



Behavioral Health and Developmental Disabilities Administration

2016–2017 External Quality Review Technical Report *for* **Prepaid Inpatient Health Plans**

April 2018



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1. Executive Summary

Purpose of Report

As required by the Code of Federal Regulations (CFR) at Title 42, Section (§)438.364,¹⁻¹ the Michigan Department of Health and Human Services (MDHHS) contracts with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual, independent, technical report. As described in the CFR, the independent report must summarize findings on timeliness, access and quality of care, including:

- A description of how data from all activities conducted in accordance with §438.358 were aggregated and analyzed and how conclusions were drawn as to the quality, timeliness of, and access to care furnished by the managed care organization (MCO), prepaid inpatient health plan (PIHP), prepaid ambulatory health plan (PAHP), or primary care case management (PCCM) entity.
- For each EQR-related activity conducted in accordance with §438.358:
 - Objectives.
 - Technical methods of data collection and analysis.
 - Description of data obtained, including validated performance measurement data for each activity conducted in accordance with §438.358(b)(1)(i) and (ii).
 - Conclusions drawn from the data.
- An assessment of each MCO, PIHP, PAHP, or PCCM entity's strengths and weaknesses for the quality and timeliness of, and access to healthcare services furnished to Medicaid beneficiaries.
- Recommendations for improving the quality of healthcare services furnished by each MCO, PIHP, PAHP, and PCCM entity, including how the State can target goals and objectives in the quality strategy, under §438.340, to better support improvement in the quality and timeliness of, and access to healthcare services furnished to Medicaid beneficiaries.
- Methodologically appropriate, comparative information about all MCOs, PIHPs, PAHPs, and PCCM entities, consistent with guidance included in the EQR protocols issued in accordance with §438.352(e).
- An assessment of the degree to which each MCO, PIHP, PAHP, or PCCM entity has addressed effectively the recommendations for quality improvement made by the EQRO during the previous year's EQR.

¹⁻¹ Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register*/Vol. 81, No. 88/Friday, May 6, 2016. 42 CFR Parts 431, 433, 438, et al. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered [*sic*] in Managed Care, and Revisions Related to Third Party Liability; Final Rule. Available at: <https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf>. Accessed on: Nov 14, 2017.

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

MDHHS contracted with the following 10 PIHPs:

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

Scope of External Quality Review (EQR) Activities Conducted

This EQR technical report focuses on the three federally mandated EQR activities conducted by HSAG. As set forth in 42 CFR §438.358, these mandatory activities were:

- **Compliance monitoring:** The 2016–2017 reporting period was the third year of the three-year compliance review cycle. A full review of all standards was completed in 2014–2015. In 2015–2016, a follow-up review of the elements scored less than *Met* was conducted. In 2016–2017, HSAG began working with MDHHS to plan the next cycle of reviews, that will be conducted in 2017–2018.
- **Validation of performance measures:** HSAG validated the performance measures identified by MDHHS to evaluate the accuracy of the rates reported by or on behalf of a PIHP. The validation also determined the extent to which Medicaid-specific performance measures calculated by a PIHP followed the specifications established by MDHHS.
- **Validation of performance improvement projects (PIPs):** For each PIHP, HSAG reviewed one PIP to ensure that the PIHP designed, conducted, and reported on the project in a methodologically sound manner, allowing real improvements in care and giving confidence in the reported improvements.

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

Definitions

The final managed care rule states that “each contract with a Medicaid managed care organization must provide for an annual external independent review conducted by a qualified independent entity of the quality outcomes and timeliness of, and access to, the items and services for which the organization is responsible.”¹⁻² The Centers for Medicare & Medicaid Services (CMS) has chosen the domains of quality, timeliness, and access as keys to evaluating the performance of MCOs and PIHPs. HSAG used the following definitions to evaluate and draw conclusions about the performance of the PIHPs in each of these domains.

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 [managed care organization], PIHP [prepaid inpatient health plan], PAHP [prepaid ambulatory health plan], or PCCM [primary care case management] entity (described in §438.310[c][2]) increases the likelihood of desired outcomes of its enrollees through: (1) Its structural and operational characteristics. (2) The provision of services that are consistent with current professional evidence-based knowledge. (3) Interventions for performance improvement.”¹⁻³

Timeliness

The National Committee for Quality Assurance (NCQA) defines “timeliness” relative to utilization decisions as follows: “The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation.”¹⁻⁴ NCQA further discusses the intent of this standard to minimize any disruption in the provision of healthcare. HSAG extends this definition of “timeliness” to include other managed care provisions that impact services to enrollees and that require timely response by the PIHP—e.g., processing expedited appeals and providing timely follow-up care. In the final 2016 federal managed care regulations, CMS recognized the importance of timeliness of services by incorporating timeliness into the general rule at 42 CFR §438.206(a) and by requiring states, at 42 CFR §438.68(b), to develop both time and distance standards for network adequacy.

Access

CMS defines “access” in the final rule at 42 CFR §438.320 as follows: “Access, as it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by managed

¹⁻² Department of Health and Human Services Centers for Medicare & Medicaid Services. *Legislative Summary: Balanced Budget Act of 1997 Medicare and Medicaid Provisions*.

¹⁻³ Department of Health and Human Services Centers for Medicare & Medicaid Services. *Federal Register. Code of Federal Regulations*. Title 42, Vol. 81, No. 88, May 6, 2016.

¹⁻⁴ National Committee on Quality Assurance. 2016 Standards and Guidelines for the Accreditation of Health Plans.

care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under §438.68 (Network adequacy standards) and §438.206 (Availability of services).”¹⁻⁵

Findings Related to Quality, Timeliness, and Access

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

The following is a high-level statewide summary of the conclusions drawn from the findings of the EQR activities, including HSAG’s recommendations with respect to **quality**, **timeliness**, and **access**. Section 3 of this report details the PIHP-specific results.

Overview

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

Table 1–1—Assignment of Activities to Performance Domains

Compliance Review Standards ^{1-6, 1-7}	Quality	Timeliness	Access
Standard I—Quality Assessment and Performance Improvement Program (QAPI) Plan and Structure	✓		
Standard II—Performance Measurement and Improvement	✓	✓	
Standard III—Practice Guidelines	✓		
Standard IV—Staff Qualifications and Training	✓		
Standard V—Utilization Management		✓	✓
Standard VI—Customer Services	✓		✓
Standard VII—Enrollee Grievance Process	✓	✓	
Standard VIII—Enrollee Rights and Protections	✓		

¹⁻⁵ Department of Health and Human Services Centers for Medicare & Medicaid Services. *Federal Register*, Vol. 81, No. 88, May 5, 2016.

¹⁻⁶ The compliance monitoring reviews addressed an additional standard (Standard XV—Disclosure of Ownership, Control, and Criminal Convictions) which was not related to any domains and was therefore not included in Table 1–1.

¹⁻⁷ Compliance monitoring activities were not required to be conducted in 2016–2017 as they were completed during the previous two years. A new cycle of reviews will begin in 2017–2018. The standards are included herein for completeness; however, a detailed discussion of findings is not included as this would duplicate information published in prior technical reports.

Compliance Review Standards ^{1-6, 1-7}	Quality	Timeliness	Access
Standard IX—Subcontracts and Delegation	✓		
Standard X—Provider Network	✓		✓
Standard XI—Credentialing	✓		
Standard XII—Access and Availability		✓	✓
Standard XIII—Coordination of Care	✓		✓
Standard XIV—Appeals	✓	✓	
Performance Measures	Quality	Timeliness	Access
Indicator #1—Preadmission Screening		✓	✓
Indicator #2—Face-to-Face Assessment		✓	✓
Indicator #3—First Service		✓	✓
Indicator #4a—Follow-Up Care	✓	✓	✓
Indicator #4b—Follow-Up Care After Detox	✓	✓	✓
Indicator #5—Penetration Rate			✓
Indicator #6—Habilitation Supports Waiver (HSW) Rate	✓		
Indicator #8—Competitive Employment	✓		
Indicator #9—Earning Minimum Wage	✓		
Indicator #10—Readmission Rate	✓		
Indicator #13—Adults with DD living in a private residence	✓		
Indicator #14—Adults with MI living in a private residence	✓		
Performance Improvement Project	Quality	Timeliness	Access
<i>Behavioral and Physical Health Care Integration</i>	✓		✓

Performance Measures

Table 1–2 displays the statewide scores and the lowest and highest scores among the PIHPs for validated performance measure indicators.

Table 1–2—Performance Measure Indicator Scores

Performance Indicator	Statewide Score	Minimum Performance Standard	PIHP Low Score	PIHP High Score
#1: The percent of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.				
Children	98.96%	95.00%	93.02%	100%
Adults	98.27%	95.00%	96.79%	100%
#2: The percent of new Medicaid beneficiaries during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service.				
MI Children	97.79%	95.00%	94.83%	99.25%
MI Adults	98.09%	95.00%	95.45%	99.53%
DD Children	99.13%	95.00%	97.14%	100%
DD Adults	99.09%	95.00%	93.02%	100%
Medicaid SA	97.61%	95.00%	86.78%	99.64%
Total	97.87%	95.00%	93.35%	98.76%
#3: The percent of new Medicaid beneficiaries during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional.				
MI Children	97.37%	95.00%	91.80%	99.53%
MI Adults	97.64%	95.00%	95.26%	99.49%
DD Children	95.37%	95.00%	87.50%	100%
DD Adults	95.24%	95.00%	92.00%	100%
Medicaid SA	97.67%	95.00%	92.54%	100%
Total	97.48%	95.00%	94.10%	99.17%
#4a: The percent of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.				
Children	98.23%	95.00%	93.55%	100%
Adults	95.16%	95.00%	90.69%	97.11%
#4b: The percent of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.				
The percent of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.	98.95%	95.00%	95.41%	100%

Performance Indicator	Statewide Score	Minimum Performance Standard	PIHP Low Score	PIHP High Score
#5: The percent of Medicaid recipients having received PIHP managed services.				
The percent of Medicaid recipients having received PIHP managed services.	6.90%	—	5.12%	8.10%
#6: The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.				
The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	98.05%	—	97.03%	99.79%
#8: The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who are employed competitively.				
MI Adults	12.24%	—	9.03%	16.23%
DD Adults	9.51%	—	5.38%	14.16%
MI/DD Adults	8.68%	—	5.97%	13.03%
#9: The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.				
MI Adults	82.83%	—	78.15%	87.05%
DD Adults	39.90%	—	13.11%	92.71%
MI/DD Adults	39.84%	—	21.25%	84.03%
#10: The percent of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.*				
Children	7.87%	15.00%	0%	11.32%
Adults	13.70%	15.00%	8.19%	18.40%
#13: The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).				
The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	18.26%	—	6.59%	29.06%
#14: The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).				
The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or with non-relative(s).	42.14%	—	29.67%	53.80%

Yellow shading indicates that the reported rate was better than the minimum performance standard.

— Indicates that a minimum performance standard was not established for this measure indicator.

* A lower rate indicates better performance.

Timeliness of care and **access** to care are demonstrated as statewide strengths for the PIHPs. As displayed preceding, the statewide score exceeds the minimum performance standard for each of the following indicators:

- *#1: The percent of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours—Children and Adults.*
- *#2: The percent of new Medicaid beneficiaries during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service—MI Children, MI Adults, DD Children, DD Adults, Medicaid SA, and Total.*
- *#3: The percent of new Medicaid beneficiaries during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional—MI Children, MI Adults, DD Children, DD Adults, Medicaid SA, and Total.*

The statewide score for the following performance indicators also exceeded the minimum performance standards, indicating statewide strengths in **quality**, **timeliness**, and **access**:

- *#4a: The percent of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days—Children and Adults.*
- *#4b: The percent of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.*

The performance indicator regarding readmissions includes a performance standard not to exceed 15 percent. For this indicator, the statewide score was below the performance standard of 15 percent, which indicates a statewide strength regarding **quality**.

- *#10: The percent of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge—Children and Adults.*

Although the statewide score for each indicator with a minimum performance standard was better than the minimum performance standard, in most instances at least one PIHP had a score that did not meet the minimum performance standard. Instances in which an individual PIHP did not meet the standard indicate opportunities for improvement. A detailed discussion regarding each PIHP, including areas for improvement in **quality**, **access**, and **timeliness**, is included in Section 3 (PIHP-specific findings).

Performance Improvement Projects

Table 1–3 displays the statewide scores and the lowest and highest scores among PIHPs for the performance improvement projects.

Table 1–3—Summary of Performance Improvement Project Activities

Measure	Statewide Score	PIHP Low Score	PIHP High Score
Performance Improvement Projects			
All evaluation elements <i>Met</i>	99%	90%	100%
Critical elements <i>Met</i>	100%	100%	100%

For the 2016–2017 validation cycle, the PIHPs provided the fourth-year submissions for topics that each selected related to behavioral and physical healthcare integration. These topics addressed the **quality** of and **access** to care and services. HSAG validated Activities I through X, assessing the Design, Implementation, and Outcomes stages for nine of 10 PIPs. All 10 PIPs received a validation status of *Met*, indicating that the PIHPs designed, conducted, and reported their projects in a methodologically sound manner—allowing real improvements in care—and achieved statistically significant improvement in the study indicators from the baseline rate to Remeasurement 2. Nine of these 10 PIPs also demonstrated sustained improvement in the study indicator outcomes, indicating achievement of statistically significant improvement over the baseline for two consecutive measurement periods.

Findings for the Validation of Performance Measures

CMS designed the validation of performance measure activity to ensure the accuracy of the results reported by the PIHPs to MDHHS. To determine that the results were valid and accurate, HSAG evaluated the PIHPs’ data collection and calculation processes and the degree of compliance with the MDHHS Codebook specifications.

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

Table 1–4 presents the percentage of performance indicators that were assigned a *Report* (*R*) validation finding, the percentage of performance indicators that were assigned a *Not Reported* (*NR*) validation finding, and the percentage of performance indicators that were assigned a *No Benefit* (*NB*) validation finding based on HSAG’s validation of the PIHPs’ performance indicators. Of note, validation findings are assigned at the performance indicator level, not at the sub-population or population-stratified level.

**Table 1–4—Overall PIHP Compliance
With MDHHS Specifications for All Performance Indicators**

Validation Finding	Percent
<i>Report (R)</i>	91%
<i>Not Reported (NR)</i>	9%
<i>No Benefit (NB)</i>	0%

Table 1–5 displays overall PIHP compliance with the MDHHS codebook specifications for each of the 12 performance indicators validated by HSAG.

Table 1–5—Performance Indicator Results—Validation Designation

Performance Indicator		Percentage of PIHPs		
		R	NR	NB
#1	<i>The percent of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.</i>	90%	10%	0%
#2	<i>The percent of new Medicaid beneficiaries during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service.</i>	80%	20%	0%
#3	<i>The percent of new Medicaid beneficiaries during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional.</i>	80%	20%	0%
#4a	<i>The percent of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.</i>	80%	20%	0%
#4b	<i>The percent of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.</i>	70%	30%	0%
#5	<i>The percent of Medicaid recipients having received PIHP managed services.</i>	100%	0%	0%
#6	<i>The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.</i>	100%	0%	0%
#8	<i>The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who are employed competitively.</i>	100%	0%	0%

Performance Indicator		Percentage of PIHPs		
		R	NR	NB
#9	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.	100%	0%	0%
#10	The percent of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.	90%	10%	0%
#13	The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	100%	0%	0%
#14	The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	100%	0%	0%

Findings—System and Reporting Capabilities

HSAG validated the performance measures for each PIHP. Six of the 10 PIHPs each received a validation designation of *Report* for all performance measures within the scope of the audit. One PIHP received a *Not Reported* rating for all performance measures calculated by the PIHPs.

HSAG validated the data integration and control process used by the PIHPs and determined that, statewide, the processes in place were acceptable. Overall, the PIHPs had sufficient and complete documentation of performance indicator calculations. PIHPs with regions spanning multiple counties provided adequate oversight of the affiliated community mental health centers and in some cases strengthened monitoring processes to ensure accuracy and completeness of data submitted to the State. Statewide, the PIHPs demonstrated compliance with requirements for receiving and processing eligibility data, claims, and encounters.

Continued strengths for the PIHPs included sufficient staff training and robust oversight of the CMHSPs. Several PIHPs added new staff members who had experience with behavioral health data and who were familiar with the performance indicator calculation processes, quality improvement measures, and data reporting requirements.

HSAG also identified areas that represent opportunities for improvement. The detailed findings regarding the individual PIHPs are included in Section 3. Issues of importance or concerns noted for more than one PIHP are included below:

- In some instances, documentation in the PIHP's transactional system was not sufficient for HSAG to validate certain cases during primary source verification.
- HSAG noted that one PIHP implemented a new transactional system; however, due to lack of adequate system training and data validation, this PIHP was unable to produce valid and complete

data timely. Due to the significance of the missing data, the results from this PIHP were determined “materially biased” and received *Not Reported* audit designations.

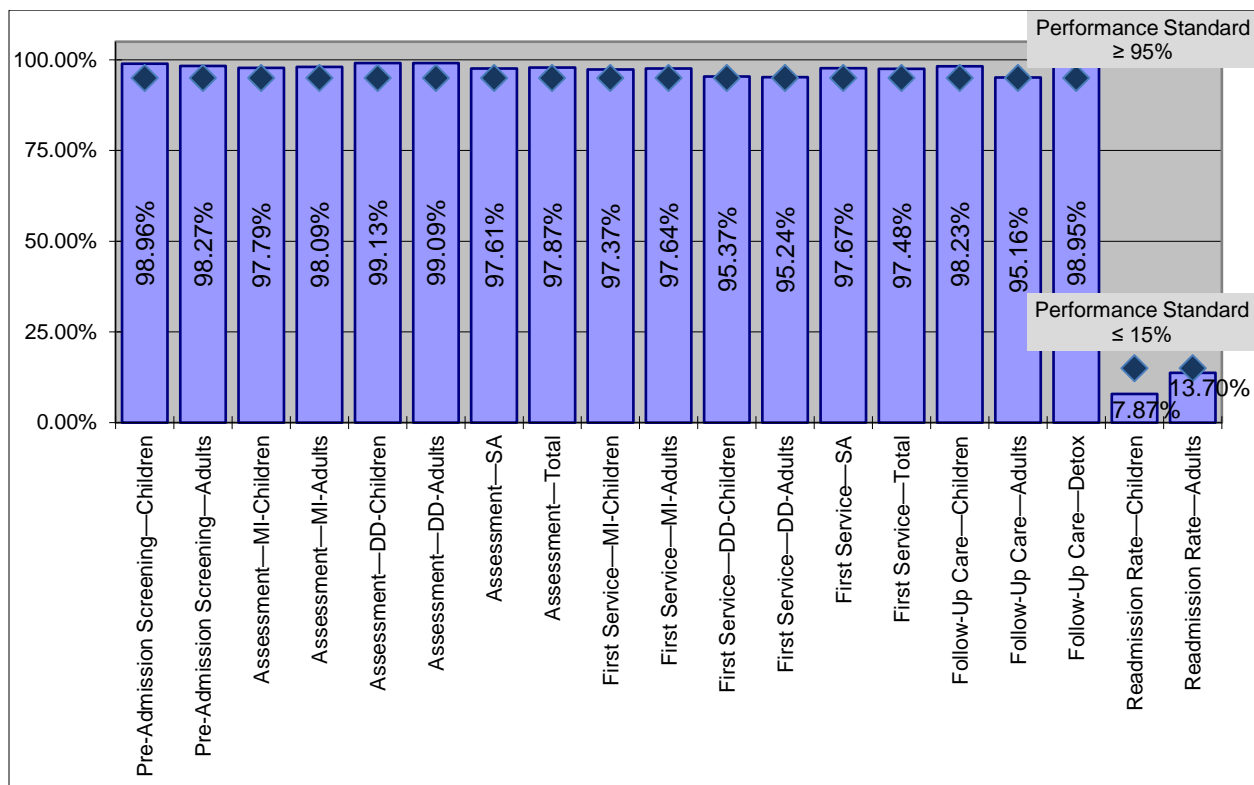
- In some instances, it was determined that cases were erroneously included as numerator-positive by a PIHP during the on-site review as evidence of numerator compliance could not be validated. Such instances resulted in *Not Reported* audit designations.
- For more than one PIHP, the PIHP was unable to provide the consumer-level detail information used for reporting measures to the State. This resulted in *Not Reported* audit designations.

Findings—Performance Measure Results

Statewide rates were calculated by summing the number of cases that met the requirements of the indicator across all PIHPs (e.g., for all 10 PIHPs, the total number of adults who received a timely follow-up service) and dividing this number by the number of applicable cases across all PIHPs (e.g., for all 10 PIHPs, the total number of adults discharged from psychiatric inpatient facilities). This calculation excluded all rates with *NR* validation finding designations; therefore, the number of PIHPs included in the statewide rates was reduced for some indicators: nine PIHPs for Indicators #1 and #10; eight PIHPs for Indicators #2, #3, and #4a; and seven PIHPs for Indicator #4b. MDHHS did not specify any standard for Indicators #5, #6, #8, #9, #13, or #14.

MDHHS does not specify a standard for all measures. Statewide performance exceeded the MDHHS-established minimum performance standards for all indicators with specified standards, as shown in Figure 1-1.

Figure 1-1—Statewide Rates for Performance Measures



As displayed in Figure 1-1, continued strong performance resulted in statewide rates that exceeded the MDHHS benchmark for all indicators. Indicator #2—Face-to-Face Assessment (DD Children) showed the highest statewide rate at 99.13 percent. Readmission Rate (Indicator #10) represented another statewide area of strength, with statewide rates meeting the performance standard of 15 percent or less for both children and adults.

Compared to performance in the prior validation cycle, most statewide rates for indicators remained essentially unchanged, with changes in rate of less than 1 percent. Refer to Appendix A, Table A-2. A few measures did achieve an improvement in performance of greater than 1 percent, which may indicate statewide strengths. These measures are listed below with commentary related to improvement specified after each.

- *#3: The percent of new Medicaid beneficiaries during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional—DD Adults.*

Although the increase is only slightly greater than 1 percent, the change is important as the current statewide average now exceeds the performance standard and did not prior year.

- *#9: The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.*

The percentage of members with mental illness and/or developmental disabilities earning minimum wage or greater from employment activities has increased. For adult members with mental illness, the increase was approximately 6 percentage points, and for adult members with DD, the increase was almost 3 percentage points. This is positive for members and may contribute to statewide workforce development.

- *#10: The percent of readmissions of MI and DD children during the quarter to an inpatient psychiatric unit within 30 days of discharge.*

The percentage of MI and DD children readmitted has decreased by more than 2 percent. This is a positive change and may indicate more efficient care.

- *#13: The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).*

The percentage of adult members with developmental disabilities living in a private residence alone, with spouse, or non-relative(s) has increased, which may indicate greater independence for this population.

Although a few performance measures had decreases of slightly more than 1 percent, no statewide measure rates were below the established minimum.

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

Table 1–6—PIHP Performance Measure Scores (Percentages)

PIHP	#1–Timeliness/ Inpatient Screening		#2–Timeliness/Face-to-Face Assessment						#3–Timeliness/First Service						#4–Continuity of Care		
	Children	Adults	MI—Children	MI—Adults	DD—Children	DD—Adults	Medicaid SA	Total	MI—Children	MI—Adults	DD—Children	DD—Adults	Medicaid SA	Total	Follow-Up Care— Children	Follow-Up Care— Adults	Follow-Up Care— Detox
Region 1—NorthCare	100.00	100.00	99.25	97.70	100.00	100.00	86.78	93.35	99.10	98.66	87.50	100.00	100.00	99.17	100.00	93.88	100.00
Region 2—Northern MI	93.02	97.31	98.20	99.53	98.55	100.00	96.30	98.01	91.80	95.26	90.02	92.00	95.05	94.10	100.00	91.96	95.41
Region 3—Lakeshore	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Region 4—Southwest MI	99.33	97.36	96.81	98.62	97.73	100.00	98.80	98.46	97.06	97.34	93.33	93.33	92.54	94.22	96.30	96.02	NR
Region 5—Mid-State	99.10	98.72	98.19	98.81	98.67	100.00	99.08	98.76	97.87	97.50	100.00	93.94	100.00	98.46	98.13	97.11	100.00
Region 6—CMHPSM	100.00	99.66	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	100	96.27	NR
Region 7—Detroit	99.38	96.79	98.35	98.45	100.00	100.00	97.52	98.07	99.20	96.76	94.96	92.96	96.93	97.25	NR	NR	99.72
Region 8—Oakland	97.50	98.92	94.83	95.66	100.00	93.02	99.64	97.20	99.53	99.49	95.65	100.00	98.29	99.04	93.55	90.69	96.82
Region 9—Macomb	100.00	99.84	95.73	97.16	97.14	100.00	99.04	98.30	96.30	97.12	97.06	93.75	99.77	98.61	95.74	93.58	98.63
Region 10 PIHP	99.65	99.73	97.73	95.45	100.00	100.00	96.44	96.78	95.73	99.14	97.14	97.62	99.77	98.68	100.00	96.73	100.00
Statewide Rate	98.96	98.27	97.79	98.09	99.13	99.09	97.61	97.87	97.37	97.64	95.37	95.24	97.67	97.48	98.23	95.16	98.95
MDHHS Standard	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%

Rates in **blue** font indicate performance not meeting the MDHHS minimum performance standard.

NR: Not Reported

Table 1–7—PIHP Performance Measure Scores (Percentages)

PIHP	#5	#6	#8—Competitive Employment			#9—Minimum Wage			#10—Inpatient Recidivism		#13/#14—Private Residence	
	Penetration Rate	HSW Rate	MI—Adults	DD—Adults	MI/DD Adults	MI—Adults	DD—Adults	MI/DD Adults	Children	Adults	DD—Adults	MI—Adults
Region 1—NorthCare	7.55	97.03	16.23	5.38	7.54	78.72	13.11	21.25	0.00	11.27	17.09	52.63
Region 2—Northern MI	8.10	98.49	12.97	13.95	13.03	86.25	44.53	52.80	5.41	8.19	29.06	53.8
Region 3—Lakeshore	5.12	97.24	12.34	11.88	12.88	83.22	56.00	49.00	NR	NR	16.73	51.65
Region 4—Southwest MI	6.62	98.06	14.99	8.89	6.72	79.39	58.20	61.33	6.25	8.79	23.52	49.62
Region 5—Mid-State	7.59	97.54	14.57	9.73	8.71	86.57	34.66	33.55	8.11	9.85	20.88	53.08
Region 6—CMHPSM	6.87	97.74	13.83	10.06	9.84	82.95	50.76	55.30	2.17	14.76	25.38	29.67
Region 7—Detroit	7.18	98.11	9.03	7.67	6.76	81.77	28.60	30.52	9.58	18.40	18.90	30.22
Region 8—Oakland	7.74	98.34	14.38	14.16	10.16	78.15	92.71	84.03	0.00	13.98	6.59	36.18
Region 9—Macomb	5.39	99.79	12.95	5.47	5.97	87.05	30.10	40.88	11.32	16.41	13.71	39.69
Region 10 PIHP	7.17	98.64	10.15	6.07	6.74	82.99	16.02	23.46	8.82	12.05	16.90	49.93
Statewide Rate	6.90	98.05	12.24	9.51	8.68	82.83	39.90	39.84	7.87	13.7	18.26	42.14
MDHHS Standard	NA	NA	NA	NA	NA	NA	NA	NA	≤15%	≤15%	NA	NA

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

NR: Not Reported

NA: Not Applicable

Findings for the Validation of Performance Improvement Projects

For each PIHP, HSAG validated one PIP based on CMS' protocol. For the current validation cycle, the PIHPs provided fourth-year submissions on their PIP topics related to behavioral and physical healthcare integration. Table 1–8 presents a summary of the 2016–2017 PIP validation status results. All 10 PIHPs received an overall validation result of *Met* for each respective PIP.

Table 1–8—PIP Validation Status

Validation Status	Number of PIHPs
<i>Met</i>	10
<i>Partially Met</i>	0
<i>Not Met</i>	0

Table 1–9 presents a statewide summary of the PIHPs' 2016–2017 validation results for each CMS PIP protocol activity.

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

Review Activity		Number of PIPs Meeting All Evaluation Elements/ Number Reviewed	Number of PIPs Meeting All Critical Elements/ Number Reviewed
Design			
I.	Appropriate Study Topic	10/10	10/10
II.	Clearly Defined, Answerable Study Question(s)	10/10	10/10
III.	Correctly Identified Study Population	10/10	10/10
IV.	Clearly Defined Study Indicator(s)	10/10	10/10
V.	Valid Sampling Techniques*	NA	NA
VI.	Accurate/Complete Data Collection	10/10	10/10
Implementation and Evaluation			
VII.	Sufficient Data Analysis and Interpretation	8/10	10/10
VIII.	Appropriate Improvement Strategies	10/10	10/10

Review Activity		Number of PIPs Meeting All Evaluation Elements/ Number Reviewed	Number of PIPs Meeting All Critical Elements/ Number Reviewed
Outcomes			
IX.	Real Improvement Achieved	10/10	10/10
X.	Sustained Improvement Achieved**	9/9	9/9

* HSAG scored all elements for Activity V as *Not Applicable (NA)* for all PIPs.

** HSAG did not assess Region 1 for sustained improvement. Sustained improvement cannot be assessed until the study indicator has achieved statistically significant improvement over baseline and results for a subsequent measurement period have been reported. For Region 1, since the improvement demonstrated during Remeasurement 1 was not statistically significant over the baseline, the PIP was not assessed for sustained improvement.

For the 2016–2017 validation cycle, HSAG validated Activities I through X for nine of the 10 PIPs. All elements in Activity V received ratings of *Not Applicable* across all PIPs as the studies did not use sampling.

The PIHPs continued their PIPs related to behavioral and physical healthcare integration. For the 2016–2017 validation cycle, the PIHPs completed the Design stage of the PIPs (which included Activities I–VI), completed the Implementation stage, (which included Activities VII and VIII), and advanced to the Outcomes stage, completing Activities IX and X. Performance on activities of all PIPs represented a statewide strength.

The initial validation of the 2016–2017 PIP submissions identified opportunities for improvement, primarily in Activity VII—Sufficient Data Analysis and Interpretation. Recommendations from the initial validation included correcting the documentation inaccuracies and inconsistencies in the narrative interpretation of data, strengthening the interpretation of findings, and documenting factors affecting validity and comparability of data across the measurement periods. Eight of the 10 PIHPs resubmitted PIPs after receiving technical assistance and correcting the identified deficiencies, improving validation results.

As the PIPs were outcome-focused, the study indicators had to demonstrate statistically significant improvement over the baseline in order for each PIP to achieve an overall *Met* validation status. The validation of the 2016–2017 PIP submissions resulted in an overall validation status of *Met* for each of the 10 PIPs, indicating that the PIHPs designed scientifically sound studies supported by key research principles and identified barriers using quality improvement tools such as brainstorming, fishbone diagrams, and data mining. The PIHPs implemented interventions that potentially impacted the outcomes and resulted in achievement of statistically significant improvement in the study indicators from baseline to Remeasurement 2. Successful interventions included enhancements to the medical record systems to facilitate documentation and tracking of events related to the study indicator; use of care alert reports to identify gaps in care; education and training for providers, staff, and beneficiaries on

aspects of the PIPs; enhanced leadership involvement in motivating the staff regarding PIP performance; and focus on improving care coordination between the PIHP staff and primary care providers. Eight PIPs, each with a validation status of *Met*, received scores of 100 percent *Met* for all evaluation elements and all critical elements. The remaining two PIPs also each received a *Met* validation status; however, neither received a score of 100 percent *Met* for all evaluation elements.

For the 2016–2017 validation, the PIHPs also completed Activity VIII—Appropriate Improvement Strategies, requiring an evaluation of the effectiveness of the implemented improvement strategies. The PIP submissions provided examples of effective process evaluations—including using the Plan-Do-Study-Act cycle, data analysis, and other methods to assess success of interventions.

Table 1–10 presents the results of the 2016–2017 PIP validation.

Table 1–10—PIP Validation Results by PIHP

PIHP	% of All Elements Met	% of All Critical Elements Met	Overall Validation Status
Region 1—NorthCare	100%	100%	<i>Met</i>
Region 2—Northern MI	100%	100%	<i>Met</i>
Region 3—Lakeshore	100%	100%	<i>Met</i>
Region 4—Southwest MI	100%	100%	<i>Met</i>
Region 5—Mid-State	100%	100%	<i>Met</i>
Region 6—CMHPSM	100%	100%	<i>Met</i>
Region 7—Detroit	96%	100%	<i>Met</i>
Region 8—Oakland	100%	100%	<i>Met</i>
Region 9—Macomb	90%	100%	<i>Met</i>
Region 10 PIHP	100%	100%	<i>Met</i>

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

Conclusions

Findings from the 2016–2017 EQR activities reflected continued improvement in the **quality** and **timeliness** of, and **access** to, care and services provided by the PIHPs. Across the 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.

Recommendations

Based on these findings and conclusions, HSAG provided recommendations for improvement to each PIHP. Detailed information about PIHP-specific findings, conclusions, and recommendations is found in Section 3 of this report. While all PIHPs demonstrated overall high levels of performance across all activities, to further support MDHHS' strategic priorities HSAG recommends that the MDHHS consider identifying one or more priorities from the recommendations below for either statewide PIPs or quality initiatives to be conducted by each PIHP. Table 1–11 outlines the MDHHS strategic priorities.

Table 1–11—MDHHS Strategic Priorities

Priorities	
Children	Ensure that Michigan youth are healthy, protected, and supported on their path to adulthood.
Adults	Safeguard, respect, and encourage the well-being of Michigan adults in our communities and our care.
Family Support	Support families and individuals on their road to self-sufficiency through responsive, innovative, and accessible service delivery.
Health Services	Transform the healthcare system and behavioral health coordination to improve outcomes for residents.
Population Health	Promote and protect the health, wellness, and safety of all Michigan residents.
Workforce	Strengthen opportunities, promote diversity, and empower our workforce to contribute to Michigan's economic development.

To improve statewide performance in the **quality**, **timeliness**, and **access** to care, HSAG makes the following recommendations to MDHHS:

- Require all PIHPs to share PIP results, including successes and lessons learned. Improvement strategies and interventions that were successful and resulted in sustained improvement should be considered for systemwide implementation. All PIHPs implemented PIPs that resulted in statistically significant improvement. The interventions used by each PIHP to achieve these improvements could be shared and potentially implemented for systemwide implementation.
- Require PIHPs, as applicable, to conduct and evaluate quality improvement strategies to address performance indicators not meeting the MDHHS standards. Examples may include timeliness of first service for children and adults with developmental disabilities and follow-up care for the adult population. Although the overall statewide rate for all performance measures met or exceeded statewide targets, not all PIHPs met all targets. Quality improvement strategies should include data trends and root cause analysis—with actionable and measurable goals, benchmarks, and interventions.
- Use data to make decisions for new quality improvement strategies. For example, performance measure validation results would be one source of information to provide insight to potential improvement. Any area in which a PIHP is not meeting MDHHS standards is a potential area for

increased attention—for example: a new PIP topic, new performance measure, or component of the quality strategy. In areas not associated with a standard, MDHHS could review trends or consider including a standard.

- Require the PIHPs to develop a formal review process regarding their oversight of the CMHSPs' data collection and submission process. For a few PIHPs, HSAG was not able to verify at least one of the measures due to errors or inconsistencies in the PIHPs' reporting system. For MDHHS to be able to rely on the information submitted by the CMHSPs, a more formalized review process may be appropriate.
- Consider engaging stakeholders, advocates, and consumers when selecting new PIP topics. HSAG has found from previous experience that if stakeholders are involved in discussion and planning, their enthusiasm and commitment to the project's success is much greater. Also, topics that are more impactful are likely to be selected. Consumer perspective is always valuable and should be considered.
- Consider a comprehensive review of the quality strategy. The federal requirements regarding the state quality strategy are delineated in §438.340. In addition, MDHHS may choose to include a plan to address any identified healthcare disparities as part of the MDHHS quality strategy.
- During the most recent compliance review, the standard with the lowest scores was Standard XV—Disclosure of Ownership, Control, and Criminal Convictions. To improve compliance with this standard, MDHHS should consider enhanced corrective actions and ongoing monitoring.
- Consider targeting efforts related to employment. Two performance indicators evaluated relate to the number of members employed competitively and the percentage of working members that earn minimum wage. The National Core Indicators Survey, in which MDHHS participates, is a potential source of additional information as it includes national benchmarks related to this topic.

2. External Quality Review Activities

Introduction

This section of the report describes how 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.

Compliance Monitoring

Objectives

According to 42 CFR §438.358, a state or its EQRO must conduct a review within a three-year period to determine the PIHPs' compliance with standards for access to care, structure and operations, and quality measurement and improvement. To complete this requirement, HSAG, through its EQRO contract with the State of Michigan, performed compliance monitoring reviews of the 10 PIHPs with which the State contracts.

The 2014–2015 and 2015–2016 compliance monitoring reviews evaluated the PIHPs' compliance with selected federal and State regulations and contractual requirements related to the following standards:

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

While the 2014–2015 compliance reviews addressed all standards and elements, the 2015–2016 follow-up reviews evaluated the PIHPs' progress in achieving compliance with federal and State regulations and contractual requirements related to those elements on the standards listed preceding that scored less than *Met* in the previous review of the standard. The 2016–2017 reporting period marked the third year of the three-year cycle; compliance monitoring activities had been completed in the previous two years. For the 2016–2017 reporting period, HSAG completed an assessment of the degree to which each of the PIHPs had addressed the recommendations for quality improvement made during the previous year's compliance monitoring activity, which can be found in Section 4 of this report. A new cycle of reviews will begin for the 2017–2018 review period.

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

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

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

Validation of Performance Measures

Objectives

As set forth in 42 CFR §438.358, the validation of performance measures calculated by the State during the preceding 12 months was one of the mandatory EQR activities. The primary objectives of the performance measure validation activities were to:

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

HSAG validated a set of 12 performance indicators developed and selected by MDHHS for validation. Six of these indicators were to be reported by the PIHPs quarterly, with MDHHS calculating the remaining six. Most of the performance indicators were reported and validated for the first quarter of the Michigan State Fiscal Year (SFY) 2017, as shown in Table 2–2.

Technical Methods of Data Collection and Analysis

The CMS Performance Measure Validation Protocol identifies key types of data that should be reviewed as part of the validation process. The list following indicates the type of data collected and how HSAG conducted an analysis of these data.

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

Pre-audit Strategy

- **Information Systems Capabilities Assessment Tool (ISCAT)**—The PIHPs were required to submit a completed ISCAT that provided information on its information systems, processes used for collecting and processing data, and processes used for performance measure calculation. Upon receipt by HSAG, the ISCAT(s) underwent a cursory review to ensure that each section was complete and that all applicable attachments were present. HSAG then thoroughly reviewed all documentation, noting any potential issues, concerns, and items that needed additional clarification. Where applicable, HSAG used the information provided in the ISCAT(s) to begin completion of the review tools.
- **Source code (programming language) for performance indicators**—PIHPs that calculated the performance indicators using computer programming language were required to submit source code for each performance indicator being validated. HSAG completed line-by-line review on the supplied source code to ensure compliance with the State-defined performance indicator specifications. HSAG identified areas of deviation from the specifications, evaluating the impact to the indicator and assessing the degree of bias (if any). PIHPs that did not use computer programming language to calculate the performance indicators were required to submit documentation describing the steps taken by the PIHP for indicator calculation.
- **Performance indicator reports**—HSAG also reviewed the PIHP performance indicator reports provided by MDHHS for the first quarter of SFY 2017. Previous reports were used along with current reports to assess trending patterns and rate reasonability.
- **Supporting documentation**—The PIHPs submitted documentation to HSAG that provided additional information to complete the validation process, including policies and procedures, file layouts, system flow diagrams, system log files, and data collection process descriptions. HSAG reviewed all supporting documentation, with issues or clarifications flagged for follow-up.

On-site Activities

HSAG conducted on-site visits with each PIHP. HSAG collected information using several methods including interviews, system demonstration, review of data output files, primary source verification, observation of data processing, and review of data reports. The on-site visit activities are described as follows:

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

Post-on-site Review Activities: For each performance measure calculated and reported by the PIHPs, the audit teams aggregated the findings from the pre-on-site and on-site activities to determine whether the reported measures were valid, based on an allowable bias. The audit teams assigned each measure one of four audit findings: (1) *Reportable* (the rate was valid and below the allowable threshold for bias), (2) *Not Applicable* (the PIHP followed the specifications but the denominator was too small to report a valid rate), (3) *No Benefit* (the PIHP did not offer the health benefits required by the measure), or (4) *Not Reportable* (the measure was significantly biased or the PIHP was not required to report the measure).

Description of Data Obtained

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

- **Information Systems Capabilities Assessment Tool**—HSAG received this tool from each PIHP. The completed ISCATs provided HSAG with background information on MDHHS' and the PIHPs' policies, processes, and data in preparation for the on-site validation activities.

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

Table 2–1 shows the data sources used in the validation of performance measures and the periods to which the data applied.

Table 2–1—Data Sources and Applicable Periods

Data Sources	Period to Which Data Applied
ISCAT and mini-ISCAT(s), if applicable (from PIHPs)	SFY 2016
Source code/programming language for performance measures (from PIHPs and MDHHS) or description of the performance measure calculation process (from PIHPs)	SFY 2016
Previous performance measure results reports (from MDHHS)	SFY 2016
Performance measure results (from PIHPs and MDHHS)	First Quarter SFY 2017
Supporting documentation (from PIHPs and MDHHS)	SFY 2016
On-site interviews and systems demonstrations (from PIHPs and MDHHS)	During on-site visit

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

Table 2–2—List of Performance Indicators for PIHPs

Performance Indicators Selected by MDHHS		Subpopulations	Review Period	Calculated By
#1	The percent of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	<ul style="list-style-type: none"> Children Adults 	1st Quarter SFY 2017	PIHP
#2	The percent of new Medicaid beneficiaries during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service.	<ul style="list-style-type: none"> MI-Adults MI-Children DD-Adults DD-Children Medicaid SA Total 	1st Quarter SFY 2017	PIHP
#3	The percent of new Medicaid beneficiaries during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional.	<ul style="list-style-type: none"> MI-Adults MI-Children DD-Adults DD-Children SA-Adult Total 	1st Quarter SFY 2017	PIHP
#4a	The percent of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.	<ul style="list-style-type: none"> Children Adults 	1st Quarter SFY 2017	PIHP
#4b	The percent of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.	<ul style="list-style-type: none"> Medicaid Recipients 	1st Quarter SFY 2017	PIHP
#5	The percent of Medicaid recipients having received PIHP managed services.	<ul style="list-style-type: none"> Medicaid Recipients 	1st Quarter SFY 2017	MDHHS
#6	The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	<ul style="list-style-type: none"> HSW Recipients 	1st Quarter SFY 2017	MDHHS
#8	The percent of (a) adults with mental illness, and the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disability served by the CMHSPs and PIHPs, who are employed competitively.	<ul style="list-style-type: none"> MI-Adults DD-Adults MI & DD Adults 	SFY 2016	MDHHS
#9	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disability served by the CMHSPs and PIHPs, who earned minimum wage or more from any employment activities.	<ul style="list-style-type: none"> MI-Adults DD-Adults MI & DD Adults 	SFY 2016	MDHHS
#10	The percentage of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.	<ul style="list-style-type: none"> MI & DD-Adults MI & DD-Children 	1st Quarter SFY 2017	PIHP
#13	The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	<ul style="list-style-type: none"> DD-Adults 	SFY 2016	MDHHS

Performance Indicators Selected by MDHHS		Subpopulations	Review Period	Calculated By
#14	The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	<ul style="list-style-type: none"> MI-Adults 	SFY 2016	MDHHS
MI=mental illness; DD=developmental disability; MI/DD=dually diagnosed with mental illness and developmental disability; Medicaid SA=Medicaid beneficiaries with substance use disorders; Total=total population; HSW=Habilitation Supports Waiver				

Data Aggregation, Analysis, and How Conclusions Were Drawn

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

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

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

Table 2–3—Assignment of Performance Measures to Performance Domains

	Indicator	Quality	Timeliness	Access
#1	The percent of Medicaid beneficiaries during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.		✓	✓
#2	The percent of new Medicaid beneficiaries during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service.		✓	✓
#3	Percent of new Medicaid beneficiaries during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional.		✓	✓
#4a	The percent of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.	✓	✓	✓
#4b	The percent of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.	✓	✓	✓
#5	The percent of Medicaid recipients having received PIHP managed services.			✓

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

Validation of Performance Improvement Projects

Objectives

As part of its QAPIP, each PIHP was required by MDHHS to conduct PIPs in accordance with 42 CFR §438.330. In accordance with 42 CFR §438.330(d), PIHPs are required to have a comprehensive quality assessment and performance improvement program which includes PIPs that focus on both clinical and non-clinical areas. Each PIP must be designed to achieve significant improvement, sustained over time, in health outcomes and beneficiary satisfaction and involve:

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

For each PIHP, HSAG performed validation activities on one PIP. For the 2016–2017 validation cycle, all PIHPs submitted a continuing statewide PIP on integrating behavioral health and physical healthcare. HSAG provided technical assistance to the PIHPs as requested. The technical assistance sessions provided an opportunity for the PIHPs to ask questions and obtain assistance for conducting a successful PIP. The PIHPs had the opportunity to receive initial PIP validation scores (shown as *Submission* scores in Section 3 of this report), request additional technical assistance from HSAG, make corrections to PIP

submissions, and resubmit the PIPs for second reviews. After the second validation, HSAG finalized the scores (shown as *Resubmission* scores in Section 3 of this report).

Technical Methods of Data Collection and Analysis

HSAG based the methodology it used to validate PIPs on CMS guidelines as outlined in the Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.²⁻¹ Using this protocol, HSAG, in collaboration with MDHHS, developed the PIP Summary Form, which each PIHP completed and submitted to HSAG for review and evaluation. The PIP Summary Form standardized the process for submitting information regarding PIPs and ensured that all CMS protocol requirements were addressed.

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

These activities are:

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

Description of Data Obtained

HSAG obtained the data needed to conduct the PIP validation from each PIHP's PIP Summary Form. This form provided detailed information about each PIHP's PIP as it related to the activities reviewed

²⁻¹ Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: <https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html>. Accessed on: Jul 18, 2017.

and evaluated. Table 2–4 presents the source from which HSAG obtained the data and the period to which the data applied.

Table 2–4—Description of PIHP Data Sources

Data Obtained	Period to Which the Data Applied
PIP Summary Form (completed by the PIHP)	SFY 2017

Data Aggregation, Analysis, and How Conclusions Were Drawn

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

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

The percentage score for all evaluation elements was calculated by dividing the number of elements (including critical elements) *Met* by the sum of evaluation elements *Met*, *Partially Met*, and *Not Met*. The percentage score for critical elements *Met* was calculated by dividing the number of critical elements *Met* by the sum of critical elements *Met*, *Partially Met*, and *Not Met*. The scoring methodology also included the *Not Applicable* designation for situations in which the evaluation element did not apply to the PIP. For example, in Activity V, if the PIP did not use sampling techniques, HSAG would score the evaluation elements in Activity V as *Not Applicable*. HSAG used the *Not Assessed* scoring designation when the PIP had not progressed to the remaining activities in the CMS protocol. HSAG used a *Point of Clarification* when documentation for an evaluation element included the basic components to meet requirements for the evaluation element (as described in the narrative of the PIP), but enhanced documentation would demonstrate a stronger application of CMS protocols.

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

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

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

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

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

The EQR activities related to PIPs were designed to evaluate the validity and reliability of the PIHP’s processes in conducting the PIPs and to draw conclusions about the PIHP’s performance in the domains of quality, timeliness, and access to care and services. The *Integrated Behavioral and Physical Health Care* PIP topic addressed CMS’ requirements related to quality outcomes— specifically, quality and access to care and services. HSAG assigned the PIPs to the **quality** and **access** domains as depicted in Table 2–5.

Table 2–5—Assignment of PIPs to Performance Domains

Topic	Quality	Timeliness	Access
<i>Behavioral and Physical Health Care Integration</i>	✓		✓

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

Introduction

This section of the report presents PIHP-specific findings from the three EQR activities—compliance monitoring, validation of performance measures, and validation of performance improvement projects. It includes a summary of each PIHP’s strengths and recommendations for improvement as well as a summary assessment related to the quality and timeliness of, and access to, care and services provided by the PIHP.

Compliance Monitoring

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, MDHHS contracted with HSAG to perform a comprehensive review of compliance with State and federal standards for the 10 PIHPs with which the State contracts.

The 2016–2017 review period was the third year of the three-year cycle of reviews. The compliance monitoring activities were completed in the previous two years. HSAG completed a full review of all standards in 2014–2015. In 2015–2016, a follow-up review of the elements scored less than *Met* was conducted. In 2016–2017, HSAG began working with MDHHS to plan the next cycle of reviews that will begin in 2017–2018. HSAG will report on the 2017–2018 compliance monitoring results in the 2017–2018 EQR technical report.

Validation of Performance Measures

This section of the report presents the results for the 2016–2017 validation of performance measures and an evaluation of each PIHP’s performance measure results. The measure results tables following show the reported rates for each measure as well as the minimum performance standard for measures for which a minimum performance standard was established. An em dash (—) is included to denote measures that do not have a minimum performance standard. Rates that exceeded the minimum performance standard are shaded yellow.

In previous years, all reported rates were displayed in the technical report regardless of whether or not the individual performance indicator was assigned an audit designation of *Report (R)* (i.e., the rate was valid and below the allowable threshold for bias) or *Not Reported (NR)* (i.e., the rate was significantly biased). Beginning with this year’s report, the rates for individual performance indicators designated *NR* are not presented as the PIHP’s performance cannot be evaluated based on biased rates. For these indicators, the biased rate reported is not shown and the rate is displayed as “NR.” For additional analyses of the performance measure results—including statewide averages, plan-to-plan comparisons, and historical rates—please refer to Appendix A.

Region 1—NorthCare Network

Findings—System and Reporting Capabilities

This was the second year that **NorthCare Network** used the ELMER system for collecting, housing, and processing substance use disorder (SUD) data. To ensure data accuracy, the PIHP and its vendor, Peter Chang Enterprises Inc. (PCE), provided data entry training in person and via video conference. In addition, a training video and training guide document were also created to ensure adequate training of new SUD providers and/or staff members. As a result of **NorthCare Network**’s robust data monitoring processes, rejection files received from the State continued to be under 1 percent. Further, **NorthCare Network** continued to use a team of professionals with extensive background and experience related to performance indicators and Behavioral Health Treatment Episode Data Set (BH-TEDS) measures reporting.

Findings—Performance Measure Results

Based on the SFY 2017 validation of performance measures activities, Table 3–1 presents **NorthCare Network**’s performance measure results.

Table 3–1—Performance Measure Results for NorthCare Network

Performance Indicator	Rate	Minimum Performance Standard
#1: The percent of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.		
Children	100.00%	95.00%
Adults	100.00%	95.00%
#2: The percent of new Medicaid beneficiaries during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service.		
MI Children	99.25%	95.00%
MI Adults	97.70%	95.00%
DD Children	100.00%	95.00%
DD Adults	100.00%	95.00%
Medicaid SA	86.78%	95.00%
Total	93.35%	95.00%
#3: The percent of new Medicaid beneficiaries during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional.		
MI Children	99.10%	95.00%
MI Adults	98.66%	95.00%
DD Children	87.50%	95.00%
DD Adults	100.00%	95.00%
Medicaid SA	100.00%	95.00%
Total	99.17%	95.00%
#4a: The percent of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.		
Children	100.00%	95.00%
Adults	93.88%	95.00%
#4b: The percent of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.		
The percent of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.	100.00%	95.00%
#5: The percent of Medicaid recipients having received PIHP managed services.		
The percent of Medicaid recipients having received PIHP managed services.	7.55%	—

Performance Indicator	Rate	Minimum Performance Standard
#6: The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.		
The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	97.03%	—
#8: The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who are employed competitively.		
MI Adults	16.23%	—
DD Adults	5.38%	—
MI/DD Adults	7.54%	—
#9: The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.		
MI Adults	78.72%	—
DD Adults	13.11%	—
MI/DD Adults	21.25%	—
#10: The percent of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.*		
Children	0.00%	15.00%
Adults	11.27%	15.00%
#13: The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).		
The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	17.09%	—
#14: The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).		
The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	52.63%	—

Yellow shading indicates that the reported rate was better than the minimum performance standard.

— Indicates that a minimum performance standard was not established for this measure indicator.

* A lower rate indicates better performance.

Strengths

NorthCare Network's performance exceeded the minimum performance standards for the following indicators, suggesting strength in these areas:

- *#1: The percent of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours—Children and Adults*
- *#2: The percent of new Medicaid beneficiaries during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service—MI Children, MI Adults, DD Children, and DD Adults*
- *#3: The percent of new Medicaid beneficiaries during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional—MI Children, MI Adults, DD Adults, Medicaid SA, and Total*
- *#4a: The percent of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days—Children*
- *#4b: The percent of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days*
- *#10: The percent of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge—Children and Adults*

Recommendations

Although most **NorthCare Network** rates were above the minimum performance standards, the following rates fell below the minimum performance standard, indicating opportunities for improvement:

- *#2: The percent of new Medicaid beneficiaries during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service—Medicaid SA and Total*
- *#3: The percent of new Medicaid beneficiaries during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional—DD Children*
- *#4a: The percent of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days—Adults*

Therefore, to identify interventions that may improve rates in these measurement areas, HSAG recommends that **NorthCare Network** monitor performance related to timely assessments for the Medicaid SA population, timely access to services for children with developmental disabilities, and timely follow-up care for adults.

Regarding validation activities, documentation in the transactional system was not sufficiently detailed for HSAG's review of certain randomly selected cases during primary source verification. Although the selected cases met all requirements outlined in the measure specifications, HSAG recommends that the PIHP develop a verification process and/or provide additional staff training to ensure that detailed and accurate documentation is present in the PIHP's transactional system.

Summary Assessment Related to Quality, Timeliness, and Access

Timeliness of care and **access** to care were demonstrated strengths for **NorthCare Network** based on its reported rates for the following measures: Indicator #1: *The percent of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours—Children and Adults*; Indicator #2: *The percent of new Medicaid beneficiaries during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service—MI Children, MI Adults, DD Children, and DD Adults*; and Indicator #3: *The percent of new Medicaid beneficiaries during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional—MI Children, MI Adults, DD Adults, Medicaid SA, and Total*.

NorthCare Network's rates for Indicator #4a: *The percent of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days—Children* and Indicator #4b: *The percent of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days* indicated strengths in the areas of **quality**, **timeliness**, and **access** to care. Additionally, **NorthCare Network**'s performance around **quality** was strong, as evidenced by the reported rates for Indicator #10: *The percent of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge—Children and Adults*.

Conversely, **NorthCare Network**'s reported rates for the following measures indicated opportunities for improvement around **timeliness** of care and **access** to care: Indicator #2: *The percent of new Medicaid beneficiaries during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service—Medicaid SA and Total*; and Indicator #3: *The percent of new Medicaid beneficiaries during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional—DD Children*. Further, the reported rate for Indicator #4a: *The percent of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days—Adults* indicated opportunities for improved **quality**, **timeliness**, and **access** to care.

Region 2—Northern Michigan Regional Entity

Findings—System and Reporting Capabilities

Northern Michigan Regional Entity experienced staffing, system, and process changes during the reporting period. Specifically, the PIHP purchased a new electronic health record (EHR) system operated by PCE to replace prior years' SUD system, CX360. SUD providers and internal staff members received sufficient system training to ensure that data housed in the new system were complete and accurate for measure reporting.

Findings—Performance Measure Results

Based on the SFY 2017 validation of performance measures activities, Table 3–2 presents **Northern Michigan Regional Entity**'s performance measure results.

Table 3–2—Performance Measure Results for Northern Michigan Regional Entity

Performance Indicator	Rate	Minimum Performance Standard
#1: The percent of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.		
Children	93.02%	95.00%
Adults	97.31%	95.00%
#2: The percent of new Medicaid beneficiaries during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service.		
MI Children	98.20%	95.00%
MI Adults	99.53%	95.00%
DD Children	98.55%	95.00%
DD Adults	100.00%	95.00%
Medicaid SA	96.30%	95.00%
Total	98.01%	95.00%
#3: The percent of new Medicaid beneficiaries during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional.		
MI Children	91.80%	95.00%
MI Adults	95.26%	95.00%
DD Children	90.20%	95.00%
DD Adults	92.00%	95.00%
Medicaid SA	95.05%	95.00%
Total	94.10%	95.00%
#4a: The percent of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.		
Children	100.00%	95.00%
Adults	91.96%	95.00%
#4b: The percent of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.		
The percent of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.	95.41%	95.00%
#5: The percent of Medicaid recipients having received PIHP managed services.		
The percent of Medicaid recipients having received PIHP managed services.	8.10%	—

Performance Indicator	Rate	Minimum Performance Standard
#6: The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.		
The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	98.49%	—
#8: The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who are employed competitively.		
MI Adults	12.97%	—
DD Adults	13.95%	—
MI/DD Adults	13.03%	—
#9: The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.		
MI Adults	86.25%	—
DD Adults	44.53%	—
MI/DD Adults	52.80%	—
#10: The percent of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.*		
Children	5.41%	15.00%
Adults	8.19%	15.00%
#13: The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).		
The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	29.06%	—
#14: The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).		
The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	53.80%	—

Yellow shading indicates that the reported rate was better than the minimum performance standard.

— Indicates that a minimum performance standard was not established for this measure indicator.

* A lower rate indicates better performance.

Strengths

Northern Michigan Regional Entity's performance exceeded the minimum performance standards for the following indicators, suggesting strength in these areas:

- *#1: The percent of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours—Adults*
- *#2: The percent of new Medicaid beneficiaries during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service—MI Children, MI Adults, DD Children, DD Adults, Medicaid SA, and Total*
- *#3: The percent of new Medicaid beneficiaries during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional—MI Adults and Medicaid SA*
- *#4a: The percent of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days—Children*
- *#4b: The percent of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days*
- *#10: The percent of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge—Children and Adults*

Recommendations

Although most of **Northern Michigan Regional Entity**'s rates for the preceding indicators were above the minimum performance standards, the following rates fell below the minimum performance standard, indicating opportunities for improvement:

- *#1: The percent of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours—Children*
- *#3: The percent of new Medicaid beneficiaries during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional—MI Children, DD Children, DD Adults, and Total*
- *#4a: The percent of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days—Adults*

HSAG recommends that **Northern Michigan Regional Entity** identify root causes for low performance related to timely psychiatric inpatient screenings for children, timely on-going services for beneficiaries in the MI Children, DD Children, and DD Adults populations, and timely psychiatric inpatient follow-up care for adults. HSAG recommends that **Northern Michigan Regional Entity** leverage this information to identify interventions that will lead to improvements in these areas.

Regarding validation activities, HSAG noted that documentation in the system was not detailed enough for primary source verification for some randomly selected sample cases. Although the selected cases met all requirements outlined in the measure specifications, HSAG recommends that **Northern Michigan Regional Entity** develop a verification process and/or provide additional staff training to ensure that detailed and accurate documentation is present in the transactional system.

Summary Assessment Related to Quality, Timeliness, and Access

Timeliness of care and **access** to care were demonstrated strengths for **Northern Michigan Regional Entity**, based on its reported rates for the following measures: Indicator #1: *The percent of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours—Adults*; Indicator #2: *The percent of new Medicaid beneficiaries during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service—MI Children, MI Adults, DD Children, DD Adults, Medicaid SA, and Total*; and Indicator #3: *The percent of new Medicaid beneficiaries during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional—MI Adults and Medicaid SA*.

Northern Michigan Regional Entity's rates for Indicator #4a: *The percent of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days—Children* and Indicator #4b: *The percent of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days* indicated strengths in the areas of **quality**, **timeliness**, and **access** to care. Additionally, **Northern Michigan Regional Entity**'s performance around **quality** was strong, as evidenced by the reported rates for Indicator #10: *The percent of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge—Children and Adults*.

Conversely, **Northern Michigan Regional Entity**'s reported rates for the following measures indicated opportunities for improvement around **timeliness** of care and **access** to care: Indicator #1: *The percent of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours—Children* and Indicator #3: *The percent of new Medicaid beneficiaries during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional—MI Children, DD Children, DD Adults, and Total*. Further, the reported rate for Indicator #4a: *The percent of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days—Adults* indicated opportunities for improved **quality**, **timeliness**, and **access** to care.

Region 3—Lakeshore Regional Entity

Findings—System and Reporting Capabilities

During the reporting period, **Lakeshore Regional Entity** experienced several challenges including staff changes and system changes, but newly hired staff did have extensive background and experience related to performance indicator and BH-TEDS measures reporting.

Findings—Performance Measure Results

Based on the SFY 2017 validation of performance measures activities, Table 3–3 presents **Lakeshore Regional Entity**'s performance measure results.

Table 3–3—Performance Measure Results for Lakeshore Regional Entity

Performance Indicator	Rate	Minimum Performance Standard
#1: The percent of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.		
Children	NR	95.00%
Adults	NR	95.00%
#2: The percent of new Medicaid beneficiaries during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service.		
MI Children	NR	95.00%
MI Adults	NR	95.00%
DD Children	NR	95.00%
DD Adults	NR	95.00%
Medicaid SA	NR	95.00%
Total	NR	95.00%
#3: The percent of new Medicaid beneficiaries during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional.		
MI Children	NR	95.00%
MI Adults	NR	95.00%
DD Children	NR	95.00%
DD Adults	NR	95.00%
Medicaid SA	NR	95.00%
Total	NR	95.00%
#4a: The percent of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.		
Children	NR	95.00%
Adults	NR	95.00%
#4b: The percent of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.		
The percent of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.	NR	95.00%
#5: The percent of Medicaid recipients having received PIHP managed services.		
The percent of Medicaid recipients having received PIHP managed services.	5.12%	—

Performance Indicator	Rate	Minimum Performance Standard
#6: The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.		
The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	97.24%	—
#8: The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who are employed competitively.		
MI Adults	12.34%	—
DD Adults	11.88%	—
MI/DD Adults	12.88%	—
#9: The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.		
MI Adults	83.22%	—
DD Adults	56.00%	—
MI/DD Adults	49.00%	—
#10: The percent of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.*		
Children	NR	15.00%
Adults	NR	15.00%
#13: The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).		
The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	16.73%	—
#14: The percent of adults with serious mental illness served who live in a private residence alone, with spouse, or with non-relative(s).		
The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	51.65%	—

NR (Not Reported) indicates that the rate was determined “materially biased.” In previous years, all rates were displayed in the technical report whether or not those rates were assigned audit designations of Report (R) or Not Reported (NR). Beginning with this year’s report, rates designated NR are not displayed because the PIHP’s performance cannot be evaluated based on biased rates.

— Indicates that a minimum performance standard was not established for this measure indicator.

* A lower rate indicates better performance.

Strengths

Lakeshore Regional Entity's rates were deemed *Not Reported* (NR) for all 19 measure indicators with minimum performance standards; therefore, HSAG identified no performance measure strengths.

Recommendations

For the validation of performance measures, HSAG received **Lakeshore Regional Entity**'s performance measure rates from MDHHS for the first quarter of 2017; however, these rates did not include data from the PIHP's largest affiliated CMHSP, Network 180. In October 2016, this CMHSP implemented a new transactional system; but, due to a lack of adequate system testing and data validation, Network 180 was unable to produce valid and complete data timely for the current reporting period. The missing data accounted for over 50 percent of **Lakeshore Regional Entity**'s data submission; therefore, the rates originally calculated by **Lakeshore Regional Entity** and submitted to MDHHS were materially biased and received *Not Reported* audit designations. HSAG recommends that **Lakeshore Regional Entity** monitor Network 180's progress reporting complete and accurate performance indicator data. HSAG also recommends that **Lakeshore Regional Entity** define and clearly communicate expectations for each CMHSP regarding the reporting requirements and implement corrective actions when any affiliated CMHSP is unable to produce valid data timely.

Summary Assessment Related to Quality, Timeliness, and Access

Lakeshore Regional Entity's rates were deemed NR for all 19 measure indicators with minimum performance standards; therefore, HSAG was unable to assess **Lakeshore Regional Entity**'s performance related to **quality, timeliness, or access**.

Region 4—Southwest Michigan Behavioral Health

Findings—System and Reporting Capabilities

Southwest Michigan Behavioral Health experienced some staffing changes in the past year; however, newly hired staff members had extensive backgrounds in behavioral health and all processes related to performance indicator and data reporting requirements. Several quality boards were formed with representatives from the PIHP and each affiliated CMHSP. These boards were focused on data integrity of and data completeness for performance measure indicators.

In addition, **Southwest Michigan Behavioral Health** continued to demonstrate robust oversight of its CMHSPs. Specifically, prior to a CMHSP's new system implementation, the PIHP ensured that this new system captured and processed data accurately. **Southwest Michigan Behavioral Health** also ensured that error messages received from the State related to submitted encounters or BH-TEDS files were incorporated into the transactional system as part of the internal system's data validation process.

Findings—Performance Measure Results

Based on the SFY 2017 validation of performance measures activities, Table 3–4 presents **Southwest Michigan Behavioral Health**’s performance measure results.

Table 3–4—Performance Measure Results for Southwest Michigan Behavioral Health

Performance Indicator	Rate	Minimum Performance Standard
#1: The percent of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.		
Children	99.33%	95.00%
Adults	97.36%	95.00%
#2: The percent of new Medicaid beneficiaries during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service.		
MI Children	96.81%	95.00%
MI Adults	98.62%	95.00%
DD Children	97.73%	95.00%
DD Adults	100.00%	95.00%
Medicaid SA	98.80%	95.00%
Total	98.46%	95.00%
#3: The percent of new Medicaid beneficiaries during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional.		
MI Children	97.06%	95.00%
MI Adults	97.34%	95.00%
DD Children	93.33%	95.00%
DD Adults	93.33%	95.00%
Medicaid SA	92.54%	95.00%
Total	94.22%	95.00%
#4a: The percent of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.		
Children	96.30%	95.00%
Adults	96.02%	95.00%
#4b: The percent of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.		
The percent of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.	NR	95.00%

Performance Indicator	Rate	Minimum Performance Standard
#5: The percent of Medicaid recipients having received PIHP managed services.		
The percent of Medicaid recipients having received PIHP managed services.	6.62%	—
#6: The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.		
The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	98.06%	—
#8: The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who are employed competitively.		
MI Adults	14.99%	—
DD Adults	8.89%	—
MI/DD Adults	6.72%	—
#9: The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.		
MI Adults	79.39%	—
DD Adults	58.20%	—
MI/DD Adults	61.33%	—
#10: The percent of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.*		
Children	6.25%	15.00%
Adults	8.79%	15.00%
#13: The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).		
The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	23.52%	—
#14: The percent of adults with serious mental illness served who live in a private residence alone, with spouse, or with non-relative(s).		
The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	49.62%	—

Yellow shading indicates that the reported rate was better than the minimum performance standard.

NR (Not Reported) indicates that the rate was determined “materially biased.” In previous years, all rates were displayed in the technical report whether or not those rates were assigned audit designations of Report (R) or Not Reported (NR). Beginning with this year’s report, rates designated NR are not displayed because the PIHP’s performance cannot be evaluated based on biased rates.

— Indicates that a minimum performance standard was not established for this measure indicator.

* A lower rate indicates better performance.

Strengths

Southwest Michigan Behavioral Health's performance exceeded the minimum performance standards for the following indicators, suggesting strength in these areas:

- *#1: The percent of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours—Children and Adults*
- *#2: The percent of new Medicaid beneficiaries during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service—MI Children, MI Adults, DD Children, DD Adults, Medicaid SA, and Total*
- *#3: The percent of new Medicaid beneficiaries during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional—MI Children and MI Adults*
- *#4a: The percent of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days—Children and Adults*
- *#10: The percent of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge—Children and Adults*

Recommendations

Although most **Southwest Michigan Behavioral Health**'s rates were above the minimum performance standards, rates for Indicator #3: *The percent of new Medicaid beneficiaries during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional—DD Children, DD Adults, Medicaid SA, and Total* fell below the minimum performance standard.

The MI Children and MI Adults rates for this measure indicated more favorable performance; therefore, HSAG recommends that **Southwest Michigan Behavioral Health** identify reasons for positive performance for beneficiaries in the MI Children and MI Adults populations as well as potential opportunities for leveraging these strategies for improved timely on-going services for children and adults with developmental disabilities and for members receiving substance abuse services.

As a result of conducting performance measure validation, HSAG recommends that **Southwest Michigan Behavioral Health** continue its work to create a snapshot of the summary and detail files for each indicator submitted to the State. Additionally, the PIHP indicated that BH-TEDS rates provided by the State did not match the PIHP's calculated rates. HSAG recommends that the PIHP continue to work with the State to resolve this discrepancy.

For the current reporting period, **Southwest Michigan Behavioral Health** erroneously reported no detox SUD discharges for Indicator #4b: *The percent of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days* due to a field-logic breakdown. The PIHP corrected this issue and plans to resubmit the newly calculated rate for this indicator to the State. However, as data were not available at the time of the audit, HSAG assigned a *Not Reported* audit

designation for this measure. Although several validation processes were in place to ensure data completeness and accuracy prior to the final rate calculation for measure reporting, **Southwest Michigan Behavioral Health** should implement additional quality control processes to further ensure validity of the data set.

Summary Assessment Related to Quality, Timeliness, and Access

Timeliness of care and **access** to care were demonstrated strengths for **Southwest Michigan Behavioral Health** based on its reported rates for the following measures: Indicator #1: *The percent of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours—Children and Adults*; Indicator #2: *The percent of new Medicaid beneficiaries during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service—MI Children, MI Adults, DD Children, DD Adults, Medicaid SA, and Total*; and Indicator #3: *The percent of new Medicaid beneficiaries during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional—MI Children and MI Adults*.

Southwest Michigan Behavioral Health's rates for Indicator #4a: *The percent of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days—Children and Adults* indicated strengths in the areas of **quality**, **timeliness**, and **access** to care. Additionally, **Southwest Michigan Behavioral Health**'s performance around **quality** was strong, as evidenced by the reported rates for Indicator #10: *The percent of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge—Children and Adults*.

Conversely, **Southwest Michigan Behavioral Health**'s reported rates for Indicator #3: *The percent of new Medicaid beneficiaries during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional—DD Children, DD Adults, Medicaid SA, and Total* indicated opportunities for improvement around **timeliness** of care and **access** to care.

Region 5—Mid-State Health Network

Findings—System and Reporting Capabilities

Mid-State Health Network's staff members were familiar with all processes related to performance indicator and BH-TEDS measures and data reporting requirements. **Mid-State Health Network**'s robust validation processes ensured that only complete and valid data were submitted to the State. For the current measurement period, all coordinating agency (CA) functions related to substance abuse services, including managing data reporting for the SUD population, were **Mid-State Health Network**'s responsibility. After the challenges experienced in 2016 regarding the introduction of the BH-TEDS questions, **Mid-State Health Network** worked with its CMHSPs to resolve issues with BH-TEDS data collection within clinical processes. In addition, **Mid-State Health Network** worked with CMHSPs to ensure that BH-TEDS questions were appropriately embedded within the CMHSPs' EHRs.

Findings—Performance Measure Results

Based on the SFY 2017 validation of performance measures activities, Table 3–5 presents **Mid-State Health Network**'s performance measure results.

Table 3–5—Performance Measure Results for Mid-State Health Network

Performance Indicator	Rate	Minimum Performance Standard
#1: The percent of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.		
Children	99.10%	95.00%
Adults	98.72%	95.00%
#2: The percent of new Medicaid beneficiaries during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service.		
MI Children	98.19%	95.00%
MI Adults	98.81%	95.00%
DD Children	98.67%	95.00%
DD Adults	100.00%	95.00%
Medicaid SA	99.08%	95.00%
Total	98.76%	95.00%
#3: The percent of new Medicaid beneficiaries during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional.		
MI Children	97.87%	95.00%
MI Adults	97.50%	95.00%
DD Children	100.00%	95.00%
DD Adults	93.94%	95.00%
Medicaid SA	100.00%	95.00%
Total	98.46%	95.00%
#4a: The percent of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.		
Children	98.13%	95.00%
Adults	97.11%	95.00%
#4b: The percent of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.		
The percent of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.	100.00%	95.00%

Performance Indicator	Rate	Minimum Performance Standard
#5: The percent of Medicaid recipients having received PIHP managed services.		
The percent of Medicaid recipients having received PIHP managed services.	7.59%	—
#6: The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.		
The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	97.54%	—
#8: The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who are employed competitively.		
MI Adults	14.57%	—
DD Adults	9.73%	—
MI/DD Adults	8.71%	—
#9: The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.		
MI Adults	86.57%	—
DD Adults	34.66%	—
MI/DD Adults	33.55%	—
#10: The percent of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.*		
Children	8.11%	15.00%
Adults	9.85%	15.00%
#13: The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).		
The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	20.88%	—
#14: The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).		
The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	53.08%	—

Yellow shading indicates that the reported rate was better than the minimum performance standard.

— Indicates that a minimum performance standard was not established for this measure indicator.

* A lower rate indicates better performance.

Strengths

Rates exceeded the minimum performance standards for 18 of the 19 measure indicators with minimum performance standards, indicating high performance overall for **Mid-State Health Network** including:

- #1: *The percent of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours—Children and Adults.*
- #2: *The percent of new Medicaid beneficiaries during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service—MI Children, MI Adults, DD Children, DD Adults, Medicaid SA, and Total.*
- #3: *The percent of new Medicaid beneficiaries during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional—MI Children, MI Adults, DD Children, Medicaid SA, and Total.*
- #4a: *The percent of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days—Children and Adults.*
- #4b: *The percent of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.*
- #10: *The percent of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge—Children and Adults.*

Recommendations

One measure, Indicator #3: *The percent of new Medicaid beneficiaries during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional—DD Adults*, fell below the minimum performance standard. HSAG recommends that **Mid-State Health Network** evaluate contributing factors that led to timely ongoing services for beneficiaries in the MI Children, MI Adults, DD Children, and Medicaid SA populations, and leverage these factors to achieve timely ongoing services for adults with developmental disabilities.

Summary Assessment Related to Quality, Timeliness, and Access

Timeliness of care and **access** to care were demonstrated strengths for **Mid-State Health Network**, based on its reported rates for the following measures: Indicator #1: *The percent of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours—Children and Adults*; Indicator #2: *The percent of new Medicaid beneficiaries during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service—MI Children, MI Adults, DD Children, DD Adults, Medicaid SA, and Total*; and Indicator #3: *The percent of new Medicaid beneficiaries during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional—MI Children, MI Adults, DD Children, Medicaid SA, and Total*.

Mid-State Health Network's rates for Indicator #4a: *The percent of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days—Children and Adults*;

and Indicator #4b: *The percent of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days* indicated strengths in the areas of **quality**, **timeliness**, and **access** to care. Additionally, **Mid-State Health Network**'s performance around **quality** was strong, as evidenced by the reported rates for Indicator #10: *The percent of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge—Children and Adults*.

Conversely, **Mid-State Health Network**'s reported rates for the following measures indicated opportunities for improvement around **timeliness** of care and **access** to care: Indicator #3: *The percent of new Medicaid beneficiaries during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional—DD Adults*.

Region 6—CMH Partnership of Southeast Michigan

Findings—System and Reporting Capabilities

CMH Partnership of Southeast Michigan continued its collaborative relationship with all affiliated CMHSPs by addressing questions or concerns that arose as well as discussing any changes that would affect performance indicator reporting. **CMH Partnership of Southeast Michigan** experienced challenges regarding the 270/271 eligibility process; however, it implemented effective workarounds to produce valid data for measure reporting. The PIHP implemented a performance improvement project to improve data accuracy and consistency for measure reporting. The PIHP worked with CMHSPs and providers to accurately capture data and created comprehensive training documents to support their data capture processes.

Findings—Performance Measure Results

Based on the SFY 2017 validation of performance measures activities, Table 3–6 presents **CMH Partnership of Southeast Michigan**'s performance measure results.

Table 3–6—Performance Measure Results for CMH Partnership of Southeast Michigan

Performance Indicator	Rate	Minimum Performance Standard
#1: The percent of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.		
<i>Children</i>	100.00%	95.00%
<i>Adults</i>	99.66%	95.00%
#2: The percent of new Medicaid beneficiaries during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service.		
<i>MI Children</i>	NR	95.00%
<i>MI Adults</i>	NR	95.00%

Performance Indicator	Rate	Minimum Performance Standard
<i>DD Children</i>	<i>NR</i>	95.00%
<i>DD Adults</i>	<i>NR</i>	95.00%
<i>Medicaid SA</i>	<i>NR</i>	95.00%
<i>Total</i>	<i>NR</i>	95.00%
#3: The percent of new Medicaid beneficiaries during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional.		
<i>MI Children</i>	<i>NR</i>	95.00%
<i>MI Adults</i>	<i>NR</i>	95.00%
<i>DD Children</i>	<i>NR</i>	95.00%
<i>DD Adults</i>	<i>NR</i>	95.00%
<i>Medicaid SA</i>	<i>NR</i>	95.00%
<i>Total</i>	<i>NR</i>	95.00%
#4a: The percent of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.		
<i>Children</i>	100.00%	95.00%
<i>Adults</i>	96.27%	95.00%
#4b: The percent of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.		
<i>The percent of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.</i>	<i>NR</i>	95.00%
#5: The percent of Medicaid recipients having received PIHP managed services.		
<i>The percent of Medicaid recipients having received PIHP managed services.</i>	6.87%	—
#6: The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.		
<i>The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.</i>	97.74%	—
#8: The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who are employed competitively.		
<i>MI Adults</i>	13.83%	—
<i>DD Adults</i>	10.06%	—
<i>MI/DD Adults</i>	9.84%	—

Performance Indicator	Rate	Minimum Performance Standard
#9: The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.		
MI Adults	82.95%	—
DD Adults	50.76%	—
MI/DD Adults	55.30%	—
#10: The percent of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.*		
Children	2.17%	15.00%
Adults	14.76%	15.00%
#13: The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).		
The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	25.38%	—
#14: The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).		
The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	29.67%	—

Yellow shading indicates that the reported rate was better than the minimum performance standard.

NR (Not Reported) indicates that the rate was determined “materially biased.” In previous years, all rates were displayed in the technical report whether or not those rates were assigned audit designations of Report (R) or Not Reported (NR). Beginning with this year’s report, rates designated NR are not displayed because the PIHP’s performance cannot be evaluated based on biased rates.

— Indicates that a minimum performance standard was not established for this measure indicator.

* A lower rate indicates better performance.

Strengths

Of the 19 measure indicators with minimum performance standards, 13 rates were deemed *Not Reported* (NR) based on HSAG’s validation activities for **CMH Partnership of Southeast Michigan**. The remaining six reported rates presented following exceeded the minimum performance standards, indicating positive performance.

- #1: The percent of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours—Children and Adults
- #4a: The percent of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days—Children and Adults
- #10: The percent of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge—Children and Adults

Recommendations

Regarding performance measure validation, **CMH Partnership of Southeast Michigan** struggled to recreate the consumer-level detail files used for performance indicator reporting because the records in the system were adjusted after the data were extracted for rate reporting. **CMH Partnership of Southeast Michigan** planned to implement a new system to enable the creation of consumer-level detail files. HSAG recommends that **CMH Partnership of Southeast Michigan** create a locked, consumer-level detail file at the time of reporting for each quarter. This step will ensure that records can be validated for each performance indicator.

CMH Partnership of Southeast Michigan indicated that the rates for performance Indicator #2: *The percent of new Medicaid beneficiaries during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service—Medicaid SA* and Indicator #3: *The percent of new Medicaid beneficiaries during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional—Medicaid SA* provided by the State did not align with the PIHP's calculations. HSAG recommends that the PIHP follow up with the State to resolve this discrepancy.

Further, **CMH Partnership of Southeast Michigan** had challenges collecting first-offered appointment dates from its SUD providers for Indicator #2 and Indicator #3. The PIHP relied on provider reports to capture whether or not the consumer requested an appointment outside the 14-day time frame. Due to the lack of documentation, the exceptions could not be validated; therefore, these records had to be part of the denominator, resulting in changes of more than 5 percent for each of these measures. Consequently, the rates for these indicators were deemed materially biased and assigned *NR* audit designations for the current reporting period. **CMH Partnership of Southeast Michigan** confirmed that it updated its system to capture the appointment-offered date for future reporting. The PIHP also trained providers to appropriately document this date. HSAG recommends that **CMH Partnership of Southeast Michigan** continue to enhance its processes to create, across all providers, uniformity in documenting appointment-offered dates.

For Indicator #4b: *The percent of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days*, **CMH Partnership of Southeast Michigan** included consumers for whom it was not financially responsible and marked them as exceptions. These consumers should have been excluded from the population. The PIHP received an *NR* audit designation for this indicator because it did not appropriately distinguish between exclusions and exceptions as outlined in the MDHHS Codebook specifications. **CMH Partnership of Southeast Michigan** confirmed that it implemented additional training for its SUD providers to ensure that this issue does not persist. HSAG recommends that **CMH Partnership of Southeast Michigan** continue to monitor exclusions and exceptions data for all performance indicators, to ensure proper alignment with the measure specifications.

Summary Assessment Related to Quality, Timeliness, and Access

CMH Partnership of Southeast Michigan's rates for Indicator #4a: *The percent of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days—Children and Adults* indicated strengths in the areas of **quality**, **timeliness**, and **access** to care. **Timeliness** of care and **access** to care were demonstrated strengths for **CMH Partnership of Southeast Michigan**, based on its reported rates for Indicator #1: *The percent of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours—Children and Adults*. Additionally, **CMH Partnership of Southeast Michigan**'s performance around **quality** was strong, as evidenced by the reported rates for Indicator #10: *The percent of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge—Children and Adults*.

Region 7—Detroit Wayne Mental Health Authority

Findings—System and Reporting Capabilities

To assist the PIHP in meeting required timelines, **Detroit Wayne Mental Health Authority** implemented a centralized process for conducting inpatient screenings and scheduling initial appointments for consumers with non-emergent requests. Additionally, **Detroit Wayne Mental Health Authority** maintained an on-demand data dashboard that Managers of Comprehensive Provider Networks (MCPNs) could access to monitor and ensure overall data completeness and accuracy.

Findings—Performance Measure Results

Based on the SFY 2017 validation of performance measures activities, Table 3–7 presents **Detroit Wayne Mental Health Authority**'s performance measure results.

Table 3–7—Performance Measure Results for Detroit Wayne Mental Health Authority

Performance Indicator	Rate	Minimum Performance Standard
#1: The percent of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.		
<i>Children</i>	99.38%	95.00%
<i>Adults</i>	96.79%	95.00%
#2: The percent of new Medicaid beneficiaries during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service.		
<i>MI Children</i>	98.35%	95.00%
<i>MI Adults</i>	98.45%	95.00%
<i>DD Children</i>	100.00%	95.00%

Performance Indicator	Rate	Minimum Performance Standard
<i>DD Adults</i>	100.00%	95.00%
<i>Medicaid SA</i>	97.52%	95.00%
<i>Total</i>	98.07%	95.00%
#3: The percent of new Medicaid beneficiaries during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional.		
<i>MI Children</i>	99.20%	95.00%
<i>MI Adults</i>	96.76%	95.00%
<i>DD Children</i>	94.96%	95.00%
<i>DD Adults</i>	92.96%	95.00%
<i>Medicaid SA</i>	96.93%	95.00%
<i>Total</i>	97.25%	95.00%
#4a: The percent of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.		
<i>Children</i>	NR	95.00%
<i>Adults</i>	NR	95.00%
#4b: The percent of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.		
<i>The percent of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.</i>	99.72%	95.00%
#5: The percent of Medicaid recipients having received PIHP managed services.		
<i>The percent of Medicaid recipients having received PIHP managed services.</i>	7.18%	—
#6: The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.		
<i>The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.</i>	98.11%	—
#8: The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who are employed competitively.		
<i>MI Adults</i>	9.03%	—
<i>DD Adults</i>	7.67%	—
<i>MI/DD Adults</i>	6.76%	—

Performance Indicator	Rate	Minimum Performance Standard
#9: The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.		
MI Adults	81.77%	—
DD Adults	28.60%	—
MI/DD Adults	30.52%	—
#10: The percent of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.*		
Children	9.58%	15.00%
Adults	18.40%	15.00%
#13: The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).		
The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	18.90%	—
#14: The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).		
The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	30.22%	—

Yellow shading indicates that the reported rate was better than the minimum performance standard.

NR (Not Reported) indicates that the rate was determined “materially biased.” In previous years, all rates were displayed in the technical report whether or not those rates were assigned audit designations of Report (R) or Not Reported (NR). Beginning with this year’s report, rates designated NR are not displayed because the PIHP’s performance cannot be evaluated based on biased rates.

— Indicates that a minimum performance standard was not established for this measure indicator.

* A lower rate indicates better performance.

Strengths

Of the 19 measure indicators with minimum performance standards, two of these rates were deemed NR based on HSAG’s validation activities for **Detroit Wayne Mental Health Authority**. Of the remaining 17 reported rates, 14 exceeded the minimum performance standards, indicating positive performance for the following measures:

- #1: The percent of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours—Children and Adults
- #2: The percent of new Medicaid beneficiaries during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service—MI Children, MI Adults, DD Children, DD Adults, Medicaid SA, and Total

- *#3: The percent of new Medicaid beneficiaries during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional—MI Children, MI Adults, Medicaid SA, and Total*
- *#4b: The percent of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days*
- *#10: The percent of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge—Children*

Recommendations

Detroit Wayne Mental Health Authority's reported rates for the following three remaining indicator rates fell below the minimum performance standards:

- *#3: The percent of new Medicaid beneficiaries during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional—DD Children and DD Adults*
- *#10: The percent of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge—Adults*

HSAG recommends that **Detroit Wayne Mental Health Authority** evaluate any contributing factors that led to timely ongoing services for beneficiaries in the MI Children, MI Adults, and Medicaid SA populations, and leverage these factors to achieve timely ongoing services specifically for adults and children with developmental disabilities. Additionally, HSAG recommends that **Detroit Wayne Mental Health Authority** monitor performance related to inpatient psychiatric readmissions for adults so as to identify interventions that may improve rates in this measurement area.

Detroit Wayne Mental Health Authority experienced issues with data completeness for the BH-TEDS. Specifically, providers submitted BH-TEDS records in batches; and the records were often received nonsequentially, resulting in file rejection. The PIHP reported that it planned to implement a new system that would allow it to create the BH-TEDS records centrally for submission to the State. HSAG encourages **Detroit Wayne Mental Health Authority** to continue to work toward improving BH-TEDS completion rates.

Detroit Wayne Mental Health Authority contracted with PCE to calculate Indicator #1: *The percent of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours*. The PCE system allowed the data to be locked at the time of reporting, so the PIHP had a consumer-level detail file reflective of the data used for reporting to the State. However, **Detroit Wayne Mental Health Authority** staff members were unable to provide the consumer-level detail information used for reporting to the State for the remaining measures. HSAG recommends that the **Detroit Wayne Mental Health Authority** continue to explore options for creating a locked patient-level detail file, whether that is accomplished via updates to the Mental Health Wellness Information Network (MH-WIN) or by saving copies of the files in a location that can be easily accessed for reference.

Additionally, for Indicator #1, **Detroit Wayne Mental Health Authority** received from providers, for the Child population, data in a Microsoft Excel template developed specifically for reporting the measure. **Detroit Wayne Mental Health Authority** reported that it reviewed the data for irregularities and followed up with providers as needed, but no formalized validation process existed for these data. HSAG recommends that **Detroit Wayne Mental Health Authority** develop a formal data validation process to ensure that numerator and denominator are correct.

As part of the primary source verification process for Indicator #4a: *The percent of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days* HSAG reviewed two cases that were reported as numerator positive, but evidence of numerator compliance within the **Detroit Wayne Mental Health Authority**'s transactional system was insufficient. Therefore, HSAG assigned an NR audit designation for this measure. HSAG recommends that **Detroit Wayne Mental Health Authority** implement a stringent validation process to ensure that only cases with sufficient evidence of numerator compliance be included in the numerator.

Summary Assessment Related to Quality, Timeliness, and Access

Timeliness of care and **access** to care were demonstrated strengths for **Detroit Wayne Mental Health Authority** based on its reported rates for the following measures: Indicator #1: *The percent of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours—Children and Adults*; Indicator #2: *The percent of new Medicaid beneficiaries during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service—MI Children, MI Adults, DD Children, DD Adults, Medicaid SA, and Total*; and Indicator #3: *The percent of new Medicaid beneficiaries during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional—MI Children, MI Adults, Medicaid SA, and Total*.

Detroit Wayne Mental Health Authority's rates for Indicator #4b: *The percent of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days* indicated strengths in the areas of **quality**, **timeliness**, and **access** to care. Additionally, **Detroit Wayne Mental Health Authority**'s performance around **quality** was strong, as evidenced by the reported rates for Indicator #10: *The percent of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge—Children*.

Conversely, **Detroit Wayne Mental Health Authority**'s reported rate for Indicator #10: *The percent of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge—Adults* indicated opportunities for improved **quality** of care. Also, the PIHP's reported rates for the following measures indicated opportunities for improvement around **timeliness** of care and **access** to care: Indicator #3: *The percent of new Medicaid beneficiaries during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional—DD Children and DD Adults*.

Region 8—Oakland County CMH Authority

Findings—System and Reporting Capabilities

Oakland County CMH Authority used the iDashboards product and shared it with providers, which helped to keep providers informed of performance pertaining to data accuracy and completeness.

Oakland County CMH Authority also transitioned to a new module in the PCE system for Indicator #2: *The percent of new Medicaid beneficiaries during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service* and Indicator #3: *The percent of new Medicaid beneficiaries during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional* that enabled providers to review and analyze their performance for these indicators on demand, which also helped to ensure data accuracy and completeness.

Findings—Performance Measure Results

Based on the SFY 2017 validation of performance measures activities, Table 3–8 presents **Oakland County CMH Authority**'s performance measure results.

Table 3–8—Performance Measure Results for Oakland County CMH Authority

Performance Indicator	Rate	Minimum Performance Standard
#1: The percent of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.		
Children	97.50%	95.00%
Adults	98.92%	95.00%
#2: The percent of new Medicaid beneficiaries during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service.		
MI Children	94.83%	95.00%
MI Adults	95.66%	95.00%
DD Children	100.00%	95.00%
DD Adults	93.02%	95.00%
Medicaid SA	99.64%	95.00%
Total	97.20%	95.00%
#3: The percent of new Medicaid beneficiaries during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional.		
MI Children	99.53%	95.00%
MI Adults	99.49%	95.00%
DD Children	95.65%	95.00%

Performance Indicator	Rate	Minimum Performance Standard
<i>DD Adults</i>	100.00%	95.00%
<i>Medicaid SA</i>	98.29%	95.00%
<i>Total</i>	99.04%	95.00%
#4a: The percent of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.		
<i>Children</i>	93.55%	95.00%
<i>Adults</i>	90.69%	95.00%
#4b: The percent of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.		
<i>The percent of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.</i>	96.82%	95.00%
#5: The percent of Medicaid recipients having received PIHP managed services.		
<i>The percent of Medicaid recipients having received PIHP managed services.</i>	7.74%	—
#6: The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.		
<i>The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.</i>	98.34%	—
#8: The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who are employed competitively.		
<i>MI Adults</i>	14.38%	—
<i>DD Adults</i>	14.16%	—
<i>MI/DD Adults</i>	10.16%	—
#9: The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.		
<i>MI Adults</i>	78.15%	—
<i>DD Adults</i>	92.71%	—
<i>MI/DD Adults</i>	84.03%	—
#10: The percent of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.*		
<i>Children</i>	0.00%	15.00%
<i>Adults</i>	13.98%	15.00%

Performance Indicator	Rate	Minimum Performance Standard
#13: The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).		
<i>The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).</i>	6.59%	—
#14: The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).		
<i>The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).</i>	36.18%	—

Yellow shading indicates that the reported rate was better than the minimum performance standard.

— Indicates that a minimum performance standard was not established for this measure indicator.

* A lower rate indicates better performance.

Strengths

Oakland County CMH Authority's performance exceeded the minimum performance standards for the following indicators, suggesting strength in these areas:

- *#1: The percent of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours—Children and Adults*
- *#2: The percent of new Medicaid beneficiaries during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service—MI Adults, DD Children, Medicaid SA, and Total*
- *#3: The percent of new Medicaid beneficiaries during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional—MI Children, MI Adults, DD Children, DD Adults, Medicaid SA, and Total*
- *#4b: The percent of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days*
- *#10: The percent of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge—Children and Adults*

Recommendations

Although most of **Oakland County CMH Authority's** rates were above the minimum performance standards, the following rates fell below the minimum performance standard, indicating opportunities for improvement:

- *#2: The percent of new Medicaid beneficiaries during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service—MI Children and DD Adults*

- *#4a: The percent of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days—Children and Adults*

HSAG recommends that **Oakland County CMH Authority** evaluate any contributing factors that led to timely assessments for members in the MI Adults, DD Children, and Medicaid SA populations following requests for non-emergent services, then leverage these factors to achieve timely assessments for MI Children and DD Adults. Additionally, HSAG recommends that **Oakland County CMH Authority** monitor performance related to inpatient psychiatric readmissions for children and adults, to identify potential interventions that may improve rates for these members.

As it relates to performance measure validation, **Oakland County CMH Authority** allowed providers to review and manually correct the consumer-level detail files that were generated for reporting. However, **Oakland County CMH Authority** did not maintain a sufficient documentation trail of these corrections. For validation purposes, HSAG recommends that **Oakland County CMH Authority** establish a formal process to track manual changes made to consumer-level detail files. This tracking will help to ensure that possible issues with programming language can be appropriately identified, and distinguished from manual data corrections.

Summary Assessment Related to Quality, Timeliness, and Access

Timeliness of care and **access** to care were demonstrated strengths for **Oakland County CMH Authority** based on its reported rates for the following measures: Indicator #1: *The percent of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours—Children and Adults*; Indicator #2: *The percent of new Medicaid beneficiaries during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service—MI Adults, DD Children, Medicaid SA, and Total*; and Indicator #3: *The percent of new Medicaid beneficiaries during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional—MI Children, MI Adults, DD Children, DD Adults, Medicaid SA, and Total*.

Oakland County CMH Authority's rates for Indicator #4b: *The percent of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days* indicated strengths in the areas of **quality**, **timeliness**, and **access** to care. Additionally, **Oakland County CMH Authority's** performance around **quality** was strong, as evidenced by the reported rates for Indicator #10: *The percent of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge—Children and Adults*.

Conversely, **Oakland County CMH Authority's** reported rates for the following measure indicated opportunities for improvement around **timeliness** of care and **access** to care: Indicator #2: *The percent of new Medicaid beneficiaries during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service—MI Children and DD Adults*. Further, the reported rate for Indicator #4a: *The percent of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days—Children and Adults* indicated opportunities for improved **quality**, **timeliness**, and **access** to care.

Region 9—Macomb County CMH Services

Findings—System and Reporting Capabilities

Macomb County CMH Services developed new training and staff support strategies to improve data collection from providers to increase the rate at which BH-TEDS were completed as compared to the prior year. **Macomb County CMH Services** worked closely with Macomb Oakland Regional Center (MORC) to identify areas in need of improvement.

Findings—Performance Measure Results

Based on the SFY 2017 validation of performance measures activities, Table 3–9 presents **Macomb County CMH Services**’ performance measure results.

Table 3–9—Performance Measure Results for Macomb County CMH Services

Performance Indicator	Rate	Minimum Performance Standard
#1: The percent of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.		
Children	100.00%	95.00%
Adults	99.84%	95.00%
#2: The percent of new Medicaid beneficiaries during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service.		
MI Children	95.73%	95.00%
MI Adults	97.16%	95.00%
DD Children	97.14%	95.00%
DD Adults	100.00%	95.00%
Medicaid SA	99.04%	95.00%
Total	98.30%	95.00%
#3: The percent of new Medicaid beneficiaries during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional.		
MI Children	96.30%	95.00%
MI Adults	97.12%	95.00%
DD Children	97.06%	95.00%
DD Adults	93.75%	95.00%
Medicaid SA	99.77%	95.00%
Total	98.61%	95.00%

Performance Indicator	Rate	Minimum Performance Standard
#4a: The percent of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.		
Children	95.74%	95.00%
Adults	93.58%	95.00%
#4b: The percent of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.		
The percent of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.	98.63%	95.00%
#5: The percent of Medicaid recipients having received PIHP managed services.		
The percent of Medicaid recipients having received PIHP managed services.	5.39%	—
#6: The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.		
The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	99.79%	—
#8: The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who are employed competitively.		
MI Adults	12.95%	—
DD Adults	5.47%	—
MI/DD Adults	5.97%	—
#9: The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.		
MI Adults	87.05%	—
DD Adults	30.10%	—
MI/DD Adults	40.88%	—
#10: The percent of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.*		
Children	11.32%	15.00%
Adults	16.41%	15.00%
#13: The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).		
The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	13.71%	—

Performance Indicator	Rate	Minimum Performance Standard
#14: The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).		
<i>The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).</i>	39.69%	—

Yellow shading indicates that the reported rate was better than the minimum performance standard.

— Indicates that a minimum performance standard was not established for this measure indicator.

* A lower rate indicates better performance.

Strengths

Macomb County CMH Services' performance exceeded the minimum performance standards for the following indicators, suggesting strength in these areas:

- *#1: The percent of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours—Children and Adults*
- *#2: The percent of new Medicaid beneficiaries during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service—MI Children, MI Adults, DD Children, DD Adults, Medicaid SA, and Total*
- *#3: The percent of new Medicaid beneficiaries during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional—MI Children, MI Adults, DD Children, Medicaid SA, and Total*
- *#4a: The percent of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days—Children*
- *#4b: The percent of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days*
- *#10: The percent of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge—Children*

Recommendations

Although most of **Macomb County CMH Services'** rates were above the minimum performance standards, the following rates fell below the minimum performance standard, indicating opportunities for improvement:

- *#3: The percent of new Medicaid beneficiaries during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional—DD Adults*
- *#4a: The percent of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days—Adults*

- *#10: The percent of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge—Adults*

Therefore, to identify interventions that may improve rates in these measurement areas, HSAG recommends that **Macomb County CMH Services** monitor performance related to timely ongoing services for adults with developmental disabilities, timely follow-up care for adults following psychiatric inpatient discharge, and reducing inpatient psychiatric readmissions for adults.

During the validation of performance measures, primary source verification uncovered issues with data accuracy for Indicator #2: *The percent of new Medicaid beneficiaries during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service* and Indicator #3: *The percent of new Medicaid beneficiaries during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional*. These issues were due to a discrepancy between the performance measure data and documentation in the electronic medical record (EMR). To improve compliance with MDHHS Codebook specifications, HSAG recommends that **Macomb County CMH Services** take the following steps:

- Implement a hard edit in FOCUS, a system used for behavioral health data, to prompt the user if that user enters an appointment date outside the 14-day time frame. In addition, an explanation by the consumer should also be required if the checkbox indicates that that consumer is requesting an appointment outside the 14-day time frame.
- If an exception is altered because of an investigative finding, document in the EMR a note or comment about the research and when it was conducted.
- Implement regular quality checks for exceptions for all indicators, and define a percentage or threshold for number of records that should be checked.

Summary Assessment Related to Quality, Timeliness, and Access

Timeliness of care and **access** to care were demonstrated strengths for **Macomb County CMH Services**, based on its reported rates for the following measures: Indicator #1: *The percent of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours—Children and Adults*; Indicator #2: *The percent of new Medicaid beneficiaries during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service—MI Children, MI Adults, DD Children, DD Adults, Medicaid SA, and Total*; and Indicator #3: *The percent of new Medicaid beneficiaries during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional—MI Children, MI Adults, DD Children, Medicaid SA, and Total*.

Macomb County CMH Services' rates for Indicator #4a: *The percent of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days—Children and* Indicator #4b: *The percent of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days* indicated strengths in the areas of **quality**, **timeliness**, and **access** to care. Additionally, **Macomb County CMH Services'** performance around **quality** was strong, as

evidenced by the reported rates for Indicator #10: *The percent of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge—Children.*

Conversely, **Macomb County CMH Services**’ reported rates for the following measure indicated opportunities for improvement around **quality**, **timeliness**, and **access** to care: Indicator #4a: *The percent of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days—Adults.*

Further, the reported rate for Indicator #3: *The percent of new Medicaid beneficiaries during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional—DD Adults* indicated opportunities for improved **timeliness** and **access** to care; and the reported rate for Indicator #10: *The percent of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge—Adults* indicated opportunity for improved **quality** of care.

Region 10 PIHP

Findings—System and Reporting Capabilities

For the current reporting period, **Region 10 PIHP** developed new training and staff-support strategies to improve data collection from providers. **Region 10 PIHP** continued to foster its relationship with its related CMHSP to ensure data accuracy and integrity.

Findings—Performance Measure Results

Based on the SFY 2017 validation of performance measures activities, Table 3–10 presents **Region 10 PIHP**’s performance measure results.

Table 3–10—Performance Measure Results for Region 10 PIHP

Performance Indicator	Rate	Minimum Performance Standard
#1: The percent of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.		
<i>Children</i>	99.65%	95.00%
<i>Adults</i>	99.73%	95.00%
#2: The percent of new Medicaid beneficiaries during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service.		
<i>MI Children</i>	97.73%	95.00%
<i>MI Adults</i>	95.45%	95.00%
<i>DD Children</i>	100.00%	95.00%
<i>DD Adults</i>	100.00%	95.00%

Performance Indicator	Rate	Minimum Performance Standard
Medicaid SA	96.44%	95.00%
Total	96.78%	95.00%
#3: The percent of new Medicaid beneficiaries during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional.		
MI Children	95.73%	95.00%
MI Adults	99.14%	95.00%
DD Children	97.14%	95.00%
DD Adults	97.62%	95.00%
Medicaid SA	99.77%	95.00%
Total	98.68%	95.00%
#4a: The percent of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.		
Children	100.00%	95.00%
Adults	96.73%	95.00%
#4b: The percent of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.		
The percent of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.	100.00%	95.00%
#5: The percent of Medicaid recipients having received PIHP managed services.		
The percent of Medicaid recipients having received PIHP managed services.	7.17%	—
#6: The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.		
The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	98.64%	—
#8: The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who are employed competitively.		
MI Adults	10.15%	—
DD Adults	6.07%	—
MI/DD Adults	6.74%	—

Performance Indicator	Rate	Minimum Performance Standard
#9: The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.		
MI Adults	82.99%	—
DD Adults	16.02%	—
MI/DD Adults	23.46%	—
#10: The percent of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.*		
Children	8.82%	15.00%
Adults	12.05%	15.00%
#13: The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).		
The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	16.90%	—
#14: The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).		
The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	49.93%	—

Yellow shading indicates that the reported rate was better than the minimum performance standard.

— Indicates that a minimum performance standard was not established for this measure indicator.

* A lower rate indicates better performance.

Strengths

Region 10 PIHP's performance exceeded the minimum performance standards for all 19 indicators with minimum performance standards, indicating overall strength in the PIHP's performance.

Recommendations

Region 10 PIHP's rates exceeded all minimum performance standards; therefore, no performance measure recommendations were identified.

During HSAG's performance measure validation activities, HSAG reviewed a case of a consumer from Genesee Health System (GHS) excluded from Indicator #2: *The percent of new Medicaid beneficiaries during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service* due to missing disability designation. **Region 10 PIHP** did not have sufficient notes to describe the reason for the consumer's exclusion or if the necessary research was conducted to locate the missing designation. Following the on-site visit, **Region 10 PIHP** indicated that the GHS staff member linked to this case did not receive clear instructions regarding the specifications

for each indicator; however, GHS staff had conducted follow-up review of all records identified as exclusions or omissions. Therefore, HSAG encourages GHS to conduct additional review of those cases identified as exclusions.

Summary Assessment Related to Quality, Timeliness, and Access

Region 10 PIHP's rates for Indicator #4a: *The percent of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days—Children and Adults* and Indicator #4b: *The percent of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days* indicated strengths in the areas of **quality**, **timeliness**, and **access** to care.

Timeliness of care and **access** to care were demonstrated strengths for **Region 10 PIHP** based on its reported rates for the following measures: Indicator #1: *The percent of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours—Children and Adults*; Indicator #2: *The percent of new Medicaid beneficiaries during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service—MI Children, MI Adults, DD Children, DD Adults, Medicaid SA, and Total*; and Indicator #3: *The percent of new Medicaid beneficiaries during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional—MI Children, MI Adults, DD Children, DD Adults, Medicaid SA, and Total*.

Additionally, **Region 10 PIHP**'s performance around **quality** was strong, as evidenced by the reported rates for Indicator #10: *The percent of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge—Children and Adults*.

Validation of Performance Improvement Projects

This section of the report presents the results of the validation of PIPs. For the 2016–2017 validation, the PIHPs continued with their selected topic related to behavioral and physical healthcare integration and presented their fourth-year submissions. The PIP topics addressed CMS’ requirements related to the **quality** of and **access** to care and services provided by the PIHPs.

Region 1—NorthCare Network

Findings

For the 2016–2017 validation, **NorthCare Network** provided its fourth-year submission on this PIP topic: *Improving Medical Nutrition Therapy Services for Consumers with Self-Reported Obesity*.

Table 3–11 and Table 3–12 show **NorthCare Network**’s scores based on HSAG’s PIP evaluation. For additional details, refer to the 2016–2017 PIP Validation Report for **NorthCare Network**.

**Table 3–11—Performance Improvement Project Validation Results
for NorthCare Network**

Stage	Activity		Percentage of Applicable Elements		
			Met	Partially Met	Not Met
Design	I.	Appropriate Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Clearly Defined, Answerable Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Correctly Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Clearly Defined Study Indicator(s)	100% (3/3)	0% (0/3)	0% (0/3)
	V.	Valid Sampling Techniques (if sampling was used)	Not Applicable		
	VI.	Accurate/Complete Data Collection	100% (4/4)	0% (0/4)	0% (0/4)
Design Total			100% (11/11)	0% (0/11)	0% (0/11)
Implementation	VII.	Sufficient Data Analysis and Interpretation	100% (8/8)	0% (0/8)	0% (0/8)
	VIII.	Appropriate Improvement Strategies	100% (3/3)	0% (0/3)	0% (0/3)
Implementation Total			100% (11/11)	0% (0/11)	0% (0/11)

Stage	Activity		Percentage of Applicable Elements		
			Met	Partially Met	Not Met
Outcomes	IX.	Real Improvement Achieved	100% (4/4)	0% (0/4)	0% (0/4)
	X.	Sustained Improvement Achieved	Not Assessed		
Outcomes Total			100% (4/4)	0% (0/4)	0% (0/4)
Percentage Score of Applicable Evaluation Elements Met			100% (26/26)		

**Table 3–12—2016–2017 Performance Improvement Project Validation Scores
for NorthCare Network**

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

NorthCare Network submitted the Design, Implementation, and Outcomes stages of the PIP for this year’s validation. Overall, 100 percent of all applicable evaluation elements received scores of *Met*.

Strengths

NorthCare Network designed a scientifically sound study supported by key research principles. The technical design of the PIP was sufficient to measure outcomes, and the PIP’s design allowed for the successful progression to the next stage of the PIP process. The PIHP used appropriate quality improvement tools to conduct causal/barrier analysis and implemented interventions that have the potential to have a positive impact on the study indicator outcomes. The study indicator demonstrated a statistically significant improvement over the baseline.

Recommendations

HSAG identified *Points of Clarification* as opportunities for improvement in Activity VII—Sufficient Data Analysis and Interpretation and Activity VIII—Appropriate Improvement Strategies. **NorthCare Network** should provide the *p* value from its statistical testing results and track the effectiveness of interventions with quantitative data if possible.

NorthCare Network should build on its momentum of improvement to ensure it can sustain the improvement achieved. The PIHP should evaluate the effectiveness of each intervention and ensure that decisions made to revise, continue, or discontinue an intervention are data driven. Additionally, the

PIHP should revisit its causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions.

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

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

NorthCare Network identified barriers through data review and brainstorming. Barriers included lack of a systemwide process or template form to make a referral for medical nutrition therapy as well as shortage of information available to staff about members in need of this service. **NorthCare Network**'s interventions included developing a standard operating procedure and a cover letter template for referrals and training staff members in the use of the electronic health record (EHR) to identify members in need of medical nutrition services.

Table 3–13 below shows baseline and remeasurement results for **NorthCare Network**'s PIP study indicator:

**Table 3–13—Performance Improvement Project Outcomes
for NorthCare Network**

<i>Improving Medical Nutrition Therapy Services for Consumers With Self-Reported Obesity</i>				
PIP Study Indicator	Baseline Period	Remeasurement 1	Remeasurement 2	Sustained Improvement
The percentage of adults with mental illness who indicate a medical diagnosis of obesity in the self-reported measures and receive medical nutrition therapy services from a primary care provider.	1.1%	1.8%	3.9%	Not Assessed*

* Not Assessed. Sustained improvement cannot be assessed until the study indicator has achieved statistically significant improvement over baseline and results for a subsequent measurement period have been reported.

For the 2016–2017 validation, **NorthCare Network** reported and interpreted its Remeasurement 2 data accurately. The Remeasurement 2 rate for the study indicator was 3.9 percent, which was a 2.8 percentage point increase over the baseline and exceeded the PIHP's goal of 2.4 percent by 1.5 percentage points. The improvement from baseline to Remeasurement 2 was statistically significant; however, since the improvement demonstrated during Remeasurement 1 was not statistically significant over the baseline, the PIP was not assessed for sustained improvement.

The demonstrated improvement in study indicator rate from baseline to Remeasurement 2 indicates that the interventions had a positive impact on the **quality** of and **access** to care and services provided by the PIHP.

Region 2—Northern Michigan Regional Entity

Findings

For the 2016–2017 validation, **Northern Michigan Regional Entity** provided its fourth-year submission on this PIP topic: *Increasing Diabetic Screenings for Consumers With SMI Prescribed an Antipsychotic Medication*.

Table 3–14 and Table 3–15 show **Northern Michigan Regional Entity**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2016–2017 PIP Validation Report for **Northern Michigan Regional Entity**.

**Table 3–14—Performance Improvement Project Validation Results
for Northern Michigan Regional Entity**

Stage	Activity		Percentage of Applicable Elements		
			Met	Partially Met	Not Met
Design	I.	Appropriate Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Clearly Defined, Answerable Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Correctly Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Clearly Defined Study Indicator(s)	100% (3/3)	0% (0/3)	0% (0/3)
	V.	Valid Sampling Techniques (if sampling was used)	Not Applicable		
	VI.	Accurate/Complete Data Collection	100% (4/4)	0% (0/4)	0% (0/4)
Design Total			100% (11/11)	0% (0/11)	0% (0/11)
Implementation	VII.	Sufficient Data Analysis and Interpretation	100% (8/8)	0% (0/8)	0% (0/8)
	VIII.	Appropriate Improvement Strategies	100% (3/3)	0% (0/3)	0% (0/3)
Implementation Total			100% (11/11)	0% (0/11)	0% (0/11)
Outcomes	IX.	Real Improvement Achieved	100% (4/4)	0% (0/4)	0% (0/4)
	X.	Sustained Improvement Achieved	100% (1/1)	0% (0/1)	0% (0/1)
Outcomes Total			100% (5/5)	0% (0/5)	0% (0/5)
Percentage Score of Applicable Evaluation Elements Met			100% (27/27)		

**Table 3–15—2016–2017 Performance Improvement Project Validation
for Northern Michigan Regional Entity**

Type of Annual Review	Percentage Score of Evaluation Elements Met	Percentage Score of Critical Elements Met	Overall Validation Status
Submission	96%	100%	<i>Met</i>
Resubmission	100%	100%	<i>Met</i>

Northern Michigan Regional Entity submitted the Design, Implementation, and Outcomes stages of the PIP for this year’s validation. Upon initial validation, the PIP received a validation status of *Met*, with an overall score of 96 percent for all evaluation elements and a score of 100 percent for critical elements. The PIHP resubmitted the PIP to address the identified deficiencies in the PIP documentation. For the final submission, 100 percent of all applicable evaluation elements received scores of *Met*.

Strengths

Northern Michigan Regional Entity designed a scientifically sound study supported by key research principles. The technical design of the PIP was sufficient to measure outcomes, and the PIP’s design allowed for the successful progression to the next stage of the PIP process. The PIHP used appropriate quality improvement tools to conduct causal/barrier analysis and implemented interventions that have the potential to have a positive impact on the study indicator outcomes. The study indicator demonstrated a statistically significant and sustained improvement over the baseline.

Recommendations

HSAG identified no opportunities for improvement in the annual PIP validation tool for **Northern Michigan Regional Entity**. The PIHP should build on its momentum of improvement to ensure it continues to sustain the improvement achieved. The PIHP should evaluate the effectiveness of each intervention and ensure that decisions made to revise, continue, or discontinue an intervention are data driven. Additionally, the PIHP should revisit its causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions.

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

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

Northern Michigan Regional Entity identified barriers using data analysis, brainstorming, and the 5-Whys technique for root-cause analysis. The PIHP determined that the greatest barrier was that providers were not following procedure/protocols developed after the baseline measurement. The barriers included lack of laboratory orders for diabetic screenings, completion of screenings outside the

recommended time frame, and consumer-level barriers. **Northern Michigan Regional Entity**'s interventions included education for staff members to follow the PIP protocols for diabetic screening, consumer education on importance of these screenings, distribution of quarterly data reports identifying anyone prescribed a second-generation antipsychotic medication for six months or more who does not have a claim for a completed diabetic screening, and an EHR with a system to alert staff when labs are due.

**Table 3–16—Performance Improvement Project Outcomes
for Northern Michigan Regional Entity**

<i>Increasing Diabetic Screenings for Consumers With SMI Prescribed an Antipsychotic Medication</i>				
PIP Study Indicator	Baseline Period	Remeasurement 1	Remeasurement 2	Sustained Improvement
The percentage of consumers 18 to 64 years of age with serious mental illness who were prescribed an antipsychotic medication by a CMH physician for six months or longer and received an HbA1c test or fasting blood sugar test during the measurement year.	63.2%	82.4%	81.1%	Yes

For the 2016–2017 validation, **Northern Michigan Regional Entity** reported and interpreted its Remeasurement 2 data accurately. The Remeasurement 2 rate for the study indicator was 81.1 percent. This demonstrates a decline in the study indicator rate from Remeasurement 1; however, the rate was 17.9 percentage points above the baseline and exceeded the PIHP's goal of 72.3 percent by 8.8 percentage points. **Northern Michigan Regional Entity** sustained the statistically significant improvement over baseline achieved during the Remeasurement 1 study period. The demonstrated improvement indicates that the interventions had a positive impact on the **quality** of and **access** to care and services provided by the PIHP.

Region 3—Lakeshore Regional Entity

For the 2016–2017 validation, **Lakeshore Regional Entity** provided its fourth-year submission on this PIP topic: *Consumers Who Filled at Least One Prescription for a Second-Generation Antipsychotic Medication Who Receive an HbA1C, Lipid Panel, or Fasting Plasma Glucose.*

Table 3–17 and Table 3–18 show **Lakeshore Regional Entity**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2016–2017 PIP Validation Report for **Lakeshore Regional Entity**.

**Table 3–17—Performance Improvement Project Validation Results
for Lakeshore Regional Entity**

Stage	Activity		Percentage of Applicable Elements		
			Met	Partially Met	Not Met
Design	I.	Appropriate Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Clearly Defined, Answerable Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Correctly Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Clearly Defined Study Indicator(s)	100% (3/3)	0% (0/3)	0% (0/3)
	V.	Valid Sampling Techniques (if sampling was used)	Not Applicable		
	VI.	Accurate/Complete Data Collection	100% (4/4)	0% (0/4)	0% (0/4)
Design Total			100% (11/11)	0% (0/11)	0% (0/11)
Implementation	VII.	Sufficient Data Analysis and Interpretation	100% (8/8)	0% (0/8)	0% (0/8)
	VIII.	Appropriate Improvement Strategies	100% (3/3)	0% (0/3)	0% (0/3)
Implementation Total			100% (11/11)	0% (0/11)	0% (0/11)
Outcomes	IX.	Real Improvement Achieved	100% (4/4)	0% (0/4)	0% (0/4)
	X.	Sustained Improvement Achieved	100% (1/1)	0% (0/1)	0% (0/1)
Outcomes Total			100% (5/5)	0% (0/5)	0% (0/5)
Percentage Score of Applicable Evaluation Elements Met			100% (27/27)		

**Table 3–18—2016–2017—Performance Improvement Project Validation Scores
for Lakeshore Regional Entity**

Type of Annual Review	Percentage Score of Evaluation Elements Met	Percentage Score of Critical Elements Met	Overall Validation Status
Submission	85%	89%	Not Met
Resubmission	100%	100%	Met

Lakeshore Regional Entity submitted the Design, Implementation, and Outcomes stages of the PIP for this year's validation. For the initial submission, the PIP received an overall *Not Met* validation status. The PIHP received technical assistance, incorporated HSAG's recommendations, and resubmitted the PIP. Upon final validation, the PIP received an overall *Met* validation status and 100 percent of all applicable evaluation elements received scores of *Met*.

Strengths

Lakeshore Regional Entity designed a scientifically sound study supported by key research principles. The technical design of the PIP was sufficient to measure outcomes, and the PIP's design allowed for the successful progression to the next stage of the PIP process. The PIHP used appropriate quality improvement tools to conduct causal/barrier analysis and implemented interventions that have the potential to have a positive impact on the study indicator outcomes. The study indicator demonstrated a statistically significant and sustained improvement over the baseline.

Recommendations

HSAG identified *Points of Clarification* as opportunities for improvement in Activity IV—Select the Study Indicator(s) and Activity VII—Sufficient Data Analysis and Interpretation. **Lakeshore Regional Entity** should include a numeric percentage for the PIHP-specific Remeasurement 2 goal. The PIHP should ensure that the reported data and interpretation of results are accurate and consistent throughout the PIP Submission Form.

The PIHP should build on its momentum of improvement to ensure it continues to sustain the improvement achieved. Additionally, the PIHP should revisit its causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions.

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

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

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

Table 3–19 following shows baseline and remeasurement results for **Lakeshore Regional Entity**’s PIP study indicator.

**Table 3–19—Performance Improvement Project Outcomes
for Lakeshore Regional Entity**

<i>Consumers Who Filled at Least One Prescription for a Second-Generation Antipsychotic Medication Who Receive an HbA1c, Lipid Panel, or Fasting Plasma Glucose</i>				
PIP Study Indicator	Baseline Period	Remeasurement 1	Remeasurement 2	Sustained Improvement
The percentage of Medicaid-eligible adults who filled a prescription for a second-generation antipsychotic medication and received lab work for an HbA1c, lipid panel, or fasting plasma glucose during the measurement period.	73.9%	76.1%	78.5%	Yes

Lakeshore Regional Entity identified errors in the calculation of the baseline and Remeasurement 1 rates and consequently recalculated and revised the rates in the current-year PIP submission. The baseline rate reported last year was 74.6 percent; however, the revised baseline rate was 0.7 percentage points lower than the previously reported baseline rate. The revised Remeasurement 1 rate for the study indicator was 76.1 percent. The PIHP demonstrated a statistically significant improvement in the study indicator rates between the baseline and Remeasurement 1.

The Remeasurement 2 rate for the study indicator was 78.5 percent, which represents a statistically significant improvement of 4.6 percentage points above the baseline; however, the rate was 1.5 percentage points below the PIHP’s goal of 80 percent. Within a subsequent measurement period the PIHP did sustain the statistically significant improvement achieved at Remeasurement 1. The demonstrated improvement indicates that the interventions had a positive impact on the **quality** of and **access** to care and services provided by the PIHP.

Region 4—Southwest Michigan Behavioral Health

For the 2016–2017 validation, **Southwest Michigan Behavioral Health** provided its fourth-year submission on this PIP topic: *Improving Diabetes Treatment for Consumers With a Co-morbid Mental Health Condition*.

Table 3–20 and Table 3–21 show **Southwest Michigan Behavioral Health**’s scores based on HSAG’s PIP evaluation. For additional details, refer to the 2016–2017 PIP Validation Report for **Southwest Michigan Behavioral Health**.

**Table 3–20—Performance Improvement Project Validation Results
for Southwest Michigan Behavioral Health**

Stage	Activity		Percentage of Applicable Elements		
			Met	Partially Met	Not Met
Design	I.	Appropriate Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Clearly Defined, Answerable Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Correctly Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Clearly Defined Study Indicator(s)	100% (3/3)	0% (0/3)	0% (0/3)
	V.	Valid Sampling Techniques (if sampling was used)	Not Applicable		
	VI.	Accurate/Complete Data Collection	100% (4/4)	0% (0/4)	0% (0/4)
Design Total			100% (11/11)	0% (0/11)	0% (0/11)
Implementation	VII.	Sufficient Data Analysis and Interpretation	100% (8/8)	0% (0/8)	0% (0/8)
	VIII.	Appropriate Improvement Strategies	100% (3/3)	0% (0/3)	0% (0/3)
Implementation Total			100% (11/11)	0% (0/11)	0% (0/11)
Outcomes	IX.	Real Improvement Achieved	100% (4/4)	0% (0/4)	0% (0/4)
	X.	Sustained Improvement Achieved	100% (1/1)	0% (0/1)	0% (0/1)
Outcomes Total			100% (5/5)	0% (0/5)	0% (0/5)
Percentage Score of Applicable Evaluation Elements Met			100% (27/27)		

**Table 3–21—2016–2017—Performance Improvement Project Validation Scores
for Southwest Michigan Behavioral Health**

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

Southwest Michigan Behavioral Health submitted the Design, Implementation, and Outcomes stages of the PIP for this year's validation. The PIP received a validation status of *Met* for the initial submission, with an overall score of 96 percent for all evaluation elements and a score of 100 percent for critical elements. The PIHP resubmitted the PIP to address the identified deficiencies in the PIP documentation. For the final submission, 100 percent of all applicable evaluation elements received scores of *Met*.

Strengths

Southwest Michigan Behavioral Health designed a scientifically sound study supported by key research principles. The technical design of the PIP was sufficient to measure outcomes, and the PIP's design allowed for the successful progression to the next stage of the PIP process. The PIHP used appropriate quality improvement tools to conduct causal/barrier analysis and implemented interventions that have the potential to have a positive impact on the study indicator outcomes. The study indicator demonstrated a statistically significant and sustained improvement over the baseline.

Recommendations

HSAG identified *Points of Clarification* as opportunities for improvement in Activity IV—Select the Study Indicator(s) and Activity VII—Sufficient Data Analysis and Interpretation. **Southwest Michigan Behavioral Health** should ensure that the reported data and interpretation of results are accurate and consistent throughout the PIP Submission Form.

The PIHP should build on its momentum of improvement to ensure it continues to sustain the improvement achieved. Additionally, the PIHP should revisit its causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions.

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

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

Southwest Michigan Behavioral Health identified barriers by using a fishbone diagram. The PIHP indicated that most barriers and interventions continued to be the same as those identified during Remeasurement 1. The barriers included lack of coordination between PIHP clinicians and medical providers, absence of goals in treatment plans to address diabetic conditions when applicable, inability to identify consumers with diabetes, and lack of information and training regarding the importance of care coordination and treatment for diabetes. **Southwest Michigan Behavioral Health's** interventions included offering education and training for providers and consumers, using a data analytics tool to verify consumers' diagnosis and treatment information, and coordinating care with primary care providers.

Table 3–22 following shows baseline and remeasurement results for **Southwest Michigan Behavioral Health**’s PIP study indicator.

**Table 3–22—Performance Improvement Project Outcomes
for Southwest Michigan Behavioral Health**

<i>Improving Diabetes Treatment for Consumers With a Co-morbid Mental Health Condition</i>				
PIP Study Indicator	Baseline Period	Remeasurement 1	Remeasurement 2	Sustained Improvement
Proportion of individuals who report having diabetes and demonstrate having been treated for the condition within the past twelve months.	52.3%	84.4%	85.0%	Yes

For the 2016–2017 validation, **Southwest Michigan Behavioral Health** reported and interpreted its Remeasurement 2 data accurately. The Remeasurement 2 rate for the study indicator was 85.0 percent, which demonstrated a statistically significant improvement of 32.7 percentage points above the baseline and an increase of 0.6 percentage point above the PIHP’s goal of 84.4 percent. **Southwest Michigan Behavioral Health** sustained the statistically significant improvement over baseline achieved during the Remeasurement 1 study period. The demonstrated improvement indicates that the interventions had a positive impact on the **quality** of and **access** to care and services provided by the PIHP.

Region 5—Mid-State Health Network

For the 2016–2017 validation, **Mid-State Health Network** provided its fourth-year submission on this PIP topic: *Increasing Diabetes Screening for Consumers With Schizophrenia or Bipolar Disorder Prescribed Antipsychotic Medications*.

Table 3–23 and Table 3–24 show **Mid-State Health Network**’s scores based on HSAG’s PIP evaluation. For additional details, refer to the 2016–2017 PIP Validation Report for **Mid-State Health Network**.

**Table 3–23—Performance Improvement Project Validation Results
for Mid-State Health Network**

Stage	Activity		Percentage of Applicable Elements		
			Met	Partially Met	Not Met
Design	I.	Appropriate Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Clearly Defined, Answerable Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Correctly Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Clearly Defined Study Indicator(s)	100% (3/3)	0% (0/3)	0% (0/3)
	V.	Valid Sampling Techniques (if sampling was used)	Not Applicable		
	VI.	Accurate/Complete Data Collection	100% (4/4)	0% (0/4)	0% (0/4)
Design Total			100% (11/11)	0% (0/11)	0% (0/11)
Implementation	VII.	Sufficient Data Analysis and Interpretation	100% (8/8)	0% (0/8)	0% (0/8)
	VIII.	Appropriate Improvement Strategies	100% (4/4)	0% (0/4)	0% (0/4)
Implementation Total			100% (12/12)	0% (0/12)	0% (0/12)
Outcomes	IX.	Real Improvement Achieved	100% (4/4)	0% (0/4)	0% (0/4)
	X.	Sustained Improvement Achieved	100% (1/1)	0% (0/1)	0% (0/1)
Outcomes Total			100% (5/5)	0% (0/5)	0% (0/5)
Percentage Score of Applicable Evaluation Elements Met			100% (28/28)		

**Table 3–24—2016–2017—Performance Improvement Project Validation Scores
for Mid-State Health Network**

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

Mid-State Health Network submitted the Design, Implementation, and Outcomes stages of the PIP for the 2016–2017 validation. The PIP received an overall *Met* validation status when originally submitted, with no identified deficiencies.

Strengths

Mid-State Health Network designed a scientifically sound study supported by key research principles. The technical design of the PIP was sufficient to measure outcomes, and the PIP’s design allowed for the successful progression to the next stage of the PIP process. The PIHP used appropriate quality improvement tools to conduct causal/barrier analysis and implemented interventions that have the potential to have a positive impact on the study indicator outcomes. The study indicator demonstrated a statistically significant and sustained improvement over the baseline.

Recommendations

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

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

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

Mid-State Health Network identified barriers by using brainstorming and a fishbone diagram. The PIHP indicated that most barriers and interventions continued to be the same as those identified during Remeasurement 1. The identified barriers included limited access to data on the completion of lab work, consumers’ lack of awareness of the importance of regular primary care visits or benefit coverage for diabetes testing, availability of only a limited number of providers, and lack of coordination with primary care physicians. **Mid-State Health Network**’s interventions included a care alert report with real-time data for the diabetes screening key performance indicator, consumer education, and coordination of care with the consumer and primary care physician regarding diabetes testing.

Table 3–25 following shows baseline and remeasurement results for **Mid-State Health Network**’s PIP study indicator.

**Table 3–25—Performance Improvement Project Outcomes for
Mid-State Health Network**

<i>Increasing Diabetes Screening for Consumers With Schizophrenia or Bipolar Disorder Prescribed Antipsychotic Medications</i>				
PIP Study Indicator	Baseline Period	Remeasurement 1	Remeasurement 2	Sustained Improvement
The proportion of the eligible population having at least one diabetes screening completed in the measurement year.	73.7%	77.5%	80.4%	Yes

For the 2016–2017 validation, **Mid-State Health Network** reported and interpreted its Remeasurement 2 data accurately. The Remeasurement 2 rate for the study indicator was 80.4 percent, which was a statistically significant improvement of 6.7 percentage points above the baseline and 1.4 percentage points above the PIHP’s goal of 79.0 percent. Within a subsequent measurement period, **Mid-State Health Network** sustained the statistically significant improvement achieved at Remeasurement 1. The demonstrated improvement indicates that the interventions had a positive impact on the **quality** of and **access** to care and services provided by the PIHP.

Region 6—CMH Partnership of Southeast Michigan

For the 2016–2017 validation, **CMH Partnership of Southeast Michigan** provided its fourth-year submission on this PIP topic: *Medication Labs*.

Table 3–26 and Table 3–27 show **CMH Partnership of Southeast Michigan**’s scores based on HSAG’s PIP evaluation. For additional details, refer to the 2016–2017 PIP Validation Report for **CMH Partnership of Southeast Michigan**.

**Table 3–26—Performance Improvement Project Validation Results
for CMH Partnership of Southeast Michigan**

Stage	Activity		Percentage of Applicable Elements		
			Met	Partially Met	Not Met
Design	I.	Appropriate Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Clearly Defined, Answerable Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Correctly Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Clearly Defined Study Indicator(s)	100% (3/3)	0% (0/3)	0% (0/3)
	V.	Valid Sampling Techniques (if sampling was used)	Not Applicable		
	VI.	Accurate/Complete Data Collection	100% (4/4)	0% (0/4)	0% (0/4)
Design Total			100% (11/11)	0% (0/11)	0% (0/11)
Implementation	VII.	Sufficient Data Analysis and Interpretation	100% (8/8)	0% (0/8)	0% (0/8)
	VIII.	Appropriate Improvement Strategies	100% (3/3)	0% (0/3)	0% (0/3)
Implementation Total			100% (11/11)	0% (0/11)	0% (0/11)
Outcomes	IX.	Real Improvement Achieved	100% (4/4)	0% (0/4)	0% (0/4)
	X.	Sustained Improvement Achieved	100% (1/1)	0% (0/1)	0% (0/1)
Outcomes Total			100% (5/5)	0% (0/5)	0% (0/5)
Percentage Score of Applicable Evaluation Elements Met			100% (27/27)		

**Table 3–27—2016–2017—Performance Improvement Project Validation Scores
for CMH Partnership of Southeast Michigan**

Type of Annual Review	Percentage Score of Evaluation Elements Met	Percentage Score of Critical Elements Met	Overall Validation Status
Submission	93%	100%	Met
Resubmission	100%	100%	Met

CMH Partnership of Southeast Michigan submitted the Design, Implementation, and Outcomes stages of the PIP for the 2016–2017 validation. Upon initial validation, the PIP received a validation status of *Met*, with an overall score of 93 percent for all evaluation elements and a score of 100 percent for critical elements. The PIHP resubmitted the PIP to address the identified deficiencies in the PIP documentation. For the final submission, 100 percent of all applicable evaluation elements received scores of *Met*.

Strengths

CMH Partnership of Southeast Michigan designed a scientifically sound study supported by key research principles. The technical design of the PIP was sufficient to measure outcomes, and the PIP’s design allowed for the successful progression to the next stage of the PIP process. The PIHP used appropriate quality improvement tools to conduct causal/barrier analysis and implemented interventions that have the potential to have a positive impact on the study indicator outcomes. The study indicator demonstrated a statistically significant and sustained improvement over the baseline.

Recommendations

HSAG identified *Points of Clarification* as opportunities for improvement in Activity VIII—Appropriate Improvement Strategies: **CMH Partnership of Southeast Michigan** should ensure evaluation of the effectiveness of each intervention and that decisions made to revise, continue, or discontinue an intervention are data driven. The PIHP should continue to identify barriers and monitor interventions to ensure it continues to sustain the improvement achieved.

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

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

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

Table 3–28 following shows baseline and remeasurement results for **CMH Partnership of Southeast Michigan**’s PIP study indicator.

**Table 3–28—Performance Improvement Project Outcomes
for CMH Partnership of Southeast Michigan**

<i>Medication Labs</i>				
PIP Study Indicator	Baseline Period	Remeasurement 1	Remeasurement 2	Sustained Improvement
The percentage of Medicaid consumers prescribed antipsychotic medication that have all of the required lab values (HbA1c or glucose, HDL cholesterol, LDL cholesterol, total cholesterol, and triglycerides) in the electronic health record during the measurement period.	44.8%	51.0%	54.3%	Yes

For the 2016–2017 validation, **CMH Partnership of Southeast Michigan** reported and interpreted its Remeasurement 2 data accurately. The Remeasurement 2 rate for the study indicator was 54.3 percent, which was a statistically significant improvement of 9.5 percentage points above the baseline and 1.8 percentage points below the PIHP’s goal of 56.1 percent. **CMH Partnership of Southeast Michigan** sustained the statistically significant improvement over baseline achieved during the Remeasurement 1 study period. The study indicator performance indicated that the interventions had a positive impact on the **quality** of and **access** to care and services provided by the PIHP.

Region 7—Detroit Wayne Mental Health Authority

For the 2016–2017 validation, **Detroit Wayne Mental Health Authority** provided its fourth-year submission on this PIP topic: *Improving Wellness Self-Management of SMI Consumers with Chronic Health Conditions*.

Table 3–29 and Table 3–30 show **Detroit Wayne Mental Health Authority**’s scores based on HSAG’s PIP evaluation. For additional details, refer to the 2016–2017 PIP Validation Report for **Detroit Wayne Mental Health Authority**.

**Table 3–29—Performance Improvement Project Validation Results
for Detroit Wayne Mental Health Authority**

Stage	Activity		Percentage of Applicable Elements*		
			Met	Partially Met	Not Met
Design	I.	Appropriate Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Clearly Defined, Answerable Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Correctly Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Clearly Defined Study Indicator(s)	100% (3/3)	0% (0/3)	0% (0/3)
	V.	Valid Sampling Techniques (if sampling was used)	Not Applicable		
	VI.	Accurate/Complete Data Collection	100% (4/4)	0% (0/4)	0% (0/4)
Design Total			100% (11/11)	0% (0/11)	0% (0/11)
Implementation	VII.	Sufficient Data Analysis and Interpretation	88% (7/8)	13% (1/8)	0% (0/8)
	VIII.	Appropriate Improvement Strategies	100% (3/3)	0% (0/3)	0% (0/3)
Implementation Total			91% (10/11)	9% (1/11)	0% (0/11)
Outcomes	IX.	Real Improvement Achieved	100% (4/4)	0% (0/4)	0% (0/4)
	X.	Sustained Improvement Achieved	100% (1/1)	0% (0/1)	0% (0/1)
Outcomes Total			100% (5/5)	0% (0/5)	0% (0/5)
Percentage Score of Applicable Evaluation Elements Met			96% (26/27)		

* Percentage totals may not equal 100 due to rounding.

**Table 3–30—2016–2017 Performance Improvement Project Validation Scores
for Detroit Wayne Mental Health Authority**

Type of Annual Review	Percentage Score of Evaluation Elements Met	Percentage Score of Critical Elements Met	Overall Validation Status
Submission	93%	100%	Met
Resubmission	96%	100%	Met

Detroit Wayne Mental Health Authority submitted the Design, Implementation, and Outcomes stages of the PIP for the 2016–2017 validation. While the initial submission received an overall *Met* validation status, the PIHP elected to resubmit the PIP for a second review. **Detroit Wayne Mental Health Authority** received technical assistance from HSAG and corrected some identified deficiencies. The final validation status remained *Met*, with an overall score of 96 percent for all evaluation elements and a score of 100 percent for critical elements.

Strengths

Detroit Wayne Mental Health Authority designed a scientifically sound study supported by key research principles. The technical design of the PIP was sufficient to measure outcomes, and the PIP’s design allowed for the successful progression to the next stage of the PIP process. The PIHP used appropriate quality improvement tools to conduct causal/barrier analysis and implemented interventions that have the potential to have a positive impact on the study indicator outcomes. The study indicator demonstrated a statistically significant and sustained improvement over the baseline.

Recommendations

HSAG identified opportunities for improvement in Activity VII—Sufficient Data Analysis and Interpretation. The PIHP should ensure that the reported data and interpretation of results are accurate and consistent throughout the PIP Submission Form.

Additionally, HSAG identified *Points of Clarification* as opportunities for improvement in Activity VII—Sufficient Data Analysis and Interpretation and Activity VIII—Appropriate Improvement Strategies. **Detroit Wayne Mental Health Authority** should calculate the *p* values for its statistical testing results accurately and should provide Plan-Do-Study-Act (PDSA) worksheets as supporting documents for evaluation of interventions for effectiveness.

The PIHP should revisit its causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions.

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

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

Detroit Wayne Mental Health Authority identified barriers using data analysis and provider discussions during the quarterly PIP workgroup meetings. The barriers included coding issues, lack of peers trained to facilitate evidence-based wellness workshops, and consumers’ inability to attend workshops due to lack of transportation. **Detroit Wayne Mental Health Authority**’s interventions included a coding manual for providers, training of additional peer support specialists, notifications to

peers and providers about evidence-based wellness trainings, and provision of bus tickets to consumers for transportation to and from wellness self-management workshops.

Table 3–31 following shows baseline and remeasurement results for **Detroit Wayne Mental Health Authority**’s PIP study indicator.

**Table 3–31—Performance Improvement Project Outcomes
for Detroit Wayne Mental Health Authority**

<i>Improving Wellness Self-Management of Serious Mental Illness (SMI) Consumers With Chronic Health Conditions</i>				
PIP Study Indicator	Baseline Period	Remeasurement 1	Remeasurement 2	Sustained Improvement
The percentage of adult SMI consumers with at least one chronic health condition who completed a wellness self-management workshop during the measurement year.	1.3%	2.7%	3.9%	Yes

For the 2016–2017 validation, **Detroit Wayne Mental Health Authority** reported and interpreted its Remeasurement 2 data accurately. The Remeasurement 2 rate for the study indicator was 3.9 percent. This rate was 2.6 percentage points and 1.2 percentage points above the baseline and Remeasurement 1 rates, respectively; however, the PIHP marginally missed its Remeasurement goal of 4.0 percent. **Detroit Wayne Mental Health Authority** sustained the statistically significant improvement over baseline achieved during the Remeasurement 1 study period. The demonstrated improvement indicates that the interventions had a positive impact on the **quality** of and **access** to care and services provided by the PIHP.

Region 8—Oakland County CMH Authority

For the 2016–2017 validation, **Oakland County CMH Authority** provided its fourth-year submission on this PIP topic: *Increasing the Proportion of Medicaid-Eligible Adults With Mental Illness and Diabetes Who Have Their Diabetes Addressed in Their Current Individual Plan of Service*.

Table 3–32 and Table 3–33 show **Oakland County CMH Authority**’s scores based on HSAG’s PIP evaluation. For additional details, refer to the 2016–2017 PIP Validation Report for **Oakland County CMH Authority**.

**Table 3–32—Performance Improvement Project Validation Results
for Oakland County CMH Authority**

Stage	Activity		Percentage of Applicable Elements		
			Met	Partially Met	Not Met
Design	I.	Appropriate Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Clearly Defined, Answerable Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Correctly Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Clearly Defined Study Indicator(s)	100% (3/3)	0% (0/3)	0% (0/3)
	V.	Valid Sampling Techniques (if sampling was used)	Not Applicable		
	VI.	Accurate/Complete Data Collection	100% (4/4)	0% (0/4)	0% (0/4)
Design Total			100% (11/11)	0% (0/11)	0% (0/11)
Implementation	VII.	Sufficient Data Analysis and Interpretation	100% (8/8)	0% (0/8)	0% (0/8)
	VIII.	Appropriate Improvement Strategies	100% (3/3)	0% (0/3)	0% (0/3)
Implementation Total			100% (11/11)	0% (0/11)	0% (0/11)
Outcomes	IX.	Real Improvement Achieved	100% (4/4)	0% (0/4)	0% (0/4)
	X.	Sustained Improvement Achieved	100% (1/1)	0% (0/1)	0% (0/1)
Outcomes Total			100% (5/5)	0% (0/5)	0% (0/5)
Percentage Score of Applicable Evaluation Elements Met			100% (27/27)		

**Table 3–33—2016–2017—Performance Improvement Project Validation Scores
for Oakland County CMH Authority**

Type of Annual Review	Percentage Score of Evaluation Elements Met	Percentage Score of Critical Elements Met	Overall Validation Status
Submission	85%	78%	Partially Met
Resubmission	100%	100%	Met

Oakland County CMH Authority submitted the Design, Implementation, and Outcomes stages of the PIP for the 2016–2017 validation. Upon initial validation, the PIP received a validation status of *Partially Met*, with an overall score of 85 percent for all evaluation elements and a score of 78 percent for critical elements. The PIHP incorporated HSAG’s recommendations and resubmitted the PIP to address the identified deficiencies in the PIP documentation. For the final submission, 100 percent of all applicable evaluation elements received scores of *Met*.

Strengths

Oakland County CMH Authority designed a scientifically sound study supported by key research principles. The technical design of the PIP was sufficient to measure outcomes, and the PIP’s design allowed for the successful progression to the next stage of the PIP process. The PIHP used appropriate quality improvement tools to conduct causal/barrier analysis and implemented interventions that have the potential to have a positive impact on the study indicator outcomes. The study indicator demonstrated a statistically significant and sustained improvement over the baseline.

Recommendations

HSAG identified *Points of Clarification* as opportunities for improvement in Activity VIII—Appropriate Improvement Strategies. **Oakland County CMH Authority** should ensure that all interventions are documented and evaluated for effectiveness.

The PIHP should build on its momentum of improvement to ensure it can sustain the improvement achieved. Additionally, the PIHP should revisit its causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions.

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

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

Oakland County CMH Authority identified barriers by using data mining and analysis of process-level data from the PIHP’s centralized data system. The primary barrier was that, at the time of development or review of the treatment plan, the person responsible for documenting the individual plan of service did not always have accurate information regarding the consumer’s chronic health condition of diabetes. **Oakland County CMH Authority**’s interventions included providing information about consumers with a diagnosis of diabetes to the persons responsible for the plans of service and sending aggregated project data to the health plan network.

Table 3–34 following shows baseline and remeasurement results for **Oakland County CMH Authority**’s PIP study indicator.

**Table 3–34—Performance Improvement Project Outcomes
for Oakland County CMH Authority**

<i>Increasing the Proportion of Medicaid-Eligible Adults With Mental Illness and Diabetes Who Have Their Diabetes Addressed in Their Current Plan of Service</i>				
PIP Study Indicator	Baseline Period	Remeasurement 1	Remeasurement 2	Sustained Improvement
The proportion of Medicaid-eligible adults with mental illness and diabetes receiving services from the PIHP who have their diabetes addressed in their Current Plan of Service.	34.0%	48.6%	56.3%	Yes

For the 2016–2017 validation, **Oakland County CMH Authority** reported and interpreted its Remeasurement 2 data accurately. The Remeasurement 2 rate for the study indicator was 56.3 percent. This rate was 22.3 percentage points above the baseline and exceeded the Remeasurement 2 goal of 42.2 percent by 14.1 percentage points. **Oakland County CMH Authority** sustained the statistically significant improvement over baseline achieved during the Remeasurement 1 study period. The demonstrated improvement indicates that the interventions had a positive impact on the **quality** of and **access** to care and services provided by the PIHP.

Region 9—Macomb County CMH Services

For the 2016–2017 validation, **Macomb County CMH Services** provided its fourth-year submission on this PIP topic: *Increasing Metabolic Syndrome Screening for Adults With Severe Mental Illness*.

Table 3–35 and Table 3–36 show **Macomb County CMH Services**’ scores based on HSAG’s PIP evaluation. For additional details, refer to the 2016–2017 PIP Validation Report for **Macomb County CMH Services**.

**Table 3–35—Performance Improvement Project Validation Results
for Macomb County CMH Services**

Stage	Activity		Percentage of Applicable* Elements		
			Met	Partially Met	Not Met
Design	I.	Appropriate Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Clearly Defined, Answerable Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Correctly Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Clearly Defined Study Indicator(s)	100% (3/3)	0% (0/3)	0% (0/3)
	V.	Valid Sampling Techniques (if sampling was used)	Not Applicable		
	VI.	Accurate/Complete Data Collection	100% (6/6)	0% (0/6)	0% (0/6)
Design Total			100% (13/13)	0% (0/13)	0% (0/13)
Implementation	VII.	Sufficient Data Analysis and Interpretation*	63% (5/8)	13% (1/8)	25% (2/8)
	VIII.	Appropriate Improvement Strategies	100% (3/3)	0% (0/3)	0% (0/3)
Implementation Total			73% (8/11)	9% (1/11)	18% (2/11)
Outcomes	IX.	Real Improvement Achieved	100% (4/4)	0% (0/4)	0% (0/4)
	X.	Sustained Improvement Achieved	100% (1/1)	0% (0/1)	0% (0/1)
Outcomes Total			100% (5/5)	0% (0/5)	0% (0/5)
Percentage Score of Applicable Evaluation Elements Met			90% (26/29)		

* Percentage totals may not equal 100 percent due to rounding.

**Table 3–36—2016–2017—Performance Improvement Project Validation Scores
for Macomb County CMH Services**

Type of Annual Review	Percentage Score of Evaluation Elements Met	Percentage Score of Critical Elements Met	Overall Validation Status
Submission	76%	70%	Not Met
Resubmission	90%	100%	Met

Macomb County CMH Services submitted the Design, Implementation, and Outcomes stages of the PIP for the 2016–2017 validation. The PIP received a validation status of *Not Met* for its initial PIP submission, with an overall score of 76 percent for all evaluation elements and a score of 70 percent for critical elements. The PIHP received technical assistance, incorporated HSAG’s recommendations, and resubmitted the PIP. For the final submission, 90 percent of all applicable evaluation elements received scores of *Met*.

Strengths

Macomb County CMH Services designed a scientifically sound study supported by key research principles. The technical design of the PIP was sufficient to measure outcomes, and the PIP’s design allowed for the successful progression to the next stage of the PIP process. The PIHP used appropriate quality improvement tools to conduct causal/barrier analysis and implemented interventions that have the potential to have a positive impact on the study indicator outcomes. The study indicator demonstrated a statistically significant and sustained improvement over the baseline.

Recommendations

HSAG identified opportunities for improvement in Activity VII—Sufficient Data Analysis and Interpretation. In the narrative interpretation of data, **Macomb County CMH Services** should report the findings accurately and the PIP documentation should discuss validity and comparability of the data,

Additionally, HSAG identified *Points of Clarification* as opportunities for improvement in Activity IV—Clearly Defined Study Indicator(s) and Activity VII—Sufficient Data Analysis and Interpretation. **Macomb County CMH Services** should document the Remeasurement 2 goal accurately and consistently throughout the PIP Submission Form.

The PIHP should build on its momentum of improvement to ensure it can sustain the improvement achieved. The PIHP should revisit its causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions.

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

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

Macomb County CMH Services identified barriers by developing a committee and analyzing consumer data. The barriers included providers’ and consumers’ lack of knowledge about the possible adverse impact of second-generation atypical antipsychotic medications, insufficient ongoing monitoring of labs ordered, inconsistent documentation of lab orders in the EMR, and lack of consumer

involvement in healthcare. **Macomb County CMH Services**’ interventions included a quality forum with handouts about metabolic syndrome; implementation of an integrated health portal to assist in the development and monitoring of health goals; EMR enhancements to allow for data entry, review, and approval of the laboratory results by appropriate clinical staff; and development of a patient portal within the EMR.

Table 3–37 following shows baseline and remeasurement results for **Macomb County CMH Services**’ PIP study indicator.

**Table 3–37—Performance Improvement Project Outcomes
for Macomb County CMH Services**

<i>Increasing Metabolic Syndrome Screening for Adults With Severe Mental Health Illness</i>				
PIP Study Indicator	Baseline Period	Remeasurement 1	Remeasurement 2	Sustained Improvement
The percentage of consumers who are prescribed atypical second generation antipsychotic medication and are also monitored for metabolic syndrome by having at least one of the Adult Treatment Panel III measures completed during the measurement period.	41.0%	54.9%	84.2%	Yes

For the 2016–2017 validation, **Macomb County CMH Services** reported its Remeasurement 2 data accurately. The Remeasurement 2 rate for the study indicator was 84.2 percent. This rate demonstrated a statistically significant improvement of 43.2 percentage points above the baseline and met the Remeasurement 2 goal of 64.1 percent. Within a subsequent measurement period, the PIHP sustained the statistically significant improvement achieved at Remeasurement 1. The demonstrated improvement indicates that the interventions had a positive impact on the **quality** of and **access** to care and services provided by the PIHP.

Region 10 PIHP

For the 2016–2017 validation, **Region 10 PIHP** provided its fourth-year submission on this PIP topic: *Behavioral and Physical Health Care Integration*.

Table 3–38 and Table 3–39 show **Region 10 PIHP**’s scores based on HSAG’s PIP evaluation. For additional details, refer to the 2016–2017 PIP Validation Report for **Region 10 PIHP**.

**Table 3–38—Performance Improvement Project Validation Results
for Region 10 PIHP**

Stage	Activity		Percentage of Applicable Elements		
			Met	Partially Met	Not Met
Design	I.	Appropriate Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Clearly Defined, Answerable Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Correctly Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Clearly Defined Study Indicator(s)	100% (3/3)	0% (0/3)	0% (0/3)
	V.	Valid Sampling Techniques (if sampling was used)	Not Applicable		
	VI.	Accurate/Complete Data Collection	100% (4/4)	0% (0/4)	0% (0/4)
Design Total			100% (11/11)	0% (0/11)	0% (0/11)
Implementation	VII.	Sufficient Data Analysis and Interpretation	100% (8/8)	0% (0/8)	0% (0/8)
	VIII.	Appropriate Improvement Strategies	100% (4/4)	0% (0/4)	0% (0/4)
Implementation Total			100% 12/12	0% 0/12	0% 0/12
Outcomes	IX.	Real Improvement Achieved	100% (4/4)	0% (0/4)	0% (0/4)
	X.	Sustained Improvement Achieved	100% (1/1)	0% (0/1)	0% (0/1)
Outcomes Total			100% (5/5)	0% (0/5)	0% (0/5)
Percentage Score of Applicable Evaluation Elements Met			100% (28/28)		

**Table 3–39—2016–2017—Performance Improvement Project Validation Scores
for Region 10 PIHP**

Type of Annual Review	Percentage Score of Evaluation Elements Met	Percentage Score of Critical Elements Met	Overall Validation Status
Submission	86%	100%	Met
Resubmission	100%	100%	Met

Region 10 PIHP submitted the Design, Implementation, and Outcomes stages of the PIP for the 2016–2017 validation. Upon initial validation, the PIP received a validation status of *Met*, with an overall score of 86 percent for all evaluation elements and a score of 100 percent for critical elements. The PIHP received technical assistance from HSAG and resubmitted the PIP to address the identified deficiencies in the PIP documentation. For the final submission, 100 percent of all applicable evaluation elements received scores of *Met*.

Strengths

Region 10 PIHP designed a scientifically sound study supported by key research principles. The technical design of the PIP was sufficient to measure outcomes, and the PIP’s design allowed for the successful progression to the next stage of the PIP process. The PIHP used appropriate quality improvement tools to conduct causal/barrier analysis and implemented interventions that have the potential to have a positive impact on the study indicator outcomes. The study indicator demonstrated a statistically significant and sustained improvement over the baseline.

Recommendations

HSAG identified no opportunities for improvement in the annual PIP validation tool for **Region 10 PIHP**. The PIHP should build on its momentum of improvement to ensure it can sustain the improvement achieved. The PIHP should revisit its causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions.

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

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

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

Table 3–40 following shows baseline and remeasurement results for **Region 10 PIHP**’s PIP study indicator.

Table 3–40—Performance Improvement Project Outcomes for Region 10 PIHP

<i>Behavioral and Physical Health Care Integration</i>				
PIP Study Indicator	Baseline Period	Remeasurement 1	Remeasurement 2	Sustained Improvement
The proportion of SMI adult Medicaid consumers identified with select cardiovascular risk conditions that had at least one reported encounter to the State’s data warehouse for a medical service to treat a cardiovascular condition.	27.2%	54.1%	57.5%	Yes

For the 2016–2017 validation, **Region 10 PIHP** reported and interpreted its baseline and remeasurement data. The PIHP identified an error in the calculation of the Remeasurement 1 rate reported in last year’s PIP Submission Form. The PIHP recalculated and updated Remeasurement 1 data in this year’s PIP submission. The original Remeasurement 1 rate was 29.9 percent, and the revised Remeasurement 1 rate was 54.1 percent. This new rate was 26.9 percentage points above the baseline rate and exceeded the Remeasurement 1 goal of 32 percent by 22.1 percentage points.

The Remeasurement 2 rate was 57.5 percent, which was 30.3 percentage points above the baseline and 1.3 percentage points below the Remeasurement 2 goal of 58.8 percent. Within a subsequent measurement period, the PIHP sustained the statistically significant improvement achieved at Remeasurement 1. The demonstrated improvement indicates that the interventions had a positive impact on the **quality** of and **access** to care and services provided by the PIHP.

4. Assessment of PIHP Follow-Up on Prior Recommendations

Introduction

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

This section presents a summary of the PIHPs' progress in implementing corrective actions identified in the 2014–2015 review of 15 compliance standards, as assessed during the most recent follow-up review in 2015–2016 and the subsequent corrective action plans (CAPs).

The validation of performance measures assessed the PIHPs' processes related to the reporting of performance indicator data and oversight of subcontractors' performance indicator reporting activities. This section presents each PIHP's status of addressing recommendations identified in the 2015–2016 validation cycle.

For the 2016–2017 validation, the PIHPs continued their PIPs related to behavioral and physical healthcare integration. This section presents an assessment of the PIHPs' follow-up on recommendations from the 2015–2016 validation cycle.

Region 1—NorthCare Network

Compliance Monitoring

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

Validation of Performance Measures

The 2015–2016 validation of performance measures for **NorthCare Network** identified no opportunities for improvement; therefore, no actions were required of **NorthCare Network**.

Validation of Performance Improvement Projects

The 2015–2016 validation of the performance improvement project for **NorthCare Network** identified opportunities for improvement in Activity IX—Assess for Real Improvement. Additionally, *Points of*

Clarification existed in Activity VII—Analyze and Interpret Study Results and Activity VIII—Implement Intervention and Improvement Strategies. In the 2016–2017 PIP submission, the PIP Remeasurement 2 data demonstrated statistically significant improvement over the baseline; however, deficiencies were pending as *Points of Clarifications* in analysis of study results and intervention evaluation for effectiveness. **NorthCare Network** partially addressed the prior recommendations.

Region 2—Northern Michigan Regional Entity

Compliance Monitoring

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

Resulting from the 2015–2016 review, for Standard XII—Access and Availability, **Northern Michigan Regional Entity** received continued recommendations to ensure that it consistently meets the MDHHS contractual standard of 95 percent for follow-up care within seven days for beneficiaries discharged from a substance abuse detoxification unit (Indicator #4b). The results of the 2016–2017 performance measure validation (PMV) activity confirmed that **Northern Michigan Regional Entity** met contractual requirements for this indicator.

Validation of Performance Measures

The 2015–2016 validation of performance measures for **Northern Michigan Regional Entity** identified opportunities for improvement regarding encounter data submission within its substance use disorder (SUD) system. For the current measurement period, **Northern Michigan Regional Entity** created sufficient documentation of all system and process changes regarding the new Peter Chang Enterprises, Inc. (PCE) system implementation for SUD services. In addition, SUD providers and internal staff members received sufficient system training to manage data flow and calculate performance indicator rates. **Northern Michigan Regional Entity** successfully addressed the prior recommendations.

Validation of Performance Improvement Projects

Northern Michigan Regional Entity's PIP received a *Met* score for 100 percent of the applicable evaluation elements in the 2015–2016 PIP Validation Tool. HSAG identified no opportunities for improvement.

Region 3—Lakeshore Regional Entity

Compliance Monitoring

The 2014–2015 compliance monitoring review of **Lakeshore Regional Entity** resulted in recommendations for improvement for the following standards: Standard I—QAPI Plan and Structure; Standard II—Performance Measurement and Improvement; Standard V—Utilization Management; Standard IX—Subcontracts and Delegation; Standard X—Provider Network; Standard XI—Credentialing; Standard XII—Access and Availability; Standard XIV—Appeals; and Standard XV—Disclosure of Ownership, Control, and Criminal Convictions. The PIHP addressed recommendations through corrective actions and implemented improvements. As determined in the 2015–2016 review, **Lakeshore Regional Entity** successfully addressed the prior recommendations for the QAPI Plan and Structure, Performance Measurement and Improvement, Credentialing, Access and Availability, and Appeals standards. However, the PIHP received continued recommendations for the Utilization Management; Subcontracts and Delegation; Provider Network; and Disclosure of Ownership, Control, and Criminal Convictions standards. The PIHP achieved full compliance on 11 of the 15 standards.

For the four standards that did not achieve full compliance, **Lakeshore Regional Entity** was required to submit to MDHHS within 30 days of receipt of the final 2015–2016 report a separate CAP for each element scored as *Substantially Met*, *Partially Met*, or *Not Met*. **Lakeshore Regional Entity** submitted its CAPs to MDHHS to address each of the seven outstanding elements.

Validation of Performance Measures

The 2015–2016 validation of performance measures for **Lakeshore Regional Entity** identified a need for substantial improvement in rates. HSAG recommended that **Lakeshore Regional Entity** investigate the causes of the decline in rates and explore options for rate improvement. For the current measurement period, the rates received for **Lakeshore Regional Entity** did not include data from the PIHP's largest affiliated CMHSP, Network180, which accounted for over 50 percent of **Lakeshore Regional Entity** data.

The 2015–2016 validation of performance measure activity identified that several manual steps were performed by one staff member. HSAG recommended that Lakeshore Regional Entity consider cross-training additional staff members to perform this function. The PIHP is currently in the planning stage of cross-training additional staff members on all reporting functions.

In the prior year review, HSAG had recommended that the PIHP consider additional validation steps to ensure that each CMHSP complies with requirements. The PIHP implemented additional validation processes to ensure that each CMHSP complied. **Lakeshore Regional Entity** has partially addressed the prior recommendations.

Validation of Performance Improvement Projects

Lakeshore Regional Entity's PIP received a *Met* score for 100 percent of the applicable evaluation elements in the 2015–2016 PIP Validation Tool. HSAG identified no opportunities for improvement.

Region 4—Southwest Michigan Behavioral Health

Compliance Monitoring

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

For the four standards that did not achieve full compliance, **Southwest Michigan Behavioral Health** was required to submit a CAP to MDHHS for all elements scored as *Substantially Met*, *Partially Met*, or *Not Met* within 30 days of receipt of the final 2015–2016 report. **Southwest Michigan Behavioral Health** submitted its CAPs to MDHHS to address each of the four outstanding elements.

HSAG could evaluate the success of **Southwest Michigan Behavioral Health**'s 2015–2016 CAP pertaining to access standards by reviewing the 2016–2017 PMV activity findings. **Southwest Michigan Behavioral Health**'s CAP included interventions to address the outstanding 2015–2016 recommendation for Standard XII—Access and Availability (continue efforts to consistently meet the contractual performance standard for timely access to ongoing services for developmentally disabled adults—Indicator #3). To ensure that adults with a developmental disability start necessary ongoing service within 14 days of a nonemergent assessment with a professional at least 95 percent of the time, **Southwest Michigan Behavioral Health** constructed and began testing a First Service report that would attempt to identify consumers who had a completed assessment but did not have a scheduled first service within the 14-day standard. Additionally, **Southwest Michigan Behavioral Health** issued CAPs to two CMHSPs that failed to meet the MDHHS standard of 95 percent for consecutive quarters.

However, the results of the 2016–2017 PMV activity demonstrated that **Southwest Michigan Behavioral Health** continued to fall below contractual performance standards for this indicator. Also, **Southwest Michigan Behavioral Health** did not meet contractual performance standards for Indicator #3 for three additional subpopulations (DD Children, SA Adults, Total).

Validation of Performance Measures

The 2015–2016 validation of performance measures for **Southwest Michigan Behavioral Health** identified opportunities for improvement around quality control activities for oversight of the CMHSPs. Based on recommendations made last year during the performance validation audit, CMHSPs experiencing data integrity issues after one reporting quarter are required to provide a CAP to the PIHP. In addition, **Southwest Michigan Behavioral Health** created a snapshot of each performance indicator summary and detail file submitted to the State for primary source verification activities. **Southwest Michigan Behavioral Health** successfully addressed the prior recommendations.

Validation of Performance Improvement Projects

The 2015–2016 validation of the performance improvement project for **Southwest Michigan Behavioral Health** identified opportunities for improvement in Activity VII—Analyze and Interpret Study Results and Activity VIII—Implement Intervention and Improvement Strategies. In the 2016–2017 PIP submission, the PIHP addressed the recommendation for Activity VIII—Implement Intervention and Improvement Strategies, and provided evaluation results for effectiveness of its interventions; however, for Activity VII—Analyze and Interpret Study Results, the PIHP only partially addressed the errors in the narrative interpretation of data and thus received a *Point of Clarification* in that activity.

Region 5—Mid-State Health Network

Compliance Monitoring

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

Validation of Performance Measures

The 2015–2016 validation of performance measures resulted in recommendations for **Mid-State Health Network** to perform additional primary source verification of samples cases of the data provided by the

CMHSPs prior to the rate calculation. During the 2016–2017 validation period, HSAG determined that **Mid-State Health Network** performed adequate primary source verification for sample cases of data provided by the CMHSPs prior to rate calculation. **Mid-State Health Network** successfully addressed the prior recommendations.

Validation of Performance Improvement Projects

Mid-State Health Network's PIP received a *Met* score for 100 percent of the applicable evaluation elements in the 2015–2016 PIP Validation Tool. HSAG identified no opportunities for improvement.

Region 6—CMH Partnership of Southeast Michigan

Compliance Monitoring

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

For the three standards that did not achieve full compliance, **CMH Partnership of Southeast Michigan** was required to submit a CAP to MDHHS for all elements scored as *Substantially Met*, *Partially Met*, or *Not Met* within 30 days of receipt of the final 2015–2016 report. **CMH Partnership of Southeast Michigan** submitted its CAPs to MDHHS to address each of the eight outstanding elements.

HSAG could evaluate the success of **CMH Partnership of Southeast Michigan**'s 2015–2016 CAP pertaining to access standards by reviewing the 2016–2017 PMV activity findings. **CMH Partnership of Southeast Michigan**'s CAP included interventions to address the outstanding 2015–2016 recommendation for Standard XII—Access and Availability (continue efforts to consistently meet the contractual performance standards for timely follow-up care for beneficiaries discharged from a detoxification unit—Indicator #4b). **CMH Partnership of Southeast Michigan** planned to work monthly with the data coordinator, statistician, and the regional performance improvement (PI) liaisons to review the aggregated data for timely follow-up care after discharge from a detoxification unit. If the data failed to meet the threshold, a plan of correction would be required 30 days after the submission date. Ongoing quarterly monitoring would be conducted to ensure that plan(s) of correction(s) were implemented. The director of Quality and Compliance and the data coordinator would work with the chief information officer and the Operations Committee to report aggregated summaries to ensure that data were cleaned, exceptions accurately recorded, and technological tools explored to achieve the

required threshold. The director of Quality and Compliance communicated to the Clinical Performance Team (CPT), per the CPT reporting schedule, to explore progress and opportunities for improvement to achieve this threshold. However, the results of the 2016–2017 PMV activity demonstrated that **CMH Partnership of Southeast Michigan** included consumers for whom it was not financially responsible and marked them as exceptions rather than excluding them from the population. As such, **CMH Partnership of Southeast Michigan** received a validation finding of *Not Reported* for Performance Indicator #4b. **CMH Partnership of Southeast Michigan** identified this issue prior to the validation audit and implemented additional training to ensure that this issue would not persist.

Validation of Performance Measures

During the 2015–2016 validation of performance measures **CMH Partnership of Southeast Michigan** was unable to recreate the same number of cases due to several records having been adjusted after the data were extracted for rate reporting. HSAG recommended for the following reporting period that **CMH Partnership of Southeast Michigan** create a consumer-level detail file for each quarter, with the snapshot of data used for rate calculation. **CMH Partnership of Southeast Michigan** now has a process in place to create a locked, consumer-level file for each performance indication for each CMHSP. However, the PIHP did not maintain a point-in-time file for the aggregated data used for reporting to the State; therefore, the total number of cases could not be validated.

During the 2015–2016 validation of performance measures, HSAG recommended that a data field containing “offered appointment” be required and that the consumer’s reason for declining an appointment be appropriately documented by each provider, ensuring data validity for reporting. In addition, HSAG recommended that **CMH Partnership of Southeast Michigan** implement a process to ensure appropriate identification of any adjustments made to the records. For the 2016–2017 validation of performance measures, **CMH Partnership of Southeast Michigan** implemented system changes, including a dropdown menu and a comment box, to document when an appointment was declined and to capture the initial appointment-offered date in line with the measure specification for Indicator #2 and Indicator #3.

The current system used by the PIHP allows no record to be deleted or changed once signed. If a change is required, the record must be amended and the system will capture the date, time, and staff person who made the change. **CMH Partnership of Southeast Michigan** partially addressed the prior recommendations.

Validation of Performance Improvement Projects

The 2015–2016 validation of the performance improvement project for **CMH Partnership of Southeast Michigan** identified opportunities for improvement in Activity VIII—Implement Intervention and Improvement Strategies and included a few *Points of Clarification* in Activity VII—Analyze Data and Interpret Study Results. In the 2016–2017 PIP submission, the PIHP provided accurate narrative interpretation of its data; however, opportunities for improvement were stated in *Points of Clarification*

in the documentation for intervention evaluation for effectiveness. **CMH Partnership of Southeast Michigan** partially addressed the prior recommendations.

Region 7—Detroit Wayne Mental Health Authority

Compliance Monitoring

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

Validation of Performance Measures

Detroit Wayne Mental Health Authority performed below the standards for Performance Indicator #1 and Indicator #10 during the previous reporting period. The PIHP implemented several performance improvements, which resulted in the PIHP meeting standards for those performance indicators for the Children populations. The PIHP still did not meet standards for the Adult population in Indicator #10.

Detroit Wayne Mental Health Authority continued to have low completion rates for BH-TEDS data.

Regarding issues encountered during data validation caused by not having a locked consumer-level detail file, **Detroit Wayne Mental Health Authority** contracted with Peter Chang Enterprises, Inc. (PCE) for calculation of Indicator #1. The PCE system was developed to create a locked consumer-level detail file for reporting purposes. The PIHP developed an internal process for saving a copy of the consumer-level detail file for reporting rates to the State.

During the previous audit, the **Detroit Wayne Mental Health Authority** reported that it performed performance measure data validation, but this often occurred after the data were submitted to the State. The PIHP has enhanced its validation processes to include a review of a 10 percent random sample of claims data for each Manager of Comprehensive Provider Network (MCPN) each month.

Regarding Indicator #1, for which **Detroit Wayne Mental Health Authority** received an *NR* designation in the previous audit, the PIHP contracted with PCE to calculate this performance measure; all cases were found to be compliant during primary source verification. **Detroit Wayne Mental Health Authority** partially addressed the prior recommendations.

Validation of Performance Improvement Projects

Detroit Wayne Mental Health Authority's PIP received a *Met* score for 100 percent of the applicable evaluation elements in the 2015–2016 PIP Validation Tool; however, HSAG identified *Points of Clarification* as opportunities for improvement in Activity VII—Analyze Data and Interpret Study Results and Activity VIII—Implement Intervention and Improvement Strategies. In the 2016–2017 PIP submission, the PIHP addressed the recommendations for Activity VIII; however, the narrative interpretation of data continued to include errors. Therefore, the PIHP received a *Partially Met* score on one evaluation element in Activity VII. **Detroit Wayne Mental Health Authority** partially addressed the prior recommendations.

Region 8—Oakland County CMH Authority

Compliance Monitoring

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

Validation of Performance Measures

Based on the prior year's recommendations, **Oakland County CMH Authority** determined that, for Performance Indicator #1, a provider had stopped reviewing records once the 95 percentage was achieved. This resulted in the PIHP underreporting the numerator for the indicator. The PIHP placed this provider on a corrective action plan (CAP), and providers are now required to review all records for compliance.

During last year's review, it was also found that **Oakland County CMH Authority** was inappropriately including consumers who had received services in the previous 90 days in the population for Indicator #2. The PIHP determined that this error resulted from incorrect programming logic. This error in logic has been corrected, and no further issues were identified.

Similarly, during last year's review, it was found that the programming logic for Indicator #4a did not correctly calculate the timeline to ensure that the consumer was seen in seven days. **Oakland County CMH Authority** reported that it updated the measure logic to examine both the discharge date and the service date so that the timeline is appropriately calculated. **Oakland County CMH Authority** successfully addressed the prior recommendations.

Validation of Performance Improvement Projects

Oakland County CMH Authority's PIP received a *Met* score for 100 percent of the applicable evaluation elements in the 2015–2016 PIP Validation Tool. HSAG identified no opportunities for improvement.

Region 9—Macomb County CMH Services

Compliance Monitoring

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

For the one standard that did not achieve full compliance, **Macomb County CMH Services** was required to submit a CAP to MDHHS for all elements scored as *Substantially Met*, *Partially Met*, or *Not Met* within 30 days of receipt of the final 2015–2016 report. **Macomb County CMH Services** submitted its CAP to MDHHS to address the one outstanding element.

HSAG could evaluate the success of **Macomb County CMH Services**' 2015–2016 CAP pertaining to access standards by reviewing the 2016–2017 PMV activity findings. **Macomb County CMH Services**' CAP included interventions to address the outstanding 2015–2016 recommendation for Standard XII—Access and Availability (continue efforts to consistently meet the contractual performance standard for timely access to ongoing services for developmentally disabled children [Indicator #3]). The topic of performance indicators and related compliance remains a standing agenda item for **Macomb County CMH Services** Utilization Management Committee. Appropriate staff should continue to communicate and collaborate with direct and contract provider staff regarding the need for availability within the provider network for the MDHHS designated time frames for services. The results of the 2016–2017 PMV activity demonstrated that **Macomb County CMH Services** met contractual requirements for this indicator for children with developmental disabilities. However, **Macomb County CMH** fell below contractual performance standards for Indicator #3 for a different subpopulation (DD adults).

Validation of Performance Measures

During the 2015–2016 validation of performance measures for **Macomb County CMH Services**, HSAG identified opportunities for improvement regarding the indicator data and documentation in the EMR. During the current reporting period, **Macomb County CMH Services** added additional oversight processes by documenting system changes and monitoring these changes for data accuracy. **Macomb County CMH Services** conducted regular meetings with MORC to ensure that quality improvement continues to be a priority. While some recommendations from 2016 continued through 2017, **Macomb County CMH Services** continues to work closely with PCE to implement additional system edits in FOCUS to further ensure data accuracy. **Macomb County CMH Services** partially addressed the prior recommendations.

Validation of Performance Improvement Projects

The 2015–2016 validation of the performance improvement project for **Macomb County CMH Services** identified opportunities for improvement in Activity VII—Analyze Data and Interpret Study Results and Activity VIII—Implement Intervention and Improvement Strategies. Additionally, *Points of Clarification* existed in Activity IV—Select the Study Indicator and Activity VI—Reliably Collect Data. In the 2016–2017 PIP submission, the PIHP provided accurate statistical testing results, documented the causal/barrier analysis and intervention evaluation results accurately, and provided the ISCAT tool for administrative data completeness. However, a few pending deficiencies existed in the narrative interpretation of data and the documentation of remeasurement goals. **Macomb County CMH Services** partially addressed the prior recommendations.

Region 10 PIHP

Compliance Monitoring

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

For the two standards that did not achieve full compliance, **Region 10 PIHP** was required to submit to MDHHS, within 30 days of receipt of the final 2015–2016 report, CAPs for all elements scored as *Substantially Met*, *Partially Met*, or *Not Met*. **Region 10 PIHP** submitted its CAPs to MDHHS to address the five outstanding elements.

Validation of Performance Measures

Based on recommendations made last year during the performance validation audit, it appeared that **Region 10 PIHP** made adequate improvements to calculate performance indicators and submit accurate data to the State. During the prior year's validation, GHS' Indicator #2 was not reportable due to data integrity issues. During this year's validation audit, HSAG specifically conducted primary source verification for Indicator #2 from data collected by GHS to ensure that no additional issues existed related to data integrity. HSAG identified just one record from GHS' Indicator #2 with data integrity concerns, as mentioned preceding. **Region 10 PIHP** partially addressed the prior recommendations.

Validation of Performance Improvement Projects

The 2015–2016 validation of the performance improvement project for **Region 10 PIHP** identified opportunities for improvement in Activity IX—Assess for Real Improvement. In the 2016–2017 PIP submission, the PIHP documented implementation of interventions in a timely manner and indicated that its data issues with the vendor were resolved. The documented remeasurement data demonstrated statistically significant improvement over the baseline for consecutive periods. **Region 10 PIHP** successfully addressed the prior recommendations.

Appendix A. Summary Tables of External Quality Review Activity Results

Introduction

This section of the report presents current-year and prior-year results for performance measure validation and PIP validation.

Results for Validation of Performance Measures

Table A–1 shows a two-year comparison of the overall statewide PIHP compliance with the MDHHS Codebook specifications for performance indicators validated by HSAG based on the audit findings. An audit finding of *Report (R)* indicates that the rate was valid and below the allowable threshold for bias, and an audit finding of *Not Reported (NR)* indicates that the rate was significantly biased or the plan chose not to report the measure.

Table A–1—Percentage of PIHPs in Compliance with MDHHS Codebook Specifications

Performance Indicator	2015–2016 <i>Report</i>	2016–2017 <i>Report</i>	2015–2016 <i>Not Reported</i>	2016–2017 <i>Not Reported</i>
#1: The percent of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	80%	90%	20%	10%
#2: The percent of new Medicaid beneficiaries during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service.	80%	80%	20%	20%
#3: The percent of new Medicaid beneficiaries during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional.	100%	80%	0%	20%
#4a: The percent of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.	90%	80%	10%	20%
#4b: The percent of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.	90%	70%	10%	30%
#5: The percent of Medicaid recipients having received PIHP managed services.	100%	100%	0%	0%
#6: The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	100%	100%	0%	0%

Performance Indicator	2015–2016 Report	2016–2017 Report	2015–2016 Not Reported	2016–2017 Not Reported
#8: The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who are employed competitively.	90%	100%	10%	0%
#9: The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.	90%	100%	10%	0%
#10: The percent of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.	100%	90%	0%	10%
#13: The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	90%	100%	10%	0%
#14: The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	90%	100%	10%	0%

Table A–2 presents the 2015–2016 and 2016–2017 statewide results for the validated performance indicators.

Table A–2—2015–2016 and 2016–2017 Statewide Performance Measure Rates

Performance Indicator	2015–2016 Rate	2016–2017 Rate
#1: The percent of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.		
Children	99.48%	98.96%
Adults	99.51%	98.27%
#2: The percent of new Medicaid beneficiaries during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service.		
MI Children	98.63%	97.79%
MI Adults	98.79%	98.09%
DD Children	98.67%	99.13%
DD Adults	99.40%	99.09%
Medicaid SA	98.01%	97.61%
Total	98.45%	97.87%

Performance Indicator	2015–2016 Rate	2016–2017 Rate
#3: The percent of new Medicaid beneficiaries during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional.		
MI Children	97.22%	97.37%
MI Adults	97.70%	97.64%
DD Children	96.48%	95.37%
DD Adults	94.05%	95.24%
Medicaid SA	98.54%	97.67%
Total	97.87%	97.48%
#4a: The percent of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.		
Children	98.86%	98.23%
Adults	96.72%	95.16%
#4b: The percent of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.		
The percent of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.	98.18%	98.95%
#5: The percent of Medicaid recipients having received PIHP managed services.		
The percent of Medicaid recipients having received PIHP managed services.	7.09%	6.90%
#6: The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.		
The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	98.26%	98.05%
#8: The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who are employed competitively.		
MI Adults	13.17%	12.24%
DD Adults	9.18%	9.51%
MI/DD Adults	7.76%	8.68%
#9: The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.		
MI Adults	76.86%	82.83%
DD Adults	36.95%	39.90%
MI/DD Adults	37.59%	39.84%

Performance Indicator	2015–2016 Rate	2016–2017 Rate
#10: The percent of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.		
<i>Children</i>	10.61%	7.87%
<i>Adults</i>	13.05%	13.70%
#13: The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).		
<i>The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).</i>	16.66%	18.26%
#14: The percent of adults with serious mental illness served who live in a private residence alone, with spouse, or with non-relative(s).		
<i>The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).</i>	42.29%	42.14%

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

Table A–3—Current Year (CY) and Prior Year (PY) PIHP-Specific Performance Measure Rates (Performance Indicators #1–4b)

PIHP		#1—Children	#1—Adults	#2—MI Children	#2—MI Adults	#2—DD Children	#2—DD Adults	#2—Medicaid SA	#2—Total	#3—MI Children	#3—MI Adults	#3—DD Children	#3—DD Adults	#3—Medicaid SA	#3—Total	#4a—Children	#4a—Adults	#4b
Region 1—NorthCare	CY	100.00	100.00	99.25	97.70	100.00	100.00	86.78	93.35	99.10	98.66	87.50	100.00	100.00	99.17	100.00	93.88	100.00
	PY	100.00	99.55	98.32	99.30	100.00	94.44	95.32	96.99	99.07	95.10	88.24	100.00	100.00	98.56	100.00	95.74	95.24
Region 2—Northern MI	CY	93.02	97.31	98.20	99.53	98.55	100.00	96.3	98.01	91.8	95.26	90.20	92.00	95.05	94.10	100.00	91.96	95.41
	PY	97.97	99.07	99.38	99.11	100.00	100.00	95.82	98.09	95.81	98.68	93.75	90.48	95.71	96.33	97.14	95.87	95.12
Region 3—Lakeshore	CY	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
	PY	98.34	97.99	99.59	99.70	100.00	100.00	100.00	99.77	97.26	98.46	94.29	94.74	97.40	97.46	96.92	97.86	98.73
Region 4—Southwest MI	CY	99.33	97.36	96.81	98.62	97.73	100.00	98.80	98.46	97.06	97.34	93.33	93.33	92.54	94.22	96.30	96.02	NR
	PY	99.43	99.54	98.77	98.58	100.00	100.00	100.00	98.87	95.42	97.39	100.00	90.00	100.00	97.35	100.00	91.16	100.00
Region 5—Mid-State	CY	99.10	98.72	98.19	98.81	98.67	100.00	99.08	98.76	97.87	97.50	100.00	93.94	100.00	98.46	98.13	97.11	100.00
	PY	99.80	99.72	98.92	99.78	100.00	100.00	98.38	99.10	96.30	97.69	98.00	98.08	100.00	98.40	97.53	98.14	100.00

PIHP		#1—Children	#1—Adults	#2—MI Children	#2—MI Adults	#2—DD Children	#2—DD Adults	#2—Medicaid SA	#2—Total	#3—MI Children	#3—MI Adults	#3—DD Children	#3—DD Adults	#3—Medicaid SA	#3—Total	#4a—Children	#4a—Adults	#4b
Region 6— CMHPSM	CY	100.00	99.66	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	100.00	96.27	NR
	PY	100.00	99.81	98.35	96.59	100.00	100.00	96.43	96.98	100.00	100.00	100.00	96.15	96.56	97.60	96.55	98.73	90.10
Region 7— Detroit Wayne	CY	99.38	96.79	98.35	98.45	100.00	100.00	97.52	98.07	99.2	96.76	94.96	92.96	96.93	97.25	NR	NR	99.72
	PY	NR	NR	98.49	97.19	99.06	100.00	98.32	98.19	98.01	96.20	97.22	95.24	98.62	97.78	100.00	96.33	NR
Region 8— Oakland	CY	97.5	98.92	94.83	95.66	100.00	93.02	99.64	97.2	99.53	99.49	95.65	100.00	98.29	99.04	93.55	90.69	96.82
	PY	NR	NR	NR	NR	NR	NR	NR	NR	100	99.80	100.00	100.00	99.58	99.75	NR	NR	99.20
Region 9— Macomb	CY	100.00	99.84	95.73	97.16	97.14	100.00	99.04	98.3	96.30	97.12	97.06	93.75	99.77	98.61	95.74	93.58	98.63
	PY	100.00	100.00	87.10	95.26	89.74	96.00	98.04	96.12	97.81	94.65	93.18	82.86	98.74	97.00	98.31	96.07	98.52
Region 10 PIHP	CY	99.65	99.73	97.73	95.45	100.00	100.00	96.44	96.78	95.73	99.14	97.14	97.62	99.77	98.68	100.00	96.73	100.00
	PY	100.00	100.00	NR	NR	NR	NR	NR	NR	96.34	98.93	100.00	93.75	98.11	97.90	100.00	99.12	100.00

NR (Not Reported) indicates that the rate was determined “materially biased.”

Table A-4—Current Year (CY) and Prior Year (PY) PHIP-Specific Performance Measure Rates (Performance Indicators #5–14)

PIHP		#5	#6	#8—MI Adults	#8—DD Adults	#8—MI/DD Adults	#9—MI Adults	#9—DD Adults	#9—MI/DD Adults	#10—Children	#10—Adults	#13	#14
Region 1—NorthCare	CY	7.55	97.03	16.23	5.38	7.54	78.72	13.11	21.25	0.00	11.27	17.09	52.63
	PY	7.87	99.72	15.00	5.99	5.60	86.49	33.57	44.92	0.00	13.33	18.80	49.06
Region 2—Northern MI	CY	8.10	98.49	12.97	13.95	13.03	86.25	44.53	52.80	5.41	8.19	29.06	53.80
	PY	8.00	99.37	12.90	13.97	13.18	77.27	45.76	56.27	6.52	10.93	25.04	53.03
Region 3—Lakeshore	CY	5.12	97.24	12.34	11.88	12.88	83.22	56.00	49.00	NR	NR	16.73	51.65
	PY	5.78	97.35	13.01	8.10	8.28	80.53	34.65	37.55	7.32	7.55	10.19	39.10
Region 4—Southwest MI	CY	6.62	98.06	14.99	8.89	6.72	79.39	58.20	61.33	6.25	8.79	23.52	49.62
	PY	7.01	98.94	14.68	7.92	7.01	73.74	42.86	40.00	6.98	9.12	16.95	49.46
Region 5—Mid-State	CY	7.59	97.54	14.57	9.73	8.71	86.57	34.66	33.55	8.11	9.85	20.88	53.08
	PY	7.28	95.40	13.73	8.33	7.29	83.67	33.45	37.81	6.31	9.18	16.82	45.91
Region 6—CMHPSM	CY	6.87	97.74	13.83	10.06	9.84	82.95	50.76	55.30	2.17	14.76	25.38	29.67
	PY	7.46	98.31	14.03	10.22	7.99	76.05	60.48	66.67	13.51	13.11	24.70	28.57

PIHP		#5	#6	#8—MI Adults	#8—DD Adults	#8—MI/DD Adults	#9—MI Adults	#9—DD Adults	#9—MI/DD Adults	#10—Children	#10—Adults	#13	#14
Region 7— Detroit Wayne	CY	7.18	98.11	9.03	7.67	6.76	81.77	28.60	30.52	9.58	18.40	18.90	30.22
	PY	7.41	98.96	NR	NR	NR	NR	NR	NR	15.38	17.05	NR	NR
Region 8— Oakland	CY	7.74	98.34	14.38	14.16	10.16	78.15	92.71	84.03	0.00	13.98	6.59	36.18
	PY	7.80	99.40	14.73	14.16	11.18	62.12	40.64	29.70	0.00	11.02	18.73	34.46
Region 9— Macomb	CY	5.39	99.79	12.95	5.47	5.97	87.05	30.10	40.88	11.32	16.41	13.71	39.69
	PY	5.56	99.79	11.45	5.08	4.93	80.93	37.50	29.60	14.52	19.31	13.52	29.76
Region 10 PIHP	CY	7.17	98.64	10.15	6.07	6.74	82.99	16.02	23.46	8.82	12.05	16.9	49.93
	PY	7.37	99.54	7.84	5.32	4.82	70.44	15.89	20.47	9.28	14.48	9.26	42.65

NR (Not Reported) indicates that the rate was determined “materially biased.”

Results for Validation of Performance Improvement Projects

Table A–5 presents a three-year comparison of the PIHPs’ PIP validation status.

Table A–5—Comparison of PIHPs’ PIP Validation Status

Validation Status	Number of PIPs		
	2014–2015	2015–2016	2016–2017
<i>Met</i>	10	7	10
<i>Partially Met</i>	0	0	0
<i>Not Met</i>	0	3	0

Table A–6 presents a three-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		
	2014–2015	2015–2016	2016–2017	2014–2015	2015–2016	2016–2017
I. Appropriate Study Topic	10/10	10/10	10/10	10/10	10/10	10/10
II. Clearly Defined, Answerable Study Question(s)	10/10	10/10	10/10	10/10	10/10	10/10
III. Correctly Identified Study Population	10/10	10/10	10/10	10/10	10/10	10/10
IV. Clearly Defined Indicator(s)	10/10	10/10	10/10	10/10	10/10	10/10
V. Valid Sampling Techniques*	NA	NA	NA	NA	NA	NA
VI. Accurate/Complete Data Collection	10/10	9/10	10/10	10/10	0/10	10/10
VII. Sufficient Data Analysis and Interpretation	10/10	8/10	8/10	10/10	9/10	10/10
VIII. Appropriate Improvement Strategies	9/9	7/10	10/10	9/9	9/10	10/10
IX. Real Improvement Achieved	<i>Not Assessed</i>	8/10	10/10	<i>Not Assessed</i>	8/10	10/10
X. Sustained Improvement Achieved	<i>Not Assessed</i>	<i>Not Assessed</i>	9/9	<i>Not Assessed</i>	<i>Not Assessed</i>	9/9

*All PIHPs included the entire eligible population in the PIP. HSAG scored all elements for Activity V as *Not Applicable (NA)* for all PIPs.

Table A–7 presents a three-year comparison of PIP validation scores for each PIHP.

Table A–7—Comparison of PIHPs’ PIP Validation Scores

PIHP	Percentage of All Evaluation Elements Met			Percentage of Critical Elements Met			Validation Status		
	2014–2015	2015–2016	2016–2017	2014–2015	2015–2016	2016–2017	2014–2015	2015–2016	2016–2017
	Activities I–VIII	Activities I–IX	Activities I–X	Activities I–VIII	Activities I–IX	Activities I–X	Activities I–VIII	Activities I–IX	Activities I–X
Region 1—NorthCare*	100	96	100	100	88	100	<i>Met</i>	<i>Not Met</i>	<i>Met</i>
Region 2—Northern MI	100	100	100	100	100	100	<i>Met</i>	<i>Met</i>	<i>Met</i>
Region 3—Lakeshore	100	100	100	100	100	100	<i>Met</i>	<i>Met</i>	<i>Met</i>
Region 4—Southwest MI	100	92	100	100	100	100	<i>Met</i>	<i>Met</i>	<i>Met</i>
Region 5—Mid-State	100	100	100	100	100	100	<i>Met</i>	<i>Met</i>	<i>Met</i>
Region 6—CMHPSM	100	96	100	100	100	100	<i>Met</i>	<i>Met</i>	<i>Met</i>
Region 7—Detroit	100	100	96	100	100	100	<i>Met</i>	<i>Met</i>	<i>Met</i>
Region 8—Oakland	100	100	100	100	100	100	<i>Met</i>	<i>Met</i>	<i>Met</i>
Region 9—Macomb	100	86	90	100	67	100	<i>Met</i>	<i>Not Met</i>	<i>Met</i>
Region 10 PIHP**	100	96	100	100	88	100	<i>Met</i>	<i>Not Met</i>	<i>Met</i>

* Please note that for the 2016–2017 validation, Region 1 PIHP’s PIP was validated for Activities I through IX only.

** Please note that for the 2014–2015 validation, Region 10 PIHP’s PIP was validated for Activities I through VII only.

Behavioral Health and Developmental Disabilities
Administration

**Review Tools for the 2016–2017
External Quality Review Activities
for Prepaid Inpatient Health Plans**

April 2018



Review Tools for the 2016–2017 External Quality Review Activities

The review tools listed below follow this cover page:

- Attachment A. Compliance Monitoring Tool (Documentation Request and Evaluation Tool)
- Attachment B. Performance Measure Validation Tools
 - Attachment B1. Information Systems Capabilities Assessment Tool
 - Attachment B2. Mini-Information Systems Capabilities Assessment Tool
- Attachment C. Performance Improvement Project (PIP) Validation Tools
 - Attachment C1. PIP Validation Tool
 - Attachment C2. PIP Summary Form



Attachment A. Documentation Request and Evaluation Tool
Michigan Department of Health and Human Services (MDHHS)
Prepaid Inpatient Health Plans (PIHPs)
for PIHP Name

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

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
1. Quality Monitoring (QM) Goals and Objectives 42 CFR 438.240 MDCH Contract Part IIA- 7.9 Attachment P7.9.1		
a. There is a written quality assessment performance improvement program (QAPIP) description.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
b. The QAPIP description specifies an adequate organizational structure that allows for clear and appropriate administration and evaluation of the QAPIP.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
2. Role of Beneficiaries The written QAPIP description includes a description of the role for beneficiaries. Attachment P7.9.1		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



Attachment A. Documentation Request and Evaluation Tool
Michigan Department of Health and Human Services (MDHHS)
Prepaid Inpatient Health Plans (PIHPs)
for PIHP Name

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

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
3. Adopting and Communicating Process and Outcome Improvements		
Attachment P7.9.1		
a. The written QAPIP description includes the mechanisms or procedures used or to be used for <u>adopting</u> process and outcome improvements.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
b. The written QAPIP description includes the mechanisms or procedures used or to be used for <u>communicating</u> process and outcome improvements.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings



Attachment A. Documentation Request and Evaluation Tool
Michigan Department of Health and Human Services (MDHHS)
Prepaid Inpatient Health Plans (PIHPs)
for PIHP Name

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

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
4. Accountability to the Governing Body Attachment P 7.9.1		
a. The QAPIP is accountable to a Governing Body.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
Responsibilities of the Governing Body for monitoring, evaluating, and making improvements to care include the following:		
b. There is documentation that the Governing Body has approved the overall <u>QAPIP Plan</u> .		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
c. There is documentation that the Governing Body has approved an annual <u>QI Plan</u> .		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
d. The Governing Body routinely receives written reports from the QAPIP.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



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Prepaid Inpatient Health Plans (PIHPs)
for PIHP Name

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

e. The PIHP produces an Annual Effectiveness Review of the QAPIP which includes analysis of whether there have been improvements in the quality of health care and services for recipients as a result of PIHP quality assessment and improvement activities and interventions. The analysis addresses trends in service delivery and health outcomes over time and includes monitoring of progress on performance goals and objectives. <div>MDCH Contract Part IIA-7.9.2</div>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
f. The Annual Effectiveness Review of the QAPIP is provided annually to network providers. <div>MDCH Contract Part IIA-7.9.2</div>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
5. Designated Senior Official There is a designated senior official responsible for the QAPIP implementation. <div>Attachment P 7.9.1</div>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement



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Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
6. Active Participation <div>Attachment P 7.9.1</div>		
a. There is active participation of <u>providers</u> in the QAPIP.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
b. There is active participation of <u>consumers</u> in the QAPIP.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings

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. <div>Attachment P7.9.1</div>		



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a. The PIHP must submit to the State for approval of its methodology for verification.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
b. The PIHP must annually submit its findings from this process and provide any follow up actions that were taken as a result of the findings.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

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 P7.9.1		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement



Attachment A. Documentation Request and Evaluation Tool
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Standard I—Quality Assessment and Performance Improvement Program Plan and Structures

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
9. Delegation The PIHP oversees and is accountable for any functions it delegates to any subcontractor. 42CFR 438.230 MDCH Contract Part I-38.0		
a. There is a written agreement that specifies the activities and report responsibilities designated to the subcontractor.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
b. The PIHP monitors the subcontractor's performance on an ongoing basis and subjects it to formal review according to a periodic schedule established by the State, consistent with industry standards or State MCO laws and regulations.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



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PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
c. If the PIHP identifies deficiencies or areas for improvement, the PIHP and the subcontractor take corrective action.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

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				=	



Attachment A. Documentation Request and Evaluation Tool
Michigan Department of Health and Human Services (MDHHS)
Prepaid Inpatient Health Plans (PIHPs)
for PIHP Name

Standard II—Performance Measurement and Improvement

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
1. Performance Measures The PIHP utilizes standardized performance measures established by the department, which, at a minimum, address: <div>42 CFR 438.240(c) Attachment P7.9.1</div>		
a. Access		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
b. Efficiency		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
c. Outcome		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings



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Standard II—Performance Measurement and Improvement

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
2. Minimum Performance Levels <div>Attachment P7.9.1</div>		
a. The PIHP utilizes its QAPIP to ensure that it achieves minimum performance levels on performance indicators as established by the department.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
b. The PIHP analyzes the causes of negative statistical outliers when they occur.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

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. <div>42 CFR 438.240(d) Attachment P7.9.1</div>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Attachment A. Documentation Request and Evaluation Tool
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Standard II—Performance Measurement and Improvement

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
4. Review of Sentinel Events		
Attachment P7.9.1		
a. The QAPIP describes the process for the <u>review</u> of sentinel events.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
b. The QAPIP describes the process for <u>follow-up</u> of sentinel events.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

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.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
Attachment P7.9.1		



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PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
6. Assessments of Beneficiary Experiences with Services		
Attachment P7.9.1		
a. The QAPIP includes periodic <u>qualitative</u> (e.g. focus groups) assessments of beneficiaries' experiences with its services.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
b. The QAPIP includes periodic <u>quantitative</u> (e.g. surveys) assessments of beneficiaries' experiences with its services.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
c. Assessments represent persons served and services and supports offered.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
d. The assessments address issues of the <u>quality</u> of care.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



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



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Standard II—Performance Measurement and Improvement

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

- ☐ **Met**
- ☐ **Substantially Met**
- ☐ **Partially Met**
- ☐ **Not Met**
- ☐ **Not Applicable**

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

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. <div>Attachment P7.9.1</div>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings



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Standard II—Performance Measurement and Improvement

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
8. Delegation The PIHP oversees and is accountable for any functions it delegates to any subcontractor. 42CFR 438.230 MDCH Contract Part I-38.0		
a. There is a written agreement that specifies the activities and report responsibilities designated to the subcontractor.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
b. The PIHP monitors the subcontractor's performance on an ongoing basis and subjects it to formal review according to a periodic schedule established by the State, consistent with industry standards or State MCO laws and regulations.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement



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Standard II—Performance Measurement and Improvement

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
c. If the PIHP identifies deficiencies or areas for improvement, the PIHP and the subcontractor take corrective action.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

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					=	

Attachment A. Documentation Request and Evaluation Tool
Michigan Department of Health and Human Services (MDHHS)
Prepaid Inpatient Health Plans (PIHPs)
for PIHP Name

Standard III—Practice Guidelines

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
1. Relevant Practice Guidelines The QAPIP describes the process for the use of practice guidelines, including the following: <div>42 CFR 438.236 Attachment P7.9.1</div>		
a. Adoption process		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
b. Development process		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
c. Implementation		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
d. Continuous monitoring		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
e. Evaluation		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



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for PIHP Name

Standard III—Practice Guidelines

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings

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



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Standard III—Practice Guidelines

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings

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

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

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for PIHP Name

Standard III—Practice Guidelines

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

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings



Attachment A. Documentation Request and Evaluation Tool
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Prepaid Inpatient Health Plans (PIHPs)
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Standard III—Practice Guidelines

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
5. Delegation The PIHP oversees and is accountable for any functions it delegates to any subcontractor. 42CFR 438.230 MDCH Contract Part I-38.0		
a. There is a written agreement that specifies the activities and report responsibilities designated to the subcontractor.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
b. The PIHP monitors the subcontractor's performance on an ongoing basis and subjects it to formal review according to a periodic schedule established by the State, consistent with industry standards or State MCO laws and regulations.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement



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Standard III—Practice Guidelines

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
c. If the PIHP identifies deficiencies or areas for improvement, the PIHP and the subcontractor take corrective action.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

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					=	

Attachment A. Documentation Request and Evaluation Tool
Michigan Department of Health and Human Services (MDHHS)
Prepaid Inpatient Health Plans (PIHPs)
for PIHP Name

Standard IV—Staff Qualifications and Training

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
1. Employed and Contracted Staff Qualifications		
Attachment P7.9.1		
a. The QAPIP contains written procedures to determine whether <u>physicians</u> are qualified to perform their services.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
b. The QAPIP contains written procedures to determine whether <u>other licensed health care professionals</u> are qualified to perform their services.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
c. The QAPIP contains written procedures to ensure <u>non-licensed providers</u> of care or support are qualified to perform their jobs.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings



Attachment A. Documentation Request and Evaluation Tool
Michigan Department of Health and Human Services (MDHHS)
Prepaid Inpatient Health Plans (PIHPs)
for PIHP Name

Standard IV—Staff Qualifications and Training

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
2. Staff Training The PIHP's QAPI program for staff training includes: <div>Attachment P7.9.1</div>		
a. Training for new personnel with regard to their responsibilities, program policy, and operating procedures		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
b. Methods for identifying staff training needs		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
c. In-service training, continuing education, and staff development activities.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings



Attachment A. Documentation Request and Evaluation Tool
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Standard IV—Staff Qualifications and Training

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
3. Delegation The PIHP oversees and is accountable for any functions it delegates to any subcontractor. 42CFR 438.230 MDCH Contract Part I-38.0		
a. There is a written agreement that specifies the activities and report responsibilities designated to the subcontractor.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
b. The PIHP monitors the subcontractor's performance on an ongoing basis and subjects it to formal review according to a periodic schedule established by the State, consistent with industry standards or State MCO laws and regulations.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement



Attachment A. Documentation Request and Evaluation Tool
Michigan Department of Health and Human Services (MDHHS)
Prepaid Inpatient Health Plans (PIHPs)
for PIHP Name

Standard IV—Staff Qualifications and Training

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
c. If the PIHP identifies deficiencies or areas for improvement, the PIHP and the subcontractor take corrective action.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

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				=	

Attachment A. Documentation Request and Evaluation Tool
Michigan Department of Health and Human Services (MDHHS)
Prepaid Inpatient Health Plans (PIHPs)
for PIHP Name

Standard V—Utilization Management

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
1. Written Program Description		
42 CFR 438.210(a)(4) Attachment P7.9.1		
a. The PIHP has a written utilization program description that includes <u>procedures</u> to evaluate medical necessity.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
b. The PIHP has a written utilization program description that includes the <u>criteria</u> used in making decisions.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
c. The PIHP has a written utilization program description that includes the process used to <u>review and approve</u> the provision of medical services.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings



Attachment A. Documentation Request and Evaluation Tool
Michigan Department of Health and Human Services (MDHHS)
Prepaid Inpatient Health Plans (PIHPs)
for PIHP Name

Standard V—Utilization Management

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
2. Scope 42 CFR 438.240(b)(3) Attachment P7.9.1		
a. The program has mechanisms to identify and correct <u>under</u> -utilization.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
b. The program has mechanisms to identify and correct <u>over</u> -utilization.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings



Attachment A. Documentation Request and Evaluation Tool
Michigan Department of Health and Human Services (MDHHS)
Prepaid Inpatient Health Plans (PIHPs)
for PIHP Name

Standard V—Utilization Management

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
3. Procedures Prospective (preauthorization), concurrent, and retrospective procedures are established and include: 42 CFR 438.210(b) Attachment P7.9.1		
a. Review decisions are supervised by qualified medical professionals.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
b. Decisions to deny or reduce services are made by health care professionals who have the appropriate clinical expertise to treat the conditions.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
c. Efforts are made to obtain all necessary information including pertinent clinical information and consult with treating physician as appropriate.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
d. The reasons for decisions are <u>clearly documented</u> .		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
e. The reasons for decisions <u>are available to the beneficiary</u> .		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Attachment A. Documentation Request and Evaluation Tool
Michigan Department of Health and Human Services (MDHHS)
Prepaid Inpatient Health Plans (PIHPs)
for PIHP Name

Standard V—Utilization Management

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



Attachment A. Documentation Request and Evaluation Tool
Michigan Department of Health and Human Services (MDHHS)
Prepaid Inpatient Health Plans (PIHPs)
for PIHP Name

Standard V—Utilization Management

l. <u>Decisions on appeals</u> are made in a timely manner as required by the exigencies of the situation.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
m. There are mechanisms to evaluate the effects of the program using data on beneficiary satisfaction, provider satisfaction, or other appropriate measures.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
4. Delegation The PIHP oversees and is accountable for any functions it delegates to any subcontractor. 42CFR 438.230 MDCH Contract Part I-38.0		
a. There is a written agreement that specifies the activities and report responsibilities designated to the subcontractor.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



Attachment A. Documentation Request and Evaluation Tool
Michigan Department of Health and Human Services (MDHHS)
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Standard V—Utilization Management

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
b. The PIHP monitors the subcontractor's performance on an ongoing basis and subjects it to formal review according to a periodic schedule established by the State, consistent with industry standards or State MCO laws and regulations.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
c. If the PIHP identifies deficiencies or areas for improvement, the PIHP and the subcontractor take corrective action.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement



Attachment A. Documentation Request and Evaluation Tool
Michigan Department of Health and Human Services (MDHHS)
Prepaid Inpatient Health Plans (PIHPs)
for PIHP Name

Standard V—Utilization Management

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				=	

Attachment A. Documentation Request and Evaluation Tool
Michigan Department of Health and Human Services (MDHHS)
Prepaid Inpatient Health Plans (PIHPs)
for PIHP Name

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. MDCH Contract Part IIA-6.3 Attachment P6.3.1		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
2. Phone Access Attachment P6.3.1		
a. Toll-Free Telephone Line The PIHP has a designated toll-free customer services telephone line and access to alternative telephonic communication methods (e.g., Relays, a TTY number, etc.). The customer services numbers are displayed in agency brochures and public information material.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
b. 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.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Attachment A. Documentation Request and Evaluation Tool
Michigan Department of Health and Human Services (MDHHS)
Prepaid Inpatient Health Plans (PIHPs)
for PIHP Name

Standard VI—Customer Services

Findings

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. The customer services unit or function will operate minimally eight hours daily, Monday through Friday, except for holidays. <div align="right">Attachment P6.3.1</div>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
4. Customer Handbook The customer handbook includes: <ul style="list-style-type: none"> ◆ All state-required topics as specified in the contract attachment. ◆ The date of the publication and revision(s). ◆ Names, addresses, phone numbers, TTYs, e-mails, and web addresses for affiliate CMHSPs, substance abuse coordinating agency, or network providers. ◆ Information about how to contact the Medicaid Health Plans or Medicaid fee-for-service programs in the PIHP service area (actual phone numbers and addresses may be omitted and held at the customer services office due to frequent turnover of plans and providers). <div align="right">Attachment P6.3.1</div>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Attachment A. Documentation Request and Evaluation Tool
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Prepaid Inpatient Health Plans (PIHPs)
for PIHP Name

Standard VI—Customer Services

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
5. Provider Listing The customer services unit maintains a current listing of all providers, both organizations and practitioners, with whom the PIHP contracts, the services they provide, languages they speak, and any specialty for which they are known. The list includes independent PCP facilitators and identification of providers that are not accepting new patients. <div align="right">Attachment P6.3.2</div>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

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. <div align="right">Attachment P6.3.1</div>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



Attachment A. Documentation Request and Evaluation Tool
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Prepaid Inpatient Health Plans (PIHPs)
for PIHP Name

Standard VI—Customer Services

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings

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. MDCH Contract Part IIA-6.3 Attachment P6.3.1.1		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

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 P6.3.1		

Attachment A. Documentation Request and Evaluation Tool
Michigan Department of Health and Human Services (MDHHS)
Prepaid Inpatient Health Plans (PIHPs)
for PIHP Name

Standard VI—Customer Services

a. Working Knowledge About:

- ◆ The populations served (serious mental illness, serious emotional disturbance, developmental disability, and substance use disorder) and eligibility criteria for various benefit plans (e.g., Medicaid, Healthy Michigan Plan, 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

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

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement



Attachment A. Documentation Request and Evaluation Tool
Michigan Department of Health and Human Services (MDHHS)
Prepaid Inpatient Health Plans (PIHPs)
for PIHP Name

Standard VI—Customer Services

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
9. Delegation The PIHP oversees and is accountable for any functions it delegates to any subcontractor. 42CFR 438.230 MDCH Contract Part I-38.0		
a. There is a written agreement that specifies the activities and report responsibilities designated to the subcontractor.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
b. The PIHP monitors the subcontractor's performance on an ongoing basis and subjects it to formal review according to a periodic schedule established by the State, consistent with industry standards or State MCO laws and regulations.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement



Attachment A. Documentation Request and Evaluation Tool
Michigan Department of Health and Human Services (MDHHS)
Prepaid Inpatient Health Plans (PIHPs)
for PIHP Name

Standard VI—Customer Services

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
c. If the PIHP identifies deficiencies or areas for improvement, the PIHP and the subcontractor take corrective action.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

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					=	

Attachment A. Documentation Request and Evaluation Tool
Michigan Department of Health and Human Services (MDHHS)
Prepaid Inpatient Health Plans (PIHPs)
for PIHP Name

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 MDCH Contract Part II A-6.3.1 Attachment P6.3.1.1		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
2. Information to Enrollees The PIHP provides enrollees with information about the grievances, procedures, and timeframes that include: <ul style="list-style-type: none"> ◆ The right to file grievances; ◆ The requirements and timeframes for filing a grievance; ◆ The availability of assistance in the filing process; and ◆ The toll-free numbers that the enrollee can use to file a grievance by phone. 42 CFR 438.10(g)(1) MDCH Contract Part II A-6.3.1 Attachment P6.3.1.1		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Attachment A. Documentation Request and Evaluation Tool
Michigan Department of Health and Human Services (MDHHS)
Prepaid Inpatient Health Plans (PIHPs)
for PIHP Name

Standard VII—Enrollee Grievance Process

Findings

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: <ul style="list-style-type: none"> ◆ The right to file grievances; ◆ The requirement and timeframes for filing a grievance; ◆ The availability of assistance in the filing process; and ◆ The toll-free numbers that the enrollee can use to file a grievance by phone. <p align="right">42 CFR 438.414 42 CFR 438.10(g)(1) MDCH Contract Part II A-7.0</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

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. <p align="right">42 CFR 438.402(b)(3)(1)</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



Attachment A. Documentation Request and Evaluation Tool
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Prepaid Inpatient Health Plans (PIHPs)
for PIHP Name

Standard VII—Enrollee Grievance Process

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings

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) Attachment P6.3.1.1		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

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 P6.3.1.1		



Attachment A. Documentation Request and Evaluation Tool
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Prepaid Inpatient Health Plans (PIHPs)
for PIHP Name

Standard VII—Enrollee Grievance Process

a. Logs the receipt of the verbal or written grievance for reporting to the PIHP QI Program.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
b. 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.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
c. Acknowledges to the beneficiary the receipt of the grievance.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
d. 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.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
e. 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.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> 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.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Attachment A. Documentation Request and Evaluation Tool
Michigan Department of Health and Human Services (MDHHS)
Prepaid Inpatient Health Plans (PIHPs)
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Standard VII—Enrollee Grievance Process

- 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**

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
7. Recordkeeping The PIHP maintains records of grievances. <div style="text-align: right;">42 CFR 438.416 MDCH Contract Part II A-6.3.1 Attachment P6.3.1.1</div>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings



Attachment A. Documentation Request and Evaluation Tool
Michigan Department of Health and Human Services (MDHHS)
Prepaid Inpatient Health Plans (PIHPs)
for PIHP Name

Standard VII—Enrollee Grievance Process

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
8. Delegation The PIHP oversees and is accountable for any functions it delegates to any subcontractor. 42CFR 438.230 MDCH Contract Part I-38.0		
a. There is a written agreement that specifies the activities and report responsibilities designated to the subcontractor.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
b. The PIHP monitors the subcontractor's performance on an ongoing basis and subjects it to formal review according to a periodic schedule established by the State, consistent with industry standards or State MCO laws and regulations.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement



Attachment A. Documentation Request and Evaluation Tool
Michigan Department of Health and Human Services (MDHHS)
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Standard VII—Enrollee Grievance Process

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
c. If the PIHP identifies deficiencies or areas for improvement, the PIHP and the subcontractor take corrective action.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

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				=		



Attachment A. Documentation Request and Evaluation Tool
Michigan Department of Health and Human Services (MDHHS)
Prepaid Inpatient Health Plans (PIHPs)
for PIHP Name

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.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
b. The PIHP has processes to ensure that its staff and affiliated providers take those rights into account when furnishing services to enrollees.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings

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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: <div align="right">42 CFR 438.100(b)(2)</div>		
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.) <div align="right">42 CFR 438.10(b) MDCH Contract Part II A-6.3.2</div>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
b. The PIHP makes its written information available in the prevalent, non-English languages in its service area. <div align="right">42 CFR 438.10(c)(3) MDCH Contract Part II A-6.3.2</div>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
c. The PIHP makes oral interpretation services available free of charge to its enrollees and potential enrollees for all non-English languages. <div align="right">42 CFR 438.10(c) (4) MDCH Contract Part II A-6.3.2 LEP Policy Guidance (Executive Order 13166 of August 11, 2002) Federal Register Vol 65, August 16, 2002.</div>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

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<p>d. The PIHP notifies its enrollees that <u>oral interpretation</u> is available for any language.</p> <p align="right">42 CFR 438.10(c)(5)(i and ii) MDCH Contract Part II A-6.3.2</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p>e. The PIHP notifies its enrollees that <u>written information</u> is available in prevalent languages.</p> <p align="right">42 CFR 438.10(c)(5)(i and ii) MDCH Contract Part II A-6.3.2</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p>f. The PIHP notifies its enrollees that written information is available about how to <u>access</u> those services.</p> <p align="right">42 CFR 438.10(c)(5)(i and ii) MDCH Contract Part II A-6.3.2</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p>g. Written material must be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually impaired or have limited reading proficiency.</p> <p align="right">42 CFR 438.10(d)(1)(ii), MDCH Contract Part II A-6.3.2 Americans with Disabilities Act (ADA)</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p>h. Enrollees and potential enrollees are <u>informed</u> that information is available in alternative formats.</p> <p align="right">42 CFR 438.10(d)(2) MDCH Contract Part II A-6.3.2</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



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Standard VIII—Enrollee Rights and Protections

- i. Enrollees and potential enrollees are informed about how to access those formats.

42 CFR 438.10(d)(2)
MDCH Contract Part II A-6.3.2

- ☐ **Met**
☐ **Substantially Met**
☐ **Partially Met**
☐ **Not Met**
☐ **Not Applicable**

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

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: <div style="text-align: right;">42 CFR 438.10(f)(3)</div>		
a. A listing of contracted providers that identifies provider name, locations, telephone numbers, any non-English languages spoken, and whether they are accepting new patients. The listing is available in the format preferred by the beneficiary: written paper copy or on-line. <div style="text-align: right;">MDCH Contract Part II A-6.3.2</div>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
b. Any restrictions on the enrollee's freedom of choice among network providers. <div style="text-align: right;">42 CFR 438.10(f)(6)(ii) MDCH Contract Part II A-6.3.2</div>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

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<p>c. Grievance, appeal, and fair hearing procedures and timeframes that include:</p> <ul style="list-style-type: none"> ◆ The right to a state fair hearing; ◆ The method for obtaining a hearing; ◆ The rules that govern representation at the hearing; ◆ The right to file grievances and appeals; ◆ The requirements and timeframes for filing a grievance or appeal; ◆ The availability of assistance in the filing process; ◆ The toll-free numbers that the beneficiary can use to file a grievance or an appeal by phone; ◆ The fact that when requested by the beneficiary, benefits will continue if the beneficiary files an appeal or a request for State fair hearing within the timeframes specified and that the beneficiary may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the beneficiary; and ◆ Any appeal rights that the State chooses to make available to providers to challenge the failure to cover a service. <p align="right">42 CFR 438.10(g)(1)(vi)(A) MDCH Contract Part II A-6.3.2</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p>d. The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled.</p> <p align="right">42 CFR 438.10(f)(6)(v) MDCH Contract Part II A-6.3.2</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

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<p>e. Procedures for obtaining benefits, including authorization requirements.</p> <p align="right">42 CFR 438.10(f)(6)(vi) MDCH Contract Part II A-6.3.2</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p>f. The extent to which, and how, enrollees may obtain benefits from out-of-network providers.</p> <p align="right">42 CFR 438.10(f)(6)(vii) MDCH Contract Part II A-6.3.2</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p>g. The extent to which, and how, after-hours and emergency coverage is provided, including:</p> <ul style="list-style-type: none"> ◆ What constitutes emergency medical condition, emergency services, and post-stabilization services; ◆ The fact that prior authorization is not required for emergency services; ◆ The process and procedures for obtaining emergency services, including use of the 911 telephone system or its local equivalent; ◆ The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered under the contract; and ◆ The fact that, subject to these provisions, the enrollee has the right to use any hospital or other setting for emergency care. <p align="right">42 CFR 438.10(f)(6)(viii) Attachment 6.3.1</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

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h. Cost sharing, if any. 42 CFR 438.10(f)(6)(xi)		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
i. 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)		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
j. 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) MDCH Contract Part II A-7.10.5		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
k. The PIHP provides to the beneficiary annually (e.g., at the time of person-centered planning) the estimated cost to the PIHP of each covered support and service he or she is receiving. MDCH Contract Part II A-6.3.2		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
l. Additional information that is available upon request, including information on the structure and operation of the PIHP and physician incentive plans in use by the PIHP or network providers. 42 CFR 438.10(g)(3)(i) 42 CFR 438.6(h) MDCH Contract Part II A-6.3.2		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement



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Findings

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) MDCH Contract Part II A-6.3.2		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
5. Notice of Termination of Providers 42 CFR 438.10(f)(5) MDCH Contract Part II A-6.3.2		
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.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



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Standard VIII—Enrollee Rights and Protections

- 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**

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
6. Right to Request and Obtain Information 42 CFR 438.10(f)(2) Attachment 6.3.1		
a. The PIHP (or State) notifies all enrollees of their right to, at least once a year request and obtain information about enrollee rights and protections.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
b. This information includes the information described in 3 a-1 on the previous pages.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement



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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) Attachment 6.3.1		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings

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)		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

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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: <ul style="list-style-type: none"> ◆ The enrollee’s health status, medical care, or treatment options, including any alternative treatment that may be self-administered; ◆ Any information the enrollee needs in order to decide among all relevant treatment options; ◆ The risks, benefits, and consequences of treatment or nontreatment; and ◆ The enrollee’s right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. <p align="right">42 CFR 438.102(a)</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

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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: <ul style="list-style-type: none"> ◆ To the State, with its application for a Medicaid contract, and whenever it adopts the policy during the term of the contract; ◆ To potential enrollees, before and during enrollment; and ◆ To enrollees, within 90 days after adopting the policy with respect to any particular service, with the overriding rule to furnish the information at least 30 days before the effective date of the policy. (The PIHP does not have to include how and where to obtain the services.) <p align="right">42 CFR 438.102(a)(2)(b)(1)</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

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. <p align="right">42 CFR 438.100(b)(2)(iv)</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



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PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings

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) Attachment P1.4.1 Attachment 6.3.1		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

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Requirement	Evidence/Documentation as Submitted by the PIHP	Score
13. Delegation The PIHP oversees and is accountable for any functions it delegates to any subcontractor. 42CFR 438.230 MDCH Contract Part I-38.0		
a. There is a written agreement that specifies the activities and report responsibilities designated to the subcontractor.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
b. The PIHP monitors the subcontractor's performance on an ongoing basis and subjects it to formal review according to a periodic schedule established by the State, consistent with industry standards or State MCO laws and regulations.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

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Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
c. If the PIHP identifies deficiencies or areas for improvement, the PIHP and the subcontractor take corrective action.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings

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



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Standard IX—Subcontracts and Delegation

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
1. Predelegation Assessment Prior to entering into delegation subcontracts or agreements, the PIHP evaluates the proposed subcontractor's ability to perform the activities to be delegated. 42 CFR 438.230(b)		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
2. Written Agreements The PIHP has a written agreement with each delegated subcontractor. 42 CFR 438.230(b)(2)		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

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Standard IX—Subcontracts and Delegation

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
3. Content of Agreement—Activities The written agreement specifies the activities delegated to the subcontractor. 42 CFR 438.230(b)(2)(i) MDCH Contract Part I-38.0		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

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. 42 CFR 438.230(b)(2)(i) MDCH Contract Part I-38.0		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

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Standard IX—Subcontracts and Delegation

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. 42 CFR 438.230(b)(2)(ii)		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
6. Monitoring of Delegates The PIHP annually monitors affiliates, as applicable, and provider networks who perform delegated functions to assure quality and performance with the standards in the Quality Assessment and Performance Improvement Technical Requirement (PIHP Contract Attachment P7.9.1). 42 CFR 438.230(b)(3) MDCH Contract Part I-38.0		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

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Standard IX—Subcontracts and Delegation

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. 42 CFR 438.230(b)(4)		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
8. PIHP Oversight The PIHP must review and follow up on any provider network monitoring of its subcontractors. MDCH Contract Part I-38.0 Attachment P7.9.1		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings



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



Attachment A. Documentation Request and Evaluation Tool
Michigan Department of Health and Human Services (MDHHS)
Prepaid Inpatient Health Plans (PIHPs)
for PIHP Name

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. 42 CFR 438.206(b)(1)		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

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. 42 CFR 438.206(b)(1)		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings



Attachment A. Documentation Request and Evaluation Tool
Michigan Department of Health and Human Services (MDHHS)
Prepaid Inpatient Health Plans (PIHPs)
for PIHP Name

Standard X—Provider Network

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. 42 CFR 438.106(b)(2)		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings

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. 42 CFR 438.106(c) MDCH Contract Part II A-7.8.2.2		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings



Attachment A. Documentation Request and Evaluation Tool
Michigan Department of Health and Human Services (MDHHS)
Prepaid Inpatient Health Plans (PIHPs)
for PIHP Name

Standard X—Provider Network

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)		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
6. 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. 42 CFR 438.12 MDCH Contract Part I-37.0 Attachment P7.1.1		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings



Attachment A. Documentation Request and Evaluation Tool
Michigan Department of Health and Human Services (MDHHS)
Prepaid Inpatient Health Plans (PIHPs)
for PIHP Name

Standard X—Provider Network

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
7. Network Changes The PIHP notifies MDCH within seven days of any significant changes to the provider network composition that affect adequate capacity and services. 42 CFR 438.207(c)(2) MDCH Contract Part II A-3.2 Attachment P7.7.1.1		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
8. 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 Contract Part II A-4.10		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings



Attachment A. Documentation Request and Evaluation Tool
Michigan Department of Health and Human Services (MDHHS)
Prepaid Inpatient Health Plans (PIHPs)
for PIHP Name

Standard X—Provider Network

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
9. 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) MDCH Contract Part II A-4.10		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
10. 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 Contract Part II A-4.9		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings



Attachment A. Documentation Request and Evaluation Tool
Michigan Department of Health and Human Services (MDHHS)
Prepaid Inpatient Health Plans (PIHPs)
for PIHP Name

Standard X—Provider Network

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
11. Delegation The PIHP oversees and is accountable for any functions it delegates to any subcontractor. 42CFR 438.230 MDCH Contract Part I-38.0		
a. There is a written agreement that specifies the activities and report responsibilities designated to the subcontractor.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
b. The PIHP monitors the subcontractor's performance on an ongoing basis and subjects it to formal review according to a periodic schedule established by the State, consistent with industry standards or State MCO laws and regulations.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement



Attachment A. Documentation Request and Evaluation Tool
Michigan Department of Health and Human Services (MDHHS)
Prepaid Inpatient Health Plans (PIHPs)
for PIHP Name

Standard X—Provider Network

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
c. If the PIHP identifies deficiencies or areas for improvement, the PIHP and the subcontractor take corrective action.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

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				=	



Attachment A. Documentation Request and Evaluation Tool
Michigan Department of Health and Human Services (MDHHS)
Prepaid Inpatient Health Plans (PIHPs)
for PIHP Name

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. 42 CFR 438.214(b)(2) MDCH Part II A-7.1 Attachment P7.1.1		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
2. Provider Discrimination The PIHP has processes to ensure: <ul style="list-style-type: none">♦ That the credentialing and recredentialing processes do not discriminate against:<ul style="list-style-type: none">▪ A health care professional solely on the basis of license, registration, or certification.▪ A health care professional who serves high-risk populations or who specializes in the treatment of conditions that require costly treatment. 42 CFR 438.12 and 438.214(c) Attachment P7.1.1		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement



Attachment A. Documentation Request and Evaluation Tool
Michigan Department of Health and Human Services (MDHHS)
Prepaid Inpatient Health Plans (PIHPs)
for PIHP Name

Standard XI—Credentialing

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>3. Retain Rights for Provider Selection</p> <p>The PIHP is responsible for oversight regarding delegated credentialing or re-credentialing decisions. If the PIHP delegates to another entity any of the responsibilities of credentialing/recredentialing or selection of providers, it must retain the right to approve, suspend, or terminate providers from participation in Medicaid funded services.</p> <p style="text-align: right;">Attachment P7.1.1</p>		<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Substantially Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Not Applicable</p>

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings



Attachment A. Documentation Request and Evaluation Tool
Michigan Department of Health and Human Services (MDHHS)
Prepaid Inpatient Health Plans (PIHPs)
for PIHP Name

Standard XI—Credentialing

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
4. Delegation The PIHP oversees and is accountable for any functions it delegates to any subcontractor. 42CFR 438.230 MDCH Contract Part I-38.0		
a. There is a written agreement that specifies the activities and report responsibilities designated to the subcontractor.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
b. The PIHP monitors the subcontractor's performance on an ongoing basis and subjects it to formal review according to a periodic schedule established by the State, consistent with industry standards or State MCO laws and regulations.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Attachment A. Documentation Request and Evaluation Tool
Michigan Department of Health and Human Services (MDHHS)
Prepaid Inpatient Health Plans (PIHPs)
for PIHP Name

Standard XI—Credentialing

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
c. If the PIHP identifies deficiencies or areas for improvement, the PIHP and the subcontractor take corrective action.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

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				=	

Attachment A. Documentation Request and Evaluation Tool
Michigan Department of Health and Human Services (MDHHS)
Prepaid Inpatient Health Plans (PIHPs)
for PIHP Name

Standard XII—Access And Availability

Findings were derived from the Michigan Mission-Based Performance Indicator System—Access Domain, Indicators 1 through 4.b. MDCH provided data directly to HSAG for April–December 2014. The PIHP’s performance was evaluated and scored based on data across the reported quarters.

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 Contract Part II A-4.1 Attachment P7.7.1.1		<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> 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		<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met
b. Adult		<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings



Attachment A. Documentation Request and Evaluation Tool
Michigan Department of Health and Human Services (MDHHS)
Prepaid Inpatient Health Plans (PIHPs)
for PIHP Name

Standard XII—Access And Availability

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

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings



Attachment A. Documentation Request and Evaluation Tool
Michigan Department of Health and Human Services (MDHHS)
Prepaid Inpatient Health Plans (PIHPs)
for PIHP Name

Standard XII—Access And Availability

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

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings

Attachment A. Documentation Request and Evaluation Tool
Michigan Department of Health and Human Services (MDHHS)
Prepaid Inpatient Health Plans (PIHPs)
for PIHP Name

Standard XII—Access And Availability

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

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings

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

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings



Attachment A. Documentation Request and Evaluation Tool
Michigan Department of Health and Human Services (MDHHS)
Prepaid Inpatient Health Plans (PIHPs)
for PIHP Name

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) MDCH Contract Part II A-4.1 Attachment P4.1.1 Attachment P7.7.1.1		<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
7. Delegation The PIHP oversees and is accountable for any functions it delegates to any subcontractor. 42CFR 438.230 MDCH Contract Part I-38.0		
a. There is a written agreement that specifies the activities and report responsibilities designated to the subcontractor.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement



Attachment A. Documentation Request and Evaluation Tool
Michigan Department of Health and Human Services (MDHHS)
Prepaid Inpatient Health Plans (PIHPs)
for PIHP Name

Standard XII—Access And Availability

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
b. The PIHP monitors the subcontractor's performance on an ongoing basis and subjects it to formal review according to a periodic schedule established by the State, consistent with industry standards or State MCO laws and regulations.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
c. If the PIHP identifies deficiencies or areas for improvement, the PIHP and the subcontractor take corrective action.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings



Attachment A. Documentation Request and Evaluation Tool
Michigan Department of Health and Human Services (MDHHS)
Prepaid Inpatient Health Plans (PIHPs)
for PIHP Name

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 =					



Attachment A. Documentation Request and Evaluation Tool
Michigan Department of Health and Human Services (MDHHS)
Prepaid Inpatient Health Plans (PIHPs)
for PIHP Name

Standard XIII—Coordination of Care

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
1. Coordination Procedures/Primary Care Providers The PIHP has procedures to ensure that coordination occurs between primary care physicians and the PIHP and/or its network. MDCH Contract Part II A-7.4		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

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) MDCH Contract Part II A-1.3 MDCH Contract Part II A 7.2 – 7.4		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings



Attachment A. Documentation Request and Evaluation Tool
Michigan Department of Health and Human Services (MDHHS)
Prepaid Inpatient Health Plans (PIHPs)
for PIHP Name

Standard XIII—Coordination of Care

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) MDCH Contract Part II A 7.2 – 7.4		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
4. Coordination Agreements The PIHP has a written, functioning coordination agreement with each MHP serving any part of the PIHP's service area. At a minimum, these arrangements must address integration of physical and mental health plans. MDCH Contract Part II A-7.3 Attachment P7.3.1		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings



Attachment A. Documentation Request and Evaluation Tool
Michigan Department of Health and Human Services (MDHHS)
Prepaid Inpatient Health Plans (PIHPs)
for PIHP Name

Standard XIII—Coordination of Care

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
5. Delegation The PIHP oversees and is accountable for any functions it delegates to any subcontractor. 42CFR 438.230 MDCH Contract Part I-38.0		
a. There is a written agreement that specifies the activities and report responsibilities designated to the subcontractor.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
b. The PIHP monitors the subcontractor's performance on an ongoing basis and subjects it to formal review according to a periodic schedule established by the State, consistent with industry standards or State MCO laws and regulations.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement



Attachment A. Documentation Request and Evaluation Tool
Michigan Department of Health and Human Services (MDHHS)
Prepaid Inpatient Health Plans (PIHPs)
for PIHP Name

Standard XIII—Coordination of Care

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
c. If the PIHP identifies deficiencies or areas for improvement, the PIHP and the subcontractor take corrective action.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

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				=	



Attachment A. Documentation Request and Evaluation Tool
Michigan Department of Health and Human Services (MDHHS)
Prepaid Inpatient Health Plans (PIHPs)
for PIHP Name

Standard XIV—Appeals

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
1. Appeals The PIHP has internal appeals procedures that address: <div>42 CFR 438.402</div> <div>MDCH Contract Part II A-6.3.1</div> <div>Attachment P 6.3.1.1</div>		
a. The beneficiary's right to a State fair hearing.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
b. The method for a beneficiary to obtain a hearing.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
c. The beneficiary's right to file appeals.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
d. The requirements and time frames for filing appeals.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Attachment A. Documentation Request and Evaluation Tool
Michigan Department of Health and Human Services (MDHHS)
Prepaid Inpatient Health Plans (PIHPs)
for PIHP Name

Standard XIV—Appeals

Findings

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. <div>42 CFR 438.406(a)(2), (c)(1)</div> <div>Attachment P 6.3.1.1</div>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
b. Ensures that oral inquiries seeking to appeal an action are treated as appeals in order to establish the earliest possible filing date. <div>42 CFR 438.406(b)(1)</div> <div>Attachment P 6.3.1.1</div>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
c. Maintains a log of all requests for appeals and reports data to the PIHP quality assessment/performance improvement program. <div>Attachment P 6.3.1.1</div>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings

Attachment A. Documentation Request and Evaluation Tool
Michigan Department of Health and Human Services (MDHHS)
Prepaid Inpatient Health Plans (PIHPs)
for PIHP Name

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. <div align="right">42 CFR 438.410(a) Attachment P 6.3.1.1</div>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

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. <div align="right">42 CFR 438.406(a)(3)(i) Attachment P 6.3.1.1</div>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings

Attachment A. Documentation Request and Evaluation Tool
Michigan Department of Health and Human Services (MDHHS)
Prepaid Inpatient Health Plans (PIHPs)
for PIHP Name

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: <ul style="list-style-type: none"> ♦ An appeal of a denial that is based on lack of medical necessity ♦ An appeal that involves clinical issues <p align="right">42 CFR 438.406(a)(3)(ii) Attachment P 6.3.1.1</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

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. <p align="right">42 CFR 438.406(b)(3)(ii)</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings

Attachment A. Documentation Request and Evaluation Tool
Michigan Department of Health and Human Services (MDHHS)
Prepaid Inpatient Health Plans (PIHPs)
for PIHP Name

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. 42 CFR 438.408(b) Attachment P 6.3.1.1		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

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. 42 CFR 438.408(e) Attachment P 6.3.1.1		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings

Attachment A. Documentation Request and Evaluation Tool
Michigan Department of Health and Human Services (MDHHS)
Prepaid Inpatient Health Plans (PIHPs)
for PIHP Name

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: <ul style="list-style-type: none"> ♦ The right to request a State fair hearing. ♦ How to request a State fair hearing. ♦ The right to request to receive benefits while the State fair hearing is pending, if requested within 12 days of the PIHP mailing the notice of disposition, and how to make the request. ♦ The fact that the beneficiary may be held liable for the cost of those benefits if the hearing decision upholds the PIHP's action. <p align="right">42 CFR 438.408(e)(2) Attachment P 6.3.1.1</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

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: <ul style="list-style-type: none"> ♦ Transfers the appeal to the time frame for standard resolution (i.e., no longer than 45 days from the date the PIHP received the appeal). ♦ Makes reasonable efforts to give the beneficiary prompt oral notice of the denial. ♦ Gives the beneficiary follow-up written notice within two calendar days. <p align="right">42 CFR 438.410(c) Attachment P 6.3.1.1</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



Attachment A. Documentation Request and Evaluation Tool
Michigan Department of Health and Human Services (MDHHS)
Prepaid Inpatient Health Plans (PIHPs)
for PIHP Name

Standard XIV—Appeals

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
11. Delegation The PIHP oversees and is accountable for any functions it delegates to any subcontractor. 42CFR 438.230 MDCH Contract Part I-38.0		
a. There is a written agreement that specifies the activities and report responsibilities designated to the subcontractor.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
b. The PIHP monitors the subcontractor's performance on an ongoing basis and subjects it to formal review according to a periodic schedule established by the State, consistent with industry standards or State MCO laws and regulations.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



Attachment A. Documentation Request and Evaluation Tool
Michigan Department of Health and Human Services (MDHHS)
Prepaid Inpatient Health Plans (PIHPs)
for PIHP Name

Standard XIV—Appeals

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
c. If the PIHP identifies deficiencies or areas for improvement, the PIHP and the subcontractor take corrective action.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

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				=	

Attachment A. Documentation Request and Evaluation Tool
Michigan Department of Health and Human Services (MDHHS)
Prepaid Inpatient Health Plans (PIHPs)
for PIHP Name

Standard XV—Disclosure of Ownership, Control, and Criminal Convictions

Federal regulations require PIHPs to disclose information about individuals with ownership or control interests in the PIHP. These regulations also require the PIHP to identify and report any additional ownership or control interests for those individuals in other entities, as well as identifying when any of the individuals with ownership or control interests have spousal, parent-child, or sibling relationships with each other. The PIHP shall comply with the federal regulations to obtain, maintain, disclose, and furnish required information about ownership and control interests, business transactions, and criminal convictions as specified in 42 C.F.R. §455.104-106. In addition, the PIHP shall ensure that any and all contracts, agreements, purchase orders, or leases to obtain space, supplies, equipment, or services provided under the Medicaid agreement require compliance with 42 C.F.R. §455.104-106. (MDCH Contract, Part I, 34.0.)

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
<p>1. Disclosure of Ownership, Controlling Interest and Management Statement and Attestation of Criminal Convictions, Sanctions, Exclusions, Debarment or Termination</p> <p>The PIHP ensures that its providers and contractors submit full disclosures identified in 42 CFR Part 455 Subpart B. Disclosures include:</p> <ul style="list-style-type: none"> ◆ Name and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity. The address for corporate entities must include primary business address, every business location, and P.O. Box location. ◆ Date of birth and Social Security number of each person with an ownership or control interest in the disclosing entity. ◆ Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has a five percent or more interest. ◆ Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity is related to another person with an ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity has a five percent or more interest is related to another person with ownership or control interest as a spouse, parent, child, or sibling. 		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Attachment A. Documentation Request and Evaluation Tool
Michigan Department of Health and Human Services (MDHHS)
Prepaid Inpatient Health Plans (PIHPs)
for PIHP Name

Standard XV—Disclosure of Ownership, Control, and Criminal Convictions

- ◆ The name of any other disclosing entity in which an owner of the disclosing entity has an ownership or control interest.
- ◆ The name, address, date of birth, and Social Security number of any managing employee of the disclosing entity.
- ◆ The identity of any individual who has an ownership or control interest in the provider, or is an agent or managing employee of the provider and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.

42 CFR 455.104
 42 CFR 455.106MDCH Contract Part I, 34.0–34.1

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
2. Time of disclosure The PIHP has a process to obtain disclosure from its providers/contractors at any of the following times: <ul style="list-style-type: none"> ◆ When the provider submits a provider application. ◆ Upon execution of the provider agreement. ◆ During recredentialing or re-contracting ◆ Within 35 days of any change in ownership of a disclosing entity. <p align="right">42 CFR 455.104 MDCH Contract Part I-34.2</p>		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement



Attachment A. Documentation Request and Evaluation Tool
Michigan Department of Health and Human Services (MDHHS)
Prepaid Inpatient Health Plans (PIHPs)
for PIHP Name

Standard XV—Disclosure of Ownership, Control, and Criminal Convictions

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
3. Monitoring Provider Networks The PIHP must search the OIG exclusions database monthly to capture exclusions since the last search and at any time providers submit new disclosure information. MDCH Contract Part I-34.1		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
4. Reporting Criminal Convictions The PIHP has a policy and process to identify and notify the MDCH BHDDA Division of Program Development, Consultation and Contracts when any disclosures are made by providers with regard to: 42 CFR 1001.1001 42 CFR 455.106 MDCH Contract Part I-34.2		
a. The ownership or control by a person that has been convicted of a criminal offense described under sections 1128(a) and 1128(b)(1)(2), or (3) of the Social Security Act, or that have had civil money penalties or assessments imposed under section 1128A of the Act.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Attachment A. Documentation Request and Evaluation Tool
Michigan Department of Health and Human Services (MDHHS)
Prepaid Inpatient Health Plans (PIHPs)
for PIHP Name

Standard XV—Disclosure of Ownership, Control, and Criminal Convictions

- b. Any staff member, director, or manager of the PIHP, individual with beneficial ownership of five percent or more, or an individual with an employment, consulting or other arrangement with PIHP has been convicted of a criminal offense described under sections 1128(a) and 1128(b)(1)(2), or (3) of the Social Security Act, or that have had civil money penalties or assessments imposed under section 1128A of the Act.

- ☐ **Met**
☐ **Substantially Met**
☐ **Partially Met**
☐ **Not Met**
☐ **Not Applicable**

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
5. Delegation and Oversight The PIHP oversees and is accountable for any functions it delegates to any subcontractor. <div>42 CFR 438.230 MDCH Contract Part I-38.0</div>		
a. There is a written agreement with each provider entity that specifies the activities and report responsibilities delegated to the subcontractor, including contract language that requires the provider entity to disclose to the PIHP any criminal convictions described under 1128 (a) and 1128 (b)(1)(2), or (3) of the Act, or that have had civil monetary penalties or assessments imposed under section 1128 A of the Act.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



Attachment A. Documentation Request and Evaluation Tool
Michigan Department of Health and Human Services (MDHHS)
Prepaid Inpatient Health Plans (PIHPs)
for PIHP Name

Standard XV—Disclosure of Ownership, Control, and Criminal Convictions

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
b. The PIHP monitors the subcontractor's performance on an ongoing basis and subjects it to formal review according to a periodic schedule established by the State, consistent with industry standards or State MCO laws and regulations.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement

Findings

Requirement	Evidence/Documentation as Submitted by the PIHP	Score
c. Corrective Action If the PIHP identifies deficiencies or areas for improvement, the PIHP and the subcontractor take corrective action.		<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement



Attachment A. Documentation Request and Evaluation Tool
Michigan Department of Health and Human Services (MDHHS)
Prepaid Inpatient Health Plans (PIHPs)
for PIHP Name

Standard XV—Disclosure of Ownership, Control, and Criminal Convictions

Findings

Results—Standard XV

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						=



Attachment B1. Michigan Department of Health and Human Services (MDHHS)

Information Systems Capabilities Assessment Tool (ISCAT) for

Prepaid Inpatient Health Plans (PIHPs)

I. GENERAL INFORMATION

Please provide the following general information:

Note: When completing this ISCAT, answer the questions in the context of the performance indicators reported to MDHHS and the QI and encounter data submitted to MDHHS 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. Community Mental Health Service Provider (CMHSP) or a Managed Comprehensive Provider Network (MCPN) should be considered a subcontractor.

A. Contact Information

Please insert (or verify the accuracy of) the PIHP identification information below, including the PIHP name, PIHP contact name and title, mailing address, telephone and fax numbers, and e-mail address, if applicable.

PIHP Name: _____	
Mailing Address: _____	
PMV Contact Name and Title: _____	
PMV Contact E-Mail Address: _____	
PMV Contact Phone Number: _____	PMV Contact Fax Number: _____
Chief Information Officer (CIO) Name and Title: _____	
CIO Phone Number: _____	
CIO E-Mail Address: _____	

I. GENERAL INFORMATION

B. PIHP Model Type

Please indicate model type (if other, please specify):

- ☐ PIHP - stand alone
- ☐ PIHP – affiliation-with CMHSPs:
- ☐ PIHP – MCPN Network
- ☐ PIHP – other (describe): _____

PIHP Structure

Please indicate general structure (if other, please specify):

- ☐ Centralized (All information system functions are performed by the PIHP)
- ☐ Mixed (Some information system functions are delegated to other entities)
- ☐ Delegated (All information system functions are delegated to other entities)
- ☐ Other (describe): _____

C. Please provide a brief narrative description of any changes that were made to your organization within the last year, including organization structure, information systems, key staff, or other significant changes: _____

D. Unduplicated Count of Medicaid Consumers Receiving Services as of:

October 2015	_____	June 2016	_____
November 2015	_____	July 2016	_____
December 2015	_____	August 2016	_____
January 2016	_____	September 2016	_____
February 2016	_____	October 2016	_____
March 2016	_____	November 2016	_____
April 2016	_____	December 2016	_____
May 2016	_____		

E. Has your organization ever undergone a formal IS capabilities assessment (other than the performance measure validation activity performed by the EQRO)? A formal IS capabilities assessment must have been performed by an external reviewer.

Note: CARF/JCHO reviews would not apply as they do not get to the level of detail necessary to meet CMS protocols.

- ☐ Yes ☐ No

If yes, who performed the assessment? _____ When was the assessment completed? _____

I. GENERAL INFORMATION

F. In an attachment to the ISCAT, please describe how your PIHP's data process flow is configured for its entire network. Label as Attachment 8.

This will likely require a multi-dimensional presentation and data flow chart. Please include any IS functions that have been delegated downstream to the Community Mental Health Service Providers (CMHSPs), MCPNs (if applicable), , and sub-panel contract agencies of CMHSPs. Identify which entity-level is responsible for which kind of data collection and submission, which entity has overall data validation responsibilities, and the data validation process involved. A typical response should generally be a two-to-three-page write-up, with some graphical flow charts attached. This description will help immensely with the reviewers' understanding of your PIHP and will help make the validation process run smoothly and efficiently.

G. Please provide a brief summary of your PIHP's experience in working with the state CHAMPS system in the past year, including any challenges your PIHP has faced related to data reporting/data acquisition through CHAMPS. _____

II. INFORMATION SYSTEMS: DATA PROCESSING PROCEDURES AND PERSONNEL

1. What database management system (DBMS) or systems does your organization use to store Medicaid claims and encounter (service) data?

2. How would you characterize this/these DBMSs? (Check all that apply.)

- ☐ Relational
- ☐ Hierarchical
- ☐ Indexed
- ☐ Other
- ☐ Network
- ☐ Flat File
- ☐ Proprietary
- ☐ Don't Know

3. Into what DBMS(s), if any, do you extract relevant Medicaid encounter/service/eligibility detail for analytic reporting purposes?

4. How would you characterize this/these DBMS(s)? (Check all that apply.)

- ☐ Relational
- ☐ Hierarchical
- ☐ Indexed
- ☐ Other
- ☐ Network
- ☐ Flat File
- ☐ Proprietary
- ☐ Don't Know

II. INFORMATION SYSTEMS: DATA PROCESSING PROCEDURES AND PERSONNEL

- 5. What programming languages do your programmers use to create Medicaid data extracts or analytic reports?** A *programmer* is defined as an individual who develops and/or runs computer programs or queries to manipulate data for submission to MDHHS (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 MDHHS, and to the submission of encounter data to MDHHS.

_____ %

- 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 MDHHS.**

If your PIHP has this information already documented, please submit the documentation or notate that you will make the documentation available to the reviewers during the site visit.

- 9. What is the process for version control when computer programming code is revised?**

This question applies to internal programmers or vendors who develop and/or run computer programming to manipulate data for encounter data submission or performance indicator reporting.

II. INFORMATION SYSTEMS: DATA PROCESSING PROCEDURES AND PERSONNEL

10. Who is responsible for your organization meeting the State Medicaid reporting requirements, as certified on file with MDHHS? (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 system back-ups being performed? _____

Where are back-up data stored? _____

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

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

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

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

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

☐ Consumers

☐ Providers

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

III. DATA ACQUISITION CAPABILITIES

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

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

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

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

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

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

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

III. DATA ACQUISITION CAPABILITIES

2. We would like to understand how claims or service/encounter data are submitted to your plan.

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

Please fill in the following table with the appropriate percentages:

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

Comments: _____

III. DATA ACQUISITION CAPABILITIES

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

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

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

III. DATA ACQUISITION CAPABILITIES

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

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

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

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

5. Principal and Secondary Diagnoses

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

☐ Yes

☐ No

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

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

Institutional Data: _____

Professional Data: _____

III. DATA ACQUISITION CAPABILITIES

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

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

9. Medicaid Claims/Encounters

9a. How are Medicaid claims/encounters received?

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

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

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

III. DATA ACQUISITION CAPABILITIES

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

	INSTITUTIONAL		PROFESSIONAL	
CODING SCHEME	Inpatient Diagnosis	Inpatient Procedure	Ambulatory/ Outpatient Diagnosis	Ambulatory/ Outpatient Procedure
ICD-9-CM (if DOS prior 10/01/2015)	___%	___%	___%	___%
ICD-10 (if DOS on or after 10/01/2015)	___%	___%	___%	___%
CPT-4		___%		___%
HCPCS		___%		___%
DSM-IV	___%		___%	
Internally Developed	___%	___%	___%	___%
Other (Specify)	___%	___%	___%	___%
Not Required	___%	___%	___%	___%
TOTAL	100%	100%	100%	100%

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

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

III. DATA ACQUISITION CAPABILITIES

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

☐ New system purchased and installed to replace old system.

Description/implementation dates _____

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

Description/implementation dates _____

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

Description/implementation dates _____

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

Description/implementation dates _____

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

Description/implementation dates _____

Comments: _____

III. DATA ACQUISITION CAPABILITIES

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

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

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

If batch, how often is it run? _____

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

How is completeness estimated? How is completeness defined?

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

Are Medicaid encounters audited regularly? Randomly?

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

19. Are diagnostic and procedure codes edited for validity? Please provide detail on system edits that are targeted to field content and consistency.

This question is to help reviewers get a sense of how accurate and valid your claims/encounter data are. If you have an existing document that identifies what edits you have in place, you may submit it as an attachment, or make it available for the reviewers on-site. If you do the latter, please note that in your response.

III. DATA ACQUISITION CAPABILITIES

20. Please complete the following table for Medicaid claims and encounter data and other Medicaid administrative data that is used for performance indicator reporting, or submitted to MDHHS 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 is the pending process happens, how it is communicated to providers, and how long something can be pended before it is rejected.

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

What triggers a processor to follow up on “pended” claims? How frequent are these triggers?

III. DATA ACQUISITION CAPABILITIES

- 23. If any Medicaid services/providers are capitated, have you performed studies on the completeness of the information collected on capitated services? If no providers are paid via capitation, how do you ensure that all services are represented within the information system?**

For example, reviewing the encounters reported and following up with providers to ensure completeness of data would be an appropriate response.

☐ Yes

☐ No

If yes, what were the results?

24. Claims/Encounters Systems

- 24a. If multiple systems are used to process performance indicator data (i.e., each CMHSP has its own IS system to process data), document how the performance data are ultimately merged into one PIHP rate.

With what frequency are performance indicator data merged?

- 24b. Beginning with receipt of a Medicaid claim or encounter in-house, describe the claim/encounter handling, logging, and processes that precede adjudication.

When are Medicaid claims/encounters assigned a document control number and logged or scanned into the system? When are Medicaid claims/encounters microfilmed? If there is a delay in microfilming, how do processors access a claim/encounter that is logged into the system, but is not yet filmed?

Note: This question should only be answered by those entities that receive paper claims and process them manually.

- 24c. Discuss which decisions in processing a Medicaid claim and encounter (service data) are automated, which are prompted by automated messages appearing on the screen, and which are manual. Document the opportunities a processor has for overriding the system manually.

Is there a report documenting overrides or “exceptions” generated on each processor and reviewed by the claim supervisor? Please describe this report.

The intent of this question is to understand how much manual intervention is required to either data-enter a claim/encounter or to adjudicate a claim. The less manual intervention there is, the less room there is for error.

III. DATA ACQUISITION CAPABILITIES

24d. Are there any outside parties or contractors used to complete adjudication, including but not limited to:

▪ Bill auditors (hospital claims, claims over a certain dollar amount)

☐ Yes

☐ No

▪ Peer or medical reviewers

☐ Yes

☐ No

▪ Sources for additional charge data (usual and customary)

☐ Yes

☐ No

▪ Bill “re-pricing” for any services provided

☐ Yes

☐ No

How are these data incorporated into your organization’s data?

24e. Describe the system’s editing capabilities that assure that Medicaid claims and encounters (service data) are processed correctly.

Keep your responses only in the context of the data used for performance indicator reporting. Keep your responses fairly general (i.e., listing the following edits: valid diagnosis and procedure codes, valid recipient ID, valid date of service, mandatory fields, etc.). If your documentation is voluminous, please simply make it available to the reviewers during the site visit.

Provide a list of the specific edits that are performed on claims as they are adjudicated, and note:

1. Whether the edits are performed pre- or post-payment, and
2. Which functions are manual and which are automated.

III. DATA ACQUISITION CAPABILITIES

24f. Please describe how Medicaid eligibility files are updated before providing services, how frequently they are updated for ongoing clients, and who has “change” authority. How and when does Medicaid eligibility verification take place (prior to beginning services, monthly, semi-annually, etc.)?

24g. Describe how your systems and procedures handle validation and payment of Medicaid claims and encounters (service data) when procedure codes are not provided.

24h. Where does the system-generated output (EOBs, remittance advices, pend/rejection reports, etc.) reside?

☐ In-house?

☐ In a separate facility?

If located elsewhere, how is such work tracked and accounted for?

25. Describe all performance monitoring standards for Medicaid claims/encounters processing and recent actual performance results.

This question addresses only those staff who are involved with data entry of claims/encounters and/or adjudication of claims.

26. Describe processor-specific performance goals and supervision of actual versus target performance. Do processors have to meet goals for processing speed? Do they have to meet goals for accuracy?

Again, this question addresses those staff who are involved with data entry of claims/encounters and/or adjudication of claims.

III. DATA ACQUISITION CAPABILITIES

27. Other Administrative Data Used for Performance Indicator Reporting

27a. Identify other administrative data sources used. Include all data sources that are utilized to calculate performance measures by your PIHP: *(check all that apply)*

- ☐ Sub-Element Cost Report (CMHSPs) or Legislative Boiler Plate Report
- ☐ 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
- ☐ Treatment Episode Data System (TEDS)
- ☐ Outcome Measurement Data
- ☐ Other: _____

27b. For each data source identified above, describe the flow of data from the point of origin through the point of entry into an administrative database, data warehouse, or reporting system maintained by your PIHP. Dataflow diagrams may be included as an attachment.

27c. For each data source identified above, identify the data elements captured within the administrative database, data warehouse, or reporting system, and used for performance measure reporting. This may be included as a separate attachment and may be documentation of table structures or a data dictionary. If the documentation is voluminous, please make it available to the reviewers during the site visit and indicate this below:

27d. For each data source identified above, describe the validation activities performed by your PIHP to ensure the data in the administrative database are accurate.

III. DATA ACQUISITION CAPABILITIES

B. Eligibility System

1. **Please describe any major changes/updates that have taken place in the last three years in your Medicaid eligibility data system.** *(Be sure to identify specific dates on which changes were implemented.)*

Examples:

- ☐ New **eligibility** system purchased and installed to replace old system
- ☐ New **eligibility** system purchased and installed to replace most of old system
—old system still used
- ☐ Major enhancements to old system (please also explain the types)
- ☐ The use of a vendor-provided eligibility service/system
- ☐ Modifications to eligibility data due to organizational restructuring

2. **Have any of these changes influenced, even temporarily, the quality and/or completeness of the Medicaid data that are collected, including changes made by MDHHS? If so, how and when?**

3. **How does your PIHP uniquely identify consumers?**

4. **How does your PIHP assign unique consumer IDs? Is this number assigned by the PIHP only or do your affiliate CMHSPs also assign unique consumer IDs?**

5. **How do you track consumer eligibility? Does the individual retain the same ID (unique consumer ID)?**

III. DATA ACQUISITION CAPABILITIES

6. Can your systems track consumers who switch from one payer source (e.g., Medicaid, commercial plan, federal block grant) to another?

☐ Yes

☐ No

6a. Can you track previous claims/encounter data for consumers who switch from one payer source to another?

☐ Yes

☐ No

6b. Are you able to link previous claims/encounter data across payer sources? For example, if a consumer received services under one payer source (e.g., state monies) and then additional services under another payer source (e.g., Medicaid), could the PIHP identify all the services rendered to the individual, regardless of the payer source?

☐ Yes

☐ No

7. Under what circumstances, if any, can a same Medicaid member have more than one identification number within your PIHP's information management systems?

This applies to your internal ID, Medicaid ID, etc. How many numbers can one consumer have within your system?

Under what circumstances, if any, can a member's identification number change?

8. How often is Medicaid enrollment information updated (e.g., how often does your PIHP receive eligibility updates)?

9. Can you track and maintain Medicaid eligibility over time, including retro-active eligibility?

III. DATA ACQUISITION CAPABILITIES

C. Incorporating Data from Subcontractor Systems

Use this section to record information on stand-alone systems or benefits provided through subcontracts, such as CMHSPs, MCPNs, sub-contract agencies, and other organizational providers.

1. Does your PIHP incorporate data from subcontractors to calculate any of the following Medicaid quality measures? If so, which measures require subcontractor data?

INDICATOR	MEASURE	SUBCONTRACTORS
#1	The percentage of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. (1 st Quarter SFY 2017)	_____
#2	The percentage of new Medicaid beneficiaries during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service. (1 st Quarter SFY 2017)	_____
#3	The percentage of new Medicaid beneficiaries during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional. (1 st Quarter SFY 2017)	_____
#4a	The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days. (1 st Quarter SFY 2017)	_____
#4b	The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days. (1 st Quarter SFY 2017)	_____
#5	The percent of Medicaid recipients having received PIHP managed services. (1 st Quarter SFY 2017)	_____
#6	The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination. (1 st Quarter SFY 2017)	_____
#8	The percent of (a) adults with mental illness, and the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disability served by the CMHSPs and PIHPs who are employed competitively. (SFY 2016)	_____
#9	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disability served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities. (SFY 2016)	_____
#10	The percentage of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge. (1 st Quarter SFY 2017)	_____
#13	The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s). (SFY 2016)	_____
#14	The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s). (SFY 2016)	_____

III. DATA ACQUISITION CAPABILITIES

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

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

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

5. Do you evaluate the quality of this information?

If so, how?

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

III. DATA ACQUISITION CAPABILITIES

D. Integration and Control of Data for Performance Measure Reporting

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

File Consolidation

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

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

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

☐ Yes

☐ No

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

☐ Yes

☐ No

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

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

☐ Yes

☐ No

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

III. DATA ACQUISITION CAPABILITIES

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

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

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

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

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

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

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

III. DATA ACQUISITION CAPABILITIES

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

☐ Yes

☐ No

If yes, please describe: _____

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

☐ Yes

☐ No

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

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

☐ Yes

☐ No

III. DATA ACQUISITION CAPABILITIES

Subcontractor Data Integration

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

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

III. DATA ACQUISITION CAPABILITIES

Performance Measure Repository Structure

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

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

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

- ☐ Yes
☐ No

Report Production

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

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

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

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

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

III. DATA ACQUISITION CAPABILITIES

E. Provider Data

Compensation Structure

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

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

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

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

IV. OUTSOURCED OR DELEGATED FUNCTIONS

This section requests information on your PIHP ensuring the quality of the performance measure data collected or processed by delegated entities.

Quality of Data Used for Performance Measure Reporting

- 1. For the purposes of performance measure reporting, were any external entities responsible for providing data used for the generation of performance measure rates?**

☐ Yes

☐ No

If so, please answer the following questions.

1a. How many entities are responsible for reporting administrative data to the PIHP? Describe each entities role in the collection of claims and encounter data.

1b. Describe how these administrative data are provided to the PIHP (if applicable).

1c. Describe how claims and encounter data submitted are integrated into your data respository.

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

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

☐ Yes ☐ No

If so, please answer the following questions.

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

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

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

IV. Outsourced or Delegated Functions

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

Vendor Oversight

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

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

☐ Yes ☐ No

If so, please answer the following questions.

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

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

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

6. Does your PIHP have any standards of delegation which address data accuracy, completeness, and timeliness of submission?

☐ Yes ☐ No

If so, please answer the following questions.

6a. Please describe your external entities' data accuracy, completeness, and timeliness standards/requirements. Include examples of language from vendor contracts.

6b. How is delegated entity performance measured against those standards? Provide documentation of periodic monitoring of the accuracy and completeness of reporting.

6c. If a deficiency is discovered, how is it addressed?

Summary of Requested Documentation

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

Requested Document	Details	Label Number
Previous Medicaid Performance Measure Reports	Please attach final documentation from any previous Medicaid performance measure reporting calculated by your PIHP for the last 4 quarters.	1
Organizational Chart	Please attach an organizational chart for your PIHP. The chart should make clear the relationship among key individuals/departments responsible for information management, including performance measure reporting.	2
Data Integration Flow Chart	Please provide a flowchart that gives an overview of the structure of your management IS. Be sure to show how all claims, encounter, membership, provider, vendor, and other data are integrated for performance measure reporting.	3
Performance Measure Repository File Structure (if applicable)	Provide a complete file structure, file format, and field definitions for the performance measure repository.	4
Program/Query Language for Performance Measure Repository Reporting (if applicable)	Provide full documentation on the software programs or codes used to convert performance measure repository data to performance measures.	5
Medicaid Claims Edits	List of specific edits performed on claims/encounters as they are adjudicated with notation of performance timing (pre- or post-payment) and whether they are manual or automated functions.	6
Statistics on Medicaid claims/encounters and other administrative data	Documentation that explains statistics reported in the ISCA.	7
Health Information System Configuration for Network	Attachment 8	8
Continuous Enrollment Source Code	Any computer programming code used to calculate continuous enrollment, if applicable.	9
Reporting Requirements for Delegated Entities	Provide excerpts from delegated entity contracts that document requirements for (1) the frequency and timeliness of reporting to your PIHP and (2) the accuracy and completeness of data reported to your PIHP	10
Documentation of Vendor Monitoring	Please provide documentation of how you monitor vendors/delegated entities against contract requirements for timeliness, accuracy, and completeness of data reporting.	11
Other/Describe: _____	_____	12

Comments: _____



Attachment B2. Michigan Department of Health and Human Services Mini-Information Systems Capabilities Assessment Tool (ISCAT)

for

Prepaid Inpatient Health Plans (PIHPs) “Community Mental Health Services (CMHSP) Version”

I. GENERAL INFORMATION

Please provide the following general information:

Note: As a subcontractor to a PIHP, you are required to complete the mini-ISCAT. When completing this ISCAT, answer the questions in the context of the performance measures reported to MDHHS, and the QI and encounter data submitted to MDHHS only. If a question does not apply whatsoever to the performance measure calculation and reporting, QI data, or encounter data submission, enter an N/A response.

A. Contact Information

Please insert (or verify the accuracy of) the PIHP subcontractor identification information below, including the organization name, contact name and title, mailing address, telephone and fax numbers, and e-mail address, if applicable.

Organization Name: _____	
Mailing Address: _____	
Contact Name and Title: _____	
Contact E-Mail Address: _____	
Contact Phone Number: _____	Contact Fax Number: _____
Chief Information Officer (CIO) Name and Title: _____	
CIO Phone Number: _____	
CIO E-Mail Address: _____	

I. GENERAL INFORMATION

B. Organizational Information

Please indicate what type of organization:

- ☐ Community Mental Health Services Program (CMHSP)
- ☐ Managed Comprehensive Provider Network (MCPN) – Wayne County
- ☐ Other (describe):

Please indicate model type (if other, please specify):

- ☐ Group model
- ☐ Network model
- ☐ Mixed model
- ☐ Other (describe)

Please provide a brief description of your organization structure: _____

C. Please provide a brief narrative description of any changes that were made to your organization within the last year, including organization structure, information systems, key staff, or other significant changes: _____

D. In an attachment to the ISCAT, please describe how your organization's data process flow is configured for its entire network. Label as Attachment 8.

This will likely require a multi-dimensional presentation and data flow chart. Please include any IS functions that have been delegated downstream (to sub-panel providers, provider groups, etc.). Identify which entity-level is responsible for which kind of data collection and submission, which entity has overall data validation responsibilities, and the data validation process involved. A typical response should generally be a two-to-three-page write-up, with some graphical flow charts attached. This description will help immensely with the reviewers' understanding of your organization and will help make the validation process run smoothly and efficiently.

II. INFORMATION SYSTEMS: DATA PROCESSING PROCEDURES AND PERSONNEL

Note: Complete Section II – Information Systems: Data Processing Procedures and Personnel and III - Data Acquisition Capabilities of the ISCAT if your organization calculates any performance indicators required by MDHHS and submits the performance indicator results to the PIHP. If your organization has delegated any Medicaid claims/encounter processing to a subcontractor, you must arrange for the subcontractor to complete a copy of Section III of the ISCAT and include it with your mini-ISCAT submission. Skip to Section III if your organization is responsible only for claims/encounter processing.

1. What database management system (DBMS) or systems does your organization use to store Medicaid claims and encounter/service data?

2. How would you characterize this/these DBMSs? (Check all that apply.)

- ☐ Relational
- ☐ Hierarchical
- ☐ Indexed
- ☐ Other
- ☐ Network
- ☐ Flat File
- ☐ Proprietary
- ☐ Don't Know

3. Into what DBMS(s), if any, do you extract relevant Medicaid encounter/service/claim/eligibility detail for analytic reporting purposes?

4. How would you characterize this/these DBMS(s)? (Check all that apply.)

- ☐ Relational
- ☐ Hierarchical
- ☐ Indexed
- ☐ Other
- ☐ Network
- ☐ Flat File
- ☐ Proprietary
- ☐ Don't Know

II. INFORMATION SYSTEMS: DATA PROCESSING PROCEDURES AND PERSONNEL

5. What programming languages do your programmers use to create Medicaid data extracts or analytic reports?

The intent of this question is to help the reviewers understand how the performance indicators are calculated by the PIHP and its subcontractors. A *programmer* is defined as an individual who develops and/or runs computer programs or queries to manipulate data for QI or encounter data submission or performance measure reporting.

How many programmers (internal staff or external vendors) are trained and capable of modifying these programs? _____

6. Approximately what percentage of your organization's programming work is outsourced?

This question pertains to the programming work necessary for the calculation of the performance measures reported to MDHHS.

_____ %

7. What is the average experience, in years, of programmers in your organization?

_____ years

8. What is the process for version control when computer programming code is revised?

This question applies to internal programmers or vendors who develop and/or run computer programming to manipulate data for performance measure reporting.

9. Staffing

9a. Describe the Medicaid claims/encounter/service data processing organization in terms of staffing and their expected productivity goals. What is the overall daily, monthly, and annual productivity of the department and of each processor? Productivity is defined as the volume of claims/encounters that are processed during a pre-established interval (i.e. per day, or per week). _____

9b. Describe claims/encounter data processor training from new hire to refresher courses for seasoned processors: _____

9c. What is the average tenure of the staff? _____

9d. What is the annual turnover? _____

II. INFORMATION SYSTEMS: DATA PROCESSING PROCEDURES AND PERSONNEL

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

10a. How is the loss of Medicaid claim and encounter data prevented in the event of system failure?

How frequently are system back-ups performed?

Where are back-up data stored?

10b. What is done to minimize the corruption of Medicaid data due to system failure or program error?

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

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

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

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

☐ Consumers

☐ Providers

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

III. DATA ACQUISITION CAPABILITIES

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

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

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

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

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

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

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

III. DATA ACQUISITION CAPABILITIES

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

Please fill in the following table with the appropriate percentages:

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

Comments: _____

III. DATA ACQUISITION CAPABILITIES

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

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

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

III. DATA ACQUISITION CAPABILITIES

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

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

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

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

5. Principal and Secondary Diagnoses

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

☐ Yes

☐ No

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

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

Institutional Data: _____

Professional Data: _____

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

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

III. DATA ACQUISITION CAPABILITIES

9. Medicaid Claims/Encounters

9a. How are Medicaid claims/encounters received?

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

SOURCE	Received Directly	Submitted Through an Intermediary
Direct CMH Programs	<input type="checkbox"/>	<input type="checkbox"/>
Sub-Panel/Contract Agency	<input type="checkbox"/>	<input type="checkbox"/>
Off-Panel/COFR Providers	<input type="checkbox"/>	<input type="checkbox"/>
Hospital:	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>

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

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

CODING SCHEME	INSTITUTIONAL		PROFESSIONAL	
	Inpatient Diagnosis	Inpatient Procedure	Ambulatory/ Outpatient Diagnosis	Ambulatory/ Outpatient Procedure
ICD-9-CM (if DOS prior 10/01/2015)	___%	___%	___%	___%
ICD-10 (if DOS on or after 10/01/2015)	___%	___%	___%	___%
CPT-4		___%		___%
HCPCS		___%		___%
DSM-IV	___%		___%	
Internally Developed	___%	___%	___%	___%
Other (Specify)	___%	___%	___%	___%
Not Required	___%	___%	___%	___%
TOTAL	100%	100%	100%	100%

III. DATA ACQUISITION CAPABILITIES

11. Please identify all information systems through which service and utilization data for the Medicaid population are processed. Describe the flow of a claim/encounter or service data from the point of service, through any external vendors, to the point it reaches the PIHP.
Your response should start with the systems used by those who handle data after a service is performed, through the point where your organization receives the data and forwards it to the PIHP.

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

- ☐ New system purchased and installed to replace old system.
Description/implementation dates
- ☐ New system purchased and installed to replace most of old system; old system still used.
Description/implementation dates
- ☐ Major enhancements made to old system. (If yes: Please describe the enhancements.)
Description/implementation dates
- ☐ New product line adjudicated (processed) on old system.
Description/implementation dates
- ☐ Conversion of a product line from one system to another.
Description/implementation dates

Comments:

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

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

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

If batch, how often is it run? _____

16. How complete are the Medicaid data three months after the close of the reporting period?

How is completeness estimated? How is completeness defined?

III. DATA ACQUISITION CAPABILITIES

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

Are Medicaid encounters audited regularly? Randomly?

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

19. Are diagnostic and procedure codes edited for validity? Please provide detail on system edits that are targeted to field content and consistency.

This question is to help to reviewers get a sense of how accurate and valid your claims/encounter data are. If you have an existing document that identifies what edits you have in place, you may submit it as an attachment, or make it available for the reviewers on-site. If you do the latter, please note that in your response.

20. Please complete the following table for Medicaid claims and encounter data and other Medicaid administrative data. For the purposes of this ISCAT, 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			

III. DATA ACQUISITION CAPABILITIES

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

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

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

What triggers a processor to follow up on “pending” claims? How frequent are these triggers?

23. If any Medicaid services/providers are capitated, have you performed studies on the completeness of the information collected on capitated services?

For example, reviewing the encounters reported and following up with providers to ensure completeness of data would be an appropriate response.

☐ Yes

☐ No

If yes, what were the results?

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

25. Claims/Encounters Systems

25a. Beginning with receipt of a Medicaid claim or encounter in-house, describe the claim/encounter handling, logging, and processes that precede adjudication.

When are Medicaid claims/encounters assigned a document control number and logged or scanned into the system? When are Medicaid claims/encounters microfilmed? If there is a delay in microfilming, how do processors access a claim/encounter that is logged into the system, but is not yet filmed?

Note: This question should only be answered by those entities that receive paper claims and process them manually.

25b. Please provide a detailed description of each system or process that is involved in adjudicating:

- Professional encounter(s) for a capitated service

III. DATA ACQUISITION CAPABILITIES

For example, how do you confirm encounter reporting when processing the reimbursement of a capitated claim? _____

Are there any services that are paid on an FFS basis that are provided during a capitated encounter? If so, how would this be processed? _____

▪ Inpatient stays (with or without authorization) _____

- 25c. Discuss which decisions in processing a Medicaid claims/encounter (service data) are automated, which are prompted by automated messages appearing on the screen, and which are manual. Document the opportunities a processor has for overriding the system manually.

Is there a report that documents overrides or “exceptions” generated on each processor and reviewed by the claim supervisor? Please describe this report.

The intent of this question is to understand how much manual intervention is required to either data-enter a claim/encounter or to adjudicate a claim. The less manual intervention there is, the less room there is for error.

III. DATA ACQUISITION CAPABILITIES

25d. Are there any outside parties or contractors used to complete adjudication, including but not limited to:

- Bill auditors (hospital claims, claims over a certain dollar amount)

☐ Yes ☐ No

- Peer or medical reviewers

☐ Yes ☐ No

- Sources for additional charge data (usual and customary)

☐ Yes ☐ No

- Bill “re-pricing” for any services provided

☐ Yes ☐ No

How are these data incorporated into your organization’s data? _____

25e. Describe the system’s editing capabilities that assure that Medicaid claims and encounters (service data) are processed correctly.

Keep your responses only in the context of the data used for performance indicator reporting. Keep your responses fairly general (i.e., listing the following edits: valid diagnosis and procedure codes, valid recipient ID, valid date of service, mandatory fields, etc.). If your documentation is voluminous, please simply make it available to the reviewers during the site visit.

Provide a list of the specific edits that are performed on claims as they are adjudicated, and note:

1. Whether the edits are performed pre- or post-payment, and
2. Which functions are manual and which are automated.

25f. Please describe how Medicaid eligibility files are updated before providing services, how frequently they updated for ongoing clients, and who has “change” authority. How and when does Medicaid eligibility verification take place (prior to beginning services, monthly, semi-annually, etc.)?

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

III. DATA ACQUISITION CAPABILITIES

25h. Where does the system-generated output (EOBs, remittance advices, pend/rejection reports, etc.) reside?

- ☐ In-house?
- ☐ In a separate facility?

If located elsewhere, how is such work tracked and accounted for?

26. Describe all performance monitoring standards for Medicaid claims/encounters processing and recent actual performance results.

This question addresses only those staff who are involved with data entry of claims/encounters and/or adjudication of claims.

27. Describe processor-specific performance goals and supervision of actual versus target performance. Do processors have to meet goals for processing speed? Do they have to meet goals for accuracy?

Again, this question addresses those staff who are involved with data entry of claims/encounters and/or adjudication of claims.

28. Other Administrative Data Used for Performance Indicator Reporting

28a. Identify other administrative data sources used. Include all data sources that are utilized to calculate performance measures by your organization: (check all that apply)

- ☐ Sub-Element Cost Report (CMHSPs)
- ☐ 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
- ☐ Treatment Episode Data System (TEDS)

III. DATA ACQUISITION CAPABILITIES

- ☐ Outcome Measurement Data
- ☐ Other:

28b. For each data source identified above, describe the flow of data from the point of origin through the point of entry into an administrative database, data warehouse, or reporting system maintained by your organization. Dataflow diagrams may be included as an attachment.

28c. For each data source identified above, identify the data elements captured within the administrative database, data warehouse, or reporting system, and used for performance measure reporting. This may be included as a separate attachment and may be documentation of table structures or a data dictionary. If the documentation is voluminous, please make it available to the reviewers during the site visit and indicate this below:

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

B. Eligibility System

1. Please describe any major changes/updates that have taken place in the last three years in your Medicaid eligibility data system. (Be sure to identify specific dates on which changes were implemented.)

Examples:

- ☐ New **eligibility** system purchased and installed to replace old system
- ☐ New **eligibility** system purchased and installed to replace most of old system
—old system still used
- ☐ Major enhancements to old system (please also explain the types)
- ☐ The use of a vendor-provided eligibility service/system
- ☐ Modifications to eligibility data due to organizational restructuring

2. How does your organization uniquely identify consumers?

3. How does your organization assign unique consumer IDs? Is this number assigned by the PIHP only or does your organization also assign unique consumer IDs?

III. DATA ACQUISITION CAPABILITIES

C. Incorporating Data from Subcontractor Systems

Use this section to record information on stand-alone systems or benefits provided through subcontracts, such as subcontractor providers, large provider groups (etc.).

Note: Complete the remainder of *Section III - Data Acquisition Capabilities* of the ISCAT if your organization calculates any performance indicators required by MDHHS and submits the performance indicator results to the PIHP. Skip to *Section III – Data Acquisition Capabilities – E. Provider Compensation* if your organization is responsible only for claims/encounter processing.

1. Does your organization incorporate data from subcontractors to calculate any of the following Medicaid quality measures? If so, which measures require subcontractor data?

Indicator	Measure	Subcontractors
#1	The percentage of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. (1 st Quarter SFY 2017)	_____
#2	The percentage of new Medicaid beneficiaries during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service. (1 st Quarter SFY 2017)	_____
#3	The percentage of new Medicaid beneficiaries during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional. (1 st Quarter SFY 2017)	_____
#4a	The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days. (1 st Quarter SFY 2017)	_____
#4b	The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days. (1 st Quarter SFY 2017)	_____
#5	The percent of Medicaid recipients having received PIHP managed services. (1 st Quarter SFY 2017)	_____
#6	The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination. (1 st Quarter SFY 2017)	_____
#8	The percent of (a) adults with mental illness, and the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disability served by the CMHSPs and PIHPs who are employed competitively. (SFY 2016)	_____
#9	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disability served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities. (SFY 2016)	_____
#10	The percentage of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge. (1 st Quarter SFY 2017)	_____
#13	The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s). (SFY 2016)	_____
#14	The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s). (SFY 2016)	_____

III. DATA ACQUISITION CAPABILITIES

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

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

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

5. Do you evaluate the quality of this information?

If so, how?

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

III. DATA ACQUISITION CAPABILITIES

D. Integration and Control of Data for Performance Measure Reporting

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

File Consolidation

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

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

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

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

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

☐ Yes ☐ No

If so, is this the same system from which all other reporting is produced? ☐ Yes ☐ No

3. Describe how your organization receives Medicaid eligibility data, and tracks Medicaid eligibility over time.

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

4a. How many different types of data are merged together to create reports?

4b. What control processes are in place to ensure data merges are accurate and complete? In other words, how do you ensure that the merges were done correctly?

4c. What control processes are in place to ensure that no extraneous data are captured (e.g.,

III. DATA ACQUISITION CAPABILITIES

lack of specificity in consumer identifiers may lead to inclusion of non-eligible members or to double-counting)?

4d. Do you compare samples of data in the repository to raw data in transaction sets (such as the 837) to verify if all the required data are captured (e.g., were any members, providers, or services lost in the process)?

4e. Describe your process (es) to monitor that the required level of coding detail is maintained (e.g., all significant digits and primary and secondary diagnoses remain) after data have been merged?

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

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

☐ Yes

☐ No

If yes, describe: _____

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

☐ Yes

☐ No

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

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

☐ Yes

☐ No

III. DATA ACQUISITION CAPABILITIES

Subcontractor Data Integration

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

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

III. DATA ACQUISITION CAPABILITIES

Performance Measure Repository Structure

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

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

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

- ☐ Yes
☐ No

Report Production

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

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

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

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

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

III. DATA ACQUISITION CAPABILITIES

E. Provider Data

Compensation Structure

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

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

III. DATA ACQUISITION CAPABILITIES

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

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

Summary of Requested Documentation

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

Requested Document	Details	Label Number
Previous Medicaid Performance Measure Reports	Please attach final documentation from any previous Medicaid performance measure reporting calculated by your organization for the last 4 quarters.	1
Organizational Chart	Please attach an organizational chart for your organization. The chart should make clear the relationship among key individuals/departments responsible for information management, including performance measure reporting.	2
Data Integration Flow Chart	Please provide a flowchart that gives an overview of the structure of your management IS. Be sure to show how all claims, encounter, membership, provider, vendor, and other data are integrated for performance measure reporting.	3
Performance Measure Repository File Structure (if applicable)	Provide a complete file structure, file format, and field definitions for the performance measure repository.	4
Program/Query Language for Performance Measure Repository Reporting (if applicable)	Provide full documentation on the software programs or codes used to convert performance measure repository data to performance measures.	5
Medicaid Claims Edits	List of specific edits performed on claims/encounters as they are adjudicated with notation of performance timing (pre- or post-payment) and whether they are manual or automated functions.	6
Statistics on Medicaid claims/encounters and other administrative data	Documentation that explains statistics reported in the ISCAT.	7
Health Information System Configuration for Network	Attachment 8	8
Other: _____	_____	9

Comments: _____



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for <PIHP Full Name>



DEMOGRAPHIC INFORMATION

Health Plan Name: <PIHP Full Name>

Project Leader Name: _____ Title: _____

Telephone Number: _____ E-Mail Address: _____

Name of Project: <PIP Topic>

Section to be completed by HSAG

Type of Project: ☐ Clinical ☐ Nonclinical
☐ Collaborative ☐ HEDIS

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

Submission Date: _____



Attachment C1. Michigan 2016–2017 PIP Validation Tool:
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for <PIHP Full Name>



EVALUATION ELEMENTS		SCORING	COMMENTS	
Performance Improvement Project Evaluation				
I.	Select the Study Topic: Topics selected for the study should reflect the Medicaid-enrolled population in terms of demographic characteristics, prevalence of disease, and the potential consequences (risks) of disease. Topics could also address the need for a specific service. The goal of the project should be to improve processes and outcomes of health care. The topic may be specified by the State Medicaid agency or based on input from Medicaid beneficiaries. The study topic:			
C*	1. Is selected following collection and analysis of data. <i>NA</i> is not applicable to this element for scoring.	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>		
	2. Has the potential to improve consumer health, functional status, or satisfaction. The scoring for this element will be <i>Met</i> or <i>Not Met</i> .	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>		
Results for Step I				
Total Evaluation Elements				
Total Evaluation Elements**	<i>Met</i>	<i>Partially Met</i>	<i>Not Met</i>	<i>NA</i>
2	0	0	0	0
Critical Elements				
Critical Elements***	<i>Met</i>	<i>Partially Met</i>	<i>Not Met</i>	<i>NA</i>
1	0	0	0	0

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

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

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



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EVALUATION ELEMENTS					SCORING					COMMENTS				
Performance Improvement Project Evaluation														
II.		Define the Study Question(s): Stating the study question(s) helps maintain the focus of the PIP and sets the framework for data collection, analysis, and interpretation. The study question(s):												
C*		1. States the problem to be studied in simple terms and is in the recommended X/Y format. NA is not applicable to this element for scoring.					<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA							
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			
1		0	0	0	0	1		0	0	0	0			

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

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

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



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for <PIHP Full Name>



EVALUATION ELEMENTS		SCORING	COMMENTS																															
Performance Improvement Project Evaluation																																		
III.	Use a Representative and Generalizable Study Population: The selected topic should represent the entire eligible Medicaid-enrolled population, with systemwide measurement and improvement efforts to which the study indicator(s) apply. The study population:																																	
C*	1. Is accurately and completely defined and captures all beneficiaries to whom the study question(s) apply. <i>NA</i> is not applicable to this element for scoring.	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>																																
Results for Step III																																		
<table border="1"><thead><tr><th colspan="5">Total Evaluation Elements</th><th colspan="5">Critical Elements</th></tr><tr><th>Total Evaluation Elements**</th><th><i>Met</i></th><th><i>Partially Met</i></th><th><i>Not Met</i></th><th><i>NA</i></th><th>Critical Elements***</th><th><i>Met</i></th><th><i>Partially Met</i></th><th><i>Not Met</i></th><th><i>NA</i></th></tr></thead><tbody><tr><td>1</td><td>0</td><td>0</td><td>0</td><td>0</td><td>1</td><td>0</td><td>0</td><td>0</td><td>0</td></tr></tbody></table>					Total Evaluation Elements					Critical Elements					Total Evaluation Elements**	<i>Met</i>	<i>Partially Met</i>	<i>Not Met</i>	<i>NA</i>	Critical Elements***	<i>Met</i>	<i>Partially Met</i>	<i>Not Met</i>	<i>NA</i>	1	0	0	0	0	1	0	0	0	0
Total Evaluation Elements					Critical Elements																													
Total Evaluation Elements**	<i>Met</i>	<i>Partially Met</i>	<i>Not Met</i>	<i>NA</i>	Critical Elements***	<i>Met</i>	<i>Partially Met</i>	<i>Not Met</i>	<i>NA</i>																									
1	0	0	0	0	1	0	0	0	0																									

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

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

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

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<PIP Topic>

for <PIHP Full Name>

EVALUATION ELEMENTS		SCORING	COMMENTS
Performance Improvement Project Evaluation			
IV.	Select the Study Indicator(s): A study indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event (e.g., an older adult has not received an influenza vaccination in the last 12 months) or a status (e.g., a consumer's blood pressure is or is not below a specified level) that is to be measured. The selected indicator(s) should track performance or improvement over time. The indicator(s) should be objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research. The study indicator(s):		
C*	1. Are well-defined, objective, and measure changes in health or functional status, consumer satisfaction, or valid process alternatives. NA is not applicable to this element for scoring.	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA	
	2. Include the basis on which the indicator(s) were adopted, if internally developed.	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA	
C*	3. Allow for the study question(s) to be answered. NA is not applicable to this element for scoring.	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA	

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

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

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

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



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EVALUATION ELEMENTS		SCORING	COMMENTS
Performance Improvement Project Evaluation			
V.	Use Sound Sampling Techniques: (This activity is scored only if sampling is used.) If sampling is used to select beneficiaries of the study, proper sampling techniques are necessary to provide valid and reliable information on the quality of care provided. Sampling methods should:		
	1. Include the measurement period for the sampling methods used (e.g., baseline, Remeasurement 1, etc.)	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>	
	2. Include the title of the applicable study indicator(s).	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>	
	3. Identify the population size.	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>	
C*	4. Identify the sample size.	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>	
	5. Specify the margin of error and confidence level.	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>	
	6. Describe in detail the methods used to select the sample.	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>	

Results for Step V

Total Evaluation Elements					Critical Elements				
Total Evaluation Elements**	<i>Met</i>	<i>Partially Met</i>	<i>Not Met</i>	<i>NA</i>	Critical Elements***	<i>Met</i>	<i>Partially Met</i>	<i>Not Met</i>	<i>NA</i>
6	0	0	0	0	1	0	0	0	0

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

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

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



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EVALUATION ELEMENTS		SCORING	COMMENTS
Performance Improvement Project Evaluation			
VI.	Reliably Collect Data: Data collection must ensure that the data collected on the study indicator(s) are valid and reliable. Validity is an indication of the accuracy of the information obtained. Reliability is an indication of the repeatability or reproducibility of a measurement. Data collection should include:		
	1. Clearly defined data elements to be collected. <i>NA</i> is not applicable to this element for scoring.	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>	
	2. A clearly defined and systematic process for collecting baseline and remeasurement data.	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>	
	3. Qualifications of staff beneficiaries collecting manual data.	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>	
C*	4. A manual data collection tool that ensures consistent and accurate collection of data according to indicator specifications.	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>	
	5. An estimated degree of administrative data completeness. <i>Met</i> = 80–100 percent complete <i>Partially Met</i> = 50–79 percent complete <i>Not Met</i> = <50 percent complete or not provided	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>	
	6. A description of the data analysis plan.	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>	

Results for Step VI

Total Evaluation Elements					Critical Elements				
Total Evaluation Elements**	<i>Met</i>	<i>Partially Met</i>	<i>Not Met</i>	<i>NA</i>	Critical Elements***	<i>Met</i>	<i>Partially Met</i>	<i>Not Met</i>	<i>NA</i>
6	0	0	0	0	1	0	0	0	0

* “C” in this column denotes a *critical* evaluation element.

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

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

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EVALUATION ELEMENTS		SCORING	COMMENTS
Performance Improvement Project Evaluation			
VII.	Analyze Data and Interpret Study Results: Review the data analysis process for the selected clinical or nonclinical study indicators. Review appropriateness of, and adherence to, the statistical analysis techniques used. The data analysis and interpretation of the study results:		
	1. Are conducted according to the data analysis plan in the study design. NA is not applicable to this element for scoring.	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>	
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 .	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>	
	3. Identify factors that threaten internal or external validity of findings. NA is not applicable to this element for scoring.	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>	
	4. Include an interpretation of findings. NA is not applicable to this element for scoring.	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>	
C*	5. Are presented in a way that provides accurate, clear, and easily understood information. NA is not applicable to this element for scoring.	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>	
	6. Identify the initial measurement and the remeasurement of study indicators.	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>	
	7. Identify statistical differences between the initial measurement and the remeasurement.	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>	
	8. Identify factors that affect the ability to compare the initial measurement with the remeasurement.	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>	



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EVALUATION ELEMENTS		SCORING	COMMENTS
Performance Improvement Project Evaluation			
VII.	Analyze Data and Interpret Study Results: Review the data analysis process for the selected clinical or nonclinical study indicators. Review appropriateness of, and adherence to, the statistical analysis techniques used. The data analysis and interpretation of the study results:		
	9. Include an interpretation of the extent to which the study was successful.	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>	

Results for Step VII

Total Evaluation Elements					Critical Elements				
Total Evaluation Elements**	<i>Met</i>	<i>Partially Met</i>	<i>Not Met</i>	<i>NA</i>	Critical Elements***	<i>Met</i>	<i>Partially Met</i>	<i>Not Met</i>	<i>NA</i>
9	0	0	0	0	2	0	0	0	0

* “C” in this column denotes a *critical* evaluation element.

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

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



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EVALUATION ELEMENTS		SCORING	COMMENTS	
Performance Improvement Project Evaluation				
VIII.	Implement Intervention and Improvement Strategies: Real, sustained improvements in care result from a continuous cycle of measuring and analyzing performance, as well as developing and implementing systemwide improvements in care. Interventions are designed to change behavior at an institutional, practitioner, or consumer level. The improvement strategies are:			
C*	1. Related to causes/barriers identified through data analysis and quality improvement processes. NA is not applicable to this element for scoring.	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>		
	2. System changes that are likely to induce permanent change.	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>		
	3. Revised if the original interventions are not successful.	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>		
	4. Evaluated for effectiveness.	<input type="checkbox"/> <i>Met</i> <input type="checkbox"/> <i>Partially Met</i> <input type="checkbox"/> <i>Not Met</i> <input type="checkbox"/> <i>NA</i>		
Results for Step VIII				
Total Evaluation Elements				
Total Evaluation Elements**	<i>Met</i>	<i>Partially Met</i>	<i>Not Met</i>	<i>NA</i>
4	0	0	0	0
Critical Elements				
Critical Elements***	<i>Met</i>	<i>Partially Met</i>	<i>Not Met</i>	<i>NA</i>
1	0	0	0	0

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

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

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



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EVALUATION ELEMENTS					SCORING					COMMENTS				
Performance Improvement Project Evaluation														
IX.		Assess for Real Improvement: Through repeated measurement of the quality indicators selected for the project, meaningful change in performance relative to the performance observed during baseline measurement must be demonstrated. Assess for any random, year-to-year variations, population changes, or sampling errors that may have occurred during the measurement process.												
		1. The remeasurement methodology was the same as the baseline methodology.				<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA								
		2. There is documented improvement in processes or outcomes of care.				<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA								
	C*	3. There is statistical evidence that observed improvement is true improvement over baseline.				<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA								
		4. The improvement appears to be the result of planned intervention(s).				<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA								
Results for 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	1		0	0	0	0			

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

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

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



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EVALUATION ELEMENTS		SCORING	COMMENTS
Performance Improvement Project Evaluation			
X.	Assess for Sustained Improvement: Sustained improvement through repeated measurements over comparable time periods.		
C*	1. Repeated measurements over comparable time periods demonstrate sustained improvement over baseline.	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> 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	1	0	0	0	0

* “C” in this column denotes a *critical* evaluation element.

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

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

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<PIP Topic>

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Table 3–1—2016–2017 PIP Validation Report Scores
for <PIP Topic>
for <PIHP Full Name>

Review Step	Total Possible Evaluation Elements (Including Critical Elements)	Total Met	Total Partially Met	Total Not Met	Total NA	Total Possible Critical Elements	Total Critical Elements Met	Total Critical Elements Partially Met	Total Critical Elements Not Met	Total Critical Elements NA
I. Select the Study Topic	2					1				
II. Define the Study Question(s)	1					1				
III. Use a Representative and Generalizable Study Population	1					1				
IV. Select the Study Indicator(s)	3					2				
V. Use Sound Sampling Techniques	6					1				
VI. Reliably Collect Data	6					1				
VII. Analyze Data and Interpret Study Results	9					2				
VIII. Implement Intervention and Improvement Strategies	4					1				
IX. Assess for Real Improvement	4					1				
X. Assess for Sustained Improvement	1					1				
Totals for All Steps	37					12				

Table 3–2—2016–2017 PIP Validation Report Overall Score
for <PIP Topic>
for <PIHP Full Name>

Percentage Score of Evaluation Elements Met*	%
Percentage Score of Critical Elements Met**	%
Validation Status***	<Met, Partially Met, or Not Met>

- * The percentage score for all evaluation elements *Met* is calculated by dividing the total *Met* by the sum of all evaluation elements *Met*, *Partially Met*, and *Not Met*.
- ** The percentage score for critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.
- *** *Met* equals high confidence/confidence that the PIP was valid.
Partially Met equals low confidence that the PIP was valid.
Not Met equals reported PIP results that were not credible.



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EVALUATION OF THE OVERALL VALIDITY AND RELIABILITY OF PIP RESULTS

HSAG assessed the implications of the study's findings on the likely validity and reliability of the results based on the CMS protocol for validating PIPs. HSAG also assessed whether the State should have confidence in the reported PIP findings.

Met = High confidence/confidence in reported PIP results

Partially Met = Low confidence in reported PIP results

Not Met = Reported PIP results not credible

Summary of Aggregate Validation Findings

☐ **Met**

☐ **Partially Met**

☐ **Not Met**



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DEMOGRAPHIC INFORMATION

Plan Name: <PIHP Full Name>

Project Leader Name: _____

Title: _____

Telephone Number: _____

E-Mail Address: _____

Name of Project: <PIP Topic>

Section to be completed by HSAG

Type of Project:

☐ Clinical

☐ Nonclinical

☐ Collaborative

☐ HEDIS

Date of Project:

From _____ to _____

Submission Date:

Validation Date:



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Step I: Select the Study Topic. PIP topics should target improvement in relevant areas of care/services and reflect the population in terms of demographic characteristics, prevalence of disease, and the potential consequences (risks) of disease. The goal of the project should be to improve processes and/or outcomes of health care or services.

The study topic should:

- ◆ Be selected following the collection and analysis of plan-specific data.
- ◆ Have the potential to improve consumer health, functional status, or satisfaction.
- ◆ Be based on a high-volume, high-risk, or problem-prone area for which improvement is needed.

Study Topic:

Provide PIHP-specific data:

Describe how the study topic has the potential to improve consumer health, functional status, or satisfaction:



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Step II: Define the Study Question(s). Stating the question(s) helps maintain the focus of the PIP and sets the framework for data collection, analysis, and interpretation.

The Study Question(s) should:

- ◆ Be structured in the recommended X/Y format: “Does doing X result in Y?”
- ◆ State the problem in clear and simple terms.
- ◆ Be answerable based on the data collection methodology and study indicator(s) provided.

Study Question(s):

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<PIP Topic>
for <PIHP Full Name>

Step III. Use a Representative and Generalizable Study Population. The study population should be clearly defined to represent the population to which the study question and indicators apply, without excluding consumers with special health care needs.

The study population definition should:

- ◆ Include the requirements for the length of enrollment, defining continuous enrollment, new enrollment, and allowable gaps in enrollment.
- ◆ Include the complete age range of the study population and the anchor dates used to identify age criteria, if applicable.
- ◆ Clearly define the inclusion, exclusion, and diagnosis criteria.
- ◆ Include a list of diagnosis/procedure/pharmacy/billing codes used to identify consumers, if applicable.
- ◆ Capture all consumers to whom the study question(s) applies.
- ◆ Include how race/ethnicity will be identified, if applicable.

Study Population:

Consumer enrollment requirements:

Consumer age criteria (if applicable):

Inclusion, exclusion, and diagnosis criteria:

Diagnosis/procedure/pharmacy/billing codes (if applicable):

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<PIP Topic>

for <PIHP Full Name>

Step IV: Select the Study Indicator(s). The selected indicator(s) should track performance or improvement over time. The study indicator(s) should be objective, completely and clearly defined, measurable, and based on current clinical knowledge or health services research.

There is a minimum requirement of one study indicator. The plan may submit additional indicators based on the focus of the PIP.

The description of the study Indicator(s) should:

- ◆ Include the complete title of the study indicator.
- ◆ Include complete descriptions of the numerators and denominators, defining the terms used.
- ◆ Include the rationale for selecting the study indicator(s).
- ◆ If indicators are based on nationally recognized measures (e.g., HEDIS), include the year of the HEDIS technical specifications used for the applicable measurement year and update the year annually, as appropriate.
- ◆ Include complete dates for all measurement periods (with the day, month, and year).
- ◆ Include plan-specific goals for the remeasurement periods and the State-designated goal, if applicable.

Study Indicator 1: Enter title of study indicator	Provide a narrative description and the rationale for selecting the study indicator: Describe the basis on which the indicators were adopted, if internally developed.
Numerator (no numeric value)	
Denominator (no numeric value)	
Baseline Measurement Period (include date range) MM/DD/YYYY to MM/DD/YYYY	
Remeasurement 1 Period (include date range) MM/DD/YYYY to MM/DD/YYYY	
PIHP-Specific Remeasurement 1 Goal	
Remeasurement 2 Period (include date range) MM/DD/YYYY to MM/DD/YYYY	
PIHP-Specific Remeasurement 2 Goal	
State-Designated Goal (if applicable)	

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for <PIHP Full Name>

Step IV: Select the Study Indicator(s). The selected indicator(s) should track performance or improvement over time. The study indicator(s) should be objective, completely and clearly defined, measurable, and based on current clinical knowledge or health services research.

There is a minimum requirement of one study indicator. The plan may submit additional indicators based on the focus of the PIP.

The description of the study Indicator(s) should:

- ◆ Include the complete title of the study indicator.
- ◆ Include complete descriptions of the numerators and denominators, defining the terms used.
- ◆ Include the rationale for selecting the study indicator(s).
- ◆ If indicators are based on nationally recognized measures (e.g., HEDIS), include the year of the HEDIS technical specifications used for the applicable measurement year and update the year annually, as appropriate.
- ◆ Include complete dates for all measurement periods (with the day, month, and year).
- ◆ Include plan-specific goals for the remeasurement periods and the State-designated goal, if applicable.

Study Indicator 2: Enter title of study indicator	Provide a narrative description and the rationale for selecting the study indicator: Describe the basis on which the indicators were adopted, if internally developed.
Numerator (no numeric value)	
Denominator (no numeric value)	
Baseline Measurement Period (include date range) MM/DD/YYYY to MM/DD/YYYY	
Remeasurement 1 Period (include date range) MM/DD/YYYY to MM/DD/YYYY	
PIHP-Specific Remeasurement 1 Goal	
Remeasurement 2 Period (include date range) MM/DD/YYYY to MM/DD/YYYY	
PIHP-Specific Remeasurement 2 Goal	
State-Designated Goal (if applicable)	



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Step IV: Select the Study Indicator(s). The selected indicator(s) should track performance or improvement over time. The study indicator(s) should be objective, completely and clearly defined, measurable, and based on current clinical knowledge or health services research.

There is a minimum requirement of one study indicator. The plan may submit additional indicators based on the focus of the PIP.

The description of the study Indicator(s) should:

- ◆ Include the complete title of the study indicator.
- ◆ Include complete descriptions of the numerators and denominators, defining the terms used.
- ◆ Include the rationale for selecting the study indicator(s).
- ◆ If indicators are based on nationally recognized measures (e.g., HEDIS), include the year of the HEDIS technical specifications used for the applicable measurement year and update the year annually, as appropriate.
- ◆ Include complete dates for all measurement periods (with the day, month, and year).
- ◆ Include plan-specific goals for the remeasurement periods and the State-designated goal, if applicable.

Study Indicator 3: Enter title of study indicator	Provide a narrative description and the rationale for selecting the study indicator: Describe the basis on which the indicators were adopted, if internally developed.
Numerator (no numeric value)	
Denominator (no numeric value)	
Baseline Measurement Period (include date range) MM/DD/YYYY to MM/DD/YYYY	
Remeasurement 1 Period (include date range) MM/DD/YYYY to MM/DD/YYYY	
PIHP-Specific Remeasurement 1 Goal	
Remeasurement 2 Period (include date range) MM/DD/YYYY to MM/DD/YYYY	
PIHP-Specific Remeasurement 2 Goal	
State-Designated Goal (if applicable)	
Additional information about the study indicators:	

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Step V: Use Sound Sampling Techniques. If sampling is to be used to select consumers of the study, proper sampling techniques are necessary to provide valid and reliable information on the quality of care provided. Sampling techniques should be in accordance with generally accepted principles of research design and statistical analysis. Representative sampling techniques should be used to ensure generalizable information.

The description of the sampling methods should:

- ◆ Include components identified in the table below.
- ◆ Be updated annually for each measurement period and for each study indicator.
- ◆ Include a detailed narrative description of the methods used to select the sample.

Measurement Period	Study Indicator	Population Size	Sample Size	Margin of Error and Confidence Level
MM/DD/YYYY–MM/DD/YYYY				

Describe in detail the methods used to select the sample:



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Step VI: Reliably Collect Data. The data collection methods must ensure that data collected on the study indicators are valid and reliable.

Data collection methodology should include the following:

- ◆ Identification of data elements and data sources.
- ◆ When and how data are collected.
- ◆ How data are used to calculate the study indicators.
- ◆ How data are analyzed.

Data Sources (Select all that apply)

☐ Hybrid—Both medical/treatment records (manual data collection) and administrative data collection processes are used

☐ Medical/Treatment Record Abstraction
Record Type

☐ Outpatient

☐ Inpatient

☐ Other _____

Other Requirements

☐ Data collection tool attached

☐ Data collection instructions attached

☐ Summary of data collection training attached

☐ IRR process and results attached

☐ Other Data

Description of manual data collection staff,
including training, experience, and
qualifications:

☐ Administrative Data

Data Source

☐ Programmed pull from claims/encounters

☐ Complaint/Appeal

☐ Pharmacy data

☐ Telephone service data/call center data

☐ Appointment/access data

☐ Delegated entity/vendor data _____

☐ Other _____

Other Requirements

☐ Codes used to identify data elements (e.g., ICD-9, CPT codes) _____

☐ Data completeness assessment attached

☐ Coding verification process attached

☐ Quality control process attached

Estimated percentage of administrative data completeness: _____
percent.

Describe the process used to determine data completeness:

☐ Survey Data

Fielding Method

☐ Personal interview

☐ Mail

☐ Phone with CATI script

☐ Phone with IVR

☐ Internet

☐ Other _____

Other Requirements

☐ Number of waves _____

☐ Response rate _____

☐ Incentives used _____

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Step VI: Reliably Collect Data. The data collection methods must ensure that data collected on the study indicators are valid and reliable.

Data collection methodology should include the following:

- ◆ Identification of data elements and data sources.
- ◆ When and how data are collected.
- ◆ How data are used to calculate the study indicators.
- ◆ How data are analyzed.

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Step VI: Reliably Collect Data. The data collection methods must ensure that data collected on the study indicators are valid and reliable.

Data collection methodology should include the following:

- ◆ Identification of data elements and data sources.
- ◆ When and how data are collected.
- ◆ How data are used to calculate the study indicators.
- ◆ How data are analyzed.

Determine the data collection cycle.

- ☐ 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):

Determine the data analysis cycle.

- ☐ Once a year
- ☐ Once a season
- ☐ Once a quarter
- ☐ Once a month
- ☐ Continuous
- ☐ Other (list and describe):



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Data analysis plan and other pertinent methodological features.

- ◆ Include how the rates or means are calculated, the type of statistical testing to be used to compare study indicator results between baseline and the most remeasurement period and between each remeasurement period, details of how data will be analyzed, and how the rates compare to the stated goal/benchmark.
- ◆ Documentation should include clear definitions of the data elements to be collected.
- ◆ Documentation should include a systematic process with an ordered sequence of steps. Each step depends on the outcome of the previous step. This can be defined in a narrative or with algorithms/flow charts.

Describe the data analysis plan:

Describe the data collection process:

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Step VII: Data Analysis and Interpretation of Results. Clearly present the results of the study indicator(s). For HEDIS-based PIPs, the data entered in the table below should align with the data reported in the PIHP's IDSS.

Enter results for each study indicator—including the goals, statistical testing with complete *p* values, and the statistical significance—in the table provided.

Study Indicator 1 Title: Enter title of study indicator

Time Period Measurement Covers	Indicator Measurement	Numerator	Denominator	Rate or Results	Goal	Statistical Test, Statistical Significance, and <i>p</i> value
MM/DD/YYYY– MM/DD/YYYY	Baseline					
	Remeasurement 1					
	Remeasurement 2					
	Remeasurement 3					

Study Indicator 2 Title: Enter title of study indicator

Time Period Measurement Covers	Indicator Measurement	Numerator	Denominator	Rate or Results	Goal	Statistical Test, Statistical Significance, and <i>p</i> value
MM/DD/YYYY– MM/DD/YYYY	Baseline					
	Remeasurement 1					
	Remeasurement 2					
	Remeasurement 3					

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Step VII: Data Analysis and Interpretation of Results. Clearly present the results for each of the study indicator(s). Describe the data analysis performed and the results of the statistical analysis, and interpret the findings. Through data analysis and interpretation, real improvement as well as sustained improvement can be determined.

The data analysis and interpretation of study indicator results should include the following for each measurement period:

- ◆ A description of the data analysis process conducted on the selected study indicators, including the statistical testing performed and the p values calculated to four decimal places (i.e., 0.0235).
- ◆ A description of the results for the statistical analysis, an interpretation of the findings, and a comparison of the results/changes from measurement period to measurement period, including a comparison to the goal.
- ◆ Identification of any factors that could influence the comparability of measurement periods or the validity of the findings for each measurement period.
- ◆ Discussion of any random, year-to-year variations, population changes, sampling errors, or statistically significant increases or decreases that may have occurred during the remeasurement process.
- ◆ A discussion of the extent to which the PIP was successful and any follow-up activities planned.

Describe the data analysis process and provide an interpretation of the results for each measurement period.

Baseline Measurement:

Remeasurement 1:

Remeasurement 2:



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Step VIII: Improvement Strategies (interventions for improvement as a result of analysis). Interventions are developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis. Describe the barriers/interventions and provide quantitative details on the processes used to identify the barriers/interventions and to evaluate the effectiveness of the interventions. Do not include intervention planning activities.

This activity will include the following:

- ◆ Pre-baseline interventions.
- ◆ Baseline and remeasurement barriers/interventions.
- ◆ The processes used to identify barriers/interventions and to evaluate the effectiveness of the interventions.

Pre-Baseline Interventions: If interventions were implemented prior to the start of the baseline period, please enter each intervention in the table below. If not, please enter “not applicable” in the first row of the Pre-Baseline table.

Use the table below to list Pre-Baseline interventions.

Date Implemented (MM/YY)	Pre-Baseline Interventions



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Step VIII: Improvement Strategies (interventions for improvement as a result of analysis). Interventions are developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis. Describe the barriers/interventions and provide quantitative details on the processes used to identify the barriers/interventions and to evaluate the effectiveness of the interventions. Do not include intervention planning activities.

This activity will include the following:

- ◆ Pre-baseline interventions.
- ◆ Baseline and remeasurement barriers/interventions.
- ◆ The processes used to identify barriers/interventions and to evaluate the effectiveness of the interventions.

Baseline Interventions: If interventions were implemented during the baseline period, please describe the process used to identify barriers and the process to develop the corresponding interventions for the baseline measurement period. Please include the team/committee/group that conducted the causal/barrier analysis and any QI tools that were used to identify barriers such as data mining, fishbone diagram, process level data, etc. Describe the process used to prioritize the barriers. Lastly, describe the process that will be used to evaluate the effectiveness of each intervention. If interventions were not implemented during the baseline period, please enter “not applicable” in the first row of the baseline table below.

Use the table below to list barriers and corresponding interventions for the baseline measurement period. For each remeasurement period, copy the ongoing interventions from the previous measurement period to the current remeasurement table and select whether the intervention was (1) new, continued, or revised, and (2) consumer, provider, or system.

Date Implemented (MM/YY)	Check if Consumer, Provider, or System Intervention	Baseline Barriers	Baseline Intervention That Addresses the Barrier Listed in the Previous Column
	Click to select status		
	Click to select status		
	Click to select status		
	Click to select status		



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Step VIII: Improvement Strategies (interventions for improvement as a result of analysis). Interventions are developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis. Describe the barriers/interventions and provide quantitative details on the processes used to identify the barriers/interventions and to evaluate the effectiveness of the interventions. Do not include intervention planning activities.

This activity will include the following:

- ◆ Pre-baseline interventions.
- ◆ Baseline and remeasurement barriers/interventions.
- ◆ The processes used to identify barriers/interventions and to evaluate the effectiveness of the interventions.

Remeasurement 1 Interventions: In the space below, please describe the process used to identify barriers and the process to develop the corresponding interventions for the Remeasurement 1 period. Please include the team/committee/group that conducted the causal/barrier analysis and any QI tools that were used to identify barriers such as data mining, fishbone diagram, process level data, etc. Describe the process used to prioritize the barriers. In addition, describe the process used to determine if existing interventions were continued, revised, or discontinued. Lastly, describe the process that will be used to evaluate the effectiveness of each intervention.

Use the table below to list barriers and corresponding interventions for the baseline measurement period. For each remeasurement period, copy the ongoing interventions from the previous measurement period to the current remeasurement table and select if the intervention was (1) new, continued, or revised, and (2) consumer, provider, or system.

Date Implemented (MM/YY)	Check if Continued, New, or Revised	Check if Consumer, Provider, or System Intervention	Remeasurement 1 Barriers	Remeasurement 1 Intervention That Addresses the Barrier Listed in the Previous Column
	Click to select status	Click to select status		
	Click to select status	Click to select status		
	Click to select	Click to select		



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Step VIII: Improvement Strategies (interventions for improvement as a result of analysis). Interventions are developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis. Describe the barriers/interventions and provide quantitative details on the processes used to identify the barriers/interventions and to evaluate the effectiveness of the interventions. Do not include intervention planning activities.

This activity will include the following:

- ◆ Pre-baseline interventions.
- ◆ Baseline and remeasurement barriers/interventions.
- ◆ The processes used to identify barriers/interventions and to evaluate the effectiveness of the interventions.

	status	status		
	Click to select status	Click to select status		

Remeasurement 2 Interventions: In the space below, please describe the process used to identify barriers and the process to develop the corresponding interventions for the Remeasurement 2 period. Please include the team/committee/group that conducted the causal/barrier analysis and any QI tools that were used to identify barriers such as data mining, fishbone diagram, process level data, etc. Describe the process used to prioritize the barriers. In addition, describe the process used to determine if existing interventions were continued, revised, or discontinued. Lastly, describe the process that will be used to evaluate the effectiveness of each intervention.

Use the table below to list barriers and corresponding interventions for the baseline measurement period. For each remeasurement period, copy the previous measurement period ongoing interventions to the current remeasurement table and select if the intervention was (1) new, continued, or revised, and (2) consumer, provider, or system.

Date Implemented (MM/YY)	Check if Continued, New, or Revised	Check if Consumer, Provider, or System Intervention	Remeasurement 2 Barriers	Remeasurement 2 Intervention That Addresses the Barrier Listed in the Previous Column
	Click to select status	Click to select status		
	Click to select	Click to select		



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Step VIII: Improvement Strategies (interventions for improvement as a result of analysis). Interventions are developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis. Describe the barriers/interventions and provide quantitative details on the processes used to identify the barriers/interventions and to evaluate the effectiveness of the interventions. Do not include intervention planning activities.

This activity will include the following:

- ◆ Pre-baseline interventions.
- ◆ Baseline and remeasurement barriers/interventions.
- ◆ The processes used to identify barriers/interventions and to evaluate the effectiveness of the interventions.

	status	status		
	Click to select status	Click to select status		
	Click to select status	Click to select status		

Remeasurement 3 Interventions: In the space below, please describe the process used to identify barriers and the process to develop the corresponding interventions for the Remeasurement 3 period. Please include the team/committee/group that conducted the causal/barrier analysis and any QI tools that were used to identify barriers such as data mining, fishbone diagram, process level data, etc. Describe the process used to prioritize the barriers. In addition, describe the process used to determine if existing interventions were continued, revised, or discontinued. Lastly, describe the process that will be used to evaluate the effectiveness of each intervention.

Use the table below to list barriers and corresponding interventions for the baseline measurement period. For each remeasurement period, copy the previous measurement period ongoing interventions to the current remeasurement table and select if the intervention was (1) new, continued, or revised, and (2) consumer, provider, or system.

Date Implemented (MM/YY)	Check if Continued, New, or Revised	Check if Consumer, Provider, or System Intervention	Remeasurement 3 Barriers	Remeasurement 3 Intervention That Addresses the Barrier Listed in the Previous Column
	Click to select status	Click to select status		



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Step VIII: Improvement Strategies (interventions for improvement as a result of analysis). Interventions are developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis. Describe the barriers/interventions and provide quantitative details on the processes used to identify the barriers/interventions and to evaluate the effectiveness of the interventions. Do not include intervention planning activities.

This activity will include the following:

- ◆ Pre-baseline interventions.
- ◆ Baseline and remeasurement barriers/interventions.
- ◆ The processes used to identify barriers/interventions and to evaluate the effectiveness of the interventions.

	Click to select status	Click to select status		
	Click to select status	Click to select status		
	Click to select status	Click to select status		