIP on the **quality** of care and services will continue.

Lakeshore Behavioral Health Alliance

Findings

Table 3-50 and Table 3-51 show **Lakeshore Behavioral Health Alliance**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2008–2009 PIP Validation Report for **Lakeshore Behavioral Health Alliance**. Validation of Steps I through VIII resulted in a validation status of *Not Met,* with an overall score of 58 percent and a score of 70 percent for critical elements. Based on the validation of this PIP, HSAG's assessment determined that the reported PIP results were not credible.

Table 3-50—PIP Validation Scores
for **Lakeshore Behavioral Health Alliance**

		All Evaluation Elements (Including Critical Elements)					Critical Elements				
Review Step		Total	*M*	*PM*	*NM*	*NA*	Total	*M*	*PM*	*NM*	*NA*
I.	Review the Selected Study Topic(s)	6	1	1	3	1	1	0	0	1	0
II.	Review the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III.	Review the Selected Study Indicator(s)	7	4	0	0	3	3	3	0	0	0
IV.	Review the Identified Study Population	3	3	0	0	0	2	2	0	0	0
V.	Review Sampling Methods	6	0	0	0	6	1	0	0	0	1
VI.	Review Data Collection Procedures	11	4	0	2	5	1	0	0	0	1
VII.	Assess Improvement Strategies	4	0	0	2	2	1	0	0	1	0
VIII.	Review Data Analysis and Study Results	9	1	2	1	5	2	0	1	0	1
IX.	Assess for Real Improvement	4	Not Assessed				No Critical Elements				
X.	Assess for Sustained Improvement	1	Not Assessed				No Critical Elements				
Totals for All Activities		**53**	**15**	**3**	**8**	**22**	**13**	**7**	**1**	**2**	**3**

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

Percentage Score of Evaluation Elements *Met*	**58%**
Percentage Score of Critical Elements *Met*	**70%**
Validation Status	***Not Met***

Strengths

Lakeshore Behavioral Health Alliance demonstrated strength in its study questions, study indicators, and study population with scores of *Met* for all applicable evaluation elements in Steps II through IV.

Recommendations

HSAG made several recommendations to provide additional information about the study topic and data collection procedures. In future submissions, **Lakeshore Behavioral Health Alliance** should also include the quality improvement process used to identify causes/barriers, describe the interventions, and link them to the causes/barriers. The PIHP should also include a complete data analysis plan, discuss factors that threaten the internal or external validity of the findings, and specify the units for the results as well as the measurement period date ranges.

For the steps related to the study indicators, data collection procedures, and data analysis and interpretation of study results, HSAG identified additional *Points of Clarification* to strengthen the study.

Summary Assessment Related to Quality, Timeliness, and Access

Lakeshore Behavioral Health Alliance had not yet implemented interventions to improve services to children with a serious emotional disorder, a developmental disability, or both a serious emotional disorder and a developmental disability. As the PIHP progresses in the study, the assessment of the impact of the PIP on the **quality** of care and services will continue.

LifeWays

Findings

Table 3-52 and Table 3-53 show **LifeWays**' scores based on HSAG's PIP evaluation. For additional details, refer to the 2008–2009 PIP Validation Report for **LifeWays**. Validation of Steps I through VIII resulted in a validation status of *Not Met,* with an overall score of 62 percent and a score of 50 percent for critical elements. Based on the validation of this PIP, HSAG's assessment determined that the reported PIP results were not credible.

Table 3-52—PIP Validation Scores *for* LifeWays

		All Evaluation Elements (Including Critical Elements)					Critical Elements				
Review Step		Total	*M*	*PM*	*NM*	*NA*	Total	*M*	*PM*	*NM*	*NA*
I.	Review the Selected Study Topic(s)	6	3	1	1	1	1	0	0	1	0
II.	Review the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III.	Review the Selected Study Indicator(s)	7	4	0	0	3	3	3	0	0	0
IV.	Review the Identified Study Population	3	1	2	0	0	2	0	2	0	0
V.	Review Sampling Methods	6	0	0	0	6	1	0	0	0	1
VI.	Review Data Collection Procedures	11	4	2	0	5	1	0	0	0	1
VII.	Assess Improvement Strategies	4	1	1	0	2	1	0	1	0	0
VIII.	Review Data Analysis and Study Results	9	1	0	3	5	2	0	0	1	1
IX.	Assess for Real Improvement	4	Not Assessed				No Critical Elements				
X.	Assess for Sustained Improvement	1	Not Assessed				No Critical Elements				
Totals for All Activities		**53**	**16**	**6**	**4**	**22**	**13**	**5**	**3**	**2**	**3**

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

Percentage Score of Evaluation Elements *Met*	**62%**
Percentage Score of Critical Elements *Met*	**50%**
Validation Status	***Not Met***

Strengths

LifeWays' study topic addressed a broad spectrum of care and services. The study questions were answerable and stated the problem to be studied in simple terms. The study indicators were well-defined, objective, and measurable. The PIHP used a defined and systematic process to collect data, and the interventions included system changes likely to induce permanent change.

Recommendations

HSAG made several recommendations to provide additional information about the study topic, study population, and data collection procedures. In future submissions, **LifeWays** should also discuss the quality improvement process for identifying causes/barriers and link all interventions to causes/barriers. The PIHP should also include a complete data analysis plan, discussion of factors that threaten the internal or external validity of the findings, and an interpretation of the results for each measurement period.

For the steps related to the study topic and study indicators, HSAG identified additional *Points of Clarification* to strengthen the study.

Summary Assessment Related to Quality, Timeliness, and Access

LifeWays implemented several interventions to improve services to children with a serious emotional disorder, a developmental disability, or both a serious emotional disorder and a developmental disability. The PIHP had not yet advanced to collecting remeasurement data. As **LifeWays** progresses in the study, the assessment of the impact of the PIP on the **quality** of care and services will continue.

Macomb County CMH Services

Findings

Table 3-54 and Table 3-55 show **Macomb County CMH Services**' scores based on HSAG's PIP evaluation. For additional details, refer to the 2008–2009 PIP Validation Report for **Macomb County CMH Services**. Validation of Steps I through VI and Step VIII resulted in a validation status of *Not Met,* with an overall score of 79 percent and a score of 78 percent for critical elements. Based on the validation of this PIP, HSAG's assessment determined that the reported PIP results were not credible.

Table 3-54—PIP Validation Scores *for* Macomb County CMH Services

Review Step		All Evaluation Elements (Including Critical Elements)					Critical Elements				
		Total	*M*	*PM*	*NM*	*NA*	Total	*M*	*PM*	*NM*	*NA*
I.	Review the Selected Study Topic(s)	6	3	0	2	1	1	0	0	1	0
II.	Review the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III.	Review the Selected Study Indicator(s)	7	4	0	0	3	3	3	0	0	0
IV.	Review the Identified Study Population	3	3	0	0	0	2	2	0	0	0
V.	Review Sampling Methods	6	0	0	0	6	1	0	0	0	1
VI.	Review Data Collection Procedures	11	6	0	0	5	1	0	0	0	1
VII.	Assess Improvement Strategies	4	Not Assessed				1	Not Assessed			
VIII.	Review Data Analysis and Study Results	9	1	1	2	5	2	0	1	0	1
IX.	Assess for Real Improvement	4	Not Assessed				No Critical Elements				
X.	Assess for Sustained Improvement	1	Not Assessed				No Critical Elements				
Totals for All Activities		**53**	**1**	**1**	**2**	**5**	**13**	**7**	**1**	**1**	**1**

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

Percentage Score of Evaluation Elements *Met*	**79%**
Percentage Score of Critical Elements *Met*	**78%**
Validation Status	***Not Met***

Strengths

Macomb County CMH Service demonstrated strength in its study design and implementation with scores of *Met* for all applicable evaluation elements in Steps II through VI. The PIHP documented that it was in the process of conducting a causal/barrier analysis.

Recommendations

HSAG made several recommendations to provide additional information about the study topic. Future submissions of the PIP should also include details about the process used to identify causes/barriers. The PIHP should link the interventions to the identified causes/barriers. **Macomb County CMH Services** should include a complete data analysis plan, discussion of factors that threaten the validity of the findings, and an interpretation of findings for each measurement period.

For the steps related to the study topic, study indicators, data collection procedures, and data analysis and interpretation of study results, HSAG identified additional *Points of Clarification* to strengthen the study.

Summary Assessment Related to Quality, Timeliness, and Access

Macomb County CMH Services did not report implementing any interventions to improve services to children with a serious emotional disorder, a developmental disability, or both a serious emotional disorder and a developmental disability. As **Macomb County CMH Services** progresses in the study, the assessment of the impact of the PIP on the **quality** of care and services will continue.

network180

Findings

Table 3-56 and Table 3-57 show **network180**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2008–2009 PIP Validation Report for **network180**. Validation of Steps I through VIII resulted in a validation status of *Not Met,* with an overall score of 58 percent and a score of 60 percent for critical elements. Based on the validation of this PIP, HSAG's assessment determined that the reported PIP results were not credible.

Table 3-56—PIP Validation Scores *for* network180

		All Evaluation Elements (Including Critical Elements)					Critical Elements				
Review Step		Total	*M*	*PM*	*NM*	*NA*	Total	*M*	*PM*	*NM*	*NA*
I.	Review the Selected Study Topic(s)	6	1	1	3	1	1	0	0	1	0
II.	Review the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III.	Review the Selected Study Indicator(s)	7	4	0	0	3	3	3	0	0	0
IV.	Review the Identified Study Population	3	1	2	0	0	2	0	2	0	0
V.	Review Sampling Methods	6	0	0	0	6	1	0	0	0	1
VI.	Review Data Collection Procedures	11	3	0	3	5	1	0	0	0	1
VII.	Assess Improvement Strategies	4	2	0	0	2	1	1	0	0	0
VIII.	Review Data Analysis and Study Results	9	2	2	0	5	2	0	1	0	1
IX.	Assess for Real Improvement	4	Not Assessed				No Critical Elements				
X.	Assess for Sustained Improvement	1	Not Assessed				No Critical Elements				
Totals for All Activities		**53**	**15**	**5**	**6**	**22**	**13**	**6**	**3**	**1**	**3**

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

Percentage Score of Evaluation Elements *Met*	**58%**
Percentage Score of Critical Elements *Met*	**60%**
Validation Status	***Not Met***

Strengths

network180's study topic addressed a broad spectrum of care and services. The study questions were answerable and stated the problem to be studied in simple terms. The study indicators were well-defined, objective, and measurable. **network180**'s interventions were related to causes/barriers identified through a quality improvement process and included system changes likely to induce permanent change.

Recommendations

HSAG made several recommendations to provide additional information about the study topic, study population, and data collection procedures. Future submissions of the PIP should also address the statistical test that will be used to compare measurements and include labels for each study indicator in the results table. The PIHP should ensure that rates are documented accurately and consistently throughout the PIP submission.

For the steps related to the study indicators, study population, and data analysis and interpretation of study results, HSAG identified additional *Points of Clarification* to strengthen the study.

Summary Assessment Related to Quality, Timeliness, and Access

network180 implemented several interventions to improve services to children with a serious emotional disorder, a developmental disability, or both a serious emotional disorder and a developmental disability. The PIHP had not yet advanced to collecting remeasurement data. As **network180** progresses in the study, the assessment of the impact of the PIP on the **quality** of care and services will continue.

NorthCare

Findings

Table 3-58 and Table 3-59 show **NorthCare**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2008–2009 PIP Validation Report for **NorthCare**. Validation of Steps I through VIII resulted in a validation status of *Not Met,* with an overall score of 69 percent and a score of 60 percent for critical elements. Based on the validation of this PIP, HSAG's assessment determined that the reported PIP results were not credible.

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

		All Evaluation Elements (Including Critical Elements)					Critical Elements				
Review Step		Total	*M*	*PM*	*NM*	*NA*	Total	*M*	*PM*	*NM*	*NA*
I.	Review the Selected Study Topic(s)	6	2	0	3	1	1	0	0	1	0
II.	Review the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III.	Review the Selected Study Indicator(s)	7	4	0	0	3	3	3	0	0	0
IV.	Review the Identified Study Population	3	1	2	0	0	2	0	2	0	0
V.	Review Sampling Methods	6	0	0	0	6	1	0	0	0	1
VI.	Review Data Collection Procedures	11	5	1	0	5	1	0	0	0	1
VII.	Assess Improvement Strategies	4	2	0	0	2	1	1	0	0	0
VIII.	Review Data Analysis and Study Results	9	2	2	0	5	2	0	1	0	1
IX.	Assess for Real Improvement	4	Not Assessed				No Critical Elements				
X.	Assess for Sustained Improvement	1	Not Assessed				No Critical Elements				
Totals for All Activities		**53**	**18**	**5**	**3**	**22**	**13**	**6**	**3**	**1**	**3**

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

Percentage Score of Evaluation Elements *Met*	**69%**
Percentage Score of Critical Elements *Met*	**60%**
Validation Status	***Not Met***

Strengths

NorthCare's study topic addressed a broad spectrum of care and services. The study questions were answerable and stated the problem to be studied in simple terms. The study indicators were well-defined, objective, and measurable. The PIHP used a defined and systematic process to collect data, and the interventions included system changes likely to induce permanent change.

Recommendations

HSAG made several recommendations to provide additional information about the study topic, study population, and data collection procedures. **NorthCare**'s future submissions of the PIP should also address how the rates were calculated, report rates for the study indicators, and include an interpretation of the rates for each measurement period.

For the steps related to the study topic, study questions, study indicators, improvement strategies, and data analysis and interpretation of study results, HSAG identified additional *Points of Clarification* to strengthen the study.

Summary Assessment Related to Quality, Timeliness, and Access

NorthCare implemented several interventions to improve services to children with a serious emotional disorder, a developmental disability, or both a serious emotional disorder and a developmental disability. The PIHP had not yet advanced to collecting remeasurement data. As **NorthCare** progresses in the study, the assessment of the impact of the PIP on the **quality** of care and services will continue.

Northern Affiliation

Findings

Table 3-60 and Table 3-61 show **Northern Affiliation**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2008–2009 PIP Validation Report for **Northern Affiliation**. Validation of Steps I through VIII resulted in a validation status of *Not Met,* with an overall score of 73 percent and a score of 80 percent for critical elements. Based on the validation of this PIP, HSAG's assessment determined that the reported PIP results were not credible.

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

		All Evaluation Elements (Including Critical Elements)					Critical Elements				
Review Step		Total	*M*	*PM*	*NM*	*NA*	Total	*M*	*PM*	*NM*	*NA*
I.	Review the Selected Study Topic(s)	6	1	1	3	1	1	0	0	1	0
II.	Review the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III.	Review the Selected Study Indicator(s)	7	4	0	0	3	3	3	0	0	0
IV.	Review the Identified Study Population	3	3	0	0	0	2	2	0	0	0
V.	Review Sampling Methods	6	0	0	0	6	1	0	0	0	1
VI.	Review Data Collection Procedures	11	5	1	0	5	1	0	0	0	1
VII.	Assess Improvement Strategies	4	2	0	0	2	1	1	0	0	0
VIII.	Review Data Analysis and Study Results	9	2	1	1	5	2	0	1	0	1
IX.	Assess for Real Improvement	4	Not Assessed				No Critical Elements				
X.	Assess for Sustained Improvement	1	Not Assessed				No Critical Elements				
Totals for All Activities		**53**	**19**	**3**	**4**	**22**	**13**	**8**	**1**	**1**	**3**

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

Percentage Score of Evaluation Elements *Met*	**73%**
Percentage Score of Critical Elements *Met*	**80%**
Validation Status	***Not Met***

Strengths

Northern Affiliation demonstrated strength in its study design and implementation with scores of *Met* for all applicable evaluation elements in Steps II through IV. The PIP included interventions related to causes/barriers identified through a quality improvement process. The interventions included system changes likely to induce permanent change.

Recommendations

HSAG made several recommendations to provide additional information about the study topic. In future submissions of the PIP, **Northern Affiliation** should also include a comprehensive description of the data collection process, a complete data analysis plan, and an interpretation of the findings for each measurement period.

For the steps related to the study indicators, data collection procedures, improvement strategies, and data analysis and interpretation of study results, HSAG identified additional *Points of Clarification* to strengthen the study.

Summary Assessment Related to Quality, Timeliness, and Access

Northern Affiliation implemented several interventions to improve services to children with a serious emotional disorder, a developmental disability, or both a serious emotional disorder and a developmental disability. The PIHP had not yet advanced to collecting remeasurement data. As **Northern Affiliation** progresses in the study, the assessment of the impact of the PIP on the **quality** of care and services will continue.

Northwest CMH Affiliation

Findings

Table 3-62 and Table 3-63 show **Northwest CMH Affiliation**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2008–2009 PIP Validation Report for **Northwest CMH Affiliation**. Validation of Steps I through VIII resulted in a validation status of *Not Met,* with an overall score of 69 percent and a score of 70 percent for critical elements. Based on the validation of this PIP, HSAG's assessment determined that the reported PIP results were not credible.

Table 3-62—PIP Validation Scores *for* Northwest CMH Affiliation

		All Evaluation Elements (Including Critical Elements)					Critical Elements				
Review Step		Total	*M*	*PM*	*NM*	*NA*	Total	*M*	*PM*	*NM*	*NA*
I.	Review the Selected Study Topic(s)	6	3	1	1	1	1	0	0	1	0
II.	Review the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III.	Review the Selected Study Indicator(s)	7	4	0	0	3	3	3	0	0	0
IV.	Review the Identified Study Population	3	3	0	0	0	2	2	0	0	0
V.	Review Sampling Methods	6	0	0	0	6	1	0	0	0	1
VI.	Review Data Collection Procedures	11	6	0	0	5	1	0	0	0	1
VII.	Assess Improvement Strategies	4	0	0	2	2	1	0	0	1	0
VIII.	Review Data Analysis and Study Results	9	0	1	3	5	2	0	0	1	1
IX.	Assess for Real Improvement	4	Not Assessed				No Critical Elements				
X.	Assess for Sustained Improvement	1	Not Assessed				No Critical Elements				
Totals for All Activities		**53**	**18**	**2**	**6**	**22**	**13**	**7**	**0**	**3**	**3**

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

Percentage Score of Evaluation Elements *Met*	**69%**
Percentage Score of Critical Elements *Met*	**70%**
Validation Status	***Not Met***

Strengths

Northwest CMH Affiliation's study topic addressed a broad spectrum of care and services. The study questions were answerable and stated the problem to be studied in simple terms. The study indicators were well-defined, objective, and measurable. The PIHP accurately defined the study population and used a defined and systematic process to collect data.

Recommendations

HSAG made several recommendations to provide additional information about the study topic. In future submissions of the PIP, **Northwest CMH Affiliation** should also document a quality improvement process used to identify causes/barriers. The PIHP should include interventions and link them to the identified causes/barriers. Future submissions should also include a complete data analysis plan, discussion of factors that threaten the validity of the findings, as well as an interpretation of the findings for each measurement period.

For the steps related to the study topic, study indicators, and data collection procedures, HSAG identified additional *Points of Clarification* to strengthen the study.

Summary Assessment Related to Quality, Timeliness, and Access

Northwest CMH Affiliation had not yet implemented any interventions to improve services to children with a serious emotional disorder, a developmental disability, or both a serious emotional disorder and a developmental disability. As **Northwest CMH Affiliation** progresses in the study, the assessment of the impact of the PIP on the **quality** of care and services will continue.

Oakland County CMH Authority

Findings

Table 3-64 and Table 3-65 show **Oakland County CMH Authority**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2008–2009 PIP Validation Report for **Oakland County CMH Authority**. Validation of Steps I through VIII resulted in a validation status of *Partially Met,* with an overall score of 81 percent and a score of 70 percent for critical elements. Based on the validation of this PIP, HSAG's assessment determined low confidence in the results.

Table 3-64—PIP Validation Scores *for* Oakland County CMH Authority

		All Evaluation Elements (Including Critical Elements)					Critical Elements				
Review Step		Total	*M*	*PM*	*NM*	*NA*	Total	*M*	*PM*	*NM*	*NA*
I.	Review the Selected Study Topic(s)	6	5	0	0	1	1	1	0	0	0
II.	Review the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III.	Review the Selected Study Indicator(s)	7	1	3	0	3	3	1	2	0	0
IV.	Review the Identified Study Population	3	3	0	0	0	2	2	0	0	0
V.	Review Sampling Methods	6	0	0	0	6	1	0	0	0	1
VI.	Review Data Collection Procedures	11	6	0	0	5	1	0	0	0	1
VII.	Assess Improvement Strategies	4	2	0	0	2	1	1	0	0	0
VIII.	Review Data Analysis and Study Results	9	2	2	0	5	2	0	1	0	1
IX.	Assess for Real Improvement	4	Not Assessed				No Critical Elements				
X.	Assess for Sustained Improvement	1	Not Assessed				No Critical Elements				
Totals for All Activities		**53**	**21**	**5**	**0**	**22**	**13**	**7**	**3**	**0**	**3**

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

Percentage Score of Evaluation Elements *Met*	**81%**
Percentage Score of Critical Elements *Met*	**70%**
Validation Status	***Partially Met***

Strengths

Oakland County CMH Authority's study topic addressed a broad spectrum of care and services and had the potential to affect beneficiary health and functional status. The study questions were answerable and stated the problem to be studied in simple terms. The PIHP accurately defined the study population and used a defined and systematic process to collect data. The interventions included system changes likely to induce permanent change.

Recommendations

HSAG made several recommendations for modifications to the study indicators. In future submissions of the PIP, **Oakland County CMH Authority** should also include a complete data analysis plan that details how the rates will be calculated, comparisons to the benchmark or goal, and the statistical test that will be used to compare measurement periods.

For the steps related to the study topic, data collection procedures, improvement strategies, and data analysis and interpretation of study results, HSAG identified additional *Points of Clarification* to strengthen the study.

Summary Assessment Related to Quality, Timeliness, and Access

Oakland County CMH Authority implemented several interventions to improve services to children with a serious emotional disorder, a developmental disability, or both a serious emotional disorder and a developmental disability. The PIHP had not yet advanced to collecting remeasurement data. As **Oakland County CMH Authority** progresses in the study, the assessment of the impact of the PIP on the **quality** of care and services will continue.

Saginaw County CMH Authority

Findings

Table 3-66 and Table 3-67 show **Saginaw County CMH Authority**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2007–2008 PIP Validation Report for **Saginaw County CMH Authority**. Validation of Steps I through VIII resulted in a validation status of *Not Met,* with an overall score of 48 percent and a score of 50 percent for critical elements. Based on the validation of this PIP, HSAG's assessment determined that the reported PIP results were not credible.

Table 3-66—PIP Validation Scores *for* Saginaw County CMH Authority

Review Step		All Evaluation Elements (Including Critical Elements)					Critical Elements				
		Total	*M*	*PM*	*NM*	*NA*	Total	*M*	*PM*	*NM*	*NA*
I.	Review the Selected Study Topic(s)	6	1	1	3	1	1	0	0	1	0
II.	Review the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III.	Review the Selected Study Indicator(s)	7	4	0	1	2	3	3	0	0	0
IV.	Review the Identified Study Population	3	1	2	0	0	2	0	2	0	0
V.	Review Sampling Methods	6	0	0	0	6	1	0	0	0	1
VI.	Review Data Collection Procedures	11	4	2	0	5	1	0	0	0	1
VII.	Assess Improvement Strategies	4	1	0	1	2	1	0	0	1	0
VIII.	Review Data Analysis and Study Results	9	0	0	4	5	2	0	0	1	1
IX.	Assess for Real Improvement	4	Not Assessed				No Critical Elements				
X.	Assess for Sustained Improvement	1	Not Assessed				No Critical Elements				
Totals for All Activities		**53**	**13**	**5**	**9**	**21**	**13**	**5**	**2**	**3**	**3**

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

Percentage Score of Evaluation Elements *Met*	**48%**
Percentage Score of Critical Elements *Met*	**50%**
Validation Status	***Not Met***

Strengths

Saginaw County CMH Authority's study topic addressed a broad spectrum of care and services. The study questions were answerable and stated the problem to be studied in simple terms. The study indicators were well-defined, objective, and measurable. The PIHP used a defined and systematic process to collect data, and the interventions included system changes likely to induce permanent change.

Recommendations

HSAG made several recommendations to provide additional information about the study topic, study indicators, study population, and data collection procedures. In future submissions of the PIP, **Saginaw County CMH Authority** should also ensure that the timelines for the remeasurement periods align with the MDCH specifications. The PIHP should include a description of the quality improvement process used to identify causes/barriers and report a complete data analysis plan. Future submissions should address factors that threaten the validity of the study findings and include an interpretation of the findings for each measurement period, as well as the baseline and remeasurement rates. **Saginaw County CMH Authority** should complete all of Activity VIII for the next annual PIP submission.

For the steps related to the study indicators and study population, HSAG identified additional *Points of Clarification* to strengthen the study.

Summary Assessment Related to Quality, Timeliness, and Access

Saginaw County CMH Authority designed interventions to improve services to children with a serious emotional disorder, a developmental disability, or both a serious emotional disorder and a developmental disability. The PIHP had not yet reported baseline or remeasurement data. As **Saginaw County CMH Authority** progresses in the study, the assessment of the impact of the PIP on the **quality** of care and services will continue.

Southwest Affiliation

Findings

Table 3-68 and Table 3-69 show **Southwest Affiliation**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2008–2009 PIP Validation Report for **Southwest Affiliation**. Validation of Steps I through VIII resulted in a validation status of *Met,* with an overall score of 85 percent and a score of 100 percent for critical elements. Based on the validation of this PIP, HSAG's assessment determined high confidence in the results.

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

		All Evaluation Elements (Including Critical Elements)					Critical Elements				
Review Step		Total	*M*	*PM*	*NM*	*NA*	Total	*M*	*PM*	*NM*	*NA*
I.	Review the Selected Study Topic(s)	6	4	1	0	1	1	1	0	0	0
II.	Review the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III.	Review the Selected Study Indicator(s)	7	4	0	0	3	3	3	0	0	0
IV.	Review the Identified Study Population	3	3	0	0	0	2	2	0	0	0
V.	Review Sampling Methods	6	0	0	0	6	1	0	0	0	1
VI.	Review Data Collection Procedures	11	4	0	2	5	1	0	0	0	1
VII.	Assess Improvement Strategies	4	2	0	0	2	1	1	0	0	0
VIII.	Review Data Analysis and Study Results	9	3	0	1	5	2	1	0	0	1
IX.	Assess for Real Improvement	4	Not Assessed				No Critical Elements				
X.	Assess for Sustained Improvement	1	Not Assessed				No Critical Elements				
Totals for All Activities		**53**	**22**	**1**	**3**	**22**	**13**	**10**	**0**	**0**	**3**

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

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

Strengths

Southwest Affiliation's demonstrated strength in its study design with scores of *Met* for all applicable evaluation elements in Steps II through IV. The PIP included proposed interventions that were linked to causes/barriers identified through a quality improvement process. The interventions included system changes likely to induce permanent change.

Recommendations

Southwest Affiliation should report plan-specific, historical penetration rate data in Activity I of the PIP Summary Form. Future PIP submissions should describe a systematic process for collecting data and include an algorithm, a data flow chart, or a narrative description that outlines all of the steps in the production of the study indicators. **Southwest Affiliation** should identify factors that threaten the validity of the study, discuss their impact on the study, and address any possible resolutions.

For the steps related to the study indicators, data collection procedures, improvement strategies, and data analysis and interpretation of study results, HSAG identified additional *Points of Clarification* to strengthen the study.

Summary Assessment Related to Quality, Timeliness, and Access

Southwest Affiliation implemented several interventions to improve services to children with a serious emotional disorder, a developmental disability, or both a serious emotional disorder and a developmental disability. The PIHP had not yet advanced to collecting remeasurement data. As **Southwest Affiliation** progresses in the study, the assessment of the impact of the PIP on the **quality** of care and services will continue.

Thumb Alliance PIHP

Findings

Table 3-70 and Table 3-71 show **Thumb Alliance PIHP**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2008–2009 PIP Validation Report for **Thumb Alliance PIHP**. Validation of Steps I through VIII resulted in a validation status of *Partially Met,* with an overall score of 85 percent and a score of 90 percent for critical elements. Based on the validation of this PIP, HSAG's assessment determined low confidence in the results.

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

		All Evaluation Elements (Including Critical Elements)					Critical Elements				
Review Step		Total	*M*	*PM*	*NM*	*NA*	Total	*M*	*PM*	*NM*	*NA*
I.	Review the Selected Study Topic(s)	6	5	0	0	1	1	1	0	0	0
II.	Review the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III.	Review the Selected Study Indicator(s)	7	4	0	0	3	3	3	0	0	0
IV.	Review the Identified Study Population	3	3	0	0	0	2	2	0	0	0
V.	Review Sampling Methods	6	0	0	0	6	1	0	0	0	1
VI.	Review Data Collection Procedures	11	5	1	0	5	1	0	0	0	1
VII.	Assess Improvement Strategies	4	2	0	0	2	1	1	0	0	0
VIII.	Review Data Analysis and Study Results	9	1	1	2	5	2	0	1	0	1
IX.	Assess for Real Improvement	4	Not Assessed				No Critical Elements				
X.	Assess for Sustained Improvement	1	Not Assessed				No Critical Elements				
Totals for All Activities		**53**	**22**	**2**	**2**	**22**	**13**	**9**	**1**	**0**	**3**

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

Percentage Score of Evaluation Elements *Met*	**85%**
Percentage Score of Critical Elements *Met*	**90%**
Validation Status	***Partially Met***

Strengths

Thumb Alliance PIHP demonstrated strength in its study design with scores of *Met* for all applicable evaluation elements in Steps I through IV. Additionally, **Thumb Alliance PIHP** defined a systematic process for collecting data. The interventions were related to causes/barriers identified through a quality improvement process and included system changes likely to induce permanent change.

Recommendations

In future PIP submissions, **Thumb Alliance PIHP** should provide a complete description of all activities for the production of the study indicators and a complete data analysis plan. The PIHP should also include an interpretation of the findings for all study indicators for each measurement period, as well as calculated rates, statistical tests, *p* values associated with the statistical tests, and comparisons to goals.

For the steps related to the study topic, study question, study indicators, data collection procedures, and improvement strategies, HSAG identified additional *Points of Clarification* to strengthen the study.

Summary Assessment Related to Quality, Timeliness, and Access

Thumb Alliance PIHP implemented several interventions to improve services to children with a serious emotional disorder, a developmental disability, or both a serious emotional disorder and a developmental disability. The PIHP had not yet advanced to collecting remeasurement data. As **Thumb Alliance PIHP** progresses in the study, the assessment of the impact of the PIP on the **quality** of care and services will continue.

Venture Behavioral Health

Findings

Table 3-72 and Table 3-73 show **Venture Behavioral Health**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2008–2009 PIP Validation Report for **Venture Behavioral Health**. Validation of Steps I through VI and Step VIII resulted in a validation status of *Met,* with an overall score of 92 percent and a score of 100 percent for critical elements. Based on the validation of this PIP, HSAG's assessment determined high confidence in the results.

Table 3-72—PIP Validation Scores *for* Venture Behavioral Health

		All Evaluation Elements (Including Critical Elements)					Critical Elements				
Review Step		Total	*M*	*PM*	*NM*	*NA*	Total	*M*	*PM*	*NM*	*NA*
I.	Review the Selected Study Topic(s)	6	5	0	0	1	1	1	0	0	0
II.	Review the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III.	Review the Selected Study Indicator(s)	7	4	0	0	3	3	3	0	0	0
IV.	Review the Identified Study Population	3	3	0	0	0	2	2	0	0	0
V.	Review Sampling Methods	6	0	0	0	6	1	0	0	0	1
VI.	Review Data Collection Procedures	11	6	0	0	5	1	0	0	0	1
VII.	Assess Improvement Strategies	4	Not Assessed				1	Not Assessed			
VIII.	Review Data Analysis and Study Results	9	2	1	1	5	2	1	0	0	1
IX.	Assess for Real Improvement	4	Not Assessed				No Critical Elements				
X.	Assess for Sustained Improvement	1	Not Assessed				No Critical Elements				
Totals for All Activities		**53**	**2**	**1**	**1**	**5**	**13**	**1**	**0**	**0**	**1**

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

Percentage Score of Evaluation Elements *Met*	**92%**
Percentage Score of Critical Elements *Met*	**100%**
Validation Status	***Met***

Strengths

Venture Behavioral Health demonstrated strength in its study design and study implementation with scores of *Met* for all applicable evaluation elements in Steps I through VI.

Recommendations

Venture Behavioral Health should include a discussion of factors that threaten the validity of the study. In future PIP submissions, the PIHP should also include a narrative description of the baseline and remeasurement rates and a comparison of the results to goals and other measurement periods.

For the steps related to the study topic, study indicators, data collection procedures, and data analysis and interpretation of study results, HSAG identified additional *Points of Clarification* to strengthen the study.

Summary Assessment Related to Quality, Timeliness, and Access

Venture Behavioral Health did not report implementing any interventions to improve services to children with a serious emotional disorder, a developmental disability, or both a serious emotional disorder and a developmental disability. As **Venture Behavioral Health** progresses in the study, the assessment of the impact of the PIP on the **quality** of care and services will continue.

4. Assessment of PIHP Follow-up on Prior Recommendations

Introduction

This section of the report presents an assessment of the PIHPs' follow-up on prior recommendations for two of the three EQR activities: compliance monitoring and validation of performance measures. In 2008–2009, the PIHPs implemented a new PIP on improving penetration rates for children. Therefore, follow-up on any recommendations related to the PIPs will be addressed in the next technical report.

The 2008–2009 compliance monitoring reviews evaluated the PIHPs' progress in implementing corrective actions identified in the 2007–2008 review of compliance standards in the areas of Subcontracts and Delegation, Provider Network, Credentialing, Access and Availability, Coordination of Care, and Appeals. The PIHP-specific parts of Section 3 contain a more detailed description of the PIHPs' performance in these areas.

The current-year validation of performance measures assessed the PIHPs' processes related to the reporting of performance indicator data and oversight of subcontractors' performance indicator reporting activities for the same set of indicators validated in 2007–2008. The PIHP-specific parts of Section 3 present a detailed description of 2008–2009 validation results.

Access Alliance of Michigan

Compliance Monitoring

Table 4-1 shows the number of opportunities for improvement for **Access Alliance of Michigan** from the 2007–2008 compliance monitoring review and the 2008–2009 assessment of the PIHP's follow-up on HSAG's recommendations.

Table 4-1—Follow-Up on Prior Recommendations *for* Access Alliance of Michigan

Standard		Recommendations		One or More Remaining Corrective Action(s)
		Identified In 2007–2008	Successfully Addressed 2008–2009	
IX	Subcontracts and Delegation			
X	Provider Network			
XI	Credentialing	1	1	
XII	Access and Availability	3	1	✓
XIII	Coordination of Care			
XIV	Appeals	1	1	

The 2007–2008 compliance monitoring review resulted in recommendations for improvement for the following standards: Credentialing, Access and Availability, and Appeals. The PIHP addressed recommendations through corrective action plans and implemented improvements. As determined in the 2008–2009 review, **Access Alliance of Michigan** successfully addressed the recommendations for the Credentialing and Appeals standards, as well as one recommendation for the Access and Availability standard, with two continuing recommendations related to accessibility of ongoing services.

Validation of Performance Measures

Table 4-2 shows the recommendations for improvement for **Access Alliance of Michigan** from the 2007–2008 validation of performance measures and the status of the PIHP's follow-up on these recommendations at the time of the 2008–2009 EQR.

Table 4-2—Follow-Up on Prior Recommendations *for* Access Alliance of Michigan	
2007–2008 Recommendation	**2008–2009 Status**
The **Access Alliance of Michigan** information technology staff should continue the implementation of the Clipper system to facilitate common practices in eligibility and demographic data collection and verification. As discussed during the on-site visit, the PIHP should consider an innovative, holistic approach to demonstrating the completeness of its encounter data. **Access Alliance of Michigan** needs to consider a formal, documented process for verifying the accuracy of claims data entry.	Information technology staff demonstrated a proactive approach to data systems through the ongoing move to a new system (Clipper). The reviewers continued to recommend that **Access Alliance of Michigan** move to a more formal process of evaluating and reporting claims/encounter volume for its affiliates and key providers. The reviewers continued to recommend that the PIHP develop a more formal process for claims data entry as well as data entry verification/audits.

CMH Affiliation of Mid-Michigan

Compliance Monitoring

Table 4-3 shows the results for **CMH Affiliation of Mid-Michigan** from the 2007–2008 compliance monitoring review and the 2008–2009 assessment of the PIHP's follow-up on HSAG's recommendations.

Table 4-3—Follow-Up on Prior Recommendations *for* CMH Affiliation of Mid-Michigan

Standard		Recommendations		One or More Remaining Corrective Action(s)
		Identified In 2007–2008	Successfully Addressed 2008–2009	
IX	Subcontracts and Delegation	1	1	
X	Provider Network	1	0	✓
XI	Credentialing			
XII	Access and Availability			
XIII	Coordination of Care			
XIV	Appeals	3	0	✓

The 2007–2008 compliance monitoring review resulted in recommendations for improvement for the following standards: Subcontracts and Delegation, Provider Network, and Appeals. The PIHP addressed recommendations through corrective action plans and implemented improvements. As determined in the 2008–2009 review, **CMH Affiliation of Mid-Michigan** successfully addressed the recommendations for the Subcontracts and Delegation standard. The PIHP received continued recommendations related to the provider network and the appeals process.

Validation of Performance Measures

Table 4-4 shows the recommendations for improvement for **CMH Affiliation of Mid-Michigan** from the 2007–2008 validation of performance measures and the status of the PIHP's follow-up on these recommendations at the time of the 2008–2009 EQR.

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

2007–2008 Recommendation	2008–2009 Status
The auditors suggested that **CMH Affiliation of Mid-Michigan** increase its performance indicator audit sample size from 4 cases per CMHSP to 8–10 cases to ensure enough data to draw valid conclusions from and improve processes based on those findings. Reviewers suggested that the PIHP explore adding reasons for exclusions—such as a drop-down box with choices to select—to its appointment entry system. Reviewers encouraged the PIHP to consider bringing all affiliates onto the same data system, which would help ensure uniformity in data capture throughout the PIHP.	**CMH Affiliation of Mid-Michigan** implemented the recommendation from auditors last year related to increasing the number of cases reviewed for its performance indicator audit from 4 cases to 8–10 cases per CMHSP. The PIHP captured exclusion data via alternative means, so a drop-down box was not necessary. The PIHP continued to focus on developing a clinical data system for all affiliates. At the time of the audit, **CMH Affiliation of Mid-Michigan** had not yet established a target date for bringing all affiliates onto the same system.

CMH for Central Michigan

Compliance Monitoring

Table 4-5 shows the results for **CMH for Central Michigan** from the 2007–2008 compliance monitoring review and the 2008–2009 assessment of the PIHP's follow-up on HSAG's recommendations.

Table 4-5—Follow-Up on Prior Recommendations *for* CMH for Central Michigan

Standard		Recommendations		One or More Remaining Corrective Action(s)
		Identified In 2007–2008	Successfully Addressed 2008–2009	
IX	Subcontracts and Delegation			
X	Provider Network			
XI	Credentialing			
XII	Access and Availability	1	1	
XIII	Coordination of Care			
XIV	Appeals	4	4	

The 2007–2008 compliance monitoring review resulted in recommendations for improvement for the following standards: Access and Availability and Appeals. The PIHP addressed recommendations through corrective action plans and implemented improvements. As determined in the 2008–2009 review, **CMH for Central Michigan** successfully addressed all prior recommendations.

Validation of Performance Measures

Table 4-6 shows the recommendations for improvement for **CMH for Central Michigan** from the 2007–2008 validation of performance measures and the status of the PIHP's follow-up on these recommendations at the time of the 2008–2009 EQR.

Table 4-6—Follow-Up on Prior Recommendations *for* CMH for Central Michigan

2007–2008 Recommendation	2008–2009 Status
CMH for Central Michigan should implement a validation process for entering preadmission screening data from the preadmission screening form and build an automated start/stop-time calculation for Indicator 1. Based on the completeness results for the QI indicators for minimum wage and developmental disability, **CMH for Central Michigan** needs to improve its data collection of these data elements. Reviewers recommended that the PIHP include these indicators in the e-mail alert system or other feedback mechanisms. **CMH for Central Michigan** should explore adding additional explanations for exclusions. One mechanism the PIHP could consider is building drop-down boxes into the data entry screen.	**CMH for Central Michigan** worked to improve on its response time to previously identified issues. The identified issue with Indicator 1 remained unresolved at the time of this year's site visit. However, the PIHP corrected this issue immediately after this year's visit. The PIHP has not taken steps to address minimum wage data completeness explicitly, and the PIHP is required to submit a corrective action plan addressing ways to address this issue. The PIHP worked to resolve the developmental disability designation and competitive employment issues and showed some improvement in data completeness. The auditors continued to recommend that the PIHP add all the QI indicators to the data verification report, associated e-mails, and clinician screens. At the time of the site visit, **CMH for Central Michigan** had not yet implemented a mechanism for capturing additional information on exclusions.

CMH Partnership of Southeastern Michigan

Compliance Monitoring

Table 4-7 shows the results for **CMH Partnership of Southeastern Michigan** from the 2007–2008 compliance monitoring review and the 2008–2009 assessment of the PIHP's follow-up on HSAG's recommendations.

Table 4-7—Follow-Up on Prior Recommendations *for* CMH Partnership of Southeastern Michigan

Standard		Recommendations		One or More Remaining Corrective Action(s)
		Identified In 2007–2008	Successfully Addressed 2008–2009	
IX	Subcontracts and Delegation			
X	Provider Network			
XI	Credentialing			
XII	Access and Availability			
XIII	Coordination of Care			
XIV	Appeals			

CMH Partnership of Southeastern Michigan achieved full compliance on all standards during the 2007–2008 compliance review.

Validation of Performance Measures

Table 4-8 shows the recommendations for improvement for **CMH Partnership of Southeastern Michigan** from the 2007–2008 validation of performance measures and the status of the PIHP's follow-up on these recommendations at the time of the 2008–2009 EQR.

Table 4-8—Follow-Up on Prior Recommendations *for* CMH Partnership of Southeastern Michigan	
2007–2008 Recommendation	**2008–2009 Status**
Reviewers recommended that **CMH Partnership of Southeastern Michigan** consider extending its audit process across each performance indicator to ensure that all indicators are evaluated in a uniform manner.	**CMH Partnership of Southeastern Michigan** used data integrity checks, which take into account performance indicator data as well as quality improvement data. These processes helped establish uniformity in reviewing data.
Reviewers encouraged the PIHP to monitor internally for the minimum wage flag until its clinical dashboard is developed and brought online.	Data integrity checks went live in September, giving the system user the ability to see missing elements, including minimum wage data. This should address the concern about low rates of completeness for these data.
Reviewers suggested that **CMH Partnership of Southeastern Michigan** implement drop-down boxes to capture reasons for exceptions, which would make them easier to track and quantify.	**CMH Partnership of Southeastern Michigan** is exploring implementation of a Peter Chang Enterprises (PCE) module for appointments, which would help streamline data capture and eliminate the need to integrate a drop-down box for exceptions.

Detroit-Wayne County CMH Agency

Compliance Monitoring

Table 4-9 shows the results for **Detroit-Wayne County CMH Agency** from the 2007–2008 compliance monitoring review and the 2008–2009 assessment of the PIHP's follow-up on HSAG's recommendations.

Table 4-9—Follow-Up on Prior Recommendations *for* Detroit-Wayne County CMH Agency

Standard		Recommendations		One or More Remaining Corrective Action(s)
		Identified In 2007–2008	Successfully Addressed 2008–2009	
IX	Subcontracts and Delegation	1	1	
X	Provider Network			
XI	Credentialing	3	3	
XII	Access and Availability	10	1	✓
XIII	Coordination of Care			
XIV	Appeals	5	3	✓

The 2007–2008 compliance monitoring review resulted in recommendations for improvement for the following standards: Subcontracts and Delegation, Credentialing, Access and Availability, and Appeals. The PIHP addressed recommendations through corrective action plans and implemented improvements. As determined in the 2008–2009 review, **Detroit-Wayne County CMH Agency** successfully addressed all recommendations for the Subcontracts and Delegation and Credentialing standards. The PIHP also addressed three of the five recommendations for appeals, with continuing recommendations related to requirements for appeal decision making and the notice of disposition. For the Access and Availability standard, the PIHP addressed the recommendation related to timely face-to-face assessments for beneficiaries with a substance use disorder, but received continuing recommendations for the other access standards.

Validation of Performance Measures

Table 4-10 shows the recommendations for improvement for **Detroit-Wayne County CMH Agency** from the 2007–2008 validation of performance measures and the status of the PIHP's follow-up on these recommendations at the time of the 2008–2009 EQR.

Table 4-10—Follow-Up on Prior Recommendations *for* Detroit-Wayne County CMH Agency

2007–2008 Recommendation	2008–2009 Status
Detroit-Wayne County CMH Agency needs to continue its efforts to improve the completeness of the QI data elements—specifically, minimum wage and employment. The PIHP should explore the possibly of the Managers of Comprehensive Provider Networks (MCPNs) submitting a QI file to the PIHP rather than continuing the current process of the PIHP creating a QI file from various data sources. **Detroit-Wayne County CMH Agency** should consider having the MCPNs research whether the QI data elements could have been entered into data systems other than the e-form file submitted to the PIHP. Reviewers also recommend that **Detroit-Wayne County CMH Agency** continue to work on the transition to the PCE system, making sure to document all systems change procedures to ensure a seamless transition with minimal loss of data.	**Detroit-Wayne County CMH Agency** had begun aggressive efforts to improve QI data completeness because of poor completeness levels in the past. The PIHP continued to create the QI file from tables and e-forms. However, The PIHP increased oversight and monitoring of this activity. There was a delay in the contracting process for implementation of the PCE system. At the time of the site visit, system transition had not yet begun. The PIHP expects to complete the transition process over a 15-month period.

Genesee County CMH

Compliance Monitoring

Table 4-11 shows the results for **Genesee County CMH** from the 2007–2008 compliance monitoring review and the 2008–2009 assessment of the PIHP's follow-up on HSAG's recommendations.

Table 4-11—Follow-Up on Prior Recommendations *for* Genesee County CMH				
Standard		Recommendations		One or More Remaining Corrective Action(s)
		Identified In 2007–2008	Successfully Addressed 2008–2009	
IX	Subcontracts and Delegation			
X	Provider Network			
XI	Credentialing			
XII	Access and Availability			
XIII	Coordination of Care			
XIV	Appeals			

Genesee County CMH achieved full compliance on all standards during the 2007–2008 compliance review.

Validation of Performance Measures

Table 4-12 shows the recommendations for improvement for **Genesee County CMH** from the 2007–2008 validation of performance measures and the status of the PIHP's follow-up on these recommendations at the time of the 2008–2009 EQR.

Table 4-12—Follow-Up on Prior Recommendations *for* Genesee County CMH

2007–2008 Recommendation	2008–2009 Status
Genesee County CMH staff should continue to work with the provider network to increase the number of providers submitting claims electronically through the online provider service center (OPSC).	**Genesee County CMH** continued to increase the use of the OPSC for external providers.

Lakeshore Behavioral Health Alliance

Compliance Monitoring

Table 4-13 shows the results for **Lakeshore Behavioral Health Alliance** from the 2007–2008 compliance monitoring review and the 2008–2009 assessment of the PIHP's follow-up on HSAG's recommendations.

Table 4-13— Follow-Up on Prior Recommendations *for* Lakeshore Behavioral Health Alliance

Standard		Recommendations		One or More Remaining Corrective Action(s)
		Identified In 2007–2008	Successfully Addressed 2008–2009	
IX	Subcontracts and Delegation			
X	Provider Network			
XI	Credentialing			
XII	Access and Availability			
XIII	Coordination of Care			
XIV	Appeals	1	1	

The 2007–2008 compliance monitoring review resulted in a recommendation for improvement for the Appeals standard. As determined in the 2008–2009 review, **Lakeshore Behavioral Health Alliance** successfully addressed the prior recommendation related to the notice of disposition for appeals.

Validation of Performance Measures

Table 4-14 shows the recommendations for improvement for **Lakeshore Behavioral Health Alliance** from the 2007–2008 validation of performance measures and the status of the PIHP's follow-up on these recommendations at the time of the 2008–2009 EQR.

Table 4-14—Follow-Up on Prior Recommendations *for* Lakeshore Behavioral Health Alliance

2007–2008 Recommendation	2008–2009 Status
The PIHP and Community Mental Health Services (CMHS) of Muskegon County should continue to work toward successful encounter data extraction from Avatar to have a reportable rate. The HSAG reviewers recommended that **Lakeshore Behavioral Health Alliance** implement validation of data entry for all manual processes. **Lakeshore Behavioral Health Alliance** should continue to work with its vendor (Avatar) toward further automation of performance indicator reporting to reduce multiple manual checks.	**Lakeshore Behavioral Health Alliance** acted upon a key recommendation from last year. Muskegon CMHS successfully generated encounter data extraction from Avatar, which allowed the PIHP to have a reportable penetration rate. The PIHP continued to work toward development of validation processes for data entry. Information management meetings focused on data accuracy and completeness. Updating and monitoring accuracy was more of a challenge, especially due to staffing issues. **Lakeshore Behavioral Health Alliance** continued to work with its vendor to further automate the performance indicator reporting process.

LifeWays

Compliance Monitoring

Table 4-15 shows the results for **LifeWays** from the 2007–2008 compliance monitoring review and the 2008–2009 assessment of the PIHP's follow-up on HSAG's recommendations.

Table 4-15—Follow-Up on Prior Recommendations *for* LifeWays

Standard		Recommendations		One or More Remaining Corrective Action(s)
		Identified In 2007–2008	Successfully Addressed 2008–2009	
IX	Subcontracts and Delegation			
X	Provider Network	1	1	
XI	Credentialing	1	1	
XII	Access and Availability			
XIII	Coordination of Care			
XIV	Appeals	4	4	

The 2007–2008 compliance monitoring review resulted in recommendations for improvement for the following standards: Provider Network, Credentialing, and Appeals. The PIHP addressed recommendations through corrective action plans and implemented improvements. As determined in the 2008–2009 review, **LifeWays** successfully addressed all prior recommendations.

Validation of Performance Measures

Table 4-16 shows the recommendations for improvement for **LifeWays** from the 2007–2008 validation of performance measures and the status of the PIHP's follow-up on these recommendations at the time of the 2008–2009 EQR.

Table 4-16—Follow-Up on Prior Recommendations *for* LifeWays

2007–2008 Recommendation	2008–2009 Status
LifeWays should continue to work with providers to ensure that they enter all QI data fields as required for submission to MDCH.	**LifeWays** was in the process of revising QI data logic and looking for ways to improve the QI data collection and reporting process.
For the first performance indicator, the PIHP should ensure that the start time for members who present for services that do not require clinical clearance is the time that the member requests the service.	**LifeWays** implemented HSAG's recommendation to improve capturing of the start time. The PIHP added fields to capture the time of the request as well as the start time of the service.

Macomb County CMH Services

Compliance Monitoring

Table 4-17 shows the results for **Macomb County CMH Services** from the 2007–2008 compliance monitoring review and the 2008–2009 assessment of the PIHP's follow-up on HSAG's recommendations.

Table 4-17—Follow-Up on Prior Recommendations *for* Macomb County CMH Services				
Standard		Recommendations		One or More Remaining Corrective Action(s)
		Identified In 2007–2008	Successfully Addressed 2008–2009	
IX	Subcontracts and Delegation			
X	Provider Network			
XI	Credentialing			
XII	Access and Availability	4	2	✓
XIII	Coordination of Care			
XIV	Appeals	5	5	

The 2007–2008 compliance monitoring review resulted in recommendations for improvement for the following standards: Access and Availability and Appeals. The PIHP addressed recommendations through corrective action plans and implemented improvements. As determined in the 2008–2009 review, **Macomb County CMH Services** successfully addressed all recommendations for the Appeals standard. The PIHP also addressed the Access and Availability recommendations regarding timely follow-up care after discharge from a psychiatric inpatient unit, with two continuing recommendations related to accessibility of ongoing services.

Validation of Performance Measures

Table 4-18 shows the recommendations for improvement for **Macomb County CMH Services** from the 2007–2008 validation of performance measures and the status of the PIHP's follow-up on these recommendations at the time of the 2008–2009 EQR.

Table 4-18—Follow-Up on Prior Recommendations *for* Macomb County CMH Services	
2007–2008 Recommendation	**2008–2009 Status**
Macomb County CMH Services should continue its QI strategy targeted at increasing performance measure rates.	**Macomb County CMH Services** demonstrated a proactive approach to the completeness of QI and performance indicator data and required a corrective action plan from providers not meeting standards.
The PIHP should continue its efforts to automate the recipient rights measure.	The PIHP continued its efforts to automate the recipient rights measure.

network180

Compliance Monitoring

Table 4-19 shows the results for **network180** from the 2007–2008 compliance monitoring review and the 2008–2009 assessment of the PIHP's follow-up on HSAG's recommendations.

Table 4-19—Follow-Up on Prior Recommendations *for* network180				
Standard		Recommendations		One or More Remaining Corrective Action(s)
		Identified In 2007–2008	Successfully Addressed 2008–2009	
IX	Subcontracts and Delegation	1	1	
X	Provider Network			
XI	Credentialing	7	5	✓
XII	Access and Availability	3	1	✓
XIII	Coordination of Care			
XIV	Appeals	4	4	

The 2007–2008 compliance monitoring review resulted in recommendations for improvement for the following standards: Subcontracts and Delegation, Credentialing, Access and Availability, and Appeals. The PIHP addressed recommendations through corrective action plans and implemented improvements. As determined in the 2008–2009 review, **network180** successfully addressed all recommendations for the Subcontracts and Delegation and Appeals standards, as well as several of the recommendations for the Credentialing and Access and Availability standards. The PIHP received two continuing recommendations related to the credentialing policy and two continuing recommendations related to timely access to ongoing services and follow-up care after discharge from a detox unit.

Validation of Performance Measures

Table 4-20 shows the recommendations for improvement for **network180** from the 2007–2008 validation of performance measures and the status of the PIHP's follow-up on these recommendations at the time of the 2008–2009 EQR.

Table 4-20—Follow-Up on Prior Recommendations *for* network180	
2007–2008 Recommendation	**2008–2009 Status**
network180 should implement a process to validate data entry for data taken from the paper form and entered into the recipient rights database to ensure accuracy. The PIHP should continue working with provider groups that have ongoing issues with timeliness of encounter data submission and should explore alternative methods to encourage these providers to submit encounter data in a timely fashion. **network180** should continue to work toward its goal of a fee-for-service structure to ensure complete encounter data submission.	**network180** acted on all recommendations made in the previous year, proactively identifying ways to improve data quality and accuracy as well as increasing efficiencies across the continuum of care. The PIHP fully automated the recipient rights reporting function and provided oversight to ensure completeness as well as accuracy. The PIHP had improved the timeliness of encounter data submissions and, for one of its groups, met face-to-face once per month to ensure that no communication breakdowns would occur. **network180** continued efforts to increase fee-for-service payment arrangements for different programs.

NorthCare

Compliance Monitoring

Table 4-21 shows the results for **NorthCare** from the 2007–2008 compliance monitoring review and the 2008–2009 assessment of the PIHP's follow-up on HSAG's recommendations.

Table 4-21—Follow-Up on Prior Recommendations *for* NorthCare

Standard		Recommendations		One or More Remaining Corrective Action(s)
		Identified In 2007–2008	Successfully Addressed 2008–2009	
IX	Subcontracts and Delegation			
X	Provider Network			
XI	Credentialing			
XII	Access and Availability	1	0	✓
XIII	Coordination of Care			
XIV	Appeals			

The 2007–2008 compliance monitoring review resulted in a recommendation for improvement for the Access and Availability standard. As determined in the 2008–2009 review, **NorthCare**'s rate for timely access to ongoing services for developmentally disabled children continued to fall below the MDCH benchmark, resulting in a continuing recommendation.

Validation of Performance Measures

Table 4-22 shows the recommendations for improvement for **NorthCare** from the 2007–2008 validation of performance measures and the status of the PIHP's follow-up on these recommendations at the time of the 2008–2009 EQR.

Table 4-22—Follow-Up on Prior Recommendations *for* NorthCare	
2007–2008 Recommendation	**2008–2009 Status**
Reviewers recommended that **NorthCare** implement audits at the CMHC level for all manual data entry of encounter data. Reviewers recommended discontinuing the practice of one of the CMHC's claims processors that had a protocol for adding a V-code to a claim if no diagnosis was submitted. **NorthCare** should also revise its performance indicator methodology document to include language specific to excluding individuals covered under the Omnibus Budget Reconciliation Act (OBRA) for Indicators 2 and 3.	**NorthCare** conducted audits at each CMHC board, which included an assessment of data entry. The boards conducted quarterly service verification audits. The CMHC discontinued the protocol for adding the V-code. **NorthCare** revised its performance indicator methodology document, which is located in the PCE System's documentation.

Northern Affiliation

Compliance Monitoring

Table 4-23 shows the results for **Northern Affiliation** from the 2007–2008 compliance monitoring review and the 2008–2009 assessment of the PIHP's follow-up on HSAG's recommendations.

Table 4-23—Follow-Up on Prior Recommendations *for* Northern Affiliation				
Standard		Recommendations		One or More Remaining Corrective Action(s)
		Identified In 2007–2008	Successfully Addressed 2008–2009	
IX	Subcontracts and Delegation			
X	Provider Network			
XI	Credentialing			
XII	Access and Availability	2	2	
XIII	Coordination of Care			
XIV	Appeals	1	0	✓

The 2007–2008 compliance monitoring review resulted in recommendations for improvement for the following standards: Access and Availability and Appeals. The PIHP addressed recommendations through corrective action plans and implemented improvements. As determined in the 2008–2009 review, **Northern Affiliation** successfully addressed the recommendations for the Access and Availability standard but received a continuing recommendation related to the appeals process.

Validation of Performance Measures

Table 4-24 shows the recommendations for improvement for **Northern Affiliation** from the 2007–2008 validation of performance measures and the status of the PIHP's follow-up on these recommendations at the time of the 2008–2009 EQR.

Table 4-24—Follow-Up on Prior Recommendations *for* Northern Affiliation	
2007–2008 Recommendation	**2008–2009 Status**
Northern Affiliation PI staff should consider adding a table with the top reasons for audit errors identified in the PIHP's internal audit report. The PIHP staff should continue moving eligibility analysis to an automated, PIHP-level process in Avatar. **Northern Affiliation** should consider modifying the dashboard reports to contain trend and/or goal information.	**Northern Affiliation** acted on opportunities for improvement identified in previous years, including implementation of a detailed data analysis report, which includes the frequency of errors/reasons. An automated mechanism for checking eligibility will be available to the PIHP in 2009 through an alternative mechanism (not Avatar). The PIHP created reports over 12 months for different populations—for example, inpatient days per 1,000 member months. These reports assisted the PIHP in focusing its reporting as well as developing quality initiatives.

Northwest CMH Affiliation

Compliance Monitoring

Table 4-25 shows the results for **Northwest CMH Affiliation** from the 2007–2008 compliance monitoring review and the 2008–2009 assessment of the PIHP's follow-up on HSAG's recommendations.

Table 4-25—Follow-Up on Prior Recommendations *for* Northwest CMH Affiliation				
Standard		Recommendations		One or More Remaining Corrective Action(s)
		Identified In 2007–2008	Successfully Addressed 2008–2009	
IX	Subcontracts and Delegation			
X	Provider Network			
XI	Credentialing	1	1	
XII	Access and Availability	3	2	✓
XIII	Coordination of Care			
XIV	Appeals			

The 2007–2008 compliance monitoring review resulted in recommendations for improvement for the following standards: Credentialing and Access and Availability. The PIHP addressed recommendations through corrective action plans and implemented improvements. As determined in the 2008–2009 review, **Northwest CMH Affiliation** successfully addressed the recommendation for the Credentialing standard as well as two recommendations for the Access and Availability standard, with one continuing recommendation related to timely follow-up care after discharge from a psychiatric unit.

Validation of Performance Measures

Table 4-26 shows the recommendations for improvement for **Northwest CMH Affiliation** from the 2007–2008 validation of performance measures and the status of the PIHP's follow-up on these recommendations at the time of the 2008–2009 EQR.

Table 4-26—Follow-Up on Prior Recommendations *for* Northwest CMH Affiliation	
2007–2008 Recommendation	**2008–2009 Status**
As resources allow, **Northwest CMH Affiliation** should continue the development of systematic edits for services based on practitioner type. **Northwest CMH Affiliation** has a file-naming convention for version control for the data assumptions document. The PIHP should consider a version control mechanism that is readily visible on the data assumptions document so that readers can easily identify the version they are using. In addition, the PIHP should continue the automation of performance measure calculations by each of the CMHCs. **Northwest CMH Affiliation** should formalize the existing performance measure outlier analysis and quality improvement data completeness processes to be consistent between the CMHCs and the CA.	**Northwest CMH Affiliation** followed up on the recommendations of previous years, including development of systematic edits for service codes based on provider type. The PIHP created a form of version control for the data assumptions document. **Northwest CMH Affiliation** increased the automation of data collection and calculation. The QI committee provided strong oversight of CMHC performance indicator data, which included outlier analysis. The Electronic Data Interchange (EDI) generation handbook also facilitated consistent methods for data reporting to MDCH.

Oakland County CMH Authority

Compliance Monitoring

Table 4-27 shows the results for **Oakland County CMH Authority** from the 2007–2008 compliance monitoring review and the 2008–2009 assessment of the PIHP's follow-up on HSAG's recommendations.

Table 4-27—Follow-Up on Prior Recommendations *for* Oakland County CMH Authority

Standard		Recommendations		One or More Remaining Corrective Action(s)
		Identified In 2007–2008	Successfully Addressed 2008–2009	
IX	Subcontracts and Delegation			
X	Provider Network			
XI	Credentialing			
XII	Access and Availability			
XIII	Coordination of Care			
XIV	Appeals	2	2	

The 2007–2008 compliance monitoring review resulted in recommendations for improvement for the Appeals standard. As determined in the 2008–2009 review, **Oakland County CMH Authority** successfully addressed both prior recommendations.

Validation of Performance Measures

Table 4-28 shows the recommendations for improvement for **Oakland County CMH Authority** from the 2007–2008 validation of performance measures and the status of the PIHP's follow-up on these recommendations at the time of the 2008–2009 EQR.

Table 4-28—Follow-Up on Prior Recommendations *for* Oakland County CMH Authority	
2007–2008 Recommendation	**2008–2009 Status**
Oakland County CMH Authority should continue to centralize its systems to ensure accurate and complete service data. The PIHP should continue to automate the calculation process for the performance indicators. **Oakland County CMH Authority** should continue to integrate benchmarking information into its analytical reporting activities.	**Oakland County CMH Authority** continued the centralization project, including completion of the electronic medical record project and use of a single system for all providers and the PIHP. The PIHP continued its efforts to automate the calculation process for the performance indicators when the data are available. **Oakland County CMH Authority** continued to integrate benchmarking information into its data analysis activities.

Saginaw County CMH Authority

Compliance Monitoring

Table 4-29 shows the results for **Saginaw County CMH Authority** from the 2007–2008 compliance monitoring review and the 2008–2009 assessment of the PIHP's follow-up on HSAG's recommendations.

Table 4-29—Follow-Up on Prior Recommendations *for* Saginaw County CMH Authority				
Standard		Recommendations		One or More Remaining Corrective Action(s)
		Identified In 2007–2008	Successfully Addressed 2008–2009	
IX	Subcontracts and Delegation			
X	Provider Network			
XI	Credentialing	1	1	
XII	Access and Availability	8	3	✓
XIII	Coordination of Care			
XIV	Appeals	1	1	

The 2007–2008 compliance monitoring review resulted in recommendations for improvement for the following standards: Credentialing, Access and Availability, and Appeals. The PIHP addressed recommendations through corrective action plans and implemented improvements. As determined in the 2008–2009 review, **Saginaw County CMH Authority** successfully addressed the recommendations for the Credentialing and Appeals standards as well as three recommendations for the Access and Availability standard. The PIHP received continuing recommendations related to timely access to ongoing services and follow-up care after discharge from a psychiatric or detox unit.

Validation of Performance Measures

Table 4-30 shows the recommendations for improvement for **Saginaw County CMH Authority** from the 2007–2008 validation of performance measures and the status of the PIHP's follow-up on these recommendations at the time of the 2008–2009 EQR.

Table 4-30—Follow-Up on Prior Recommendations *for* Saginaw County CMH Authority	
2007–2008 Recommendation	**2008–2009 Status**
Saginaw County CMH Authority staff should continue the rigorous verification of performance measure data. The performance measure reporting staff should continue increasing the automation of the measure calculation process. The PIHP staff should continue to work with the CA on the integration of substance abuse data into the Encompass system and data warehouse.	**Saginaw County CMH Authority** continued its rigorous data verification activities. The PIHP continued to work toward further automation of performance indicator reporting processes. **Saginaw County CMH Authority** has fully integrated the substance abuse data into the Encompass system.

Southwest Affiliation

Compliance Monitoring

Table 4-31 shows the results for **Southwest Affiliation** from the 2007–2008 compliance monitoring review and the 2008–2009 assessment of the PIHP's follow-up on HSAG's recommendations.

Table 4-31—Follow-Up on Prior Recommendations *for* Southwest Affiliation

Standard		Recommendations		One or More Remaining Corrective Action(s)
		Identified In 2007–2008	Successfully Addressed 2008–2009	
IX	Subcontracts and Delegation	1	1	
X	Provider Network			
XI	Credentialing	4	4	
XII	Access and Availability	2	2	
XIII	Coordination of Care			
XIV	Appeals			

The 2007–2008 compliance monitoring review resulted in recommendations for improvement for the following standards: Subcontracts and Delegation, Credentialing, and Access and Availability. The PIHP addressed recommendations through corrective action plans and implemented improvements. As determined in the 2008–2009 review, **Southwest Affiliation** successfully addressed all prior recommendations.

Validation of Performance Measures

Table 4-32 shows the recommendations for improvement for **Southwest Affiliation** from the 2007–2008 validation of performance measures and the status of the PIHP's follow-up on these recommendations at the time of the 2008–2009 EQR.

Table 4-32—Follow-Up on Prior Recommendations *for* Southwest Affiliation	
2007–2008 Recommendation	**2008–2009 Status**
Southwest Affiliation should continue to work on the transition of the PIHP's present claims/ encounter data processing system to the Avatar system, with an expected completion in October 2008. The PIHP should document the steps in the transition to the Avatar system and any issues encountered during this process. **Southwest Affiliation** may consider conducting audits on the processes for generating the performance indicators (similar to the encounter data validation audits). The results from this type of audit would add further validity to the reported performance indicator rates.	The full transition to Avatar had not yet taken place at the time of the site visit. Reviewers again advised **Southwest Affiliation** to document the transition to Avatar thoroughly, as the full transition had not yet occurred. As recommended last year, the PIHP was again encouraged to consider conducting performance indicator audits to assess the accuracy of the reported rates.

Thumb Alliance PIHP

Compliance Monitoring

Table 4-33 shows the results for **Thumb Alliance PIHP** from the 2007–2008 compliance monitoring review and the 2008–2009 assessment of the PIHP's follow-up on HSAG's recommendations.

Table 4-33—Follow-Up on Prior Recommendations *for* Thumb Alliance PIHP

Standard		Recommendations		One or More Remaining Corrective Action(s)
		Identified In 2007–2008	Successfully Addressed 2008–2009	
IX	Subcontracts and Delegation			
X	Provider Network			
XI	Credentialing			
XII	Access and Availability			
XIII	Coordination of Care			
XIV	Appeals			

Thumb Alliance PIHP achieved full compliance on all standards during the 2007–2008 compliance review.

Validation of Performance Measures

Table 4-34 shows the recommendations for improvement for **Thumb Alliance PIHP** from the 2007–2008 validation of performance measures and the status of the PIHP's follow-up on these recommendations at the time of the 2008–2009 EQR.

Table 4-34—Follow-Up on Prior Recommendations *for* Thumb Alliance PIHP

2007–2008 Recommendation	2008–2009 Status
Thumb Alliance PIHP should continue the integration of its data by moving the CA data into the Optimal Alliance Software Information System (OASIS). The PIHP should also continue to increase the percentage of providers, including hospitals, that are directly entering services into OASIS.	The PIHP completed the integration of CA data into the OASIS system. **Thumb Alliance PIHP** continued its efforts to increase the number of providers entering data directly into OASIS.

Venture Behavioral Health

Compliance Monitoring

Table 4-35 shows the results for **Venture Behavioral Health** from the 2007–2008 compliance monitoring review and the 2008–2009 assessment of the PIHP's follow-up on HSAG's recommendations.

Table 4-35—Follow-Up on Prior Recommendations *for* Venture Behavioral Health

Standard		Recommendations		One or More Remaining Corrective Action(s)
		Identified In 2007–2008	Successfully Addressed 2008–2009	
IX	Subcontracts and Delegation			
X	Provider Network			
XI	Credentialing			
XII	Access and Availability	2	2	
XIII	Coordination of Care			
XIV	Appeals			

The 2007–2008 compliance monitoring review resulted in recommendations for improvement for the Access and Availability standard. As determined in the 2008–2009 review, **Venture Behavioral Health** successfully addressed both prior recommendations.

Validation of Performance Measures

Table 4-36 shows the recommendations for improvement for **Venture Behavioral Health** from the 2007–2008 validation of performance measures and the status of the PIHP's follow-up on these recommendations at the time of the 2008–2009 EQR.

Table 4-36—Follow-Up on Prior Recommendations *for* Venture Behavioral Health

2007–2008 Recommendation	2008–2009 Status
HSAG recommended that **Venture Behavioral Health** implement front-end edits to ensure entry of required QI data elements and improve the completeness of these data.	**Venture Behavioral Health** did not incorporate front-end edits because the PIHP needed the ability to create records in an emergency, and the edits in the program may circumvent that activity.
HSAG suggested that the PIHP consider combining the Missing QI Data Indicators and dashboard reports to ensure that providers have regular access to the information.	The PIHP established a data integrity work group that focuses on QI data completeness. Missing data were tracked back to the CMHCs for completion and review. **Venture Behavioral Health** acknowledged that improving QI data completeness remains a challenge.
Venture Behavioral Health should continue to work with the CMHCs on efforts to decrease the lag time for entering paper claims. The timeliness of receiving data from the CA continued to be a concern of the PIHP.	The PIHP remains challenged with the lag time for receipt and entry of paper claims, and was again encouraged to work with the CMHCs to resolve the issue.
Venture Behavioral Health should continue its efforts to work with the CA to find a way to receive the substance abuse data on a more regular and real-time basis so that these data can be reviewed and outliers can be identified and corrected, if possible.	**Venture Behavioral Health** brought data processing in-house as of October 1, 2008. This has helped to eliminate concerns with the timeliness of substance abuse data.

Appendix A. Summary Tables of External Quality Review Activity Results

Introduction

This section of the report presents results for the prior and current years for all 14 compliance monitoring standards reviewed this year, as well as two-year comparison tables for statewide and PIHP scores for the validation of performance measures and the validation of PIPs.

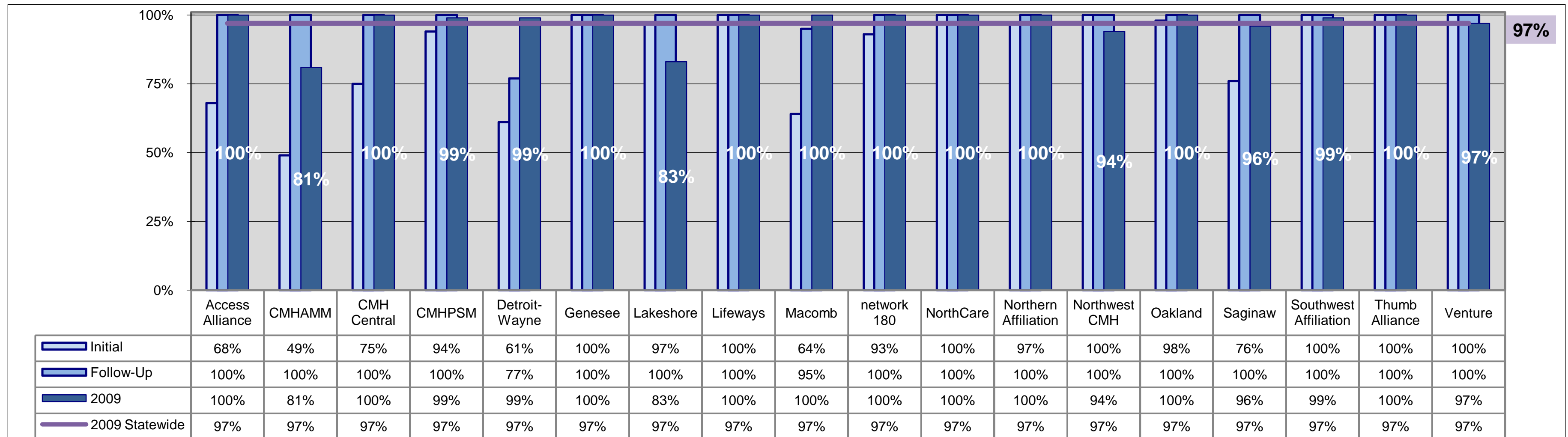
Results for Compliance Monitoring

The following tables and graphs present the results from the 2008–2009 compliance monitoring reviews compared to the previous initial and follow-up reviews to provide an overview of the PIHP and statewide performance trends on all 14 compliance monitoring standards.

Compliance Monitoring Standards

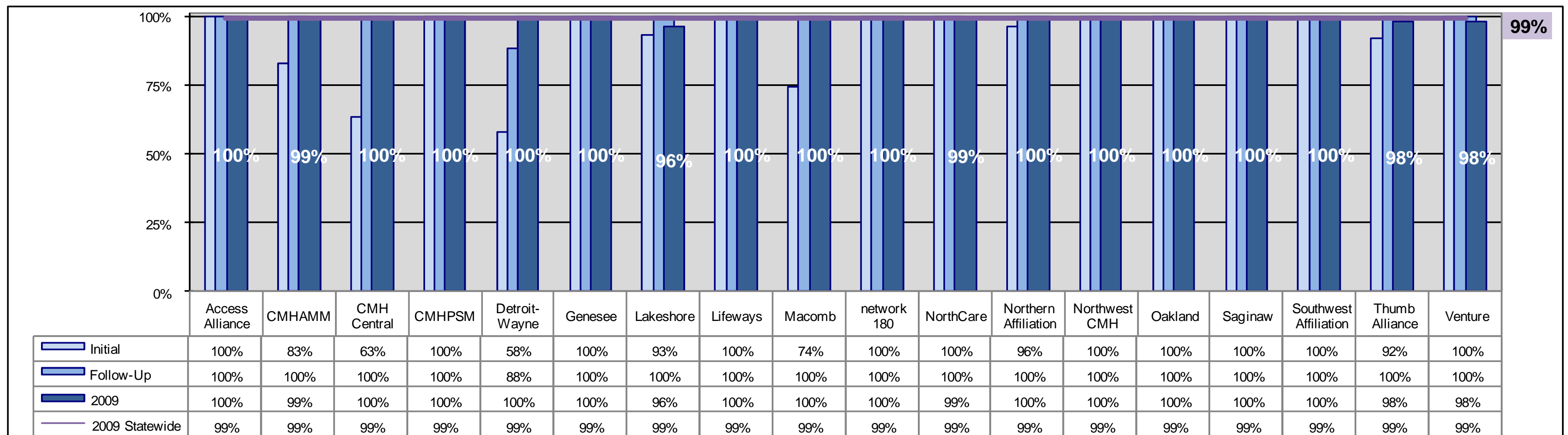
Figure A-1 through Figure A-14 present compliance scores for each of the 18 PIHPs for the initial, follow-up, and current-year reviews, as well as the 2009 statewide score for each of the 14 compliance monitoring standards. For Standards I through VIII, the initial, full review of all elements in each standard occurred in 2004–2005. The follow-up review, which assessed PIHP compliance for only those elements that received a score of less than Met in the initial review, was conducted in 2005–2006. For Standards IX through XIV, the initial review occurred in 2006–2007, and the follow-up review was conducted in 2007–2008. The Customer Services standard was completely revised for the 2008–2009 review to reflect current contract requirements in this area. Therefore, compliance scores on the Customer Services standard for the three review periods are not fully comparable.

Figure A-1—Standard I: QAPIP



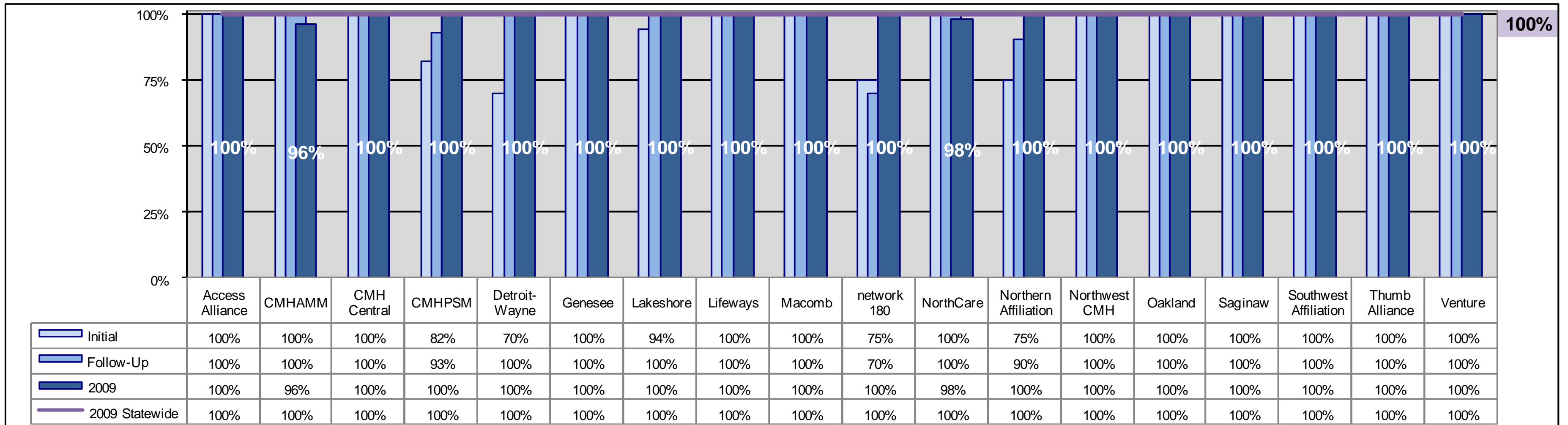
	Access Alliance	CMHAMM	CMH Central	CMHPSM	Detroit-Wayne	Genesee	Lakeshore	Lifeways	Macomb	network 180	NorthCare	Northern Affiliation	Northwest CMH	Oakland	Saginaw	Southwest Affiliation	Thumb Alliance	Venture
Initial	68%	49%	75%	94%	61%	100%	97%	100%	64%	93%	100%	97%	100%	98%	76%	100%	100%	100%
Follow-Up	100%	100%	100%	100%	77%	100%	100%	100%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%
2009	100%	81%	100%	99%	99%	100%	83%	100%	100%	100%	100%	100%	94%	100%	96%	99%	100%	97%
2009 Statewide	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%

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



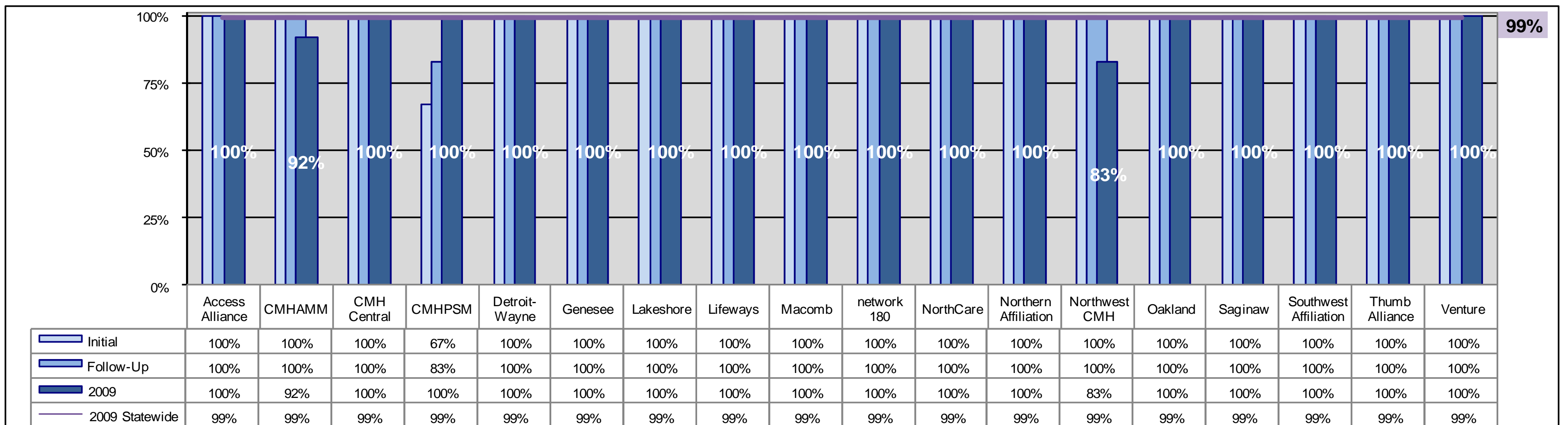
	Access Alliance	CMHAMM	CMH Central	CMHPSM	Detroit-Wayne	Genesee	Lakeshore	Lifeways	Macomb	network 180	NorthCare	Northern Affiliation	Northwest CMH	Oakland	Saginaw	Southwest Affiliation	Thumb Alliance	Venture
Initial	100%	83%	63%	100%	58%	100%	93%	100%	74%	100%	100%	96%	100%	100%	100%	100%	92%	100%
Follow-Up	100%	100%	100%	100%	88%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
2009	100%	99%	100%	100%	100%	100%	96%	100%	100%	100%	99%	100%	100%	100%	100%	100%	98%	98%
2009 Statewide	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%

Figure A-3—Standard III: Practice Guidelines



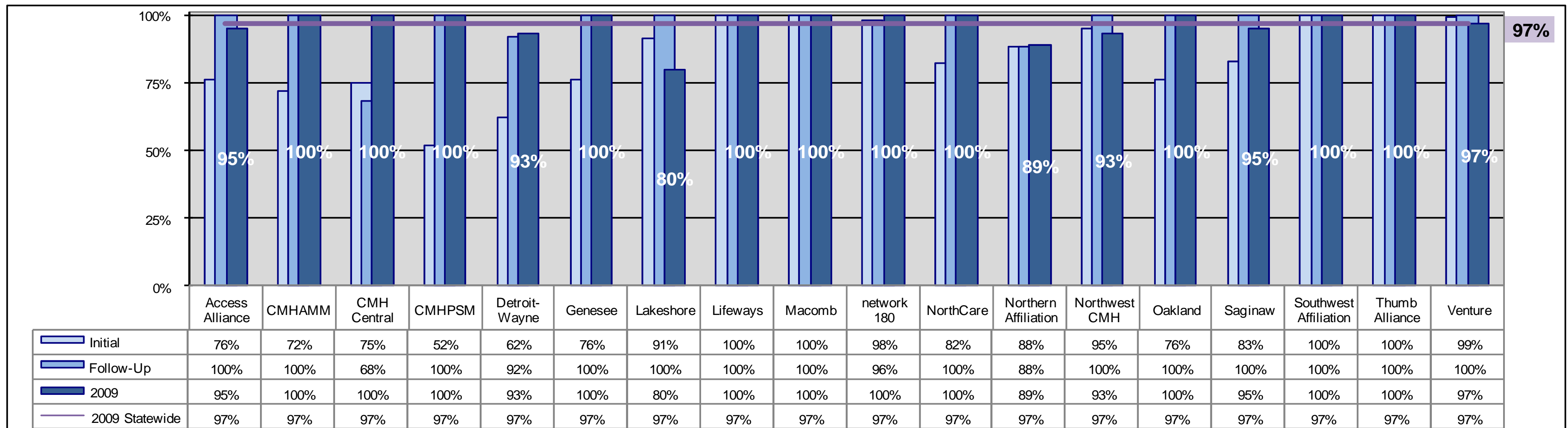
	Access Alliance	CMHAMM	CMH Central	CMHPSM	Detroit-Wayne	Genesee	Lakeshore	Lifeways	Macomb	network 180	NorthCare	Northern Affiliation	Northwest CMH	Oakland	Saginaw	Southwest Affiliation	Thumb Alliance	Venture
Initial	100%	100%	100%	82%	70%	100%	94%	100%	100%	75%	100%	75%	100%	100%	100%	100%	100%	100%
Follow-Up	100%	100%	100%	93%	100%	100%	100%	100%	100%	70%	100%	90%	100%	100%	100%	100%	100%	100%
2009	100%	96%	100%	100%	100%	100%	100%	100%	100%	100%	98%	100%	100%	100%	100%	100%	100%	100%
2009 Statewide	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

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



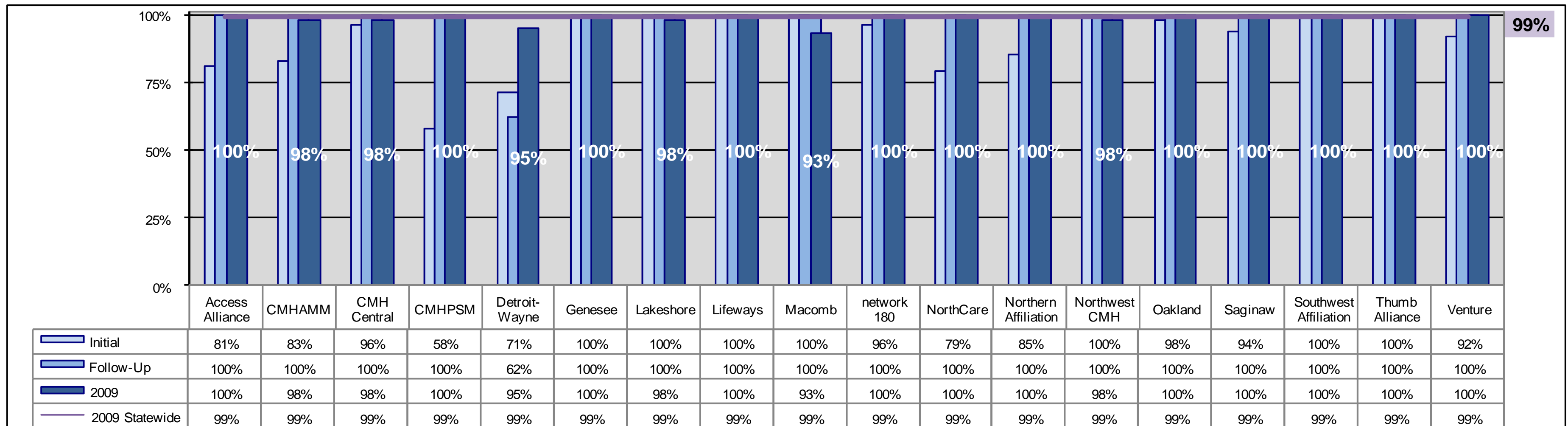
	Access Alliance	CMHAMM	CMH Central	CMHPSM	Detroit-Wayne	Genesee	Lakeshore	Lifeways	Macomb	network 180	NorthCare	Northern Affiliation	Northwest CMH	Oakland	Saginaw	Southwest Affiliation	Thumb Alliance	Venture
Initial	100%	100%	100%	67%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Follow-Up	100%	100%	100%	83%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
2009	100%	92%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	83%	100%	100%	100%	100%	100%
2009 Statewide	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%

Figure A-5—Standard V: Utilization Management



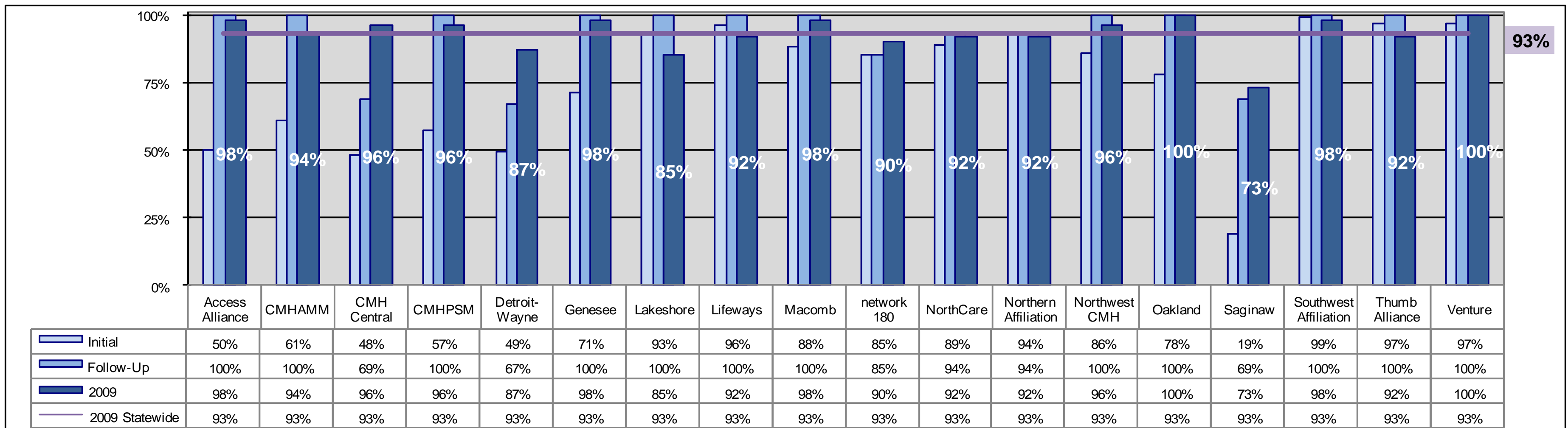
	Access Alliance	CMHAMM	CMH Central	CMHPSM	Detroit-Wayne	Genesee	Lakeshore	Lifeways	Macomb	network 180	NorthCare	Northern Affiliation	Northwest CMH	Oakland	Saginaw	Southwest Affiliation	Thumb Alliance	Venture
Initial	76%	72%	75%	52%	62%	76%	91%	100%	100%	98%	82%	88%	95%	76%	83%	100%	100%	99%
Follow-Up	100%	100%	68%	100%	92%	100%	100%	100%	100%	96%	100%	88%	100%	100%	100%	100%	100%	100%
2009	95%	100%	100%	100%	93%	100%	80%	100%	100%	100%	100%	89%	93%	100%	95%	100%	100%	97%
2009 Statewide	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%

Figure A-6—Standard VI: Customer Services



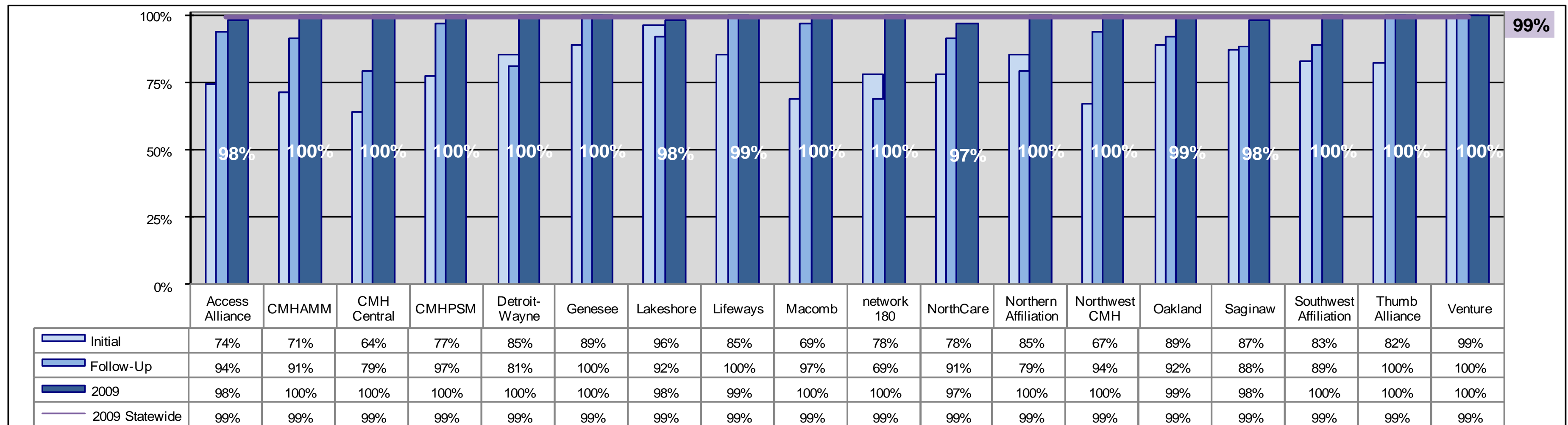
	Access Alliance	CMHAMM	CMH Central	CMHPSM	Detroit-Wayne	Genesee	Lakeshore	Lifeways	Macomb	network 180	NorthCare	Northern Affiliation	Northwest CMH	Oakland	Saginaw	Southwest Affiliation	Thumb Alliance	Venture
Initial	81%	83%	96%	58%	71%	100%	100%	100%	100%	96%	79%	85%	100%	98%	94%	100%	100%	92%
Follow-Up	100%	100%	100%	100%	62%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
2009	100%	98%	98%	100%	95%	100%	98%	100%	93%	100%	100%	100%	98%	100%	100%	100%	100%	100%
2009 Statewide	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%

Figure A-7—Standard VII: Recipient Grievance Process



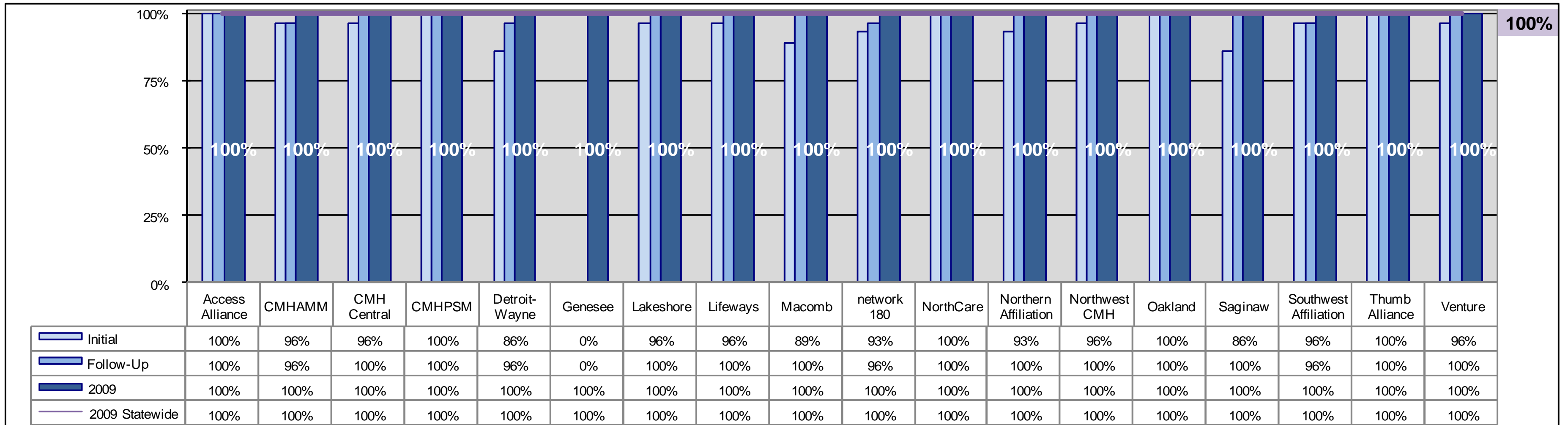
	Access Alliance	CMHAMM	CMH Central	CMHPSM	Detroit-Wayne	Genesee	Lakeshore	Lifeways	Macomb	network 180	NorthCare	Northern Affiliation	Northwest CMH	Oakland	Saginaw	Southwest Affiliation	Thumb Alliance	Venture
Initial	50%	61%	48%	57%	49%	71%	93%	96%	88%	85%	89%	94%	86%	78%	19%	99%	97%	97%
Follow-Up	100%	100%	69%	100%	67%	100%	100%	100%	100%	85%	94%	94%	100%	100%	69%	100%	100%	100%
2009	98%	94%	96%	96%	87%	98%	85%	92%	98%	90%	92%	92%	96%	100%	73%	98%	92%	100%
2009 Statewide	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%

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



	Access Alliance	CMHAMM	CMH Central	CMHPSM	Detroit-Wayne	Genesee	Lakeshore	Lifeways	Macomb	network 180	NorthCare	Northern Affiliation	Northwest CMH	Oakland	Saginaw	Southwest Affiliation	Thumb Alliance	Venture
Initial	74%	71%	64%	77%	85%	89%	96%	85%	69%	78%	78%	85%	67%	89%	87%	83%	82%	99%
Follow-Up	94%	91%	79%	97%	81%	100%	92%	100%	97%	69%	91%	79%	94%	92%	88%	89%	100%	100%
2009	98%	100%	100%	100%	100%	100%	98%	99%	100%	100%	97%	100%	100%	99%	98%	100%	100%	100%
2009 Statewide	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%

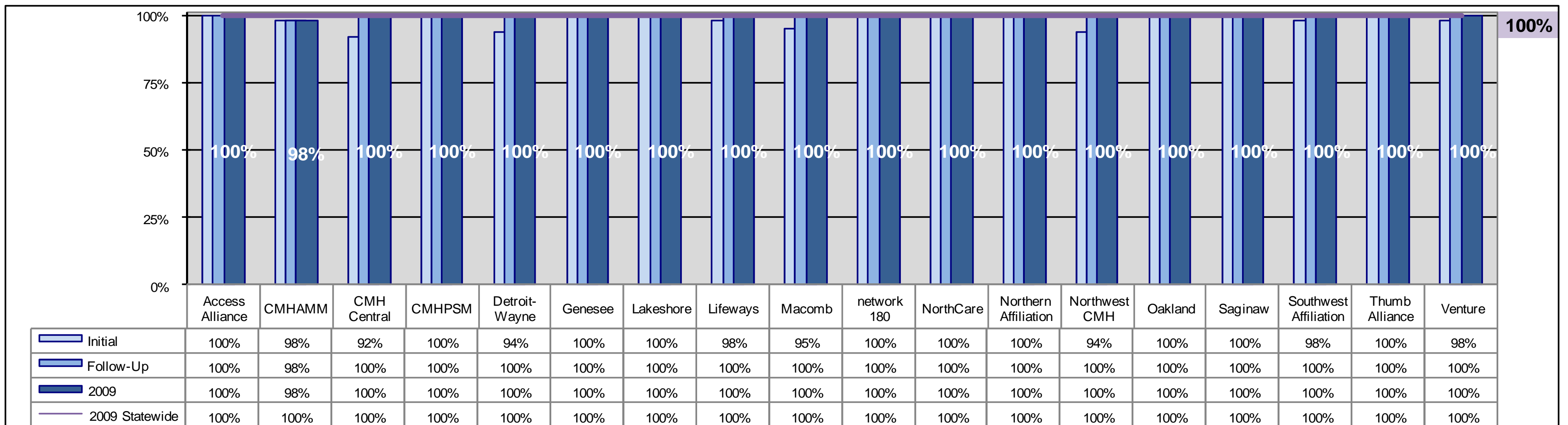
Figure A-9—Standard IX: Subcontracts and Delegation



	Access Alliance	CMHAMM	CMH Central	CMHPSM	Detroit-Wayne	Genesee	Lakeshore	Lifeways	Macomb	network 180	NorthCare	Northern Affiliation	Northwest CMH	Oakland	Saginaw	Southwest Affiliation	Thumb Alliance	Venture
Initial	100%	96%	96%	100%	86%	0%	96%	96%	89%	93%	100%	93%	96%	100%	86%	96%	100%	96%
Follow-Up	100%	96%	100%	100%	96%	0%	100%	100%	100%	96%	100%	100%	100%	100%	100%	96%	100%	100%
2009	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
2009 Statewide	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

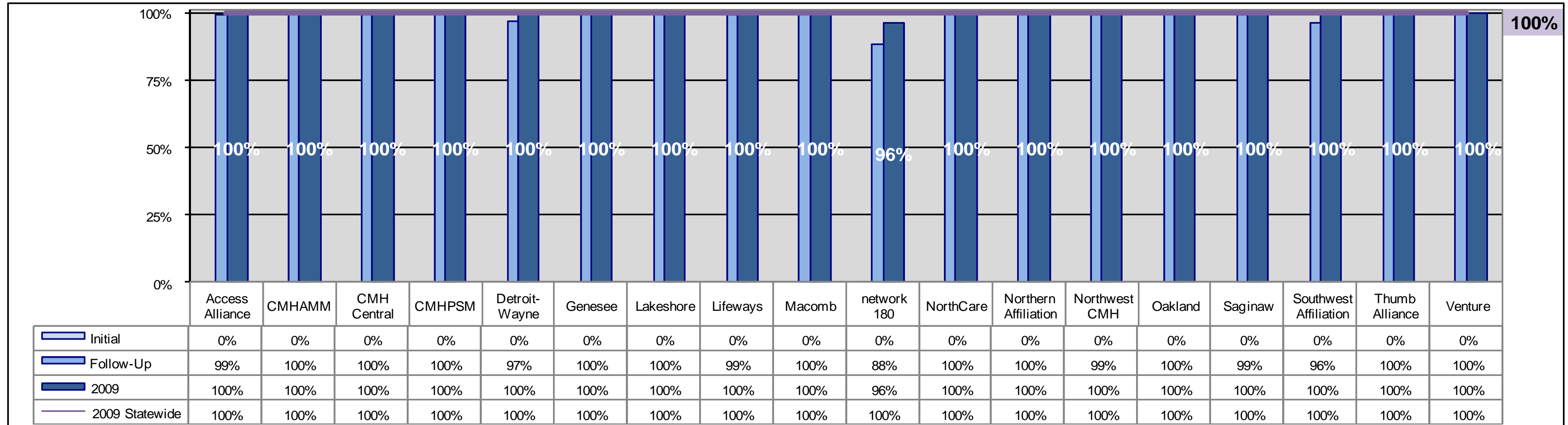
Note: This standard was rated *NA* for Genesee in the initial and follow-up reviews.

Figure A-10—Standard X: Provider Network



	Access Alliance	CMHAMM	CMH Central	CMHPSM	Detroit-Wayne	Genesee	Lakeshore	Lifeways	Macomb	network 180	NorthCare	Northern Affiliation	Northwest CMH	Oakland	Saginaw	Southwest Affiliation	Thumb Alliance	Venture
Initial	100%	98%	92%	100%	94%	100%	100%	98%	95%	100%	100%	100%	94%	100%	100%	98%	100%	98%
Follow-Up	100%	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
2009	100%	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
2009 Statewide	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

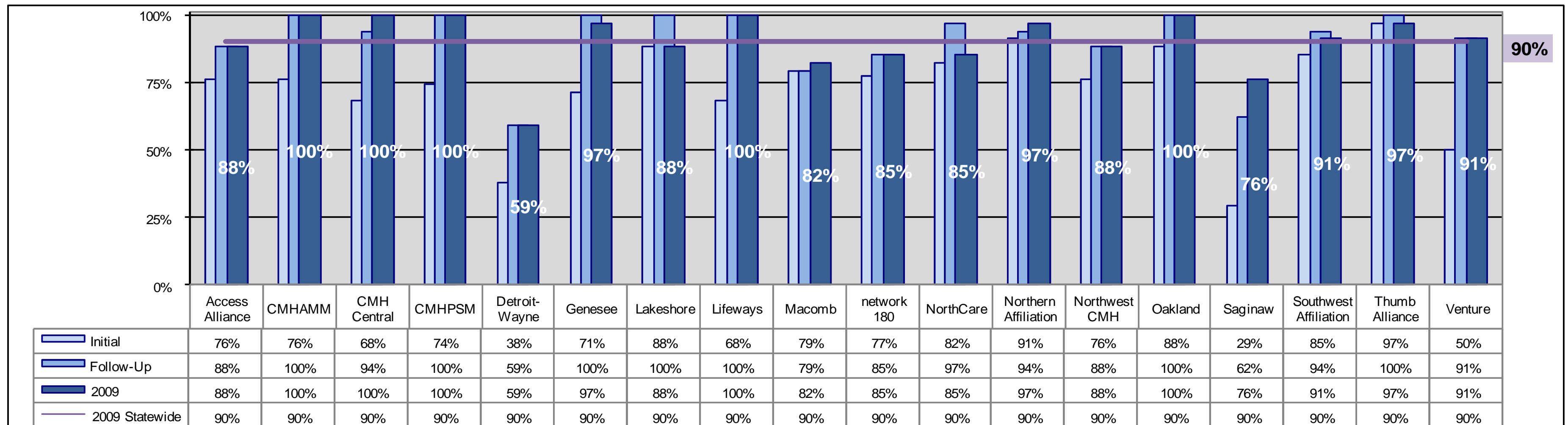
Figure A-11—Standard XI: Credentialing



	Access Alliance	CMHAMM	CMH Central	CMHPSM	Detroit-Wayne	Genesee	Lakeshore	Lifeways	Macomb	network 180	NorthCare	Northern Affiliation	Northwest CMH	Oakland	Saginaw	Southwest Affiliation	Thumb Alliance	Venture
Initial	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Follow-Up	99%	100%	100%	100%	97%	100%	100%	99%	100%	88%	100%	100%	99%	100%	99%	96%	100%	100%
2009	100%	100%	100%	100%	100%	100%	100%	100%	100%	96%	100%	100%	100%	100%	100%	100%	100%	100%
2009 Statewide	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

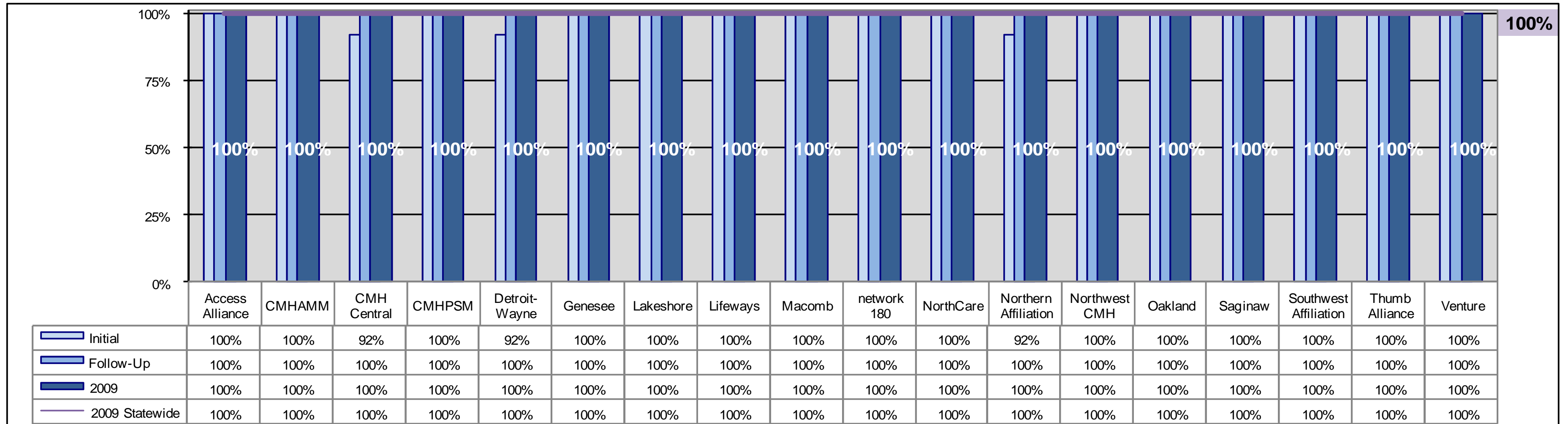
Note: The PIHPs did not receive a standards score for this standard in the initial review.

Figure A-12—Standard XII: Access and Availability



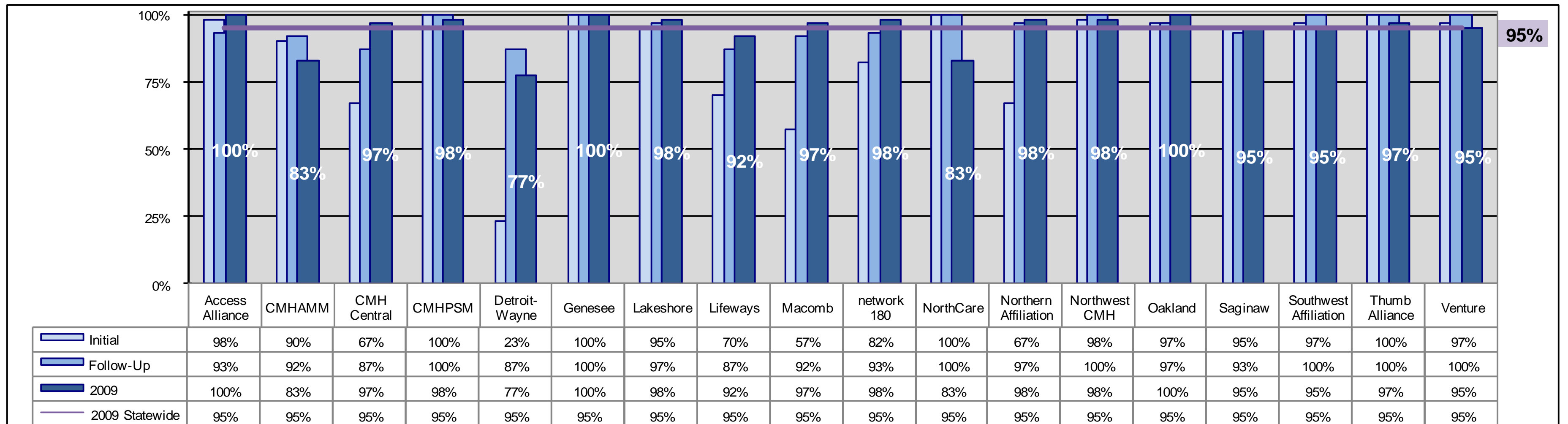
	Access Alliance	CMHAMM	CMH Central	CMHPSM	Detroit-Wayne	Genesee	Lakeshore	Lifeways	Macomb	network 180	NorthCare	Northern Affiliation	Northwest CMH	Oakland	Saginaw	Southwest Affiliation	Thumb Alliance	Venture
Initial	76%	76%	68%	74%	38%	71%	88%	68%	79%	77%	82%	91%	76%	88%	29%	85%	97%	50%
Follow-Up	88%	100%	94%	100%	59%	100%	100%	100%	79%	85%	97%	94%	88%	100%	62%	94%	100%	91%
2009	88%	100%	100%	100%	59%	97%	88%	100%	82%	85%	85%	97%	88%	100%	76%	91%	97%	91%
2009 Statewide	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%

Figure A-13—Standard XIII: Coordination of Care



	Access Alliance	CMHAMM	CMH Central	CMHPSM	Detroit-Wayne	Genesee	Lakeshore	Lifeways	Macomb	network 180	NorthCare	Northern Affiliation	Northwest CMH	Oakland	Saginaw	Southwest Affiliation	Thumb Alliance	Venture
Initial	100%	100%	92%	100%	92%	100%	100%	100%	100%	100%	100%	92%	100%	100%	100%	100%	100%	100%
Follow-Up	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
2009	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
2009 Statewide	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Figure A-14—Standard XIV: Appeals



	Access Alliance	CMHAMM	CMH Central	CMHPSM	Detroit-Wayne	Genesee	Lakeshore	Lifeways	Macomb	network 180	NorthCare	Northern Affiliation	Northwest CMH	Oakland	Saginaw	Southwest Affiliation	Thumb Alliance	Venture
Initial	98%	90%	67%	100%	23%	100%	95%	70%	57%	82%	100%	67%	98%	97%	95%	97%	100%	97%
Follow-Up	93%	92%	87%	100%	87%	100%	97%	87%	92%	93%	100%	97%	100%	97%	93%	100%	100%	100%
2009	100%	83%	97%	98%	77%	100%	98%	92%	97%	98%	83%	98%	98%	100%	95%	95%	97%	95%
2009 Statewide	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

PIHP Compliance

Table A-1 presents the compliance scores for all 18 PIHPs on the 14 compliance monitoring standards reviewed this year. Prior-year scores represent the percentage of compliance after the follow-up review on each standard. Follow-up review for Standards I through VIII was completed in 2005–2006, and for Standards IX through XIV, in 2007–2008. Current-year scores represent the 2008–2009 compliance monitoring review results.

Table A-1—Summary of PIHP Compliance Scores (Percentage of Compliance) for Prior-Year (P) and Current-Year (C) Reviews

PIHP	Review Year	I. QAPIP Plan and Structure	II. Performance Measurement and Improvement	III. Practice Guidelines	IV. Staff Qualifications and Training	V. Utilization Management	VI. Customer Services	VII. Enrollee Grievance Process	VIII. Enrollee Rights	IX. Subcontracts and Delegation	X. Provider Network	XI. Credentialing	XII. Access and Availability	XIII. Coordination of Care	XIV. Appeals
Access Alliance	P	100	100	100	100	100	100	100	94	100	100	99	88	100	93
	C	100	100	100	100	95	100	98	98	100	100	100	88	100	100
CMHAMM	P	100	100	100	100	100	100	100	91	96	98	100	100	100	92
	C	81	99	96	92	100	98	94	100	100	98	100	100	100	83
CMH Central	P	100	100	100	100	68	100	69	79	100	100	100	94	100	87
	C	100	100	100	100	100	98	96	100	100	100	100	100	100	97
CMHPSM	P	100	100	93	83	100	100	100	97	100	100	100	100	100	100
	C	99	100	100	100	100	100	96	100	100	100	100	100	100	98
Detroit-Wayne	P	77	88	100	100	92	62	67	81	96	100	97	59	100	87
	C	99	100	100	100	93	95	87	100	100	100	100	59	100	77
Genesee	P	100	100	100	100	100	100	100	100	NA	100	100	100	100	100
	C	100	100	100	100	100	100	98	100	100	100	100	97	100	100
Lakeshore	P	100	100	100	100	100	100	100	92	100	100	100	100	100	97
	C	83	96	100	100	80	98	85	98	100	100	100	88	100	98
LifeWays	P	100	100	100	100	100	100	100	100	100	98	99	100	100	87
	C	100	100	100	100	100	100	92	99	100	100	100	100	100	92
Macomb	P	95	100	100	100	100	100	100	97	100	100	100	79	100	92
	C	100	100	100	100	100	93	98	100	100	100	100	82	100	97
network180	P	100	100	70	100	96	100	85	69	96	100	88	85	100	93
	C	100	100	100	100	100	100	90	100	100	100	96	85	100	98
NorthCare	P	100	100	100	100	100	100	94	91	100	100	100	97	100	100
	C	100	99	98	100	100	100	92	97	100	100	100	85	100	83
Northern Affiliation	P	100	100	90	100	88	100	94	79	100	100	100	94	100	97
	C	100	100	100	100	89	100	92	100	100	100	100	97	100	98

Table A-1—Summary of PIHP Compliance Scores (Percentage of Compliance) for Prior-Year (P) and Current-Year (C) Reviews

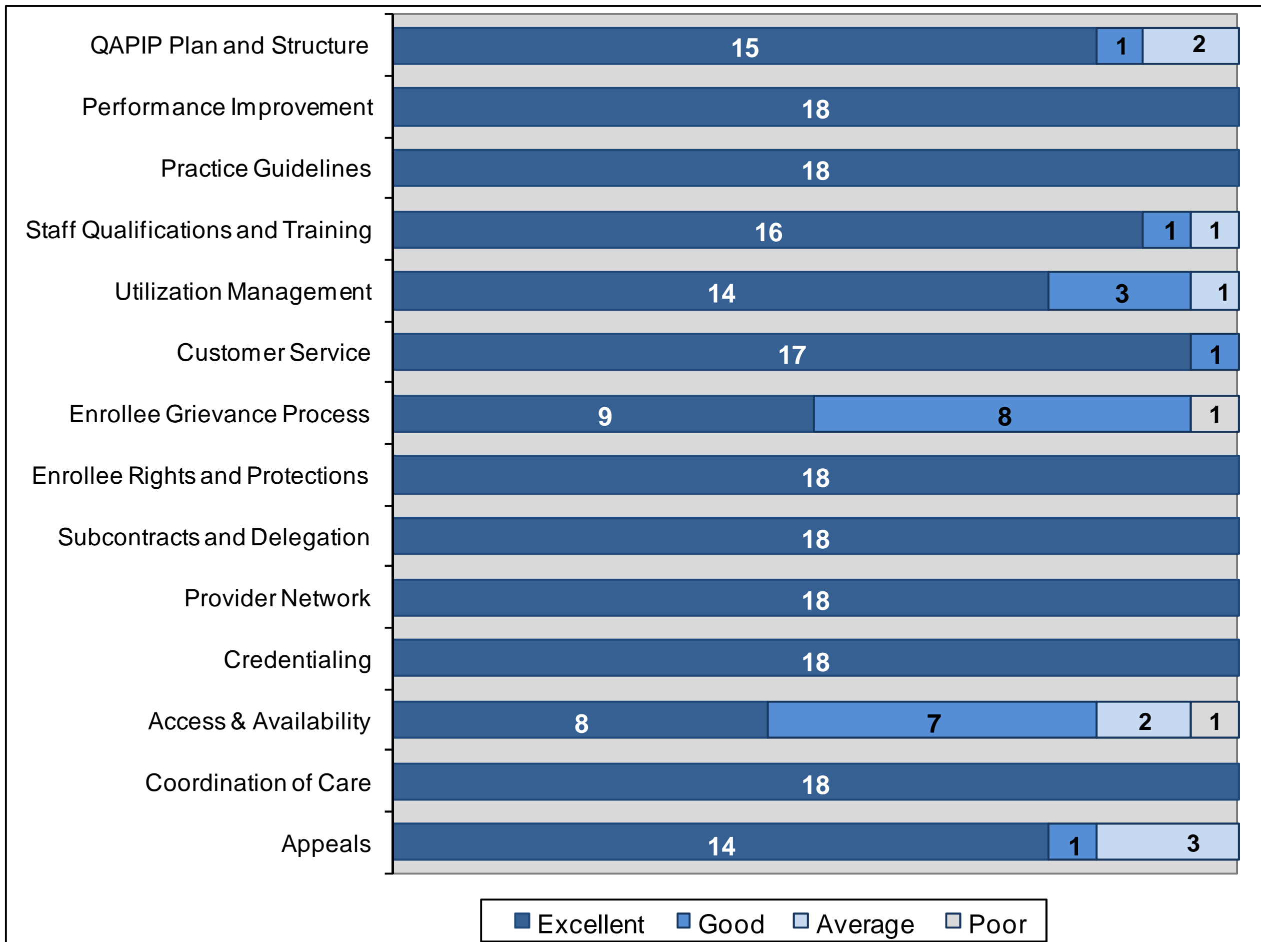
PIHP	Review Year	I. QAPIP Plan and Structure	II. Performance Measurement and Improvement	III. Practice Guidelines	IV. Staff Qualifications and Training	V. Utilization Management	VI. Customer Services	VII. Enrollee Grievance Process	VIII. Enrollee Rights	IX. Subcontracts and Delegation	X. Provider Network	XI. Credentialing	XII. Access and Availability	XIII. Coordination of Care	XIV. Appeals
Northwest CMH	P	100	100	100	100	100	100	100	94	100	100	99	88	100	100
	C	94	100	100	83	93	98	96	100	100	100	100	88	100	98
Oakland	P	100	100	100	100	100	100	100	92	100	100	100	100	100	97
	C	100	100	100	100	100	100	100	99	100	100	100	100	100	100
Saginaw	P	100	100	100	100	100	100	69	88	100	100	99	62	100	93
	C	96	100	100	100	95	100	73	98	100	100	100	76	100	95
Southwest Affiliation	P	100	100	100	100	100	100	100	89	96	100	96	94	100	100
	C	99	100	100	100	100	100	98	100	100	100	100	91	100	95
Thumb Alliance	P	100	100	100	100	100	100	100	100	100	100	100	100	100	100
	C	100	98	100	100	100	100	92	100	100	100	100	97	100	97
Venture	P	100	100	100	100	100	100	100	100	100	100	100	91	100	100
	C	97	98	100	100	97	100	100	100	100	100	100	91	100	95
Statewide Score	P	**98**	**99**	**98**	**99**	**97**	**98**	**94**	**91**	**99**	**100**	**99**	**91**	**100**	**95**
	C	**97**	**99**	**100**	**99**	**97**	**99**	**93**	**99**	**100**	**100**	**100**	**90**	**100**	**95**

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-15 presents the number of PIHPs receiving *Excellent/Good/Average/Poor* compliance scores after follow-up review for each of the 15 standards.

Figure A-15—Number of PIHPs Receiving *Excellent/Good/Average/Poor* Compliance Scores



Results for Validation of Performance Measures

Table A-2 shows the overall statewide PIHP compliance with the MDCH code book specifications for performance indicators validated by HSAG in 2007–2008 and 2008–2009.

Table A-2—Degree of Compliance for Performance Measures								
Indicator		Percentage of PIHPs						
		Fully Compliant		Substantially Compliant		Not Valid		
		2007–2008	2008–2009	2007–2008	2008–2009	2007–2008	2008–2009
1.	Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	89%	100%	11%	0%	0%	0%
2.	Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	100%	100%	0%	0%	0%	0%
3.	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional.	100%	100%	0%	0%	0%	0%
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	100%	100%	0%	0%	0%	0%
4b.	Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	100%	100%	0%	0%	0%	0%
5.	Percentage of Medicaid recipients having received PIHP-managed services (penetration rate).	94%	100%	0%	0%	6%	0%
8.	Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination (HSW rate).	100%	100%	0%	0%	0%	0%
10.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who are employed competitively.	94%	83%	6%	17%	0%	0%
11.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who earned minimum wage or more from any employment activities.	94%	83%	6%	17%	0%	0%
12.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	100%	100%	0%	0%	0%	0%
13.	Annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by the PIHPs.	100%	100%	0%	0%	0%	0%
14.	Number of sentinel events during the six-month period per 1,000 Medicaid beneficiaries served, by the following populations: adults with mental illness, children with mental illness, persons with developmental disabilities not on the HSW, persons on the HSW, and persons with substance abuse disorder.	100%	100%	0%	0%	0%	0%

Table A-3 and Table A-4 present a two-year comparison of the statewide results for the validated performance indicators.

Table A-3—Performance Measure Results			
	Indicator	Reported Rate	
		2007–2008	2008–2009
1.	Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.		
	Children	99%	99%
	Adults	96%	98%
2.	Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	98%	96%
3.	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional.	97%	96%
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.		
	Children	95%	97%
	Adults	89%	96%
4b.	Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	98%	96%
5.	Percentage of Medicaid recipients having received PIHP-managed services (penetration rate).	6%	9%
8.	Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination (HSW rate).	97%	82%
10.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who are employed competitively.		
	Adults with MI	9%	10%
	Adults with DD	9%	11%
11.	Percentage of adults with mental illness and the percentage of adults with developmental disabilities served by the PIHPs who earned minimum wage or more from any employment activities.		
	Adults with MI	45%	79%
	Adults with DD	23%	29%
12.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.		
	Children	7%	8%
	Adults	13%	12%

Table A-4—PIHP Performance Measure Results—Percentage Scores
Comparison of Prior-Year (2007–2008) and Current-Year (2008–2009) Rates

PIHP	Year	1. Preadmission Screening		2. Initial Assessment Within 14 Days	3. Initiate Ongoing Service Within 14 Days	4. Follow-Up Care			5. Penetration Rate	8. HSW Rate	10. Competitive Employment		11. Earning Minimum Wage		12. 30-Day Readmission Rate	
		Children	Adults			Psychiatric — Children	Psychiatric — Adults	Detox			Adults With Mental Illness	Adults With Developmental Disabilities	Adults With Mental Illness	Adults With Developmental Disabilities	Children	Adults
Access Alliance	P	100	98.90	99.43	97.70	96.15	92.93	100	6.94	97.38	12.51	8.77	42.38	34.32	3.57	18.92
	C	98.65	98.72	98.25	98.90	96.55	98.18	94.12	10.34	96.05	12.34	14.23	82.96	40.23	6.25	10.45
CMHAMM	P	100	97.54	99.78	98.90	100	96.36	100	5.82	98.92	11.24	10.03	72.37	47.78	0.00	13.56
	C	100	97.36	98.65	98.08	93.75	92.00	100	8.43	96.29	12.31	13.45	85.00	48.46	0.00	10.53
CMH Central	P	97.22	100	100	98.10	100	97.78	100	8.12	99.45	14.10	12.55	12.16	4.85	0.00	0.00
	C	100	98.13	99.46	98.17	100	100	100	11.69	96.20	12.92	14.34	93.28	28.85	0.00	9.09
CMHPSM	P	100	100	98.03	98.97	100	98.51	100	5.83	96.97	13.27	13.55	43.61	40.43	6.06	5.95
	C	100	100	98.59	100	100	100	97.37	7.72	82.23	12.15	17.54	81.82	68.85	28.95	8.75
Detroit-Wayne	P	99.07	89.30	92.00	93.94	89.42	74.88	100	5.08	93.93	3.12	2.80	10.32	1.49	6.82	13.41
	C	99.30	92.90	81.64	89.96	96.97	92.15	100	8.89	12.25	8.99	2.29	90.54	6.92	2.43	13.37
Genesee	P	98.11	97.46	97.33	97.12	96.00	97.04	100	5.04	97.38	5.35	4.09	74.56	18.59	3.13	12.12
	C	98.98	99.68	98.92	97.19	100	98.44	100	8.46	91.03	5.71	4.82	78.60	20.28	11.11	9.01
Lakeshore	P	96.30	99.12	95.08	94.48	100	100	100	NV	98.25	11.43	15.38	57.14	33.33	0.00	8.33
	C	97.44	100	98.39	96.56	100	100	100	7.38	98.24	9.59	14.90	71.90	37.42	0.00	6.45
LifeWays	P	100	100	100	98.57	100	100	100	6.27	99.26	11.18	8.46	61.48	39.19	9.09	33.33
	C	100	100	97.80	98.80	100	100	100	9.01	93.33	11.34	13.33	81.75	75.00	15.00	15.87
Macomb	P	100	99.61	98.85	94.51	100	98.08	100	6.67	98.76	9.09	6.84	37.40	16.35	15.38	12.65
	C	100	98.68	99.55	99.26	100	97.64	98.04	10.46	97.98	11.31	10.48	56.12	25.89	10.94	14.65
network180	P	94.55	98.17	99.37	94.62	94.74	99.01	80.00	5.40	100	12.51	10.17	35.42	13.63	4.88	9.38
	C	97.62	96.83	98.52	84.57	100	97.41	100	7.43	91.76	10.64	17.82	72.65	50.00	0.00	8.59
NorthCare	P	100	100	98.29	98.09	92.86	98.00	100	6.24	96.46	14.58	8.76	50.11	31.54	4.55	17.86
	C	100	100	97.49	98.07	100	96.43	100	8.82	97.00	14.72	11.85	74.42	43.06	8.70	11.90
Northern Affiliation	P	100	100	99.28	97.70	100	97.73	100	6.99	97.94	12.15	9.78	59.18	46.82	8.33	12.50
	C	100	97.81	98.37	98.27	100	97.92	100	10.71	95.23	11.93	21.91	77.00	53.70	6.90	14.08
Northwest CMH	P	100	100	94.88	97.81	87.50	91.18	100	7.47	96.11	14.33	15.94	66.39	66.19	21.05	13.70
	C	97.44	99.18	99.17	98.47	100	97.67	100	11.88	93.37	13.58	17.07	92.25	88.96	5.00	8.62
Oakland	P	97.27	96.30	99.14	98.67	100	98.75	100	7.33	98.62	10.68	10.87	52.43	23.44	3.45	12.90
	C	99.07	98.51	99.76	98.44	97.78	96.15	100	9.70	98.27	9.31	20.46	67.83	26.43	13.51	13.75
Saginaw	P	100	99.55	100	97.40	100	100	70.00	4.44	95.65	5.98	10.38	33.58	12.92	0.00	15.22
	C	100	100	98.36	93.38	61.54	93.18	54.17	7.16	95.73	9.01	13.04	49.23	19.63	12.50	22.45
Southwest Alliance	P	98.90	98.83	99.69	98.04	100	95.74	94.44	6.21	98.05	9.83	18.58	66.22	66.76	12.50	5.26
	C	100	100	94.54	99.15	92.31	96.67	90.91	9.06	93.58	9.62	15.15	85.77	60.94	0.00	5.56
Thumb Alliance	P	100	100	98.92	97.82	100	100	89.47	7.35	100	11.62	4.99	35.48	10.12	0.00	11.86
	C	100	100	99.47	99.14	100	97.33	100	10.53	96.60	10.79	5.55	53.26	14.15	15.00	18.37
Venture	P	100	100	98.34	96.68	100	100	100	6.26	97.78	11.96	7.78	25.33	13.99	0.00	4.11
	C	95.65	99.38	99.10	96.72	100	100	100	10.01	92.88	13.24	13.63	64.85	36.57	18.18	4.48

Results for Validation of Performance Improvement Projects

Table A-5 presents a two-year comparison of the PIHPs' PIP validation status.

Table A-5—Comparison of PIHPs' PIP Validation Status		
Validation Status	Number of PIPs	
	2007–2008	2008–2009
Met	13	4
Partially Met	4	4
Not Met	1	10

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

Table A-6—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	
	2007–2008	2008–2009	2007–2008	2008–2009
I. Review the Selected Study Topic(s)	18/18	6/18	18/18	8/18
II. Review the Study Question(s)	18/18	18/18	18/18	18/18
III. Review the Selected Study Indicator(s)	17/18	15/18	17/18	16/18
IV. Review the Identified Study Population	18/18	11/18	18/18	12/18
V. Review Sampling Methods	18/18*	18/18*	18/18*	18/18*
VI. Review Data Collection Procedures	13/18	7/18	17/18	18/18*
VII. Assess Improvement Strategies	11/17	11/16	14/17	11/16
VIII. Review Data Analysis and Study Results	6/17	2/18	16/17	5/18
IX. Assess for Real Improvement	6/17	0/0	*NA*	*NA*
X. Assess for Sustained Improvement	1/1	0/0	*NA*	*NA*

* HSAG scored all elements *NA* for all PIPs.

Table A-7 presents a two-year comparison of PIP scores for each PIHP.

Table A-7—Comparison of PIHP PIP Validation Scores

PIHP	% of All Evaluation Elements *Met*		% of All Critical Elements *Met*		Validation Status	
	2007–2008	2008–2009	2007–2008	2008–2009	2007–2008	2008–2009
Access Alliance	94%	92%	100%	90%	*Met*	*Partially Met*
CMHAMM	95%	38%	100%	30%	*Met*	*Not Met*
CMH Central	75%	96%	90%	100%	*Partially Met*	*Met*
CMHPSM	100%	100%	100%	100%	*Met*	*Met*
Detroit-Wayne	80%	62%	91%	70%	*Partially Met*	*Partially Met*
Genesee	100%	75%	100%	89%	*Met*	*Not Met*
Lakeshore	91%	58%	90%	70%	*Partially Met*	*Not Met*
LifeWays	94%	62%	100%	50%	*Met*	*Not Met*
Macomb	91%	79%	100%	78%	*Met*	*Not Met*
network180	91%	58%	100%	60%	*Met*	*Not Met*
NorthCare	88%	69%	100%	60%	*Met*	*Not Met*
Northern Affiliation	86%	73%	100%	80%	*Met*	*Not Met*
Northwest CMH	63%	69%	82%	70%	*Not Met*	*Not Met*
Oakland	93%	81%	100%	70%	*Met*	*Partially Met*
Saginaw	100%	48%	100%	50%	*Met*	*Not Met*
Southwest Alliance	94%	85%	100%	100%	*Met*	*Met*
Thumb Alliance	96%	85%	100%	90%	*Met*	*Partially Met*
Venture	94%	92%	90%	100%	*Partially Met*	*Met*

Appendix B. Compliance Monitoring Tool

The compliance monitoring tool follows this cover page.

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

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

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

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

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

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

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

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

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

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

Findings

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

Findings

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

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
7. Verification of Services The written description of the PIHP's QAPIP addresses how it will verify whether services reimbursed by Medicaid were actually furnished to beneficiaries by affiliates (as applicable), providers, and subcontractors. Attachment P 6.7.1.1		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

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

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

Standard II—Performance Measurement and Improvement

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
1. Performance Measures The PIHP utilizes standardized performance measures established by the department, which, at a minimum, address: 42 CFR 438.240(c) Attachment P 6.7.1.1		
a. Access		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
b. Efficiency		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
c. Outcome		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings		

Standard II—Performance Measurement and Improvement

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

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
3. Performance Improvement Projects The PIHP's QAPIP includes at least two affiliation-wide performance improvement projects (PIPs) during the waiver renewal period. 42 CFR 438.240(d) Attachment P 6.7.1.1		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings		

Standard II—Performance Measurement and Improvement

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
4. Review of Sentinel Events Attachment P 6.7.1.1		
a. The QAPIP describes the process for the review of sentinel events.		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
b. The QAPIP describes the process for follow-up of sentinel events.		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings		

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
5. Appropriate Credentials PIHP has a process to ensure that persons involved in the review of sentinel events must have the appropriate credentials to review the scope of care. Attachment P 6.7.1.1		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings		

Standard II—Performance Measurement and Improvement

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
6. Assessments of Beneficiary Experiences with Services Attachment P 6.7.1.1		
a. The QAPIP includes periodic <u>qualitative</u> assessments of beneficiaries' experiences with its services.		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
b. The QAPIP includes periodic <u>quantitative</u> assessments of beneficiaries' experiences with its services.		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
c. Assessments represent persons served and services and supports offered.		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
d. The assessments address issues of the <u>quality</u> of care.		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
e. The assessments address issues of the <u>availability</u> of care.		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Performance Measurement and Improvement

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

Standard II—Performance Measurement and Improvement

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
k. The organization evaluates the effects of the above activities.		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
7. Consumer Inclusion The organization ensures the incorporation of consumers receiving long-term supports or services (persons receiving case management or supports coordination) into the review and analysis of the information obtained from quantitative and qualitative methods. Attachment P 6.7.1.1		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Findings

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

Standard III—Practice Guidelines

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
1. Relevant Practice Guidelines The QAPIP describes the process for the use of practice guidelines, including the following: Attachment P 6.7.1.1 42 CFR 438.236		
a. Adoption process		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
b. Development process		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
c. Implementation		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
d. Continuous monitoring		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Practice Guidelines

e. Evaluation		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
2. Practice Guideline Development If practice guidelines are adopted, the PIHP meets the following requirements: 42 CFR 438.236(b)		
a. Practice guidelines are based on valid and reliable clinical evidence or consensus of health care professionals.		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
b. Practice guidelines consider the <u>needs of beneficiaries</u>.		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
c. Practice guidelines are adopted in <u>consultation</u> with contracting health care professionals.		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Practice Guidelines

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
d. Practice guidelines are reviewed and updated periodically, as appropriate.		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings		

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

Standard III—Practice Guidelines

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

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

Standard IV—Staff Qualifications and Training

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

Standard IV—Staff Qualifications and Training

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

Findings

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

Standard V—Utilization Management

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

Standard V—Utilization Management

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

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
3. Procedures Prospective (preauthorization), concurrent, and retrospective procedures are established and include: 42 CFR 438.210(b) Attachment P 6.7.1.1		
a. Review decisions are supervised by qualified medical professionals.		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Utilization Management

b. Decisions to deny or reduce services are made by health care professionals who have the appropriate clinical expertise to treat the conditions.		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
c. Efforts are made to obtain all necessary information including pertinent clinical information and consult with treating physician as appropriate.		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
d. The reasons for decisions are clearly documented.		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
e. The reasons for decisions are available to the beneficiary.		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
f. There are well-publicized and readily available appeals mechanisms for providers.		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
g. There are well-publicized and readily available appeals mechanisms for beneficiaries.		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Utilization Management

Standard		Score
h. Notification of the denial is sent to the beneficiary.		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
i. Notification of the denial is sent to the provider.		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
j. Notification of a denial includes a description of how to file an appeal.		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
k. UM Decisions are made in a timely manner as required by the exigencies of the situation.		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
l. Decisions on appeals are made in a timely manner as required by the exigencies of the situation.		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
m. There are mechanisms to evaluate the effects of the program using data on beneficiary satisfaction, provider satisfaction, or other appropriate measures.		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Utilization Management

n. If the organization delegates responsibility for utilization management, it has mechanisms to ensure that these standards are met by the delegate.		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Findings

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

Standard VI—Customer Services

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
1. Designated Unit The PIHP has a designated unit called "Customer Services", with a minimum of one full-time equivalent (FTE) performing the customer services function, within the customer services unit or elsewhere within the PIHP. Attachment P.6.3.1.1		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings		

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
2. Phone Access Attachment P.6.3.1.1		
a. Toll-Free Telephone Line The PIHP has a designated toll-free customer services telephone line and access to a TTY number. The telephone numbers are displayed in agency brochures and public information material.		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
b. Live Voice The PIHP ensures that the customer services telephone line is answered by a live voice during business hours. The PIHP uses methods other than telephone menus to triage high volumes of calls and ensures that that there is a response to each call within one business day.		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings		

Standard VI—Customer Services

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
3. Hours of Operation The PIHP publishes the hours of customer services unit operation and the process for accessing information from customer services outside those hours. Attachment P.6.3.1.1		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings		

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
4. Customer Handbook The customer handbook includes: ◆ All state-required topics as specified in the contract attachment. ◆ The date of the publication and revision(s). ◆ Names, addresses, phone numbers, TTYs, e-mails, and web addresses for affiliate CMHSPs, substance abuse coordinating agency, or network providers. ◆ Information about how to contact the Medicaid Health Plans or Medicaid fee-for-service programs in the PIHP service area (actual phone numbers and addresses may be omitted and held at the customer services office due to frequent turnover of plans and providers). Attachment P.6.3.1.1		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings		

Standard VI—Customer Services

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
5. Provider Listing Attachment P.6.3.1.1		
a. Current Provider Listing The customer services unit maintains a current listing of all providers, both organizations and practitioners, with whom the PIHP contracts, the services they provide, languages they speak, and any specialty for which they are known. The list includes independent PCP facilitators and identification of providers that are not accepting new patients.		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
b. Distribution Beneficiaries receive the provider listing initially and are informed of its availability annually.		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings		

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
6. Access to Information The customer services unit has access to information about the PIHP, including CMHSP affiliate annual report; current organizational chart; CMHSP board member list, meeting schedule, and minutes, that are available to be provided in a timely manner to the beneficiary upon request. Attachment P.6.3.1.1		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings		

Standard VI—Customer Services

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
7. Assistance with Grievances and Appeals Upon request, the customer services unit assists beneficiaries with the grievance, appeals, and local dispute resolution processes and coordinates, as appropriate, with the Fair Hearing Officer and the local Office of Recipient Rights. Attachment P.6.3.1.1		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
8. Training Customer services staff receives training to welcome people to the public mental health system and to possess current working knowledge, or know where in the organization detailed information can be obtained, in at least the following areas: Attachment P.6.3.1.1		
a. Working Knowledge About: ◆ The populations served (serious mental illness, serious emotional disturbance, developmental disability, and substance abuse disorder) and eligibility criteria for various benefit plans (e.g., Medicaid, Adult Benefit Waiver, MIChild) ◆ Service array (including substance abuse treatment services), medical necessity requirements, and eligibility for and referral to specialty services ◆ Grievance and appeals, fair hearings, local dispute resolution processes, and recipient rights ◆ Information about and referral for Medicaid-covered services within the PIHP as well as outside to Medicaid health plans, fee-for-service practitioners, and the Department of Human Services		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Customer Services

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

Findings

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

Standard VII—Enrollee Grievance Process

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

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

Standard VII—Enrollee Grievance Process

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

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

Standard VII—Enrollee Grievance Process

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

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

Standard VII—Enrollee Grievance Process		
c. Acknowledges to the beneficiary the receipt of the grievance.		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
d. Submits the written grievance to appropriate staff, including a PIHP administrator with the authority to require corrective action and none of whom shall have been involved in the initial determination.		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
e. For grievances regarding denial of expedited resolution of an appeal and for a grievance that involves clinical issues, the grievance is reviewed by health care professionals who have the appropriate clinical expertise in treating the enrollee's condition or disease.		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
f. Facilitates resolution of the grievance as expeditiously as the enrollee's health condition requires, but no later than 60 calendar days of receipt of the grievance.		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Enrollee Grievance Process

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
g. Provides a written disposition within 60 calendar days of the PIHP's receipt of the grievance to the customer, guardian, or parent of a minor child. The content of the notice of disposition includes: ◆ The results of the grievance process; ◆ The date the grievance process was conducted; ◆ The beneficiary's right to request a fair hearing if the notice is more than 60 calendar days from the date of the request for a grievance; and ◆ How to access the fair hearing process.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

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

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

Standard VIII—Enrollee Rights and Protections

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
1. Written Policies 42 CFR 438.100 (a)(1) 42 CFR 438.100(a)(2)		
a. The PIHP has written policies regarding enrollee rights.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
b. The PIHP has processes to ensure that its staff and affiliated providers take those rights into account when furnishing services to enrollees.		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Standard VIII—Enrollee Rights and Protections

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

Standard VIII—Enrollee Rights and Protections

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

Standard VIII—Enrollee Rights and Protections

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
3. General Information for All Enrollees Information is made available to PIHP enrollees within a reasonable time after PIHP enrollment, including: 42 CFR 438.10(f)(3)		
a. Any restrictions on the enrollee's freedom of choice among network providers. 42 CFR 438.10(f)(6)(ii) PIHP Contract 6.3.3		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Standard VIII—Enrollee Rights and Protections

Requirement	Evidence	Score
b. Grievance, appeal, and fair hearing procedures and timeframes that include: ◆ The right to a state fair hearing; ◆ The method for obtaining a hearing; ◆ The rules that govern representation at the hearing; ◆ The right to file grievances and appeals; ◆ The requirements and timeframes for filing a grievance or appeal; ◆ The availability of assistance in the filing process; ◆ The toll-free numbers that the beneficiary can use to file a grievance or an appeal by phone; ◆ The fact that when requested by the beneficiary, benefits will continue if the beneficiary files an appeal or a request for State fair hearing within the timeframes specified and that the beneficiary may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the beneficiary; and ◆ Any appeal rights that the State chooses to make available to providers to challenge the failure to cover a service. 42 CFR 438.10(g)(1)(vi)(A) PIHP Contract 6.3.3		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
c. The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled. 42 CFR 438.10(f)(6)(v) PIHP Contract 6.3.3		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Standard VIII—Enrollee Rights and Protections		
d. Procedures for obtaining benefits, including authorization requirements. 42 CFR 438.10(f)(6)(vi) PIHP Contract 6.3.3		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
e. The extent to which, and how, enrollees may obtain benefits from out-of-network providers. 42 CFR 438.10(f)(6)(vii) PIHP Contract 6.3.3		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
f. The extent to which, and how, after-hours and emergency coverage is provided, including: ◆ What constitutes emergency medical condition, emergency services, and post-stabilization services; ◆ The fact that prior authorization is not required for emergency services; ◆ The process and procedures for obtaining emergency services, including use of the 911 telephone system or its local equivalent; ◆ The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered under the contract; and ◆ The fact that, subject to these provisions, the enrollee has the right to use any hospital or other setting for emergency care. 42 CFR 438.10(f)(6)(viii) PIHP Contract 6.3.3		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**

Standard VIII—Enrollee Rights and Protections

Requirement		Score
g. Policy on referrals for specialty care and for other benefits not furnished by the enrollee's primary care provider. 42 CFR 438.10(f)(6)(x)		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
h. Cost sharing, if any. 42 CFR 438.10(f)(6)(xi)		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
i. How and where to access any benefits that are available under the State plan but are not covered under the contract, including any cost sharing and how transportation is provided. 42 CFR 438.10 (e)(2)(ii)(E)		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
j. The PIHP provides adult enrollees with written information on advance directives policies, and include a description of applicable State law. The information reflects changes in State law as soon as possible, but not later than 90 days after the effective date of the change. 42 CFR 438.10(g)(2), 42 CFR 438.6(i) PIHP Contract 6.8.6		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
k. Additional information that is available upon request, including information on the structure and operation of the PIHP and physician incentive plans in use by the PIHP or network providers. 42 CFR 438.10(g)(3)(i) 42 CFR 438.6(h) PIHP Contract 6.3.3		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Findings

Standard VIII—Enrollee Rights and Protections

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
4. Written Notice of Significant Change The PIHP gives each enrollee written notice of any significant change, as defined by the State, in any of the general information (3 A-L), including change in its provider network (e.g., addition of new providers and planned termination of existing providers). 42 CFR 438.10(f)(4) PIHP Contract 6.3.3		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings		

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
5. Notice of Termination of Providers 42 CFR 438.10(f)(5) PIHP Contract 6.3.3		
a. The PIHP makes a good faith effort to give written notice of termination of a contracted provider to each enrollee who received his or her primary care from, or was seen on a regular basis by, the terminated provider.		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
b. The PIHP makes a good faith effort to give written notice of termination of a contracted provider within 15 days after receipt or issuance of the termination notice.		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings		

Standard VIII—Enrollee Rights and Protections

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

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

Standard VIII—Enrollee Rights and Protections

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

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
9. Provider-Enrollee Communication The PIHP does not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a enrollee who is his or her patient, for the following: ◆ The enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered; ◆ Any information the enrollee needs in order to decide among all relevant treatment options; ◆ The risks, benefits, and consequences of treatment or nontreatment; and ◆ The enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. 42 CFR 438.102(a)		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings		

Standard VIII—Enrollee Rights and Protections

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
10. Services Not Covered on Moral/Religious Basis A PIHP not electing to provide, reimburse for, or provide coverage of, a counseling or referral service based on objections to the service on moral or religious grounds must furnish information about the services it does not cover as follows: ◆ To the State, with its application for a Medicaid contract, and whenever it adopts the policy during the term of the contract; ◆ To potential enrollees, before and during enrollment; and ◆ To enrollees, within 90 days after adopting the policy with respect to any particular service, with the overriding rule to furnish the information at least 30 days before the effective date of the policy. (The PIHP does not have to include how and where to obtain the services.) 42 CFR 438.102(a)(2)(b)(1)		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
11. Right to Participate The PIHP policies provide the enrollee the right to participate in decisions regarding his or her health care, including the right to refuse treatment. 42 CFR 438,100(b)(2)(iv)		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Standard VIII—Enrollee Rights and Protections

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

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

Standard IX—Subcontracts and Delegation

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

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

Standard IX—Subcontracts and Delegation

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

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

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

Standard IX—Subcontracts and Delegation

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

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

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

Standard X—Provider Network

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

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

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

Standard X—Provider Network

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

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

Standard X—Provider Network

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

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

Standard X—Provider Network

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

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

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

Standard X—Provider Network

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

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

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

Standard XI—Credentialing

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

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

Standard XI—Credentialing

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

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
4. Provider Discrimination The PIHP has processes to ensure: ◆ That the credentialing and recredentialing processes do not discriminate against: ▪ A health care professional solely on the basis of license, registration, or certification. ▪ A health care professional who serves high-risk populations or who specializes in the treatment of conditions that require costly treatment. ◆ Compliance with Federal Requirements that prohibit employment or contracts with providers excluded from participation under either Medicare or Medicaid. 438.12 and 438.214(c) MDCH 6.4.1 Attachment P.6.4.3.1		☐ **Met** ☐ **Substantially Met** ☐ **Partially Met** ☐ **Not Met** ☐ **Not Applicable**
Findings		

Standard XI—Credentialing

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

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

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

Standard XI—Credentialing

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

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

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

Standard XI—Credentialing

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

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

Standard XI—Credentialing

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

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

Standard XI—Credentialing

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

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

Standard XI—Credentialing

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

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

Standard XI—Credentialing

Findings

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

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
18. Organizational Providers—Credentialing for Individuals Employed by, or Contracted with, an Organizational Provider The PIHP must ensure that the contract between the PIHP and any organizational provider requires the organizational provider to credential and recredential their directly employed and subcontracted direct service providers in accordance with the PIHP's credentialing/recredentialing policies and procedures (which must conform to MDCH's credentialing process.		☐ Met ☐ Substantially Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Findings

Standard XI—Credentialing

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

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

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

Standard XI—Credentialing

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

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

Standard XII—Access And Availability

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

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

Standard XII—Access And Availability

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

Findings

Standard XII—Access And Availability

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

Standard XII—Access And Availability

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

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

Standard XII—Access And Availability

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

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

Standard XIII—Coordination of Care

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

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

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

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

Standard XIV—Appeals

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

Standard XIV—Appeals

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

Findings

Standard XIV—Appeals

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

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

Standard XIV—Appeals

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

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

Standard XIV—Appeals

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

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

Standard XIV—Appeals

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

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

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

Appendix C. Performance Measure Validation Tool

The performance measure validation tool follows this cover page.

The PIHPs were given the Information Systems Capabilities Assessment Tool (ISCAT) to complete and submit as a part of the performance measure validation process. A modified, abbreviated version of the ISCAT (the mini-ISCAT) was submitted by the PIHP subcontractors, as well.

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Appendix C: Michigan Department of Community Health Information Systems Capabilities Assessment (ISCA) for Prepaid Inpatient Health Plans (PIHPs)

I. GENERAL INFORMATION

Please provide the following general information:

Note: When completing this ISCA, answer the questions in the context of the performance indicators reported to MDCH, and the QI and encounter data submitted to MDCH only. If a question does not apply whatsoever to the performance indicator calculation and reporting, QI data, or encounter data submission, enter an N/A response. Coordinating Agencies (CAs) should be considered a subcontractor, on the same level as a Community Mental Health Service Provider (CMHSP) or a Managed Comprehensive Provider Network (MCPN).
ITEMS HIGHLIGHTED IN YELLOW INDICATE CHANGES FROM LAST YEAR'S VERSION.

A. Contact Information

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

PIHP Name: _____
Contact Name and Title: _____
Mailing Address: _____
Phone Number: _____
Fax Number: _____
E-Mail Address: _____
Chief Information Officer (CIO) Name and Title: _____
Phone Number: _____
E-Mail Address: _____

I. GENERAL INFORMATION

B. PIHP Model Type

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

- ☐ PIHP - stand alone
- ☐ PIHP - affiliation
- ☐ PIHP – MCPN Network
- ☐ PIHP – other (describe): _____

PIHP Structure

Please indicate general structure (if other, please specify):

- ☐ Centralized (All information system functions are performed by the PIHP)
- ☐ Mixed (Some information system functions are delegated to other entities)
- ☐ Delegated (All information system functions are delegated to other entities)
- ☐ Other (describe): _____

C. Please provide a brief narrative description of any changes that were made to your organization within the last year, including organization structure, information systems, key staff, or other significant changes: _____

D. Unduplicated Count of Medicaid Consumers Receiving Services as of:

June 2008 _____

July 2008 _____

August 2008 _____

September 2008 _____

October 2008 _____

November 2008 _____

December 2008_____

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I. GENERAL INFORMATION

E. Has your organization ever undergone a formal IS capabilities assessment (other than the performance measure validation activity performed by the EQRO)? A formal IS capabilities assessment must have been performed by an external reviewer.

Note: CARF/JCHO reviews would not apply as they do not get to the level of detail necessary to meet CMS protocols.

☐ Yes

☐ No

If *yes*, who performed the assessment? _____

When was the assessment completed? _____

F. In an attachment to the ISCA, please describe how your PIHP's data process flow is configured for its entire network. Label as Attachment 8.

This will likely require a multi-dimensional presentation and data flow chart. Please include any IS functions that have been delegated downstream to the Community Mental Health Service Providers (CMHSPs), MCPNs (if applicable), the Coordinating Agency (CA) office, and sub-panel contract agencies of both the CA/CMHSPs. Identify which entity-level is responsible for which kind of data collection and submission, which entity has overall data validation responsibilities, and the data validation process involved. A typical response should generally be a two-to-three-page write-up, with some graphical flow charts attached. This description will help immensely with the reviewers' understanding of your PIHP and will help make the validation process run smoothly and efficiently.

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II. INFORMATION SYSTEMS: DATA PROCESSING PROCEDURES AND PERSONNEL

1. What database management system (DBMS) or systems does your organization use to store Medicaid claims and encounter (service) data?

_____

2. How would you characterize this/these DBMSs? *(Check all that apply.)*

- ☐ Relational
- ☐ Hierarchical
- ☐ Indexed
- ☐ Other
- ☐ Network
- ☐ Flat File
- ☐ Proprietary
- ☐ Don't Know

3. Into what DBMS(s), if any, do you extract relevant Medicaid encounter/service/eligibility detail for analytic reporting purposes?

_____

4. How would you characterize this/these DBMS(s)? *(Check all that apply.)*

- ☐ Relational
- ☐ Hierarchical
- ☐ Indexed
- ☐ Other
- ☐ Network
- ☐ Flat File
- ☐ Proprietary
- ☐ Don't Know

II. INFORMATION SYSTEMS: DATA PROCESSING PROCEDURES AND PERSONNEL

5. **What programming languages do your programmers use to create Medicaid data extracts or analytic reports?** A *programmer* is defined as an individual who develops and/or runs computer programs or queries to manipulate data for submission to MDCH (QI data and encounter data) or performance indicator reporting.

   The intent of this question is to help the reviewers understand how the performance indicators are calculated by your PIHP.

   ______

   How many programmers (internal staff or external vendors) are trained and capable of modifying these programs?

   ______

6. **Approximately what percentage of your organization's programming work is outsourced?**

   This question pertains to the programming work necessary for the calculation of the performance measures reported to MDCH, and to the submission of encounter data to MDCH.

   ______%

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

   ______ years

8. **What steps are necessary to meet performance indicator and encounter data reporting requirements? Your response should address the steps necessary to prepare and submit encounter data to MDCH.**

   If your PIHP has this information already documented, please submit the documentation or notate that you will make the documentation available to the reviewers during the site visit.

   ______

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II. INFORMATION SYSTEMS: DATA PROCESSING PROCEDURES AND PERSONNEL

9. What is the process for version control when computer programming code is revised?

This question applies to internal programmers or vendors who develop and/or run computer programming to manipulate data for encounter data submission or performance indicator reporting.

_____

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

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

11. Staffing

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

_____

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

_____

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

11d. What is the annual turnover? _____

II. INFORMATION SYSTEMS: DATA PROCESSING PROCEDURES AND PERSONNEL

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

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

_____

How frequently are system back-ups performed? _____

Where are back-up data stored? _____

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

_____

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

_____

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

_____

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

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

☐ Consumers

☐ Providers

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

_____

III. DATA ACQUISITION CAPABILITIES

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

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

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

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

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

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

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

III. DATA ACQUISITION CAPABILITIES

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

   Please fill in the following table with the appropriate percentages:

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

Comments: ______

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III. DATA ACQUISITION CAPABILITIES

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

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

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

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III. DATA ACQUISITION CAPABILITIES

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

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

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

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

5. Principal and Secondary Diagnoses

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

☐ Yes

☐ No

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

_____

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

Institutional Data: _____

Professional Data: _____

III. DATA ACQUISITION CAPABILITIES

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

_____

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

_____

9. Medicaid Claims/Encounters

9a. How are Medicaid claims/encounters received?

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

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

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

_____

III. DATA ACQUISITION CAPABILITIES

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

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

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

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

_____

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

☐ New system purchased and installed to replace old system.

Description/implementation dates _____

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

Description/implementation dates _____

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

Description/implementation dates _____

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

Description/implementation dates _____

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

Description/implementation dates _____

Comments: _____

13. Have any of these changes influenced, even temporarily, the quality and/or completeness of the Medicaid data that are collected? If so, how and when? ______
14. How many years of Medicaid data are retained online? How are historical Medicaid data accessed when needed? ______
15. How much volume of Medicaid data is processed online versus batch? Batch processing refers to collecting claims/encounters/service data and processing them in bulk on a pre-determined schedule. ______ If batch, how often is it run? ______
16. How complete are the Medicaid data three months after the close of a reporting period (i.e. a quarter)? ______ How is completeness estimated? How is completeness defined? ______
17. What is your policy regarding Medicaid claims/encounter audits? Are any audits performed evaluating the data submitted compared with the consumer record? ______ **Are Medicaid encounters audited regularly? Randomly?** ______
18. What are the standards regarding timeliness of processing? Within what timeframe must claims/encounters or service data be entered? ______

19. Are diagnostic and procedure codes edited for validity? Please provide detail on system edits that are targeted to field content and consistency.

This question is to help reviewers get a sense of how accurate and valid your claims/encounter data are. If you have an existing document that identifies what edits you have in place, you may submit it as an attachment, or make it available for the reviewers on-site. If you do the latter, please note that in your response.

20. Please complete the following table for Medicaid claims and encounter data and other Medicaid administrative data that is used for performance indicator reporting, or submitted to MDCH as QI or encounter data. For the purposes of this ISCA, a *claim* is defined as a service for which direct reimbursement is made (FFS). An *encounter* is defined as a capitated service, in which no direct reimbursement for the service is provided—rather, the provider receives a capitation payment based on member panels. *Administrative data* is defined as any service data that is housed electronically in a database that is not represented in claims or encounters. Examples would include Sub-Element Cost Report (CMHs), authorization systems, consumer surveys, etc.

Provide any documentation that should be reviewed to explain the data that are being submitted.

	Claims	Encounters	QI Data
Percent of Total Service Volume	___%	___%	
Percent Complete	___%	___%	___%
Other Administrative Data (list types)	_____		
How Are the Above Statistics Quantified?	_____		
Incentives for Data Submission	_____		

Comments: _____

21. Describe the Medicaid claims/encounter suspend ("pend") process, including timeliness of reconciling pended services.

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

_____

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

What triggers a processor to follow up on "pended" claims? How frequent are these triggers?

_____

23. If any Medicaid services/providers are capitated, have you performed studies on the completeness of the information collected on capitated services? If no providers are paid via capitation, how do you ensure that all services are represented within the information system?

For example, reviewing the encounters reported and following up with providers to ensure completeness of data would be an appropriate response.

☐ Yes

☐ No

If *yes*, what were the results?

_____

24. Claims/Encounters Systems

24a. If multiple systems are used to process performance indicator data (i.e., each CMHSP has its own IS system to process data), document how the performance data are ultimately merged into one PIHP rate.

_____

With what frequency are performance indicator data merged?

_____

24b. Beginning with receipt of a Medicaid claim or encounter in-house, describe the claim/encounter handling, logging, and processes that precede adjudication.

When are Medicaid claims/encounters assigned a document control number and logged or scanned into the system? When are Medicaid claims/encounters microfilmed? If there is a delay in microfilming, how do processors access a claim/encounter that is logged into the system, but is not yet filmed?

Note: This question should only be answered by those entities that receive paper claims and process them manually.

_____

24c. Discuss which decisions in processing a Medicaid claim and encounter (service data) are automated, which are prompted by automated messages appearing on the screen, and which are manual. Document the opportunities a processor has for overriding the system manually.

Is there a report documenting overrides or "exceptions" generated on each processor and reviewed by the claim supervisor? Please describe this report.

The intent of this question is to understand how much manual intervention is required to either data-enter a claim/encounter or to adjudicate a claim. The less manual intervention there is, the less room there is for error.

24d. Are there any outside parties or contractors used to complete adjudication, including but not limited to:

- Bill auditors (hospital claims, claims over a certain dollar amount)
  - ☐ Yes
  - ☐ No
- Peer or medical reviewers
  - ☐ Yes
  - ☐ No
- Sources for additional charge data (usual and customary)
  - ☐ Yes
  - ☐ No
- Bill "re-pricing" for any services provided
  - ☐ Yes
  - ☐ No

How are these data incorporated into your organization's data?

24e. Describe the system's editing capabilities that assure that Medicaid claims and encounters (service data) are processed correctly.

Keep your responses only in the context of the data used for performance indicator reporting. Keep your responses fairly general (i.e., listing the following edits: valid diagnosis and procedure codes, valid recipient ID, valid date of service, mandatory fields, etc.). If your documentation is voluminous, please simply make it available to the reviewers during the site visit.

Provide a list of the specific edits that are performed on claims as they are adjudicated, and note:

1. Whether the edits are performed pre- or post-payment, and
2. Which are manual and which are automated functions.

24f. Please describe how Medicaid eligibility files are updated before providing services, how frequently they updated for ongoing clients, and who has “change” authority. How and when does Medicaid eligibility verification take place (prior to beginning services, monthly, semi-annually, etc.)?

______

24g. Describe how your systems and procedures handle validation and payment of Medicaid claims and encounters (service data) when procedure codes are not provided.

______

24h. Where does the system-generated output (EOBs, remittance advices, pend/rejection reports, etc.) reside?

- ☐ In-house?
- ☐ In a separate facility?

If located elsewhere, how is such work tracked and accounted for?

______

25. Describe all performance monitoring standards for Medicaid claims/encounters processing and recent actual performance results.

This question addresses only those staff who are involved with data entry of claims/encounters and/or adjudication of claims.

______

26. Describe processor-specific performance goals and supervision of actual versus target performance. Do processors have to meet goals for processing speed? Do they have to meet goals for accuracy?

Again, this question addresses those staff who are involved with data entry of claims/encounters and/or adjudication of claims.

______

27. Other Administrative Data Used for Performance Indicator Reporting

27a. Identify other administrative data sources used. Include all data sources that are utilized to calculate performance measures by your PIHP: (*check all that apply)*

- ☐ Sub-Element Cost Report (CMHSPs) or Legislative Boiler Plate Report (CAs)
- ☐ QI Data
- ☐ Appointment/Access Database
- ☐ Consumer Surveys
- ☐ Preadmission Screening Data
- ☐ Case Management Authorization System
- ☐ Client Assessment Records
- ☐ Supported Employment Data
- ☐ Recipient Complaints
- ☐ Telephone Service Data
- ☐ Outcome Measurement Data
- ☐ Other: _____
- ☐ Other: _____

27b. For each data source identified above, describe the flow of data from the point of origin through the point of entry into an administrative database, data warehouse, or reporting system maintained by your PIHP. Dataflow diagrams may be included as an attachment.

_____

27c. For each data source identified above, identify the data elements captured within the administrative database, data warehouse, or reporting system, and used for performance measure reporting. This may be included as a separate attachment and may be documentation of table structures or a data dictionary. If the documentation is voluminous, please make it available to the reviewers during the site visit and indicate this below:

_____

27d. For each data source identified above, describe the validation activities performed by your PIHP to ensure the data in the administrative database are accurate.

_____

B. Eligibility System

1. Please describe any major changes/updates that have taken place in the last three years in your Medicaid eligibility data system. *(Be sure to identify specific dates on which changes were implemented.)*

Examples:

- ☐ New **eligibility** system purchased and installed to replace old system
- ☐ New **eligibility** system purchased and installed to replace most of old system —old system still used
- ☐ Major enhancements to old system (please also explain the types)
- ☐ The use of a vendor-provided eligibility service/system
- ☐ Modifications to eligibility data due to organizational restructuring

______

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

______

3. How does your PIHP uniquely identify consumers?

______

4. How does your PIHP assign unique consumer IDs? Is this number assigned by the PIHP only or do your affiliate CMHSPs also assign unique consumer IDs?

______

5. How do you track consumer eligibility? Does the individual retain the same ID (unique consumer ID)?

6. Can your systems track consumers who switch from one payer source (e.g., Medicaid, commercial plan, federal block grant) to another?

- ☐ Yes
- ☐ No

6a. Can you track previous claims/encounter data for consumers who switch from one payer source to another?

- ☐ Yes
- ☐ No

6b. Are you able to link previous claims/encounter data across payer sources? For example, if a consumer received services under one payer source (e.g., state monies) and then additional services under another payer source (e.g., Medicaid), could the PIHP identify all the services rendered to the individual, regardless of the payer source?

- ☐ Yes
- ☐ No

7. Under what circumstances, if any, can a Medicaid member exist under more than one identification number within your PIHP's information management systems?

This applies to your internal ID, Medicaid ID, etc. How many numbers can one consumer have within your system?

Under what circumstances, if any, can a member's identification number change?

______

8. How often is Medicaid enrollment information updated (e.g., how often does your PIHP receive eligibility updates)?

______

9. Can you track and maintain Medicaid eligibility over time, including retro-active eligibility?

______

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C. Incorporating Data from Subcontractor Systems

Use this section to record information on stand-alone systems or benefits provided through subcontracts, such as CMHSPs, MCPNs, CAs, sub-contract agencies, and other organizational providers.

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

Measure	Subcontractors
The percent of children and adults receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	_____
The percent of new persons receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service.	_____
The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional.	_____
The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days. The percent of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	_____ _____
The percent of Medicaid recipients having received PIHP managed services (this indicator is calculated by MDCH).	_____
The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination. (This indicator is calculated by MDCH)	_____
The percent of adults with mental illness and the percent of adults with developmental disabilities served by PIHPs who are in competitive employment. (This indicator is calculated by MDCH). The validation will focus on FY08 and the first quarter of FY09	_____

for this indicator.	
The percent of adults with mental illness and the percent of adults with developmental disabilities served by CMHSPs and PIHPs who earn minimum wage or more from employment activities (competitive, supported or self employment, or sheltered workshop). (This indicator is calculated by MDCH). The validation will focus on FY08 and the first quarter of FY09 for this indicator.	______
The percent of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	______
The annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by PIHPs.	______
Number of sentinel events during the six-month period per 1,000 Medicaid beneficiaries served by the following populations: adults with mental illness, children with mental illness, and persons with developmental disabilities not on the Habilitation Supports Waiver, persons on the Habilitation Supports Waiver, and persons with substance abuse disorder.	______

2. Discuss any concerns you may have about the quality or completeness of any subcontractor data.
3. Please identify which PIHP mental health services are adjudicated through a separate system that belongs to a subcontractor.
4. Describe the kinds of information sources available to the PIHP from the subcontractor (e.g., monthly hard copy reports, full claims data).
5. Do you evaluate the quality of this information? **If so, how?**
6. Did you incorporate these subcontractor data into the creation of Medicaid-related studies or performance indicator reporting? If not, why not?

D. Integration and Control of Data for Performance Measure Reporting

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

File Consolidation

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

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

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

  ☐ Yes

  ☐ No

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

  ☐ Yes

  ☐ No

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

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

  ☐ Yes

  ☐ No

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

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

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

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

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

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

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

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

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

☐ Yes

☐ No

If yes, please describe: _____

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

☐ Yes

☐ No

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

_____

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

☐ Yes

☐ No

<u>Subcontractor Data Integration</u>

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

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

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

III. DATA ACQUISITION CAPABILITIES

Performance Measure Repository Structure

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

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

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

☐ Yes

☐ No

Report Production

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

______

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

______

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

______

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

______

III. DATA ACQUISITION CAPABILITIES

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

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III. DATA ACQUISITION CAPABILITIES

E. Provider Data

Compensation Structure

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

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

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

   ______

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

   ______

Summary of Requested Documentation

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

Requested Document	Details	Label Number
Previous Medicaid Performance Measure Reports	Please attach final documentation from any previous Medicaid performance measure reporting calculated by your PIHP for the last 4 quarters.	**1.**
Organizational Chart	Please attach an organizational chart for your PIHP. The chart should make clear the relationship among key individuals/departments responsible for information management, including performance measure reporting.	**2.**
Data Integration Flow Chart	Please provide a flowchart that gives an overview of the structure of your management IS. Be sure to show how all claims, encounter, membership, provider, vendor, and other data are integrated for performance measure reporting.	**3.**
Performance Measure Repository File Structure (if applicable)	Provide a complete file structure, file format, and field definitions for the performance measure repository.	**4.**
Program/Query Language for Performance Measure Repository Reporting (if applicable)	Provide full documentation on the software programs or codes used to convert performance measure repository data to performance measures.	**5.**
Medicaid Claims Edits	List of specific edits performed on claims/encounters as they are adjudicated with notation of performance timing (pre- or post-payment) and whether they are manual or automated functions.	**6.**
Statistics on Medicaid claims/encounters and other administrative data	Documentation that explains statistics reported in the ISCA.	**7.**
Health Information System Configuration for Network	Attachment 8	**8.**
______	______	**9.**

Comments:______

Appendix D. Performance Improvement Project Validation Tool

The performance improvement project validation tool and summary form follows this cover page.

Appendix D: Michigan 2008–2009 PIP Validation Tool: <PIP Topic> *for* <PIHP Full Name>

DEMOGRAPHIC INFORMATION	
PIHP Name: **<Full PIHP Name>**	
Study Leader Name: ____________	Title: ____________
Telephone Number: ____________	E-mail Address: ____________
Name of Project/Study: **<PIP Topic>**	
Type of Study: ☐ Clinical ☐ Nonclinical ☐ Collaborative ☐ HEDIS	**Section to be completed by HSAG** _____ Year 1 Validation _____ Initial Submission _____ Resubmission _____ Year 2 Validation _____ Initial Submission _____ Resubmission _____ Year 3 Validation _____ Initial Submission _____ Resubmission
Type of Delivery System – check all that apply: ☐ PIHP ☐ Other: ___________	_____ Baseline Assessment _____ Remeasurement 1 _____Remeasurement 2 _____ Remeasurement 3
Date of Study: ___________ to ___________	Year 1 validated through Step _____ Year 2 validated through Step _____ Year 3 validated through Step _____
Number of Medicaid Beneficiaries Served by PIHP ____________ Number of Medicaid Beneficiaries in Project/Study ____________	
Submission Date: ___________	

Appendix D: Michigan 2008–2009 PIP Validation Tool: <PIP Topic> *for* <PIHP Full Name>

EVALUATION ELEMENTS		SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation			
I.	**Review the Selected Study Topic(s): Topics selected for the study should reflect the Medicaid-enrollment population in terms of demographic characteristics, prevalence of disease, and the potential consequences (risks) of disease. Topics could also address the need for a specific service. The goal of the project should be to improve processes and outcomes of health care for the affected population. The topic may be specified by the state Medicaid agency or based on input from Medicaid beneficiaries. The study topic:**		
—	1. Reflects high-volume or high-risk conditions	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
—	2. Is selected following collection and analysis of data. ***NA*** is not applicable to this element for scoring.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
—	3. Addresses a broad spectrum of care and services The score for this element will be ***Met*** **or** ***Not Met.***	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
—	4. Includes all eligible populations that meet the study criteria. ***NA*** is not applicable to this element for scoring.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
—	5. Does not exclude beneficiaries with special health care needs. The score for this element will be ***Met*** **or** ***Not Met.***	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	

Appendix D: Michigan 2008–2009 PIP Validation Tool: <PIP Topic> *for* <PIHP Full Name>

	EVALUATION ELEMENTS	SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation			
I.	**Review the Selected Study Topic(s): Topics selected for the study should reflect the Medicaid-enrollment population in terms of demographic characteristics, prevalence of disease, and the potential consequences (risks) of disease. Topics could also address the need for a specific service. The goal of the project should be to improve processes and outcomes of health care for the affected population. The topic may be specified by the state Medicaid agency or based on input from Medicaid beneficiaries. The study topic:**		
C*	6. Has the potential to affect beneficiary health, functional status, or satisfaction. The score for this element will be ***Met*** **or** ***Not Met.***	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	

Results for Step I

Total Evaluation Elements					Critical Elements				
Total Evaluation Elements**	*Met*	*Partially Met*	*Not Met*	*NA*	Critical Elements***	*Met*	*Partially Met*	*Not Met*	*NA*
6	0	0	0	0	1	0	0	0	0

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

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

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

EVALUATION ELEMENTS		SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation			
II.	**Review the Study Question(s): Stating the study question(s) helps maintain the focus of the PIP and sets the framework for data collection, analysis, and interpretation. The study question:**		
C	1. States the problem to be studied in simple terms. ***NA*** is not applicable to this element for scoring.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
C	2. Is answerable. ***NA*** is not applicable to this element for scoring.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	

Results for Step II

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

EVALUATION ELEMENTS		SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation			
III.	**Review the Selected Study Indicator(s): A study indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event (e.g., an older adult has not received a influenza vaccination in the last 12 months) or a status (e.g., a beneficiary's blood pressure is or is not below a specified level) that is to be measured. The selected indicators should track performance or improvement over time. The indicators should be objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research. The study indicators:**		
C	1. Are well-defined, objective, and measurable. ***NA*** is not applicable to this element for scoring.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
—	2. Are based on current, evidence-based practice guidelines, pertinent peer-reviewed literature, or consensus expert panels.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
C	3. Allow for the study question to be answered. ***NA*** is not applicable to this element for scoring.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
—	4. Measure changes (outcomes) in health or functional status, beneficiary satisfaction, or valid process alternatives. ***NA*** is not applicable to this element for scoring.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
C	5. Have available data that can be collected on each indicator. ***NA*** is not applicable to this element for scoring.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
—	6. Are nationally recognized measures such as HEDIS technical specifications, when appropriate. The scoring for this element will be ***Met* or *NA*.**	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	

EVALUATION ELEMENTS		SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation			
III.	**Review the Selected Study Indicator(s): A study indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event (e.g., an older adult has not received a influenza vaccination in the last 12 months) or a status (e.g., a beneficiary's blood pressure is or is not below a specified level) that is to be measured. The selected indicators should track performance or improvement over time. The indicators should be objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research. The study indicators:**		
—	7. Includes the basis on which indicator(s) was adopted, if internally developed.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	

Results for Step III

Total Evaluation Elements					Critical Elements				
Total Evaluation Elements	*Met*	*Partially Met*	*Not Met*	*NA*	Critical Elements	*Met*	*Partially Met*	*Not Met*	*NA*
7	0	0	0	0	3	0	0	0	0

EVALUATION ELEMENTS		SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation			
IV.	**Review the Identified Study Population: The selected topic should represent the entire eligible Medicaid-enrollment population, with systemwide measurement and improvement efforts to which the study indicators apply. The study population:**		
C	1. Is accurately and completely defined. ***NA*** is not applicable to this element for scoring.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
—	2. Includes requirements for the length of an beneficiary's enrollment in the MCO.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
C	3. Captures all beneficiaries to whom the study question applies. ***NA*** is not applicable to this element for scoring.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	

Results for Step IV									
Total Evaluation Elements					Critical Elements				
Total Evaluation Elements	*Met*	*Partially Met*	*Not Met*	*NA*	Critical Elements	*Met*	*Partially Met*	*Not Met*	*NA*
3	0	0	0	0	2	0	0	0	0

EVALUATION ELEMENTS		SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation			
V.	**Review Sampling Methods: (This step is scored only if sampling is used.) If sampling is used to select beneficiaries of the study, proper sampling techniques are necessary to provide valid and reliable information on the quality of care provided. The true prevalence or incidence rate for the event in the population may not be known the first time a topic is studied. Sampling methods:**		
—	1. Consider and specify the true or estimated frequency of occurrence.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
—	2. Identify the sample size.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
—	3. Specify the confidence level.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
—	4. Specify the acceptable margin of error.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
C	5. Ensure a representative sample of the eligible population.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
—	6. Are in accordance with generally accepted principles of research design and statistical analysis.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	

Results for Step V

Total Evaluation Elements					Critical Elements				
Total Evaluation Elements	*Met*	*Partially Met*	*Not Met*	*NA*	Critical Elements	*Met*	*Partially Met*	*Not Met*	*NA*
6	0	0	0	0	1	0	0	0	0

EVALUATION ELEMENTS		SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation			
VI.	**Review Data Collection Procedures: Data collection must ensure that the data collected on the study indicators are valid and reliable. Validity is an indication of the accuracy of the information obtained. Reliability is an indication of the repeatability or reproducibility of a measurement. Data collection procedures include:**		
—	1. The identification of data elements to be collected. ***NA*** is not applicable to this element for scoring.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
—	2. The identification of specified sources of data. **NA** is not applicable to this element for scoring.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
—	3. A defined and systematic process for collecting Baseline and remeasurement data. ***NA*** is not applicable to this element for scoring.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
—	4. A timeline for the collection of Baseline and remeasurement data. ***NA*** is not applicable to this element for scoring.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
—	5. Qualified staff and personnel to abstract manual data.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
C*	6. A manual data collection tool that ensures consistent and accurate collection of data according to indicator specifications.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
—	7. A manual data collection tool that supports interrater reliability.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
—	8. Clear and concise written instructions for completing the manual data collection tool.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
—	9. An overview of the study in written instructions.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
—	10. Administrative data collection algorithms/ flow charts that show activities in the production of indicators.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	

EVALUATION ELEMENTS		SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation			
VI.	**Review Data Collection Procedures: Data collection must ensure that the data collected on the study indicators are valid and reliable. Validity is an indication of the accuracy of the information obtained. Reliability is an indication of the repeatability or reproducibility of a measurement. Data collection procedures include:**		
—	11. An estimated degree of administrative data completeness. *Met* =80–100 percent *Partially Met* =50–79 percent *Not Met* =<50 percent or not provided	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	

Results for Step VI

Total Evaluation Elements					Critical Elements				
Total Evaluation Elements	*Met*	*Partially Met*	*Not Met*	*NA*	Critical Elements	*Met*	*Partially Met*	*Not Met*	*NA*
11	0	0	0	0	1	0	0	0	0

Appendix D: Michigan 2008–2009 PIP Validation Tool: <PIP Topic> *for* <PIHP Full Name>

EVALUATION ELEMENTS		SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation			
VII.	**Assess Improvement Strategies: Real, sustained improvements in care result from a continuous cycle of measuring and analyzing performance, as well as developing and implementing systemwide improvements in care. Interventions are designed to change behavior at an institutional, practitioner, or beneficiary level. The improvement strategies are:**		
C*	1. Related to causes/barriers identified through data analysis and quality improvement processes. ***NA*** is not applicable to this element for scoring.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
—	2. System changes that are likely to induce permanent change.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
—	3. Revised if the original interventions are not successful.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
—	4. Standardized and monitored if interventions are successful.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	

Results for Step VII

Total Evaluation Elements					Critical Elements				
Total Evaluation Elements	*Met*	*Partially Met*	*Not Met*	*NA*	Critical Elements	*Met*	*Partially Met*	*Not Met*	*NA*
4	0	0	0	0	1	0	0	0	0

EVALUATION ELEMENTS		SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation			
VIII.	**Review Data Analysis and the Interpretation of Study Results: Review the data analysis process for the selected clinical or nonclinical study indicators. Review appropriateness of, and adherence to, the statistical analysis techniques used. The data analysis and interpretation of the study results:**		
C	1. Are conducted according to the data analysis plan in the study design. ***NA*** is not applicable to this element for scoring.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
C	2. Allow for the generalization of results to the study population if a sample was selected. If sampling was not used, this score will be ***NA.***	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
—	3. Identify factors that threaten internal or external validity of findings. ***NA*** is not applicable to this element for scoring.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
—	4. Include an interpretation of findings. ***NA*** is not applicable to this element for scoring.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
—	5. Are presented in a way that provides accurate, clear, and easily understood information. ***NA*** is not applicable to this element for scoring.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
—	6. Identify the initial measurement and the remeasurement of study indicators.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
—	7. Identify statistical differences between the initial measurement and the remeasurement.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
—	8. Identify factors that affect the ability to compare the initial measurement with the remeasurement.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	

EVALUATION ELEMENTS		SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation			
VIII.	**Review Data Analysis and the Interpretation of Study Results: Review the data analysis process for the selected clinical or nonclinical study indicators. Review appropriateness of, and adherence to, the statistical analysis techniques used. The data analysis and interpretation of the study results:**		
—	9. Include an interpretation of the extent to which the study was successful.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	

Results for Step VIII									
Total Evaluation Elements					Critical Elements				
Total Evaluation Elements	*Met*	*Partially Met*	*Not Met*	*NA*	Critical Elements	*Met*	*Partially Met*	*Not Met*	*NA*
9	0	0	0	0	2	0	0	0	0

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

Results for Step IX

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

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

Results for Step X

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

Appendix D: Michigan 2008–2009 PIP Validation Tool: <PIP Topic> *for* <PIHP Full Name>

Table 3–1—2008–2009 PIP Validation Summary Scores *for* <PIP Topic> *for* <PIHP Full Name>										
Review Steps	**Total Possible Evaluation Elements** (Including Critical Elements)	**Total *Met***	**Total *Partially Met***	**Total *Not Met***	**Total *NA***	**Total Possible Critical Elements**	**Total Critical Elements *Met***	**Total Critical Elements *Partially Met***	**Total Critical Elements *Not Met***	**Total Critical Elements *NA***
I. Review the Selected Study Topic	6					1				
II. Review the Study Question(s)	2					2				
III. Review the Selected Study Indicators	7					3				
IV. Review the Identified Study Population	3					2				
V. Review Sampling Methods	6					1				
VI. Review Data Collection Procedures	11					1				
VII. Assess Improvement Strategies	4					1				
VIII. Review Data Analysis and Interpretation of Study Results	9					2				
IX. Assess for Real Improvement	4					No Critical Elements				
X. Assess for Sustained Improvement	1					No Critical Elements				
Totals for All Steps	**53**					**13**				

Table 3–2—2008–2009 PIP Validation Summary Overall Score *for* <PIP Topic> *for* <PIHP Full Name>	
Percentage Score of Evaluation Elements *Met**	%
Percentage Score of Critical Elements *Met***	%
Validation Status***	***<Met, Partially Met, or Not Met>***

* The percentage score for all evaluation elements *Met* is calculated by dividing the total *Met* by the sum of all evaluation elements *Met, Partially Met*, and *Not Met*.

** The percentage score for critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

*** *Met* equals confidence/high confidence that the PIP was valid.
Partially Met equals low confidence that the PIP was valid.
Not Met equals reported PIP results that were not credible.

EVALUATION OF THE OVERALL VALIDITY AND RELIABILITY OF PIP RESULTS
HSAG assessed the implications of the study's findings on the likely validity and reliability of the results based on the CMS Protocol for validating PIPs. HSAG also assessed whether the State should have confidence in the reported PIP findings.
Met **= Confidence/high confidence in the reported PIP results** ***Partially Met*** **= Low confidence in the reported PIP results** ***Not Met*** **= Reported PIP results that were not credible**
Summary of Aggregate Validation Findings ☐ ***Met*** ☐ ***Partially Met*** ☐ ***Not Met***
Summary statement on the validation findings: Steps xx through xx were assessed for this PIP Validation Report. Based on the validation of this PIP, HSAG's assessment determined xx confidence in the results.

Appendix D: Michigan 2008-2009 PIP Summary Form: Improving The Penetration Rates For Children *FOR* <PIHP FULL NAME>

DEMOGRAPHIC INFORMATION

PIHP Name: <PIHP Full Name>

Study Leader Name: __________ Title: __________

Telephone Number: __________ E-mail Address: __________

Name of Project/Study: Improving the Penetration Rates for Children with Serious Emotional Disturbance, Children with a Developmental Disability, and Children who have both a Serious Emotional Disturbance, and a Developmental Disability

Type of Study:

☐ Clinical ☐ Nonclinical

☐ Collaborative ☐ HEDIS

Type of Delivery System: PIHP

Date of Study: __________ to __________

Number of Medicaid Beneficiaries Served by PIHP __________

Number of Medicaid Beneficiaries in Project/Study __________

Submission Date: __________

Section to be completed by HSAG

_____ Year 1 Validation _____ Initial Submission _____ Resubmission

_____ Year 2 Validation _____ Initial Submission _____ Resubmission

_____ Year 3 Validation _____ Initial Submission _____ Resubmission

_____ Baseline Assessment _____ Remeasurement 1

_____Remeasurement 2 _____ Remeasurement 3

Year 1 validated through Step _____

Year 2 validated through Step _____

Year 3 validated through Step _____

Appendix D: Michigan 2008-2009 PIP Summary Form: Improving The Penetration Rates For Children

FOR <PIHP FULL NAME>

A. Activity I: Choose the study topic. PIP topics should target improvement in relevant areas of services and reflect the population in terms of demographic characteristics, prevalence of disease, and the potential consequences (risks) of disease. Topics may be derived from utilization data (ICD-9 or CPT coding data related to diagnoses and procedures; NDC codes for medications; HCPCS codes for medications, medical supplies, and medical equipment; adverse events; admissions; readmissions; etc.); grievances and appeals data; survey data; provider access or appointment availability data; beneficiary characteristics data such as race/ethnicity/language; other fee-for-service data; or local or national data related to Medicaid risk populations. The goal of the project should be to improve processes and outcomes of health care or services to have a potentially significant impact on beneficiary health, functional status, or satisfaction. The topic may be specified by the state Medicaid agency or CMS, or it may be based on input from beneficiaries. Over time, topics must cover a broad spectrum of key aspects of beneficiary care and services, including clinical and nonclinical areas, and should include all enrolled populations (i.e., certain subsets of beneficiaries should not be consistently excluded from studies).
Study topic:

B. Activity II: Define the study question(s). Stating the question(s) helps maintain the focus of the PIP and sets the framework for data collection, analysis, and interpretation.
Study question: 1.

C. Activity III: Select the study indicator(s). A study indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event (e.g., an older adult has not received an influenza vaccination in the last 12 months) or a status (e.g., a beneficiaries blood pressure is/is not below a specified level) that is to be measured. The selected indicators should track performance or improvement over time. The indicators should be objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research.	
Study Indicator 1	**Describe the rationale for selection of the study indicator:**
Numerator: (no numeric value)	
Denominator: (no numeric value)	
Baseline Measurement Period	
Baseline Goal	
Remeasurement 1 Period	
Remeasurement 2 Period	
Benchmark	
Source of Benchmark	
Study Indicator 2	**Describe the rationale for selection of the study indicator:**
Numerator: (no numeric value)	
Denominator: (no numeric value)	
Baseline Measurement Period	

C. Activity III: Select the study indicator(s). A study indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event (e.g., an older adult has not received an influenza vaccination in the last 12 months) or a status (e.g., a beneficiaries blood pressure is/is not below a specified level) that is to be measured. The selected indicators should track performance or improvement over time. The indicators should be objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research.	
Baseline Goal	
Remeasurement 1 Period	
Remeasurement 2 Period	
Benchmark	
Source of Benchmark	

C. Activity III: Select the study indicator(s). A study indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event (e.g., an older adult has not received an influenza vaccination in the last 12 months) or a status (e.g., a beneficiaries blood pressure is/is not below a specified level) that is to be measured. The selected indicators should track performance or improvement over time. The indicators should be objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research.	
Study Indicator 3	**Describe the rationale for selection of the study indicator:**
Numerator: (no numeric value)	
Denominator: (no numeric value)	
Baseline Measurement Period	
Baseline Goal	
Remeasurement 1 Period	
Remeasurement 2 Period	
Benchmark	
Source of Benchmark	
Use this area to provide additional information. Discuss the guidelines used and the basis for each study indicator.	

D. Activity IV: Use a representative and generalizable study population. The selected topic should represent the entire eligible population of Medicare beneficiaries, with systemwide measurement and improvement efforts to which the study indicators apply. Once the population is identified, a decision must be made whether or not to review data for the entire population or a sample of that population. The length of beneficiaries' enrollment needs to be defined to meet the study population criteria.
Study population:

E. Activity V: Use sound sampling methods. If sampling is used to select beneficiaries of the study, proper sampling techniques are necessary to provide valid and reliable information on the quality of care provided. The true prevalence or incidence rate for the event in the population may not be known the first time a topic is studied.

Measure	Sample Error and Confidence Level	Sample Size	Population	Method for Determining Size (*Describe*)	Sampling Method (*Describe*)

F. Activity VIa: Use valid and reliable data collection procedures. Data collection must ensure that data collected on PIP indicators are valid and reliable. Validity is an indication of the accuracy of the information obtained. Reliability is an indication of the repeatability or reproducibility of a measurement.

Data Sources

[ ] Hybrid (medical/treatment records and administrative)

[ ] Medical/Treatment Record Abstraction

Record Type
- [ ] Outpatient
- [ ] Inpatient
- [ ] Other ______________________________

Other Requirements
- [ ] Data collection tool attached
- [ ] Data collection instructions attached
- [ ] Summary of data collection training attached
- [ ] IRR process and results attached

[ ] Other Data

____

____

____

____

Description of data collection staff to include training, experience, and qualifications:

____

____

____

[ ] Administrative Data

Data Source
- [ ] Programmed pull from claims/encounters
- [ ] Complaint/appeal
- [ ] Pharmacy data
- [ ] Telephone service data /call center data
- [ ] Appointment/access data
- [ ] Delegated entity/vendor data ______________________________
- [ ] Other ______________________________

Other Requirements
- [ ] Data completeness assessment attached
- [ ] Coding verification process attached

[ ] Survey Data

Fielding Method
- [ ] Personal interview
- [ ] Mail
- [ ] Phone with CATI script
- [ ] Phone with IVR
- [ ] Internet
- [ ] Other ______________________________

Other Requirements
- [ ] Number of waves ______________________________
- [ ] Response rate ______________________________
- [ ] Incentives used ______________________________

Appendix D: Michigan 2008-2009 PIP Summary Form: Improving The Penetration Rates For Children

FOR <PIHP FULL NAME>

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F. Activity VIb: Determine the data collection cycle.	Determine the data analysis cycle.
[ ] Once a year [ ] Twice a year [ ] Once a season [ ] Once a quarter [ ] Once a month [ ] Once a week [ ] Once a day [ ] Continuous [ ] Other (list and describe):	[ ] Once a year [ ] Once a season [ ] Once a quarter [ ] Once a month [ ] Continuous [ ] Other (list and describe):

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

Estimated percentage degree of administrative data completeness: ______ percent.

Describe the process used to determine data completeness and accuracy:

Supporting documentation:

G. Activity VIIa: Include improvement strategies (interventions for improvement as a result of analysis). List chronologically the interventions that have had the most impact on improving the measure. Describe only the interventions and provide quantitative details whenever possible (e.g., “Hired four customer service representatives” as opposed to “Hired customer service representatives”). Do not include intervention planning activities.

Date Implemented (MMYY)	Check if Ongoing	Interventions	Barriers That Interventions Address

G. Activity VIIa: Include improvement strategies (interventions for improvement as a result of analysis). List chronologically the interventions that have had the most impact on improving the measure. Describe only the interventions and provide quantitative details whenever possible (e.g., "Hired four customer service representatives" as opposed to "Hired customer service representatives"). Do not include intervention planning activities.			
Date Implemented (MMYY)	**Check if Ongoing**	**Interventions**	**Barriers That Interventions Address**
Describe the process used for the casual/barrier analyses that led to the development of the interventions:			

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

H. Activity VIIIa: Data analysis. Describe the data analysis process done in accordance with the data analysis plan and any ad hoc analyses (e.g., data mining) done on the selected clinical or nonclinical study indicators. Include the statistical analysis techniques used and *p* values.
Describe the data analysis process (include the data analysis plan): **Baseline Measurement:** **Baseline to Remeasurement 1:** **Remeasurement 1 to Remeasurement 2:** **Remeasurement 2 to Remeasurement 3:**

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

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FOR <PIHP FULL NAME>

I. Activity IX: Report improvement. Enter results for each study indicator, including benchmarks and statistical testing with complete *p* values, and statistical significance.

Quantifiable Measure 1: Enter title of study indicator

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

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

Quantifiable Measure 2: Enter title of study indicator

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

I. Activity IX: Report improvement. Enter results for each study indicator, including benchmarks and statistical testing with complete *p* values, and statistical significance.
Describe any demonstration of meaningful change in performance observed from Baseline and each measurement period (e.g., Baseline to Remeasurement 1, Remeasurement 1 to Remeasurement 2, or Baseline to final remeasurement):

Appendix D: Michigan 2008-2009 PIP Summary Form: Improving The Penetration Rates For Children
FOR <PIHP FULL NAME>

I. Activity IX: Report improvement. Enter results for each study indicator, including benchmarks and statistical testing with complete *p* values, and statistical significance.						
Quantifiable Measure 3: Enter title of study indicator						
Time Period Measurement Covers	**Baseline Project Indicator Measurement**	**Numerator**	**Denominator**	**Rate or Results**	**Industry Benchmark**	**Statistical Test Significance, and *p* value**
	Baseline:					
	Remeasurement 1					
	Remeasurement 2					
	Remeasurement 3					
	Remeasurement 4					
	Remeasurement 5					

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

Appendix D: **Michigan 2008-2009 PIP Summary Form: Improving The Penetration Rates For Children**
***FOR* <PIHP FULL NAME>**

J. Activity X: Describe sustained improvement. Describe any demonstrated improvement through repeated measurements over comparable time periods. Discuss any random, year-to-year variations, population changes, sampling errors, or statistically significant declines that may have occurred during the remeasurement process.
Sustained improvement: