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Behavioral Health and Developmental Disabilities Administration

2017–2018 External Quality Review Technical Report *for* Prepaid Inpatient Health Plans

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HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Purpose and Overview of Report

States with Medicaid managed care delivery systems are required to annually provide an assessment of managed care entities' performance related to the quality of, timeliness of, and access to care and services provided by each entity, as mandated by 42 Code of Federal Regulations (CFR) §438.364. To meet this requirement, the Michigan Department of Health and Human Services (MDHHS) has contracted with Health Services Advisory Group, Inc. (HSAG) to perform the assessment and produce this annual report.

MDHHS administers and oversees the Michigan Medicaid managed care program. The Michigan Medicaid managed care program's managed care entities include 10 MDHHS-contracted prepaid inpatient health plans (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 (DD) supports and services. The PIHPs include the following:

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

Scope of External Quality Review (EQR) Activities

To conduct this assessment, HSAG used the results of mandatory external quality review (EQR) activities, as described in 42 CFR §438.358. The purpose of these activities, in general, is to provide valid and reliable data and information about the PIHPs' performance. For the 2017–2018 assessment, HSAG used findings from the following mandatory EQR activities to derive conclusions and make recommendations about the quality of, timeliness of, and access to care and services provided by each PIHP. More detailed information about each activity is provided in Section 4 of this report.

- **Compliance monitoring:** The 2017–2018 reporting period was the first year of the three-year compliance review cycle. HSAG reviewed 50 percent of federally-mandated standards and their associated State-specific requirements, when applicable.
- **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 each 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 about the project in a methodologically sound manner, allowing real improvements in care and giving confidence in the reported improvements.

High-Level Findings and Conclusions

HSAG used its analyses and evaluations of EQR activity findings from the preceding 12 months to comprehensively assess the performance of the PIHPs in providing quality, timely, and accessible healthcare services to Michigan Medicaid members. For each PIHP reviewed, HSAG provides a summary of its overall key findings, conclusions, and recommendations based on the PIHP's performance. For a more detailed and comprehensive discussion of the strengths, weaknesses, conclusions, and recommendations for each PIHP, please refer to Section 5 of this report.

The overall findings and conclusions for all PIHPs were also compared and analyzed to develop overarching conclusions and recommendations for the Michigan Medicaid managed care program and, specifically, the Medicaid program managed by the Behavioral Health and Developmental Disabilities Administration (BHDDA). For a more detailed discussion of the strengths, weaknesses, conclusions, and recommendations for the Michigan Medicaid managed care program under BHDDA, please refer to Section 6 of this report.

Michigan Behavioral Health and Developmental Disabilities Administration

Through completion of this annual comprehensive EQR, HSAG aggregated and analyzed the performance results for the BHDDA, identifying areas of strength across the program. Through the compliance monitoring review activity, the program demonstrated areas of high performance in managing and adhering to expectations established for the Medicaid program through State and federal requirements. Four of the eight program standards evaluated during the review received PIHP aggregated scores of 90 percent or higher. Additionally, as demonstrated through the performance measure activities, statewide average scores exceeded all corresponding MDHHS-established performance standards related to providing high-quality, assessible, and timely behavioral health and substance use disorder services. Further, through participation in PIPs, the PIHPs are focusing efforts on specific quality outcomes, with an end goal to improve the health outcomes of Michigan Medicaid members.

This annual comprehensive assessment of the program through this EQR also revealed that predominant areas of the program had opportunities for improvement when overall performance of the program was evaluated. Access and availability of services and information, management of the appeal process, and oversight of delegated entities are key areas of opportunity for the BHDDA and the Michigan Medicaid managed care program. Although statewide average performance measure scores exceeded their corresponding MDHHS-established performance standards, with the exception of one, all PIHPs had at least one performance measure rate that fell below the established standard, indicating that network deficiencies or other barriers to receiving timely access to services may exist for some members. In addition to having an adequate network of providers available to see members timely, the PIHPs must also ensure that members have sufficient access to information to help them maximize their benefits, have awareness of available providers, and have knowledge of treatment options. The 2017–2018 compliance monitoring review revealed an opportunity to improve upon the information available and being distributed to Medicaid members receiving behavioral health and substance use disorder services. Additionally, results from the 2017–2018 compliance monitoring review exposed opportunities for the PIHPs to improve their internal appeal processes to ensure that members can challenge the denial of coverage of prescribed services, receive notice of resolution timely, and have an opportunity to request a State fair hearing when the internal PIHP appeal process has been exhausted. Finally, concerns and deficiencies were noted in the Subcontracts and Delegation standard during the compliance monitoring review as well as in other standards, due to PIHPs' lack of oversight of delegated entities in some performance areas.

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

- To further assess member access to and availability of services, MDHHS should consider requiring PIHPs, as applicable, to incorporate efforts for improvement as part of its quality improvement strategy within the quality assessment and performance improvement program (QAPIP) to address performance indicators not meeting the MDHHS standards. The quality improvement plan should be provided to MDHHS at least bi-annually.
- Since statewide average performance consistently meets the 95 percent performance standard for each performance measure indicator, MDHHS could consider increasing the minimum performance standard for each indicator to 98 percent.
- To continue efforts to assess access to care and availability of services provided to Medicaid members, MDHHS should proceed with evaluating its current performance indicators to determine whether revisions should be made.
- To ensure that all materials being distributed to members meet State and federal requirements and include the necessary information to help navigate the Medicaid managed care program, HSAG recommends that MDHHS initiate a workgroup to specifically target member materials, including the customer handbook and the PIHPs' provider directories.
- To ensure that members' rights are not impeded and that members can effectively navigate the grievance and appeal system, PIHPs must have adequate grievance and appeal processes in place. MDHHS should consider prohibiting the PIHPs from delegating grievance and appeal processes.

NorthCare Network

Based on the aggregated results of the 2017–2018 EQR activities, **NorthCare Network** demonstrated both strengths and weaknesses. HSAG concludes and recommends the following:

- **NorthCare Network** received a total compliance score of 87 percent across all standards reviewed during the 2017–2018 compliance monitoring review, comparable to the statewide average.
- **NorthCare Network** scored above 90 percent for the Grievance Process, Subcontracts and Delegation, Provider Network, Access and Availability, and Disclosure of Ownership, Control, and Criminal Convictions standards, indicating strong performance in these areas.
- **NorthCare Network** scored 87 percent, 78 percent, and 83 percent respectively in the Customer Service, Appeals, and Management Information Systems standards, indicating that additional focus is needed in these areas.
- **NorthCare Network**'s performance measure rates were above the MDHHS-established minimum performance standards for 15 of the 19 indicators, indicating strengths in these areas.
- **NorthCare Network**'s minimum performance standards related to timely assessments for new Medicaid members in the DD Adults and Medicaid SA (members diagnosed with a substance use disorder) populations, timely follow-up care for adults discharged from psychiatric inpatient units, and timely substance abuse detox follow-up care were not met, indicating opportunities for improvement in these areas. Additionally, although indicator #3 (timely start of ongoing services) for children diagnosed with a mental illness (MI Children) met the performance standard, performance in this area decreased by more than 2 percentage points from the prior year, indicating that **NorthCare Network** should focus efforts on ensuring that the rate in this area remains stable. Further, a greater than 5 percent increase in readmissions to inpatient psychiatric units from the prior year for child members occurred, suggesting that focus on this measure should be heightened to ensure that the rate does not continue to increase.
- **NorthCare Network** designed a scientifically sound study related to *Follow-Up After Hospitalization for Mental Illness Within Seven Days of Discharge for Members Ages 6 Years and Older*, which was supported by key research principles, meeting all requirements of the PIP Design stage.

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **NorthCare Network** to members, HSAG recommends that **NorthCare Network** develop a quality improvement strategy to address the performance indicators requiring improvement, listed in Section 5. **NorthCare Network** should incorporate these improvement efforts in its quality improvement strategy within the QAPIP to prioritize areas of low performance. The strategy should include data trends and root cause analyses with actionable and measurable goals, benchmarks, and interventions, addressing development and implementation of mechanisms for sustaining and spreading improvement in health outcomes, member satisfaction, and other focus areas. **NorthCare Network** should also develop comprehensive and effective plans of action to mitigate any deficiencies identified during the 2017–2018 compliance monitoring review. Further, **NorthCare Network** should take proactive steps to ensure a successful PIP, including identifying any barriers to success and subsequently implementing interventions to address those barriers timely.

Northern Michigan Regional Entity

Based on the aggregated results of the 2017–2018 EQR activities, **Northern Michigan Regional Entity** demonstrated both strengths and weaknesses. HSAG concludes and recommends the following:

- **Northern Michigan Regional Entity** received a total compliance score of 86 percent across all standards reviewed during the 2017–2018 compliance monitoring review, which was slightly below the statewide average.
- **Northern Michigan Regional Entity** scored 90 percent or above in the Customer Service, Subcontracts and Delegation, Provider Network, Disclosure of Ownership, Control, and Criminal Convictions, and Management Information Systems standards, indicating strong performance in these areas.
- **Northern Michigan Regional Entity** scored 81 percent, 63 percent, and 81 percent respectively in the Grievance Process, Access and Availability, and Appeals standards, indicating that additional focus is needed in these areas.
- **Northern Michigan Regional Entity**'s performance measure rates were above the MDHHS-established minimum performance standards for 14 of the 19 indicators, indicating strengths in these areas.
- **Northern Michigan Regional Entity**'s minimum performance standards related to timely assessments for DD Children and ongoing services for new Medicaid members in DD Adults populations, timely follow-up care for children and adults discharged from psychiatric inpatient units, and timely substance abuse detox follow-up care were not met, indicating opportunities for improvement in these areas. Further, an increase of greater than 5 percent occurred in readmissions to inpatient psychiatric units from the prior year for child members, suggesting that focus should be heightened related to this measure to ensure that the rate does not continue to increase.
- **Northern Michigan Regional Entity** designed a scientifically sound study related to *Follow-Up Care for Children Prescribed ADHD Medication*, which was supported by key research principles, meeting all requirements of the PIP Design stage.

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Northern Michigan Regional Entity** to members, HSAG recommends that **Northern Michigan Regional Entity** develop a quality improvement strategy to address the performance indicators requiring improvement, which are listed in Section 5. **Northern Michigan Regional Entity** should incorporate these improvement efforts in its quality improvement strategy within the QAPIP to prioritize areas of low performance. The strategy should include data trends and root cause analyses with actionable and measurable goals, benchmarks, and interventions, addressing development and implementation of mechanisms for sustaining and spreading improvement in health outcomes, member satisfaction, and other improvement effort targets. **Northern Michigan Regional Entity** should also develop comprehensive and effective plans of action to mitigate any deficiencies identified during the 2017–2018 compliance monitoring review. Further, **Northern Michigan Regional Entity** should take proactive steps to ensure a successful PIP, including identifying any barriers to success and subsequently implementing interventions to address those barriers timely.

Lakeshore Regional Entity

Based on the aggregated results of the 2017–2018 EQR activities, **Lakeshore Regional Entity** demonstrated both strengths and weaknesses. HSAG concludes the following:

- **Lakeshore Regional Entity** received a total compliance score of 79 percent across all standards reviewed during the 2017–2018 compliance monitoring review, 8 percent below the statewide average.
- **Lakeshore Regional Entity** scored 90 percent or above in the Grievance Process, Provider Network, and Disclosure of Ownership, Control, and Criminal Convictions standards, indicating strong performance in these areas.
- **Lakeshore Regional Entity** scored 85 percent, 82 percent, 63 percent, 61 percent, and 83 percent respectively in the Customer Service, Subcontracts and Delegation, Access and Availability, Appeals, and Management Information Systems standards, indicating that additional focus is needed in these areas.
- **Lakeshore Regional Entity**'s rates were deemed *Not Reported* for all 19 measure indicators with a corresponding MDHHS-established minimum performance standard, indicating opportunities for improvement in all measures.
- **Lakeshore Regional Entity** designed a scientifically sound study related to *Diabetes Monitoring for People With Diabetes and Schizophrenia*, which was supported by key research principles, meeting all requirements of the PIP Design stage.

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Lakeshore Regional Entity** to members, HSAG recommends that **Lakeshore Regional Entity** develop a quality improvement strategy to address the performance indicators requiring improvement, listed in Section 5. **Lakeshore Regional Entity** should incorporate these improvement efforts in its quality improvement strategy within the QAPIP to prioritize areas of low performance. The strategy should include data trends and root cause analyses with actionable and measurable goals, benchmarks, and interventions, addressing development and implementation of mechanisms for sustaining and spreading improvement in health outcomes, member satisfaction, and other focus areas. **Lakeshore Regional Entity** should also develop comprehensive and effective plans of action to mitigate any deficiencies identified during the 2017–2018 compliance monitoring review. Further, **Lakeshore Regional Entity** should take proactive steps to ensure a successful PIP, including identifying any barriers to success and subsequently implementing interventions to address those barriers timely.

Southwest Michigan Behavioral Health

Based on the aggregated results of the 2017–2018 EQR activities, **Southwest Michigan Behavioral Health** demonstrated both strengths and weaknesses. HSAG concludes the following:

- **Southwest Michigan Behavioral Health** received a total compliance score of 89 percent across all standards reviewed during the 2017–2018 compliance monitoring review, which was slightly above the statewide average.
- **Southwest Michigan Behavioral Health** scored 90 percent or above in Subcontracts and Delegation, Provider Network, Disclosure of Ownership, Control, and Criminal Convictions, and Management Information Systems standards, indicating strong performance in these areas.
- **Southwest Michigan Behavioral Health** scored 87 percent, 81 percent, 89 percent, and 87 percent respectively in the Customer Service, Grievance Process, Access and Availability, and Appeals standards, indicating that additional focus is needed in these areas.
- **Southwest Michigan Behavioral Health**'s performance measure rates were above the MDHHS-established minimum performance standards for all 19 indicators, indicating strengths across all performance measures. Additionally, while slight decreases in performance from the prior year existed for several indicators, the decreases were each less than 2 percentage points, indicating stable performance.
- **Southwest Michigan Behavioral Health** designed a scientifically sound study related to *Improving Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using An Antipsychotic Medication*, which was supported by key research principles, meeting all requirements of the PIP Design stage.

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Southwest Michigan Behavioral Health** to members, HSAG recommends that **Southwest Michigan Behavioral Health** develop a quality improvement strategy to ensure that all performance indicators remain stable. **Southwest Michigan Behavioral Health** should incorporate these improvement efforts in its quality improvement strategy within the QAPIP to prioritize areas of performance. The strategy should include data trends and root cause analyses with actionable and measurable goals, benchmarks, and interventions, addressing development and implementation of mechanisms for sustaining and spreading improvement in health outcomes, member satisfaction, and other focus areas. **Southwest Michigan Behavioral Health** should also develop comprehensive and effective plans of action to mitigate any deficiencies identified during the 2017–2018 compliance monitoring review. Further, **Southwest Michigan Behavioral Health** should take proactive steps to ensure a successful PIP, including identifying any barriers to success and subsequently implementing interventions to address those barriers timely.

Mid-State Health Network

Based on the aggregated results of the 2017–2018 EQR activities, **Mid-State Health Network** demonstrated both strengths and weaknesses. HSAG concludes the following:

- **Mid-State Health Network** received a total compliance score of 93 percent across all standards reviewed during the 2017–2018 compliance monitoring review; this was above the statewide average. Additionally, **Mid-State Health Network** and another PIHP were the highest-performing plans.
- **Mid-State Health Network** scored 90 percent or above in the Grievance Process, Subcontracts and Delegation, Provider Network, Access and Availability, Appeals, Disclosure of Ownership, Control, and Criminal Convictions, and Management Information Systems standards, indicating strong performance in these areas.
- **Mid-State Health Network** scored 87 percent in the Customer Service standard, indicating that additional focus is needed in this area.
- **Mid-State Health Network**'s performance measure rates were above the MDHHS-established minimum performance standards for 18 of the 19 indicators, indicating strengths in these areas.
- **Mid-State Health Network**'s minimum performance standard related to timely ongoing services for DD Children was not met, indicating an opportunity for improvement in this area. Additionally, while the performance standards were met for indicator #3 (timely assessments for ongoing services) for MI Children and indicator #4b (timely follow-up care after discharge from a substance abuse detox unit), performance in these areas decreased by more than 2 percentage points from the prior year, indicating that **Mid-State Health Network** should focus efforts on ensuring that the rates in these areas remain stable.
- **Mid-State Health Network** designed a scientifically sound study related to *Patients With Schizophrenia and Diabetes Who Had an HbA1c and LDL-C Test*, which was supported by key research principles, meeting all requirements of the PIP Design stage.

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Mid-State Health Network** to members, HSAG recommends that **Mid-State Health Network** develop a quality improvement strategy to address the performance indicators requiring improvement, which are listed in Section 5. **Mid-State Health Network** should incorporate these improvement efforts in its quality improvement strategy within the QAPIP to prioritize areas of low performance. The strategy should include data trends and root cause analyses with actionable and measurable goals, benchmarks, and interventions, addressing development and implementation of mechanisms for sustaining and spreading improvement in health outcomes, member satisfaction, and other focus areas. **Mid-State Health Network** should also develop comprehensive and effective plans of action to mitigate any deficiencies identified during the 2017–2018 compliance monitoring review. Further, **Mid-State Health Network** should take proactive steps to ensure a successful PIP, including identifying any barriers to success and subsequently implementing interventions to address those barriers timely.

CMH Partnership of Southeast Michigan

Based on the aggregated results of the 2017–2018 EQR activities, **CMH Partnership of Southeast Michigan** demonstrated both strengths and weaknesses. HSAG concludes the following:

- **CMH Partnership of Southeast Michigan** received, across all standards reviewed during the 2017–2018 compliance monitoring review, a total compliance score of 91 percent, which was higher than the statewide average. Additionally, **CMH Partnership of Southeast Michigan** was one of the top three highest-performing plans.
- **CMH Partnership of Southeast Michigan** scored 90 percent or above in the Grievance Process, Subcontracts and Delegation, Disclosure of Ownership, Control, and Criminal Convictions, and Management Information Systems standards, indicating strong performance in these areas.
- **CMH Partnership of Southeast Michigan** scored 87 percent, 83 percent, 89 percent, and 87 percent respectively in the Customer Service, Provider Network, Access and Availability, and Appeals standards, indicating that additional focus is needed in these areas.
- **CMH Partnership of Southeast Michigan**'s performance measure rates were above the MDHHS-established minimum performance standards for 18 of the 19 indicators, indicating strengths in these areas.
- **CMH Partnership of Southeast Michigan**'s minimum performance standard related to timely follow-up care for substance abuse detox was not met, indicating an opportunity for improvement in this area. Additionally, its percentage of child members being readmitted to inpatient psychiatric units within 30 days of discharge increased by more than 10 percentage points from the prior year.
- **CMH Partnership of Southeast Michigan** designed a scientifically sound study related to *Patients With Schizophrenia and Diabetes Who Had an HbA1c and LDL-C Test*, which was supported by key research principles, meeting all requirements of the PIP Design stage.

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **CMH Partnership of Southeast Michigan** to members, HSAG recommends that **CMH Partnership of Southeast Michigan** develop a quality improvement strategy to address the performance indicators requiring improvement, which are listed in Section 5. **CMH Partnership of Southeast Michigan** should incorporate these improvement efforts in its quality improvement strategy within the QAPIP to prioritize areas of low performance. The strategy should include data trends and root cause analyses with actionable and measurable goals, benchmarks, and interventions, addressing development and implementation of mechanisms for sustaining and spreading improvement in health outcomes, member satisfaction, and other focus areas. **CMH Partnership of Southeast Michigan** should also develop comprehensive and effective plans of action to mitigate any deficiencies identified during the 2017–2018 compliance monitoring review. Further, **CMH Partnership of Southeast Michigan** should take proactive steps to ensure a successful PIP, including identifying any barriers to success and subsequently implementing interventions to address those barriers timely.

Detroit Wayne Mental Health Authority

Based on the aggregated results of the 2017–2018 EQR activities, **Detroit Wayne Mental Health Authority** demonstrated both strengths and weaknesses. HSAG concludes and recommends the following:

- **Detroit Wayne Mental Health Authority** received a total compliance score of 89 percent across all standards reviewed during the 2017–2018 compliance monitoring review, which was slightly higher than the statewide average.
- **Detroit Wayne Mental Health Authority** scored 90 percent or above in the Grievance Process, Provider Network, and Disclosure of Ownership, Control, and Criminal Convictions standards, indicating strong performance in these areas.
- **Detroit Wayne Mental Health Authority** scored 87 percent, 82 percent, 89 percent, 83 percent, and 75 percent respectively in the Customer Service, Subcontracts and Delegation, Access and Availability, Appeals, and Management Information Systems standards, indicating that additional focus is needed in these areas.
- **Detroit Wayne Mental Health Authority**'s rates were deemed *Not Reported* for all 19 measure indicators with a corresponding MDHHS-established minimum performance standard, indicating opportunities for improvement in all measures.
- **Detroit Wayne Mental Health Authority** designed a scientifically sound study related to *Improving Diabetes Screening Rates for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*, which was supported by key research principles, meeting all requirements of the PIP Design stage.

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Detroit Wayne Mental Health Authority** to members, HSAG recommends that **Detroit Wayne Mental Health Authority** develop a quality improvement strategy to address the performance indicators requiring improvement, which are listed in Section 5. **Detroit Wayne Mental Health Authority** should incorporate these improvement efforts in its quality improvement strategy within the QAPIP to prioritize areas of low performance. The strategy should include data trends and root cause analyses with actionable and measurable goals, benchmarks, and interventions, addressing development and implementation of mechanisms for sustaining and spreading improvement in health outcomes, member satisfaction, and other focus areas. **Detroit Wayne Mental Health Authority** should also develop comprehensive and effective plans of action to mitigate any deficiencies identified during the 2017–2018 compliance monitoring review. Further, **Detroit Wayne Mental Health Authority** should take proactive steps to ensure a successful PIP, including identifying any barriers to success and subsequently implementing interventions to address those barriers timely.

Oakland County CMH Authority

Based on the aggregated results of the 2017–2018 EQR activities, **Oakland County CMH Authority** demonstrated both strengths and weaknesses. HSAG concludes the following:

- **Oakland County CMH Authority** received a total compliance score of 86 percent across all standards reviewed during the 2017–2018 compliance monitoring review, which was slightly below the statewide average.
- **Oakland County CMH Authority** scored 100 percent in the Disclosure of Ownership, Control, and Criminal Convictions standard, indicating strong performance in this area.
- **Oakland County CMH Authority** scored 82 percent, 88 percent, 82 percent, 83 percent, 89 percent, 85 percent, and 83 percent respectively in the Customer Service, Grievance Process, Subcontracts and Delegation, Provider Network, Access and Availability, Appeals, and Management Information Systems standards, indicating that additional focus is needed in these areas.
- **Oakland County CMH Authority**'s performance measure rates were above the MDHHS-established minimum performance standards for 17 of the 19 indicators, indicating strengths in these areas.
- **Oakland County CMH Authority**'s minimum performance standards related to timely pre-admission screenings for psychiatric care for members in the Children and Adults populations were not met, indicating opportunities for improvement in these areas. Additionally, while the performance standard was met for indicator #2 (timely assessment for services) for DD Children, performance in this area decreased by more than 2 percentage points from the prior year, indicating that **Oakland County CMH Authority** should focus efforts on ensuring that the rate in this area remains stable. Further, a greater than 5 percent increase in readmissions to inpatient psychiatric units from the prior year for child members occurred, suggesting that heightened focus on this measure should occur to ensure that the rate does not continue to increase.
- **Oakland County CMH Authority** designed a scientifically sound study related to *Improving Diabetes Screening Rates for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*, which was supported by key research principles, meeting all requirements of the PIP Design stage.

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Oakland County CMH Authority** to members, HSAG recommends that **Oakland County CMH Authority** develop a quality improvement strategy to address the performance indicators requiring improvement, which are listed in Section 5. **Oakland County CMH Authority** should incorporate these improvement efforts in its quality improvement strategy within the QAPIP to prioritize areas of low performance. The strategy should include data trends and root cause analyses with actionable and measurable goals, benchmarks, and interventions, addressing development and implementation of mechanisms for sustaining and spreading improvement in health outcomes, member satisfaction, and other focus areas. **Oakland County CMH Authority** should also develop comprehensive and effective plans of action to mitigate any deficiencies identified during the 2017–2018 compliance monitoring review. Further, **Oakland County CMH Authority** should take proactive steps to ensure a successful PIP, including identifying any barriers to success and subsequently implementing interventions to address those barriers timely.

Macomb County CMH Services

Based on the aggregated results of the 2017–2018 EQR activities, **Macomb County CMH Services** demonstrated both strengths and weaknesses. HSAG concludes the following:

- **Macomb County CMH Services** received a total compliance score of 93 percent across all standards reviewed during the 2017–2018 compliance monitoring review, which was above the statewide average. Additionally, **Macomb County CMH Services** and another PIHP were the highest performing plans.
- **Macomb County CMH Services** scored 90 percent or above for each of the Grievance Process; Provider Network; Appeals; Disclosure of Ownership, Control, and Criminal Convictions; and Management Information Systems standards, indicating strong performance in these areas.
- **Macomb County CMH Services** scored 87 percent, 55 percent, and 84 percent respectively in the Customer Service, Subcontracts and Delegation, and Access and Availability standards, indicating that additional focus is needed in these areas.
- **Macomb County CMH Services**' performance measure rates were above the MDHHS-established minimum performance standards for 12 of the 19 indicators, indicating strengths in these areas.
- **Macomb County CMH Services**' minimum performance standards related to timely assessments for MI Children, DD Children, and DD Adults and ongoing services for new Medicaid members in the DD Children populations; timely follow-up care for children and adults following psychiatric inpatient discharge; and reducing inpatient psychiatric readmissions for adults were not met, indicating opportunities for improvement in these areas.
- **Macomb County CMH Services** designed a scientifically sound study related to *Reducing Acute Inpatient Recidivism for Adults With Serious Mental Illness*, which was supported by key research principles, meeting all requirements of the PIP Design stage.

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Macomb County CMH Services** to members, HSAG recommends that **Macomb County CMH Services** develop a quality improvement strategy to address the performance indicators requiring improvement, which are listed in Section 5. **Macomb County CMH Services** should incorporate these improvement efforts in its quality improvement strategy within the QAPIP to prioritize areas of low performance. The strategy should include data trends and root cause analyses with actionable and measurable goals, benchmarks, and interventions, addressing development and implementation of mechanisms for sustaining and spreading improvement in health outcomes, member satisfaction, and other focus areas. **Macomb County CMH Services** should also develop comprehensive and effective plans of action to mitigate any deficiencies identified during the 2017–2018 compliance monitoring review. Further, **Macomb County CMH Services** should take proactive steps to ensure a successful PIP, including identifying any barriers to success and subsequently implementing interventions to address those barriers timely.

Region 10 PIHP

Based on the aggregated results of the 2017–2018 EQR activities, **Region 10 PIHP** demonstrated both strengths and weaknesses. HSAG concludes and recommends the following:

- **Region 10 PIHP** received a total compliance score of 75 percent across all standards reviewed during the 2017–2018 compliance monitoring review, which was 12 percentage points below the statewide average.
- **Region 10 PIHP** scored 90 percent or above in the Provider Network; Access and Availability; and Disclosure of Ownership, Control, and Criminal Convictions standards, indicating strong performance in these areas.
- **Region 10 PIHP** scored 87 percent, 77 percent, 82 percent, 43 percent, and 83 percent respectively in the Customer Service, Grievance Process, Subcontracts and Delegation, Appeals, and Management Information Systems standards, indicating that additional focus is needed in these areas.
- **Region 10 PIHP**'s performance measure rates were above the MDHHS-established minimum performance standards for 18 of the 19 indicators, indicating strengths in these areas.
- **Region 10 PIHP**'s minimum performance standard 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* for adult members was not met, indicating opportunities for improvement in reducing inpatient psychiatric readmissions for adults. Additionally, although indicator #4a (timely follow-up for care after psychiatric inpatient unit discharge) for the child population met the performance standard, performance in this area decreased by more than 2 percentage points from the prior year, indicating that **Region 10 PIHP** should focus efforts on ensuring that the rate in this area remains stable.
- **Region 10 PIHP** designed a scientifically sound study related to *Medical Assistance for Tobacco Use Cessation*, which was supported by key research principles, meeting all requirements of the PIP Design stage.

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Region 10 PIHP** to members, HSAG recommends that **Region 10 PIHP** develop a quality improvement strategy to address the performance indicators requiring improvement, which are listed in Section 5. **Region 10 PIHP** should incorporate these improvement efforts in its quality improvement strategy within the QAPIP to prioritize areas of low performance. The strategy should include data trends and root cause analyses with actionable and measurable goals, benchmarks, and interventions, addressing development and implementation of mechanisms for sustaining and spreading improvement in health outcomes, member satisfaction, and other focus areas. **Region 10 PIHP** should also develop comprehensive and effective plans of action to mitigate any deficiencies identified during the 2017–2018 compliance monitoring review. Further, **Region 10 PIHP** should take proactive steps to ensure a successful PIP, including identifying any barriers to success and subsequently implementing interventions to address those barriers timely.

2. Introduction to the Annual Technical Report

Purpose of Report

States that provide Medicaid services through contracts with PIHPs are required to conduct EQR activities of the PIHPs and to ensure that the results of those activities are used to perform an external, independent assessment and to produce an annual report. The annual assessment evaluates each PIHP's performance related to the quality of, timeliness of, and access to the care and services it provides. To meet the requirement to conduct this annual evaluation and produce this report of results, MDHHS contracted with HSAG as its external quality review organization (EQRO).

Organizational Structure of Report

As mandated by CFR §438.364 and in compliance with the Centers for Medicare & Medicaid Services' (CMS') EQR protocols and the External Quality Review Toolkit for States, this technical report:

- Describes how data from EQR activities conducted in accordance with §438.358 were aggregated and analyzed by HSAG.
- Describes the scope of the EQR activities.
- Assesses each PIHP's strengths and weaknesses and presents conclusions drawn about the quality of, timeliness of, and access to care furnished by the PIHPs.
- Includes recommendations for improving the quality of, timeliness of, and access to care and services furnished by the PIHPs, including recommendations for each individual PIHP and recommendations for MDHHS to target Michigan's Quality Strategy to improve the quality of care provided by the Michigan Medicaid managed care program as a whole.
- Contains methodological and comparative information for all PIHPs.
- Assesses the degree to which each PIHP has addressed the recommendations for quality improvement made by the EQRO during the 2016–2017 EQR.

This report is composed of six sections: Executive Summary, Introduction to the Annual Technical Report, Overview of the Michigan Medicaid Managed Care Program, External Quality Review Activities, Assessment of PIHP Performance, and PIHP Comparative Information With Recommendations for Michigan Department of Health and Human Services (MDHHS). This report also includes summary tables of EQR activity results and review tools for the 2017–2018 external quality review activities.

Section 1—Executive Summary

The Executive Summary section presents a high-level overview of the EQR activities, conclusions, and recommendations for the MDHHS managed care program and the PIHPs.

Section 2—Introduction to the Annual Technical Report

The Introduction section provides information about the purpose, contents, and organization of the annual technical report.

Section 3—Overview of Michigan Medicaid Managed Care Program

The Overview of the Michigan Medicaid managed care program section gives a description of the Michigan Medicaid managed care program; brief descriptions of each of the PIHPs that contract with MDHHS to provide services to members; and a brief overview of Michigan's Quality Strategy and goals for the health of Michigan's Medicaid population.

Section 4—External Quality Review Activities

The EQR Activities section presents information about each of the EQR activities conducted, including the activity's objectives, technical methods of data collection and analysis, a description of the data obtained, and the time period under review.

Section 5—Assessment of PIHP Performance

The Assessment of PIHP Performance section presents the PIHP-specific results for each of the EQR activities conducted during the 2017–2018 review period.

Section 6—PIHP Comparative Information With Recommendations for Michigan Department of Health and Human Services (MDHHS)

The PIHP Comparative Information With Recommendations for MDHHS section presents summarized data and comparative information about the PIHPs' performance. This section also identifies areas in which MDHHS could leverage or modify Michigan's Quality Strategy to promote improvement based on PIHP performance.

3. Overview of Michigan Medicaid Managed Care Program

Managed Care in Michigan and Overview of PIHPs

The Michigan Department of Health and Human Services (MDHHS) oversees the health insurance programs for the State of Michigan. Under approval granted by CMS, MDHHS operates a Section 1915(b) Medicaid Managed Specialty Services and Support Program Waiver. Under this waiver, selected Medicaid state plan specialty services related to mental health and developmental disability services, as well as certain covered substance abuse services, have been carved out from Medicaid primary physical healthcare plans and arrangements. The 1915(b) Specialty Services Waiver Program operates in conjunction with Michigan's existing 1915(c) Habilitation Supports Waiver for persons with developmental disabilities. Additionally, CMS has approved an 1115 Demonstration project, the Healthy Michigan Plan, which provides healthcare coverage for adults who become eligible for Medicaid under section 1902(2) (10)(A)(i)(VIII) of the Social Security Act. Such arrangements have been designated as "Concurrent 1915(b)/(c)" Programs by CMS. In Michigan, the Concurrent 1915(b)/(c) Programs and the Healthy Michigan Plan are managed on a shared-risk basis by specialty Prepaid Inpatient Health Plans (PIHPs), selected through an Application for Participation process. Further, under the approval of the Substance Abuse and Mental Health Services Administration (SAMHSA), MDHHS operates a substance use disorder (SUD) prevention and treatment program under the SUD Community Grant.

MDHHS selected 10 PIHPs to manage the concurrent 1915(b)/(c) programs, the Healthy Michigan Plan, and SUD Community Grant programs. The MDHHS-contracted PIHPs partner with CMHSPs and local recovery-oriented systems of care to provide a comprehensive array of specialty mental health and substance abuse services and supports to members in their designated service areas. Member populations in these programs are commonly referenced throughout this report using the following abbreviations.

- MI Children—Children diagnosed with mental illness
- MI Adults—Adults diagnosed with mental illness
- DD Children—Children with developmental disabilities
- DD Adults—Adults with developmental disabilities
- MI/DD Adults—Adults dually diagnosed with mental illness and developmental disabilities
- Medicaid SA—Adults diagnosed with substance abuse disorder

Overview of PIHPs

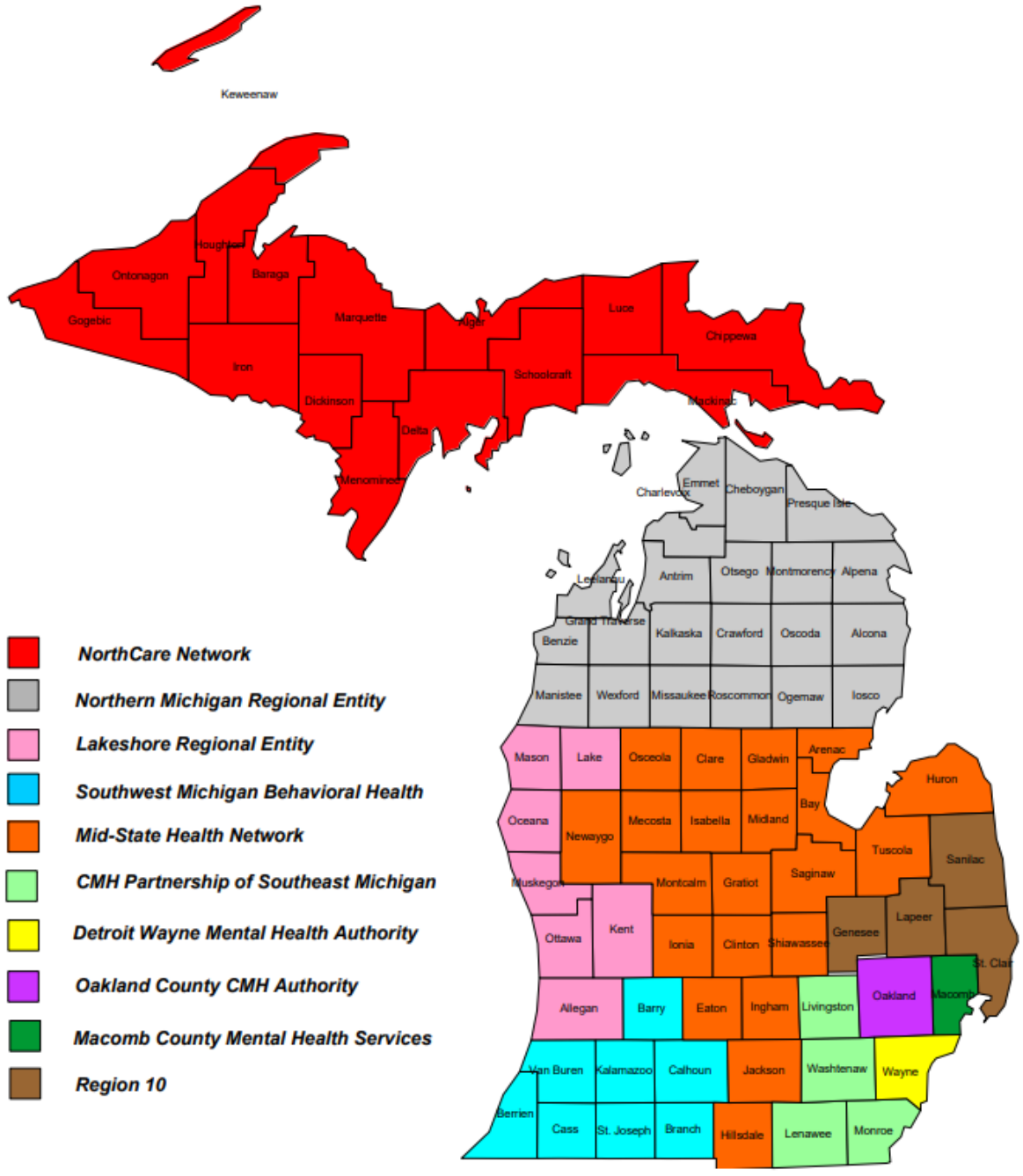
During the 2017–2018 review period, MDHHS contracted with 10 qualified PIHPs. Table 3-1 provides a profile for each PIHP. Each PIHP is responsible for managing one region of the State, and each region may comprise a single county or multiple counties. Figure 3-1 shows a visual representation of the counties included in each of the 10 PIHP regions.

Table 3-1—PIHP Profiles

PIHP	Operating Region	Affiliated CMHSP(s)	Medicaid Members Served*
NorthCare Network	Region 1	Pathways CMH, Copper Country CMH, Hiawatha CMH, Northpointe CMH, Gogebic CMH	7,323
Northern Michigan Regional Entity	Region 2	AuSable CMH, Manistee-Benzie CMH, North Country CMH, Northern Lakes CMH, Northeast CMH	16,013
Lakeshore Regional Entity	Region 3	Allegan CMH, Muskegon CMH, Network 180, Ottawa CMH, West MI CMH	25,686
Southwest Michigan Behavioral Health	Region 4	Barry CMH, Berrien CMH, Kalamazoo CMH, Pines CMH, St. Joseph CMH, Summit Pointe CMH, Van Buren CMH, Woodlands CMH	24,896
Mid-State Health Network	Region 5	Bay-Arenac CMH, CMH for Central MI, Clinton-Eaton-Ingham CMH, Gratiot CMH, Huron CMH, Ionia CMH, Lifeways CMH, Montcalm CMH, Newaygo CMH, Saginaw CMH, Shiawassee CMH, Tuscola CMH	48,772
CMH Partnership of Southeast Michigan	Region 6	Washtenaw CMH, Lenawee CMH, Livingston CMH, Monroe CMH	12,688
Detroit Wayne Mental Health Authority	Region 7	Detroit-Wayne CMH	71,627
Oakland County CMH Authority	Region 8	Oakland CMH	20,133
Macomb County CMH Services	Region 9	Macomb CMH	16,286
Region 10 PIHP	Region 10	Genesee CMH, Lapeer CMH, Sanilac CMH, St. Clair CMH	20,805

* Unique number of members served, Fiscal Year 2017. Total count includes traditional Medicaid, Healthy Michigan, and MIChild populations.

Figure 3-1—Michigan PIHP Regions



Quality Strategy

To carry out its mission to provide opportunities, services, and programs that promote a healthy, safe, and stable environment for Michigan residents to be self-sufficient, MDHHS has established six strategic priority areas. Table 3-2 outlines the MDHHS strategic priorities.

Table 3-2—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.

The 10 PIHPs are instrumental in improving health and quality of care for the Michigan Medicaid population, which includes participating in MDHHS' efforts to achieve its goals and focus improvement efforts on the afore-mentioned priorities. To assist in these efforts, each PIHP has a quality assessment and performance improvement program (QAPIP) that includes the following components:

- Active participation of providers and members in the QAPIP processes.
- Performance measurement using standardized indicators in the areas of access, efficiency, and outcomes.
- Performance improvement projects that achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical and non-clinical services that can be expected to have a beneficial effect on health outcomes and member satisfaction.
- Process for the review and follow-up of sentinel events and other critical incidents and events that put members at risk of harm.
- Periodic quantitative and qualitative assessments of member experiences with its services.
- Process for the adoption, development, implementation, and continuous monitoring and evaluation of practice guidelines when there are nationally accepted, or mutually agreed-upon (by MDHHS and the PIHPs) clinical standards, evidence-based practices, practice-based evidence, best practices, and promising practices relevant to the members served.

- Written procedures to determine whether physicians and other healthcare professionals, who are licensed by the State and who are employees of the PIHP or under contract to the PIHP, are qualified to perform services.
- Process for verifying whether services reimbursed by Medicaid were actually furnished to members by affiliates (as applicable), providers, and subcontractors.
- Written utilization management program description that includes, at a minimum, procedures to evaluate medical necessity, criteria used, information sources, and the process used to review and approve the provision of medical services.
- Annual monitoring of provider network(s), affiliates, and subcontractors.

Additionally, MDHHS emphasizes continuous evaluation of each PIHP's oversight of vulnerable members to determine opportunities for improving oversight of their care and outcomes. MDHHS continues to work with the PIHPs to develop uniform methods for targeted monitoring of vulnerable members. Further, MDHHS requires the PIHPs to annually analyze whether improvements have occurred in quality of healthcare and services for members as a result of quality assessment and improvement activities and implemented interventions.

In addition to the QAPIP activities, MDHHS has implemented several initiatives that focus on quality improvement. Examples of these initiatives include:

- **Performance Bonus Integration of Behavioral Health and Physical Health Services—**In an effort to ensure collaboration and integration among the PIHPs and Medicaid Health Plans, MDHHS developed joint expectations for both entities. These expectations include implementing joint care management processes and working collaboratively to meet set standards for follow-up after hospitalization for mental illness within 30 days of discharge.
- **Recovery-Oriented Systems of Care Recovery—**In order to move toward a recovery-based system of services, MDHHS worked with the Recover- Oriented System of Care (ROSC) Transformation Steering Committee (TSC) to develop expectations for systems change. These expectations are included in a formal document called *Transformation Steering Committee, Recovery- Oriented System of Care Recovery Policy and Practice Advisory*. The recovery-oriented system of care supports an individual's journey toward recovery and wellness by creating and sustaining networks of formal and informal services and supports. The ROSC TSC created guiding principles of recovery and established expectations to guide organizations, including the PIHPs, in creating an environment and system of behavioral health services and supports that foster recovery and create a recovery-oriented system of care.
- **National Core Indicators Program—**Since the 2011–2012 measurement period, MDHHS has voluntarily participated in the National Core Indicators (NCI) program. The NCI program is an effort by State developmental disability agencies to track performance using a standardized set of member and family/guardian surveys with nationally validated measures. MDHHS uses the information gathered through the surveys to assess the outcomes of services for individuals in the areas of employment, rights, service planning, community inclusion, choice, health, and safety. The NCI program is coordinated by the National Association of State Directors of Developmental Disabilities Services and the Human Services Research Institute.

Compliance Monitoring

Activity 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 set forth in 42 CFR §438—Managed Care Subpart D and the quality assessment and performance improvement requirements described in 42 CFR §438.330. To complete this requirement, HSAG, through its EQRO contract with MDHHS, performed compliance monitoring reviews of the 10 PIHPs with which the State contracts.

The review standards are separated into 17 performance areas. MDHHS has elected to review the full set of standards over two review periods, as displayed in Table 4-1.

Table 4-1—Division of Standards Over Review Periods

2017–2018	2018–2019
Standard VI—Customer Service	Standard I—Quality Assessment Performance Improvement Program (QAPIP) Plan and Structure
Standard VII—Grievance Process	Standard II—Performance Measurement and Improvement
Standard IX—Subcontracts and Delegation	Standard III—Practice Guidelines
Standard X—Provider Network	Standard IV—Staff Qualifications and Training
Standard XII—Access and Availability	Standard V—Utilization Management
Standard XIV—Appeals	Standard VIII—Enrollees' Rights and Protections
Standard XV—Disclosure of Ownership, Control, and Criminal Convictions	Standard XI—Credentialing
Standard XVII—Management Information Systems	Standard XIII—Coordination of Care
	Standard XVI—Confidentiality of Health Information

This report presents the results of the 2017–2018 review period. MDHHS and the individual PIHPs use the information and findings from the compliance monitoring 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.

Technical Methods of Data Collection and Analysis

Prior to beginning compliance reviews of the PIHPs, HSAG developed standardized tools for use during the reviews. The content of the tools was based on applicable federal regulations and the requirements set forth in the contractual agreement between MDHHS and the PIHPs. The review processes and scoring methodology used by HSAG in evaluating the PIHPs' compliance were consistent with CMS' publication, *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[4-1]

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

Pre-on-site review activities included:

- Scheduling the on-site review.
- Developing the compliance monitoring review tools (*Documentation Request and Evaluation Tool*, *Desk Audit Form*, *Customer Handbook Checklist*, *Provider Network Checklist*, *Grievance Audit Tool*, and *Appeal Audit Tool*).
- Preparing for and forwarding to each PIHP the compliance monitoring review tools and instructions for submitting the requested documentation.
- Hosting a training webinar for all PIHPs in preparation for the review.
- Generating the sample selection for the on-site grievance and appeal case file reviews.
- Conducting a desk review of all completed review tools and supporting documentation submitted by the PIHP. The desk review enabled HSAG reviewers to increase their knowledge and understanding of the PIHP's operations, identify areas needing clarification, and begin compiling information before the on-site review.
- Preparing and forwarding the on-site review agenda to the PIHP.

On-site review activities included:

- An opening session, with introductions and a review of the agenda for and logistics of HSAG's two-day review activities.
- A review of 10 grievance and 10 appeal case files.[4-2]
- A review of the online customer handbook and provider directory.
- Interview sessions with the PIHP's key administrative and program staff members.
- A closing session during which HSAG reviewed and summarized preliminary findings.

[4-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-1.pdf. Accessed on: November 27, 2018.

[4-2] For PIHPs with fewer than 10 grievance or appeal case files during the review period, HSAG reviewed the total number of cases available.

Reviewers used the compliance monitoring review tools to document findings regarding PIHP compliance with the standards. Based on the evaluation of findings, reviewers noted compliance with each element. The *Documentation Request and Evaluation Tool* listed the score for each element evaluated.

HSAG evaluated and scored each element addressed in the compliance monitoring review as *Met* (*M*), *Not Met* (*NM*), or *Not Applicable* (*NA*). The overall score for each of the eight standards was determined by totaling the number of *Met* (1 point), *Not Met* (0 points), and *Not Applicable* (no value) elements, then dividing the summed score by the total number of applicable elements for that standard. The scoring methodology is displayed in Table 4-2.

Table 4-2—Scoring Methodology[4-3]

Compliance Designation	Point Value	Definition
Met	Value = 1 point	***Met*** indicates full compliance defined as *all* of the following: • All documentation and data sources reviewed, including PIHP data and documentation, MDHHS data and documentation, file reviews, and systems demonstrations for a regulatory provision or component thereof are present and provide supportive evidence of congruence. • Staff members provide to reviewers responses consistent with one another, with the data and documentation reviewed, and with the regulatory provisions.
Not Met	Value = 0 points	***Not Met*** indicates noncompliance defined as *one or more* of the following: • Documentation and data sources are not present and/or do not provide supportive evidence of congruence with the regulatory provision. • Staff members demonstrate little or no knowledge of processes or issues addressed by the regulatory provisions.
Not Applicable	No value	• The requirement does not apply to the PIHP line of business during the review period.

Several modifications to the review methodology may affect the comparability of findings from the 2017–2018 review to prior review periods. These modifications include, but are not limited to the following:

- The *Documentation Request and Evaluation Tool* was revised to align with new and/or revised federal and contract requirements, where applicable.
- The number of performance areas increased from 15 to 17. Standard XVII—Management Information Systems was reviewed during the 2017–2018 review period and Standard XVI—Confidentiality of Health Information will be reviewed during the 2018–2019 review period.

[4-3] This scoring methodology is consistent with CMS' final protocol, *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.

- Case file review findings were used in conjunction with the PIHP's supporting documentation to determine compliance with scoring elements, when applicable.
- *Substantially Met* and *Partially Met* were removed from the scoring methodology.

The number of scoring elements increased. While many requirements remained the same, HSAG divided prior requirements with multiple components into separate elements that were scored independently.

Description of Data Obtained and Related Time Period

To assess the PIHP's compliance with federal regulations and contract requirements, HSAG obtained information from a wide range of written documents produced by the PIHP, including, but not limited to, the following:

- Committee meeting agendas, minutes, and handouts.
- Written policies and procedures.
- Management and monitoring reports.
- Provider manual and provider directory.
- Provider service and delegation agreements and contracts.
- Customer handbook and other written informational materials.
- Grievance and appeal records.
- Narrative and/or data reports across a broad range of performance and content areas.

Findings for Standard XII—Access and Availability were derived from the Michigan Mission-Based Performance Indicator System (MMBPIS)—Access Domain, Performance Indicators 1 through 4b. The PIHPs routinely reported quarterly performance data to MDHHS. MDHHS provided data directly to HSAG for the three reporting quarters.

Interviews with PIHP staff (e.g., PIHP leadership, customer services staff, and grievances and appeals staff) provided additional information.

Table 4-3 lists the major data sources that HSAG used in determining the PIHP's performance in complying with requirements and states the time period to which the data applied.

Table 4-3—Data Sources and Applicable Time Periods

Data Source	Time Period to Which the Data Applied
Desk review documentation	January 1, 2017, through March 31, 2018
Interviews	January 1, 2017, through March 31, 2018
MMBPIS	April 1, 2017, through December 31, 2017
Grievance and appeal records	October 1, 2017, through December 31, 2017

Validation of Performance Measures

Activity 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 performance indicators were reported and validated for the first quarter of the Michigan State Fiscal Year (SFY) 2018, as shown in Table 4-5.

Technical Methods of Data Collection and Analysis

CMS' publication, *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012[4-4] 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.

[4-4] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-2.pdf. Accessed on: November 27, 2018.

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 2018. 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) *Report* (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 Reported* (the measure was significantly biased, or the PIHP was not required to report the measure).

Description of Data Obtained and Related Time Period

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 4-4 shows the data sources used in the validation of performance measures and the periods to which the data applied.

Table 4-4—Data Sources and Applicable Periods

Data Sources	Period to Which Data Applied
ISCAT and mini-ISCAT(s), if applicable (from PIHPs)	SFY 2017
Source code/programming language for performance measures (from PIHPs and MDHHS) or description of the performance measure calculation process (from PIHPs)	SFY 2017
Previous performance measure results reports (from MDHHS)	SFY 2017
Performance measure results (from PIHPs and MDHHS)	First Quarter SFY 2018
Supporting documentation (from PIHPs and MDHHS)	SFY 2017
On-site interviews and systems demonstrations (from PIHPs and MDHHS)	During on-site visit

Table 4-5 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 4-5—List of Performance Indicators for PIHPs

Performance Indicators Selected by MDHHS		Subpopulations	Review Period	Calculated By
#1	The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	• Children • Adults	1st Quarter SFY 2018	PIHP
#2	The percentage of new persons 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 • MI Children • DD Adults • DD Children • Medicaid SA	1st Quarter SFY 2018	PIHP
#3	The percentage of new persons during the quarter starting any needed ongoing service within 14 days of a non-emergent face-to-face assessment with a professional.	• MI Adults • MI Children • DD Adults • DD Children • Medicaid SA	1st Quarter SFY 2018	PIHP
#4a	The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.	• Children • Adults	1st Quarter SFY 2018	PIHP

Performance Indicators Selected by MDHHS		Subpopulations	Review Period	Calculated By
#4b	The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.	• Consumers	1st Quarter SFY 2018	PIHP
#5	The percent of Medicaid recipients having received PIHP managed services.	• Medicaid Recipients	1st Quarter SFY 2018	MDHHS
#6	The percent of Habilitation Supports Waiver (HSW) enrollees in the quarter who received at least one HSW service each month other than supports coordination.	• HSW Recipients	1st Quarter SFY 2018	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.	• MI Adults • DD Adults • MI and DD Adults	SFY 2017	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.	• MI Adults • DD Adults • MI and DD Adults	SFY 2017	MDHHS
#10	The percentage of readmissions of children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.	• MI and DD Adults • MI and DD Children	1st Quarter SFY 2018	PIHP
#13	The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	• DD Adults	SFY 2017	MDHHS
#14	The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	• MI Adults	SFY 2017	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

Validation of Performance Improvement Projects

Activity Objectives

Validating PIPs is one of the mandatory activities described at 42 CFR §438.330(b)(1). In accordance with 42 CFR §438.330(d), PIHPs are required to have a comprehensive QAPIP 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 member satisfaction and to 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.

The EQR technical report must include information on the validation of PIPs required by the State and underway during the preceding 12 months.

The primary objective of PIP validation is to determine the PIHP's compliance with the requirements of 42 CFR §438.330(d). HSAG's evaluation of the PIP includes two key components of the quality improvement process:

1. HSAG evaluates the technical structure of the PIP to ensure that the PIHP designs, conducts, and reports the PIP in a methodologically sound manner, meeting all State and federal requirements. HSAG's review determines whether or not the PIP design (e.g., study question, population, indicator[s], sampling techniques, and data collection methodology) is based on sound methodological principles and could reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and capable of measuring sustained improvement.
2. HSAG evaluates the implementation of the PIP. Once designed, a PIP's effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, identification of causes and barriers, and subsequent development of relevant interventions. Through this component, HSAG evaluates how well the PIHP improves its rates through implementation of effective processes (i.e., barrier analyses, intervention design, and evaluation of results).

The goal of HSAG's PIP validation is to ensure that MDHHS and key stakeholders can have confidence that any reported improvement is related and can be directly linked to the quality improvement strategies and activities conducted by the PIHP during the life of the PIP.

MDHHS requires that each PIHP conduct at least one PIP subject to validation by HSAG. In 2017–2018, the PIPs initiated in 2014–2015 were retired and the PIHPs implemented a new PIP on one of the 10, State-recommended PIP topics. HSAG performed validation activities on the PIP study

design of the newly selected PIP topic for each PIHP. The PIP topics chosen by PIHPs addressed CMS' requirements related to quality outcomes—specifically, quality and access to care and services.

Technical Methods of Data Collection and Analysis

The methodology used to validate PIPs was based on CMS guidelines as outlined in the Department of Health and Human Services, CMS publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[4-5] 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 HSAG PIP Review Team consisted of, at a minimum, an analyst with expertise in statistics and study design and a clinician with expertise in performance improvement processes. The CMS protocols identify 10 steps that should be validated for each PIP. For the 2017–2018 submissions, since the PIHPs submitted the study design only, the PIHPs were assessed for Step 1 through Step VI in the PIP Validation Tool. Once the data collection begins and improvement strategies are implemented, the PIPs will be assessed for the remaining steps.

The 10 steps included in the PIP Validation Tool are listed below:

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

[4-5] 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/downloads/eqr-protocol-3.pdf. Accessed on: November 28, 2018.

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

Each required step is evaluated on one or more elements that form a valid PIP. The HSAG PIP Review Team scores each evaluation element within a given step as *Met*, *Partially Met*, *Not Met*, *Not Applicable*, or *Not Assessed*. HSAG designates evaluation elements pivotal to the PIP process as critical elements. For a PIP to produce valid and reliable results, all critical elements must be *Met*. Given the importance of critical elements to the scoring methodology, any critical element that receives a *Not Met* score results in an overall validation rating of *Not Met* for the PIP. The PIHP is assigned a *Partially Met* score if 60 percent to 79 percent of all evaluation elements are *Met* or one or more critical elements are *Partially Met*. HSAG provides a *Point of Clarification* when enhanced documentation would have demonstrated a stronger understanding and application of the PIP activities and evaluation elements.

In addition to the validation status (e.g., *Met*) HSAG assigns the PIP an overall percentage score for all evaluation elements (including critical elements). HSAG calculates the overall percentage score by dividing the total number of elements scored as *Met* by the total number of elements scored as *Met*, *Partially Met*, and *Not Met*. HSAG also calculates a critical element percentage score by dividing the total number of critical elements scored as *Met* by the sum of the critical elements scored as *Met*, *Partially Met*, and *Not Met*.

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

- *Met*: 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*.

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 review. After the second validation, HSAG finalized the scores (shown as Resubmission scores in Section 3 of this report) and documented the findings and recommendations for each validated PIP. HSAG forwarded the completed PIP Validation Tools to MDHHS and the applicable PIHPs.

Description of Data Obtained and Related Time Period

For 2017–2018, the PIHPs submitted the PIP study design only, and the submissions did not include baseline data. The study indicator measurement period dates for the PIP are listed below.

Table 4-6—Measurement Period Dates

Data Obtained	Reporting Year (Measurement Period)
Baseline	HEDIS 2019 (CY 2018)
Remeasurement 1	HEDIS 2020 (CY 2019)
Remeasurement 2	HEDIS 2021 (CY 2020)

5. Assessment of PIHP Performance

Methodology for Aggregating and Analyzing EQR Activity Results

HSAG used findings across mandatory EQR activities conducted during the previous 12 months to evaluate the performance of Medicaid PIHPs on providing quality, timely, and accessible healthcare services to Michigan Medicaid managed care members.

To identify strengths and weaknesses and draw conclusions for each PIHP, HSAG analyzed and evaluated each EQR activity and its resulting findings related to behavioral health, developmental disability, and substance abuse services across the Michigan Medicaid managed care program. The composite findings for each PIHP were analyzed and aggregated to identify overarching conclusions and focus areas for the PIHP in alignment with the priorities of MDHHS, and specifically, BHDDA.

Region 1—NorthCare Network

To conduct the 2017–2018 EQR, HSAG reviewed **NorthCare Network**'s results for mandatory EQR activities. Those results were analyzed and evaluated to develop conclusions and make recommendations about the quality of, timeliness of, and access to care and services provided by **NorthCare Network**.

EQR Activity Results

This section provides the results and notable findings for the mandatory EQR activities performed for **NorthCare Network**.

Compliance Monitoring

NorthCare Network was evaluated in eight Medicaid managed care program areas referred to as standards. Table 5-1 presents the total number of elements for each standard as well as the number of elements for each standard that received a score of *Met*, *Not Met*, or *Not Applicable (N/A*). Table 5-1 also presents **NorthCare Network**'s overall compliance score for each standard, the totals across the eight standards reviewed, and the total compliance score across all standards for the 2017–2018 compliance monitoring review.

Table 5-1—Summary of 2017–2018 Compliance Monitoring Review Results

Standard	Total # of Applicable Elements	Number of Elements			Total Compliance Score
		Met	*Not Met*	*N/A*	
Standard VI—Customer Service	39	34	5	0	**87%**
Standard VII—Grievance Process	26	24	2	0	**92%**
Standard IX—Subcontracts and Delegation	11	10	1	0	**91%**
Standard X—Provider Network	12	11	1	1	**92%**
Standard XII—Access and Availability	19	18	1	0	**95%**
Standard XIV—Appeals	54	42	12	0	**78%**
Standard XV—Disclosure of Ownership, Control, and Criminal Convictions	14	14	0	0	**100%**
Standard XVII—Management Information Systems	12	10	2	2	**83%**
Total Compliance Score	**187**	**163**	**24**	**3**	**87%**

Total # of Applicable Elements—The total number of elements within each standard minus any elements that received designations of *N/A*.
Total Compliance Score—Elements scored *Met* were given full value (1 point). The point values were then totaled, and the sum was divided by the number of applicable elements to derive a percentage score.

NorthCare Network demonstrated compliance for 163 of 187 elements, with an overall compliance score of 87 percent. **NorthCare Network** demonstrated strong performance, scoring 90 percent or above in five standards, with one of those standards achieving full compliance. These areas of strength include Grievance Process; Subcontracts and Delegation; Provider Network; Access and Availability; and Disclosure of Ownership, Control, and Criminal Convictions.

Opportunities for improvement were identified in seven of the eight standards, including deficiencies related to the following requirements:

- Content of the customer handbook.
- Content, maintenance, and/or dissemination of the provider directory.
- Providing notice of the member's right to request a State fair hearing, if the notice of resolution was more than 90 days from the date of the grievance.
- Subcontract provision specifying that the right to audit exists through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.
- Consistent mechanism to ensure that MDHHS is notified within seven days of any compositional changes to the provider network which could negatively affect access to care.
- Minimum performance standards for timely face-to-face assessments (for the substance abuse [SA] population).
- Appeals processes including but not limited to those related to obtaining a written, signed request for an appeal; continuation or reinstatement of services; denial of expedited appeal request provisions; extension of time frame provision; and format and content of resolution letters.
- Annual certification to attest to the accuracy, completeness, and truthfulness of information in data sets submitted to MDHHS.

NorthCare Network's lowest performing area was in Standard XIV—Appeals, with 12 *Not Met* findings and a compliance score of 78 percent. **NorthCare Network** was required to develop and implement a corrective action plan for each requirement in all standards scored *Not Met*. Refer to **NorthCare Network**'s 2017–2018 External Quality Review Compliance Monitoring Report for Prepaid Inpatient Health Plan for a detailed review of the findings.

Validation of Performance Measures

The purpose of the performance measure validation activity was to assess the accuracy of performance indicators reported by **NorthCare Network** and to determine the extent to which performance indicators reported by **NorthCare Network** followed State specifications and reporting requirements. HSAG evaluated **NorthCare Network**'s data systems for the processing of each type of data used for reporting MDHHS performance indicators. High-level findings are presented below. Refer to State Fiscal Year 2018 Validation of Performance Measures for Region 1—NorthCare Network report for a detailed review of the findings.

- Eligibility and Enrollment Data System Findings—HSAG identified no concerns with how **NorthCare Network** received and processed eligibility data.
- Medical Services Data System (Claims and Encounters) Findings—HSAG had no concerns with how **NorthCare Network** received and processed claims and encounters or processed data for performance indicator reporting.
- Behavioral Health Treatment Episode Data Set (BH-TEDS) Data Production—Based on demonstrations of two CMHSPs' BH-TEDS data entry and submission processes (i.e., Pathways Community Mental Health and Northpointe Behavioral Health Systems), HSAG identified no concerns with submission of records. Some BH-TEDS records reviewed in the CMHSPs' electronic medical records (EMRs) contained conflicting values (e.g., unemployed, but listed as earning minimum wage or more). HSAG identified gaps that would indicate that the **NorthCare Network** and the CMHSPs would benefit from employing more robust data quality and reasonability checks of the BH-TEDS records.
- PIHP Oversight of Affiliate Community Mental Health Centers—HSAG found that **NorthCare Network** had appropriate oversight of its five affiliated CMHSPs.

Based on all validation methods used to collect information during the Michigan SFY 2018 validation of performance measures activity, HSAG determined results for each performance indicator and assigned each an indicator designation of *Report*, *Not Reported*, or *No Benefit*. **NorthCare Network** received an indicator designation of *Report* for all indicators, signifying that **NorthCare Network** had calculated all indicators in compliance with the MDHHS Codebook specifications and that rates could be reported. Table 5-2 presents **NorthCare Network**'s performance measure results and the corresponding minimum performance standard (MPS) when an MPS was established by MDHHS.

Table 5-2—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	99.54%	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	98.80%	95.00%
MI Adults	99.52%	95.00%
DD Children	100.00%	95.00%
DD Adults	93.33%	95.00%
Medicaid SA	91.24%	95.00%
Total	95.86%	95.00%
#3: The percent of new Medicaid beneficiaries during the quarter starting any needed ongoing service within 14 days of a non-emergent face-to-face assessment with a professional.		
MI Children	96.80%	95.00%
MI Adults	100.00%	95.00%
DD Children	100.00%	95.00%
DD Adults	100.00%	95.00%
Medicaid SA	99.68%	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	94.00%	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.	86.67%	95.00%
#5: The percent of Medicaid recipients having received PIHP managed services.		
The percent of Medicaid recipients having received PIHP managed services.	7.08%	—

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 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.	98.66%	—
#8: The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who are employed competitively.		
MI Adults	15.93%	—
DD Adults	5.18%	—
MI/DD Adults	7.05%	—
#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	92.09%	—
DD Adults	92.11%	—
MI/DD Adults	90.91%	—
#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	5.26%	15.00%
Adults	4.71%	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).	16.05%	—
#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).	50.56%	—

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.

NorthCare Network's performance exceeded their corresponding MPSs for 15 of the 19 measure indicators, suggesting strength in these areas.

Although most **NorthCare Network** rates were above the MPSs, the rates for at least one population under indicators #2, #4a, and #4b fell below their corresponding MPSs, indicating opportunities for improvement.

Validation of Performance Improvement Projects

For the 2017–2018 validation, **NorthCare Network** provided its first-year submission on the PIP topic: *Follow-Up After Hospitalization for Mental Illness Within Seven Days of Discharge for Members Ages 6 Years and Older.* The goal of this PIP is to increase follow-up visits with a mental health practitioner within seven days after an inpatient discharge for selected mental illness diagnoses.

Table 5-3 outlines the study indicators for the PIP.

Table 5-3—Study Indicators

PIP Topic	Study Indicators
Follow-Up After Hospitalization for Mental Illness Within Seven Days of Discharge for Members Ages 6 Years and Older	1. The percentage of discharged enrollees ages 6 to 20 years, who were hospitalized for treatment of selected mental illness diagnoses, and who had a follow-up visit with a mental health practitioner within seven days of discharge. 2. The percentage of discharged enrollees ages 21 and older, who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner within seven days of discharge.

Table 5-4 and Table 5-5 show **NorthCare Network**'s scores based on HSAG's PIP evaluation. For additional details, refer to the 2017–2018 PIP validation report for **NorthCare Network**.

Table 5-4—Performance Improvement Project Validation Results for NorthCare Network

Stage	Step		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% (1/1)	0% (0/1)	0% (0/1)
	V.	Valid Sampling Techniques (if sampling was used)	*Not Applicable*		
	VI.	Accurate/Complete Data Collection	100% (3/3)	0% (0/3)	0% (0/3)
Design Total			**100% (8/8)**	**0% (0/8)**	**0% (0/8)**

Stage	Step		Percentage of Applicable Elements		
			Met	*Partially Met*	*Not Met*
Implementation	VII.	Sufficient Data Analysis and Interpretation	*Not Assessed*		
	VIII.	Appropriate Improvement Strategies	*Not Assessed*		
Implementation Total			***Not Assessed***		
Outcomes	IX.	Real Improvement Achieved	*Not Assessed*		
	X.	Sustained Improvement Achieved	*Not Assessed*		
Outcomes Total			***Not Assessed***		
Percentage Score of Applicable Evaluation Elements *Met*			**100% (8/8)**	**0% (0/8)**	**0% (0/8)**

Table 5-5—2017–2018 Performance Improvement Project Validation Scores for NorthCare Network

Name of Project	Type of Annual Review	Percentage Score of Evaluation Elements *Met*	Percentage Score of Critical Elements *Met*	Overall Validation Status
Follow-Up After Hospitalization for Mental Illness Within Seven Days of Discharge for Members Ages 6 Years and Older	Submission	88%	80%	*Partially Met*
	Resubmission	100%	100%	*Met*

NorthCare Network submitted the Design stage of the PIP for this year's validation. Overall, 100 percent of all applicable evaluation elements received a score of *Met* for the first six steps of the PIP process. The PIP had not progressed to the Implementation and Outcomes stages during this validation cycle.

NorthCare Network designed a scientifically sound study supported by key research principles and meeting all requirements in the Design stage. The technical design of the PIP was sufficient to measure and monitor PIP outcomes. **North Care Network** indicated that it plans to include its entire eligible population in this PIP. A sound study design created the foundation for **NorthCare Network** to progress to subsequent PIP stages—collecting data and implementing interventions with the potential to impact study indicator outcomes.

Strengths, Weaknesses, and Overall Conclusions

NorthCare Network demonstrated both strengths and weaknesses based on the results of the 2017–2018 EQR activities. **NorthCare Network** received a total compliance score of 87 percent across all standards reviewed during the 2017–2018 compliance monitoring review. **NorthCare Network** scored above 90 percent in the Grievance Process; Subcontracts and Delegation; Provider Network; Access and Availability; and Disclosure of Ownership, Control, and Criminal Convictions standards, indicating strong performance in these areas, but did not perform as well in the Customer Service, Appeals, and Management Information Systems standards, as demonstrated by moderate to low performance scores (87 percent, 78 percent, and 83 percent respectively), reflecting that additional focus is needed in these areas. While 15 of the 19 performance measure rates were above the MDHHS-established MPSs, indicating strengths in these areas, **NorthCare Network**'s rates for indicators #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—DD 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—Adults*; and #4b: *The percent of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days* fell below their corresponding MPSs, indicating opportunities for improvement in these measures.

NorthCare Network's overall performance demonstrates the following impact to the Medicaid population's quality of, timeliness of, and access to care and services:

Table 5-6—Quality, Timeliness, and Access Performance Impact

Performance Area*	Overall Performance Impact
Quality	• Strength: Received a performance score of 92 percent in the Grievance Process standard, indicating that the PIHP had an effective grievance process in place for members to express dissatisfaction. • Strength: Received a performance score of 100 percent in the Disclosure of Ownership, Control, and Criminal Convictions standards, indicating a strong focus on program integrity, which includes appropriate screening of the PIHP's contracted providers. • Strength: Low percentage of readmission rates for children and adults discharged from inpatient psychiatric units, as indicated by performance of indicator #10. • Strength: Designed a scientifically sound study related to *Follow-Up After Hospitalization for Mental Illness Within Seven Days of Discharge for Members Ages 6 Years and Older*, which was supported by key research principles, meeting all requirements of the PIP Design stage. • Weakness: Received five deficiencies in the Customer Service standard related to the customer handbook and provider directory, indicating that members may have challenges navigating the Medicaid managed care program and knowing which providers can meet their unique healthcare needs.

Performance Area*	Overall Performance Impact
Timeliness	• Strength: Minimum performance standards were met related to timely pre-admission screening for psychiatric inpatient care for children and adults; timely face-to-face assessments with a professional for non-emergency request for services for MI Children, MI Adults, DD Children, and Total; and receiving timely needed, ongoing services for MI Children, MI Adults, DD Children, DD Adults, Medicaid SA, and Total. • Weakness: Minimum performance standards related to timely assessments for new Medicaid members in the DD Adults and Medicaid SA populations, timely follow-up care for adults discharged from a psychiatric inpatient unit, and timely substance abuse detox follow-up care were not met, indicating that members were not always receiving services as soon as needed.
Access	• Strength: Received a performance score of 92 percent in the Provider Network standard, indicating that the PIHP maintains a network of providers to provide behavioral health and substance use disorder services to members. • Strength: At 95 percent in the Access and Availability standard, indicating that most members had access to providers and treatment when necessary. • Strength: As indicated by the performance measure rate, 100 percent of children discharged from a psychiatric inpatient unit were seen for follow-up care within seven days. • Weakness: Received the third lowest score at 78 percent in the Appeals standard, suggesting that members may not be aware of all rights afforded to them under the appeal process, which may include opportunity to challenge denial of prescribed services.

*Performance impact may be applicable to one or more performance areas; however, for purposes of this report impact was aligned to either quality, timeliness, or access.

Follow-Up on Prior EQR Recommendations

CMS requires that EQROs report annually the degree to which PIHPs addressed the EQR recommendations made from the prior year's technical report. During the 2016–2017 EQR, HSAG made the following recommendations to **NorthCare Network**, and **NorthCare Network** addressed these recommendations by taking the following actions:

Compliance Monitoring

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 provided no recommendations during the 2016–2017 review period; therefore, no actions were required of **NorthCare Network**.

Validation of Performance Measures

The 2016–2017 validation of performance measures for **NorthCare Network** identified opportunities for improvement in the following performance indicators:

- *#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 ongoing 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

HSAG recommended that **NorthCare Network** identify root causes, identify and implement interventions, and 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. Based upon results of the 2017–2018 validation, while **NorthCare Network** improved upon its rates for indicator #3 and achieved the MPS, it did not meet the MPS for indicator #2 for DD Adults and Medicaid SA or indicator #4a for Adults, indicating that **NorthCare Network** partially addressed the prior recommendations.

Validation of Performance Improvement Projects

For the 2016–2017 validation, **NorthCare Network** provided its fourth-year submission on the PIP topic: *Improving Medical Nutrition Therapy Services for Consumers With Self-Reported Obesity*. HSAG identified *Points of Clarification* as opportunities for improvement in Activity VII—Sufficient Data Analysis and Interpretation and Activity VIII—Appropriate Improvement Strategies and recommended that **NorthCare Network** provide the *p* value from its statistical testing results and track the effectiveness of interventions with quantitative data when possible. HSAG also recommended that **NorthCare Network** build on its momentum of improvement to ensure ability to sustain the improvement achieved; evaluate the effectiveness of each intervention; ensure that decisions made to revise, continue, or discontinue an intervention are data driven; and revisit its causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers as well as to see if any new barriers exist that require the development of interventions. For the 2017–2018 validation, **NorthCare Network** selected a new PIP topic; and, as **NorthCare Network** proceeds through each phase of the new PIP, HSAG will continue to assess **NorthCare Network**'s performance related to improving upon the areas recommended in the previous PIP.

Recommendations

As a result of the findings related to quality of, timeliness of, and access to care and services provided by **NorthCare Network** to members, HSAG recommends that **NorthCare Network** incorporate efforts for improvement of the following performance indicators with an MPS as part of its quality improvement strategy within the QAPIP:

Ratings Below the MPS[5-1]

- *#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*—DD 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*—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*

Performance Declined >2 Percent From Previous Year

- *#3: The percent of new Medicaid beneficiaries during the quarter starting any needed ongoing service within 14 days of a non-emergent face-to-face assessment with a professional—MI Children*

Increase in Readmissions >5 Percent From Previous Year

- *#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*

NorthCare Network should include within its next annual QAPIP review the results of analyses for the performance indicators listed above that answer the following questions:

1. What were the root causes associated with low-performing rates?
2. What unexpected outcomes were found within the data?
3. What disparities were identified in the analyses?
4. What are the most significant areas of focus (or populations) for which improvement initiatives are planned? What is the highest impact area(s) to make an improvement(s) (low effort/high yield)?
5. What intervention(s) is **NorthCare Network** considering or has already implemented to improve rates and performance for each identified indicator?

[5-1] Performance indicators listed under "Ratings Below the MPS" could have demonstrated either a greater than 2 percent decline or a greater than 5 percent increase from the previous year, but they were not repeated under "Performance Declined >2 Percent From Previous Year" or "Increase in Readmissions >5 Percent From Previous Year," respectively.

Based on the information presented preceding, **NorthCare Network** should include the following within its quality improvement plan:

- Measurable goals and benchmarks for each indicator.
- Mechanisms to measure performance.
- Mechanisms to review data trends to identify improvement, decline, or stability in the performance rates.
- Identified opportunities for improvement.
- Ongoing analysis to identify factors that impact adequacy of rates.
- Quality improvement interventions that address the root cause of the deficiency.
- A plan to monitor the quality improvement interventions to detect whether they effect improvement.

Additionally, **NorthCare Network** should have defined data entry processes, including its documented processes for data quality and data completeness checks.

HSAG also recommends that **NorthCare Network** develop meaningful plans of action to bring into compliance each of the following deficient standards:

- Standard VI—Customer Service
- Standard VII—Grievance Process
- Standard IX—Subcontracts and Delegation
- Standard X—Provider Network
- Standard XII—Access and Availability
- Standard XIV—Appeals
- Standard XVII—Management Information Systems

NorthCare Network should include the following in each of its plans of action, and the plans of action should be provided to MDHHS within 30 days of receipt of required corrective action:

- Detailed narrative of the deficiency.
- Detailed corrective action steps to resolve each deficiency.
- Any resources required to resolve the deficiency.
- Due dates for completing each action step.
- Assigned party responsible for completing each action step.
- Any required deliverables to show that a deficiency has been resolved.
- Any dependencies to resolve deficiencies.

Finally, **NorthCare Network** should take proactive steps to ensure a successful PIP. As the PIP progresses, **NorthCare Network** should ensure the following:

- Follow the approved PIP methodology to calculate and report baseline data accurately in next year's annual submission.
- To impact the Remeasurement 1 study indicator rate, complete a causal/barrier analysis to identify barriers to desired outcomes and implement interventions to address those barriers timely. Interventions implemented late in the Remeasurement 1 study period will not have enough time to impact the study indicator rate.
- Document the process and steps used to determine barriers to improvement and attach completed quality improvement tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis.
- Implement active, innovative improvement strategies with the potential to directly impact study indicator outcomes.
- Implement a process for evaluating the performance of each PIP intervention and its impact on the study indicators, and allow continual refinement of improvement strategies. The evaluation process should be ongoing and cyclical.

Region 2—Northern Michigan Regional Entity

To conduct the 2017–2018 EQR, HSAG reviewed **Northern Michigan Regional Entity**'s results for mandatory EQR activities. Those results were analyzed and evaluated to develop conclusions and make recommendations about the quality of, timeliness of, and access to care and services provided by **Northern Michigan Regional Entity**.

EQR Activity Results

This section provides the results and notable findings for the mandatory EQR activities performed for **Northern Michigan Regional Entity**.

Compliance Monitoring

Table 5-7 presents the total number of elements for each standard as well as the number of elements for each standard that received a score of *Met*, *Not Met*, or *Not Applicable (N/A*). Table 5-7 also presents **Northern Michigan Regional Entity**'s overall compliance score for each standard, the totals across the eight standards reviewed, and the total compliance score across all standards for the 2017–2018 compliance monitoring review.

Table 5-7—Summary of 2017–2018 Compliance Monitoring Review Results

Standard	Total # of Applicable Elements	Number of Elements			Total Compliance Score
		Met	*Not Met*	*N/A*	
Standard VI—Customer Service	39	35	4	0	**90%**
Standard VII—Grievance Process	26	21	5	0	**81%**
Standard IX—Subcontracts and Delegation	11	10	1	0	**91%**
Standard X—Provider Network	12	12	0	1	**100%**
Standard XII—Access and Availability	19	12	7	0	**63%**
Standard XIV—Appeals	54	44	10	0	**81%**
Standard XV—Disclosure of Ownership, Control, and Criminal Convictions	14	14	0	0	**100%**
Standard XVII—Management Information Systems	12	12	0	2	**100%**
Total Compliance Score	**187**	**160**	**27**	**3**	**86%**

Total # of Applicable Elements—The total number of elements within each standard minus any elements that received designations of *N/A*.
Total Compliance Score—Elements scored *Met* were given full value (1 point). The point values were then totaled, and the sum was divided by the number of applicable elements to derive a percentage score.

Northern Michigan Regional Entity demonstrated compliance for 160 of 187 elements, with an overall compliance score of 86 percent. **Northern Michigan Regional Entity** demonstrated strong performance, scoring 90 percent or above in five standards, with three of those standards achieving full compliance. These areas of strength include Customer Services; Subcontracts and Delegation; Provider

Network; Disclosure of Ownership, Control, and Criminal Convictions; and Management Information Systems.

Opportunities for improvement were identified in five of the eight standards, including deficiencies related to the following requirements:

- Content of the customer handbook.
- Content, maintenance, and/or dissemination of the provider directory.
- Grievance processes including but not limited to obtaining written consent from the member, acknowledgement of the grievance, maintenance of records, and format and content of resolution letters.
- Subcontract provision specifying that the right to audit exists through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.
- Minimum performance standards for ongoing services (for the MI Children, DD Children, and DD Adults populations), follow-up care after discharge from a psychiatric inpatient unit (for the Children and Adults populations), and follow-up care after discharge from a detoxification unit.
- Prompt responses to identified problems and development of corrective action plans for the MMBPIS.
- Appeals processes including but not limited to those related to time frames for filing an appeal, continuation or reinstatement of services, resolution time frames, extension of time frame provisions, and format of resolution letters.

Northern Michigan Regional Entity's lowest performing area was in Standard XII—Access and Availability, with seven *Not Met* findings and a compliance score of 63 percent. **Northern Michigan Regional Entity** was required to develop and implement a corrective action plan for each requirement in all standards scored *Not Met*. Refer to **Northern Michigan Regional Entity**'s 2017–2018 External Quality Review Compliance Monitoring Report for Prepaid Inpatient Health Plan for a detailed review of the findings.

Validation of Performance Measures

The purpose of the performance measure validation activity was to assess the accuracy of performance indicators reported by **Northern Michigan Regional Entity** and to determine the extent to which performance indicators reported by **Northern Michigan Regional Entity** followed State specifications and reporting requirements. HSAG evaluated **Northern Michigan Regional Entity**'s data systems for the processing of each type of data used for reporting MDHHS performance indicators. High-level findings are presented below. Refer to State Fiscal Year 2018 Validation of Performance Measures for Region 2—Northern Michigan Regional Entity report for a detailed review of the findings.

- Eligibility and Enrollment Data System Findings—HSAG had no concern with how **Northern Michigan Regional Entity** received and processed eligibility data.

- Medical Services Data System (Claims and Encounters) Findings—HSAG had no concerns with how **Northern Michigan Regional Entity** received and processed claims and encounters or processed data performance indicator reporting.
- Behavioral Health Treatment Episode Data Set (BH-TEDS) Data Production—Based on demonstrations of three CMHSPs' BH-TEDS data entry and submission processes (i.e., Northern Lakes CMH Authority, North Country Community Mental Health, and AuSable Valley Community Mental Health Authority), HSAG identified no concerns with submission of records. Some BH-TEDS records reviewed in the CMHSPs' EMRs contained conflicting values (e.g., unemployed, but listed as earning minimum wage or more). Additionally, as mandatory fields were populated with the value of "not evaluated," the CMHSPs and the PIHP relied on manual processes to identify and populate these fields with the true values after the answers were collected. Therefore, HSAG concluded that the PIHP and the CMHSPs would benefit from employing more robust data quality and reasonability checks of the BH-TEDS records.
- PIHP Oversight of Affiliate Community Mental Health Centers—HSAG found that **Northern Michigan Regional Entity** had sufficient oversight of its five CMHSPs.

Based on all validation methods used to collect information during the Michigan SFY 2018 Validation of Performance Measures activity, HSAG determined results for each performance indicator and assigned each an indicator designation of *Report*, *Not Reported*, or *No Benefit*. **Northern Michigan Regional Entity** received an indicator designation of *Report* for all indicators, signifying that **Northern Michigan Regional Entity** had calculated all indicators in compliance with the MDHHS Codebook specifications and that rates could be reported. Table 5-8 presents **Northern Michigan Regional Entity**'s performance measure results and the corresponding MPS when an MPS was established by MDHHS.

Table 5-8—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	97.14%	95.00%
Adults	96.71%	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	96.93%	95.00%
MI Adults	98.36%	95.00%
DD Children	93.94%	95.00%
DD Adults	100.00%	95.00%
Medicaid SA	98.12%	95.00%
Total	97.91%	95.00%

Performance Indicator	Rate	Minimum Performance Standard
#3: The percent of new Medicaid beneficiaries during the quarter starting any needed ongoing service within 14 days of a non-emergent face-to-face assessment with a professional.		
MI Children	96.74%	95.00%
MI Adults	97.20%	95.00%
DD Children	96.43%	95.00%
DD Adults	90.00%	95.00%
Medicaid SA	98.17%	95.00%
Total	97.20%	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	82.14%	95.00%
Adults	94.07%	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.	76.19%	95.00%
#5: The percent of Medicaid recipients having received PIHP managed services.		
The percent of Medicaid recipients having received PIHP managed services.	7.90%	—
#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 HSW enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	96.78%	—
#8: The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs, who are employed competitively.		
MI Adults	15.25%	—
DD Adults	12.18%	—
MI/DD Adults	13.73%	—
#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	90.60%	—
DD Adults	50.29%	—

Performance Indicator	Rate	Minimum Performance Standard
MI/DD Adults	82.35%	—
#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	14.71%	15.00%
Adults	9.89%	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).	25.82%	—
#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).	55.29%	—

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.

Northern Michigan Regional Entity's performance exceeded their corresponding MPSs for 14 of 19 measure indicators, suggesting strength in these areas.

Although most of **Northern Michigan Regional Entity**'s rates were above the MPSs, the rates for at least one population under indicators #2, #3, #4a, and #4b fell below their corresponding MPSs, indicating opportunities for improvement.

Validation of Performance Improvement Projects

For the 2017–2018 validation, **Northern Michigan Regional Entity** provided its first-year submission on the new PIP topic: *Follow-Up Care for Children Prescribed ADHD Medication.* The goal of this PIP is to increase the percentage of children, with newly prescribed attention/hyperactivity disorder (ADHD) medication, who have two follow-up care visits within a 10-month period—one within 30 days of when the first ADHD medication was dispensed.

Table 5-9 outlines the study indicators for the PIP.

Table 5-9—Study Indicators

PIP Topic	Study Indicators
Follow-Up Care for Children Prescribed ADHD Medication	1. The percentage of members 6–12 years of age as of the index prescription start date (IPSD) and with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day initiation phase. 2. The percentage of members 6–12 years of age as of the IPSD and with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the initiation phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the initiation phase ended.

Table 5-10 and Table 5-11 show **Northern Michigan Regional Entity** scores based on HSAG's PIP evaluation. For additional details, refer to the 2017–2018 PIP validation report for **Northern Michigan Regional Entity**.

Table 5-10—Performance Improvement Project Validation Results for Northern Michigan Regional Entity

Stage	Step		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% (1/1)	0% (0/1)	0% (0/1)
	V.	Valid Sampling Techniques (if sampling was used)	*Not Applicable*		
	VI.	Accurate/Complete Data Collection	100% (3/3)	0% (0/3)	0% (0/3)
Design Total			**100% (8/8)**	**0% (0/8)**	**0% (0/8)**

Stage	Step		Percentage of Applicable Elements		
			Met	*Partially Met*	*Not Met*
Implementation	VII.	Sufficient Data Analysis and Interpretation	*Not Assessed*		
	VIII.	Appropriate Improvement Strategies	*Not Assessed*		
Implementation Total			***Not Assessed***		
Outcomes	IX.	Real Improvement Achieved	*Not Assessed*		
	X.	Sustained Improvement Achieved	*Not Assessed*		
Outcomes Total			***Not Assessed***		
Percentage Score of Applicable Evaluation Elements *Met*			**100% (8/8)**	**0% (0/8)**	**0% (0/8)**

Table 5-11—2017–2018 Performance Improvement Project Validation Scores for Northern Michigan Regional Entity

Name of Project	Type of Annual Review	Percentage Score of Evaluation Elements *Met*	Percentage Score of Critical Elements *Met*	Overall Validation Status
Follow-Up Care for Children Prescribed ADHD Medication	Submission	100%	100%	*Met*
	Resubmission	*NA*	*NA*	*NA*

Northern Michigan Regional Entity submitted the Design stage of the PIP for this year's validation. Overall, 100 percent of all applicable evaluation elements received a score of *Met* for the first six steps of the PIP process. The PIP had not progressed to the Implementation and Outcomes stages during this validation cycle.

Northern Michigan Regional Entity designed a scientifically sound study supported by key research principles and meeting all requirements in the Design stage. The technical design of the PIP was sufficient to measure and monitor PIP outcomes. **Northern Michigan Regional Entity** indicated that it plans to include its entire eligible population in this PIP. A sound study design created the foundation for **Northern Michigan Regional Entity** to progress to subsequent PIP stages—collecting data and implementing interventions with the potential to impact study indicator outcomes.

Strengths, Weaknesses, and Overall Conclusions

Northern Michigan Regional Entity demonstrated both strengths and weaknesses based on the results of the 2017–2018 EQR activities. **Northern Michigan Regional Entity** received a total compliance score of 86 percent across all standards reviewed during the 2017–2018 compliance monitoring review. **Northern Michigan Regional Entity** scored 90 percent or above in the Customer Service; Subcontracts and Delegation; Provider Network; Disclosure of Ownership, Control, and Criminal Convictions; and Management Information Systems standards, indicating strong performance in these areas, but did not perform as well in the Grievance Process, Access and Availability, and Appeals standards, as demonstrated by moderate to low performance scores (81 percent, 63 percent, and 81 percent respectively), indicating that additional focus is needed in these areas. While 14 of the 19 performance measure rates were above the MDHHS-established MPSs, indicating strengths in these areas, **Northern Michigan Regional Entity**'s rates for indicators #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—DD Children*; #3: *The percent of new Medicaid beneficiaries during the quarter starting any needed ongoing service within 14 days of a non-emergent face-to-face assessment with a professional—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*; and #4b: *The percent of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days* fell below their corresponding MPSs, indicating opportunities for improvement in these measures.

Northern Michigan Regional Entity's overall performance demonstrates the following impact to the Medicaid population's quality of, timeliness of, and access to care and services:

Table 5-12—Quality, Timeliness, and Access Performance Impact

Performance Area*	Overall Performance Impact
Quality	• Strength: Received a performance score of 100 percent in the Disclosure of Ownership, Control, and Criminal Convictions standard, indicating a strong focus on program integrity, which includes appropriate screening of its contracted providers. • Strength: Received a performance score of 100 percent in the Management Information Systems standard, suggesting that the PIHP has the systems necessary to meet all obligations under its contract with MDHHS. • Strength: Low percentage of readmission rates for children and adults discharged from inpatient psychiatric units, as indicated by performance of indicator #10. • Strength: Designed a scientifically sound study related to *Follow-Up Care for Children Prescribed ADHD Medication*, which was supported by key research principles, meeting all requirements of the PIP Design stage. • Weakness: Although the overall performance score was 90 percent, the PIHP received four deficiencies in the Customer Service standard related to the customer handbook and provider directory, indicating that members may have challenges navigating the

Performance Area*	Overall Performance Impact
	Medicaid managed care program and knowing which providers can meet their unique healthcare needs. • Weakness: Received a performance score of 81 percent in the Grievance Process standard, indicating that an effective grievance process may not be in place for members to express dissatisfaction.
Timeliness	• Strength: Minimum performance standards were met related to timely pre-admission screening for psychiatric inpatient care for children and adults; timely face-to-face assessments with a professional for non-emergency request for services for MI Children, MI Adults, DD Adults, Medicaid SA, and Total; receiving timely needed ongoing services for MI Children, MI Adults, DD Children, Medicaid SA, and Total. • Weakness: Minimum performance standards related to timely assessments and ongoing services for new Medicaid members in the DD Children and DD Adults populations, timely follow-up care for children and adults discharged from a psychiatric inpatient unit, and timely substance abuse detox follow-up care were not met, indicating that members were not always receiving services as soon as needed.
Access	• Strength: Received a performance score of 100 percent in the Provider Network standard, indicating that the PIHP maintains a network of providers to provide behavioral health and substance use disorder services to members. • Weakness: The lowest performance score at 63 percent in the Access and Availability standard, indicating that members may have challenges accessing providers and treatment when necessary. • Weakness: Received a performance score of 81 percent in the Appeals standard, suggesting that members may not be aware of all rights afforded to them under the appeal process, which may include opportunity to challenge denial of prescribed services.

*Performance impact may be applicable to one or more performance areas, however, for purposes of this report impact was aligned to either quality, timeliness, or access.

Follow-Up on Prior EQR Recommendations

CMS requires that EQROs report annually the degree to which PIHPs addressed the EQR recommendations made from the prior year's technical report. During the 2016–2017 EQR, HSAG made the following recommendations to **Northern Michigan Regional Entity**; and, **Northern Michigan Regional Entity** addressed these recommendations by taking the following actions:

Compliance Monitoring

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 provided no recommendations during the 2016–2017 review period; therefore, no actions were required of **Northern Michigan Regional Entity**.

Validation of Performance Measures

The 2016–2017 validation of performance measures for **Northern Michigan Regional Entity** identified opportunities for improvement related to the following performance 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
- *#3: The percent of new Medicaid beneficiaries during the quarter starting any needed ongoing service within 14 days of a non-emergent face-to-face assessment with a professional*—MI Children, 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 recommended that **Northern Michigan Regional Entity** identify root causes, identify and implement interventions, and monitor performance related to timely psychiatric inpatient screenings for children; timely ongoing services for members in the MI Children, DD Children, and DD Adults populations; and timely psychiatric inpatient follow-up care for adults. Based on results of the 2017–2018 validation, while **Northern Michigan Regional Entity** improved upon its rates and met the MPS for indicator #1 and for most populations under indicator #3, it did not meet the MPS for indicator #3 for DD Adults or for indicator #4a for both Children and Adults, indicating that **Northern Michigan Regional Entity** partially addressed the prior recommendations.

Validation of Performance Improvement Projects

For the 2016–2017 validation, **Northern Michigan Regional Entity** provided its fourth-year submission on the PIP topic: *Increasing Diabetic Screenings for Consumers With SMI Prescribed an Antipsychotic Medication*. HSAG identified no opportunities for improvement in the annual PIP validation tool for **Northern Michigan Regional Entity**, but did recommend that **Northern Michigan Regional Entity** build on its momentum of improvement to ensure ability to sustain the improvement achieved; evaluate the effectiveness of each intervention; ensure that decisions made to revise, continue, or discontinue an intervention are data driven; and 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. For the 2017–2018 validation, **Northern Michigan Regional Entity** selected a new PIP topic; and, as **Northern Michigan Regional Entity** proceeds through each phase of the new PIP, HSAG will continue to assess **Northern Michigan Regional Entity**'s performance related to improving upon the areas as recommended in the previous PIP.

Recommendations

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Northern Michigan Regional Entity** to members, HSAG recommends that **Northern Michigan Regional Entity** incorporate efforts for improvement of the following performance indicators with an MPS as part of its quality improvement strategy within the QAPIP:

Ratings Below the MPS[5-2]

- *#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*—DD Children
- *#3: The percent of new Medicaid beneficiaries during the quarter starting any needed ongoing service within 14 days of a non-emergent face-to-face assessment with a professional*—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
- *#4b: The percent of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days*

Increase in Readmissions >5 Percent From Previous Year

- *#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

Northern Michigan Regional Entity should include within its next annual review the results of analyses for the performance indicators listed above that answer the following questions:

1. What were the root causes associated with low-performing areas?
2. What unexpected outcomes were found within the data?
3. What disparities were identified in the analyses?
4. What are the most significant areas of focus (or populations) for which improvement initiatives are planned? What is the highest impact area(s) to make an improvement(s) (low effort/high yield)?
5. What intervention(s) is **Northern Michigan Regional Entity** considering or has already implemented to improve rates and performance for each identified indicator?

Based on the information presented above, **Northern Michigan Regional Entity** should include the following within its quality improvement plan:

- Measurable goals and benchmarks for each indicator.
- Mechanisms to measure performance.
- Mechanisms to review data trends to identify improvement, decline, or stability in the performance rates.
- Identified opportunities for improvement.
- Ongoing analysis to identify factors that impact adequacy of rates.
- Quality improvement interventions that address the root cause of the deficiency.
- A plan to monitor the quality improvement interventions to detect whether they effect improvement.

[5-2] Performance indicators listed under "Ratings Below the MPS" could have demonstrated a greater than 5 percent increase from the previous year, but they were not repeated under "Increase in Readmissions >5 Percent From Previous Year."

Additionally, **Northern Michigan Regional Entity** should have defined data entry processes, including documented processes for data quality and data completeness checks.

HSAG also recommends that **Northern Michigan Regional Entity** develop meaningful plans of action to bring into compliance each of the following deficient standards:

- Standard VI—Customer Service
- Standard VII—Grievance Process
- Standard IX—Subcontracts and Delegation
- Standard XII—Access and Availability
- Standard XIV—Appeals

Northern Michigan Regional Entity should include the following in each of its plans of action, and the plans of action should be provided to MDHHS within 30 days of receipt of required corrective action:

- Detailed narrative of the deficiency.
- Detailed corrective action steps to resolve each deficiency.
- Any resources required to resolve the deficiency.
- Due dates for completing each action step.
- Assigned party responsible for completing each action step.
- Any required deliverables to show that a deficiency has been resolved.
- Any dependencies to resolve deficiencies.

Finally, **Northern Michigan Regional Entity** should take proactive steps to ensure a successful PIP. As the PIP progresses, **Northern Michigan Regional Entity** should ensure the following:

- Follow the approved PIP methodology to calculate and report baseline data accurately in next year's annual submission.
- To impact the Remeasurement 1 study indicator rate, complete a causal/barrier analysis to identify barriers to desired outcomes and implement interventions to address those barriers timely. Interventions implemented late in the Remeasurement 1 study period will not have enough time to impact the study indicator rate.
- Document the process and steps used to determine barriers to improvement; and attach completed quality improvement tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis.
- Implement active, innovative improvement strategies with the potential to directly impact study indicator outcomes.
- Implement a process for evaluating the performance of each PIP intervention and its impact on the study indicators and allow continual refinement of improvement strategies. The evaluation process should be ongoing and cyclical.

Region 3—Lakeshore Regional Entity

To conduct the 2017–2018 EQR, HSAG reviewed **Lakeshore Regional Entity**'s results for mandatory EQR activities. Those results were analyzed and evaluated to develop conclusions and make recommendations about the quality of, timeliness of, and access to care and services provided by **Lakeshore Regional Entity**.

EQR Activity Results

This section provides the results and notable findings for the mandatory EQR activities performed for **Lakeshore Regional Entity**.

Compliance Monitoring

Table 5-13 presents the total number of elements for each standard as well as the number of elements for each standard that received a score of *Met*, *Not Met*, or *Not Applicable (N/A*). Table 5-13 also presents **Lakeshore Regional Entity**'s overall compliance score for each standard, the totals across the eight standards reviewed, and the total compliance score across all standards for the 2017–2018 compliance monitoring review.

Table 5-13—Summary of 2017–2018 Compliance Monitoring Review Results

Standard	Total # of Applicable Elements	Number of Elements			Total Compliance Score
		Met	*Not Met*	*N/A*	
Standard VI—Customer Service	39	33	6	0	**85%**
Standard VII—Grievance Process	26	26	0	0	**100%**
Standard IX—Subcontracts and Delegation	11	9	2	0	**82%**
Standard X—Provider Network	12	11	1	1	**92%**
Standard XII—Access and Availability	19	12	7	0	**63%**
Standard XIV—Appeals	54	33	21	0	**61%**
Standard XV—Disclosure of Ownership, Control, and Criminal Convictions	14	13	1	0	**93%**
Standard XVII—Management Information Systems	12	10	2	2	**83%**
Total Compliance Score	**187**	**147**	**40**	**3**	**79%**

Total # of Applicable Elements—The total number of elements within each standard minus any elements that received designations of *NA*.
Total Compliance Score—Elements scored *Met* were given full value (1 point). The point values were then totaled, and the sum was divided by the number of applicable elements to derive a percentage score.

Lakeshore Regional Entity demonstrated compliance for 147 of 187 elements, with an overall compliance score of 79 percent. **Lakeshore Regional Entity** demonstrated strong performance, scoring 90 percent or above in three standards, with one of those standards achieving full compliance. These areas of strength include Grievance Process; Provider Network; and Disclosure of Ownership, Control, and Criminal Convictions.

Opportunities for improvement were identified in seven of the eight standards, including deficiencies related to the following requirements:

- Content of the customer handbook.
- Content, maintenance and/or dissemination of the provider directory.
- Subcontract provisions related to the delegated activities or obligations and reporting responsibilities.
- Subcontract provision specifying that the right to audit exists through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.
- Giving providers not selected for inclusion in the network written notice of the reason for the decision.
- Minimum performance standards for face-to-face assessment (for the DD Adults population), ongoing services (for the MI Children, MI Adults, DD Children, and DD Adults populations), and follow-up care after discharge from a psychiatric inpatient unit (for the Adults population).
- Appeals processes including but not limited to those related to having a documented process for appeals; obtaining a written, signed request for an appeal, written consent from the member, continuation or reinstatement of services; acknowledgment of the appeal; documentation of clinical decision-makers, resolution time frames, denial of expedited appeal request provisions, or extension of time frame provisions; and format and content of resolution letters.
- Monthly searches of the Office of Inspector General (OIG) exclusion database.
- Annual certification to attest to the accuracy, completeness, and truthfulness of information in data sets submitted to MDHHS.

Lakeshore Regional Entity's lowest performing areas were in Standard XII—Access and Availability with seven *Not Met* findings and a compliance score of 63 percent and Standard XIV—Appeals, with 21 *Not Met* findings and a compliance score of 61 percent. **Lakeshore Regional Entity** was required to develop and implement a corrective action plan for each requirement in all standards scored *Not Met*. Refer to **Lakeshore Regional Entity**'s 2017–2018 External Quality Review Compliance Monitoring Report for Prepaid Inpatient Health Plan for a detailed review of the findings.

Validation of Performance Measures

The purpose of the performance measure validation activity was to assess the accuracy of performance indicators reported by **Lakeshore Regional Entity** and to determine the extent to which performance indicators reported by **Lakeshore Regional Entity** followed State specifications and reporting requirements. HSAG evaluated **Lakeshore Regional Entity**'s data systems for the processing of each type of data used for reporting MDHHS performance indicators. High-level findings are presented below. Refer to State Fiscal Year 2018 Validation of Performance Measures for Region 3—Lakeshore Regional Entity report for a detailed review of the findings.

- Eligibility and Enrollment Data System Findings—HSAG had no concerns with **Lakeshore Regional Entity**'s receipt and processing of eligibility data.
- Medical Services Data System (Claims and Encounters) Findings—HSAG had no major concerns with how **Lakeshore Regional Entity** received and processed claims and encounter data for submission to MDHHS. However, HSAG identified that data completeness and data quality processes used for performance indicator reporting presented some concerns. CMHSPs were responsible for appropriately billing services for members retroactively enrolled and for updating encounters for members retroactively disenrolled; however, **Lakeshore Regional Entity** did not employ validation checks to ensure that claims and encounters were properly submitted based on any retroactive eligibility information from the State. Additionally, each CMHSP was responsible for identifying cases for inclusion in each data element (e.g., denominator, numerator, exceptions) based on the measure specifications provided in the MDHHS Codebook. Member-level detail files, along with summary rate files, were submitted to **Lakeshore Regional Entity** via a secure FTP site. The files were reviewed by the **Lakeshore Regional Entity**, and **Lakeshore Regional Entity** discussed any notable data issues with the CMSHPs prior to submission to the State. However, most of **Lakeshore Regional Entity**'s manual verification and quality assurance activities were completed after the measures were reported to the State. Therefore, any additional issues identified by **Lakeshore Regional Entity** were not corrected before reporting measure data to the State. Further, based on a review of the CMHSPs' programming logic used to derive the performance metrics, HSAG determined that the CMSHPs erroneously included children with autism in the performance indicator rates and did not limit indicator #2 to only those individuals whose last date of service was 90 days or more before the assessment. As a result, the reported rates for all indicators were potentially over-reported with the inclusion of members with autism; and indicator #2 was over-reported with the inclusion of members who received services more than 90 days before the assessment.
- Behavioral Health Treatment Episode Data Set (BH-TEDS) Data Production—Based on demonstrations of three CMHSPs' BH-TEDS data entry and submission processes (i.e., Allegan County Community Mental Health Services, HealthWest, and Network180), no concerns were identified with the CMHSPs' adherence to the State-specified submission requirements. However, HSAG recommends that **Lakeshore Regional Entity** and the CMHSPs perform additional data quality and completeness checks before the data are submitted to the State. Multiple BH-TEDS records in the CMHSPs' EMRs contained conflicting values (for example, unemployed, but listed as earning minimum wage or more). Additionally, as mandatory fields were populated with the value of "not evaluated," neither the CMHSPs nor **Lakeshore Regional Entity** employed clearly defined processes to populate these fields with the true values after the answers were collected.
- PIHP Oversight of Affiliate Community Mental Health Centers—HSAG found that **Lakeshore Regional Entity** had sufficient oversight of its five affiliated CMHSPs; but, as discussed in the BH-TEDS data production section above, areas for improvement still existed. Not all reporting complied with the measure specifications; therefore, **Lakeshore Regional Entity**/CMHSP did not retain copies of all files used for performance indicator reporting, and gaps existed in **Lakeshore Regional Entity**'s process for validating the performance indicator data. Related to this, the performance indicator values submitted to MDHHS were considered materially biased and received Not Reported (NR) audit designations.

Based on all validation methods used to collect information during the Michigan SFY 2018 Validation of Performance Measures activity, HSAG determined results for each performance indicator and assigned each an indicator designation of *Report*, *Not Reported*, or *No Benefit*. **Lakeshore Regional Entity** received an indicator designation of *Report* for six performance indicators, signifying that **Lakeshore Regional Entity** had calculated these indicators in compliance with the MDHHS Codebook specifications and that rates could be reported. However, **Lakeshore Regional Entity** received an indicator designation of *Not Reported* for the remaining six performance indicators, indicating that **Lakeshore Regional Entity**/CMHSPs did not calculate this indicator in compliance with MDHHS Codebook specifications. HSAG also identified gaps in **Lakeshore Regional Entity**'s process for validating the performance indicator data; therefore, the reported rates were considered materially biased. Table 5-14 presents **Lakeshore Regional Entity**'s performance measure results and the corresponding MPS when an MPS was established by MDHHS.

Table 5-14—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 ongoing 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%

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	*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.	5.27%	—
#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 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%	—
#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	13.21%	—
DD Adults	11.87%	—
MI/DD Adults	12.60%	—
#9: The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.		
MI Adults	80.24%	—
DD Adults	65.73%	—
MI/DD Adults	55.43%	—
#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).	14.40%	—

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 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).	51.40%	—

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)*. 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.

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

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, Network180 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.

Validation of Performance Improvement Projects

For the 2017–2018 validation, **Lakeshore Regional Entity** provided its first-year submission on the new PIP topic: *Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD).* The goal of this PIP is to increase hemoglobin (Hb) A1c and low-density lipoprotein cholesterol (LDL-C) testing among Medicaid members with diabetes and schizophrenia.

Table 5-15 outlines the study indicators for the PIP.

Table 5-15—Study Indicator

PIP Topic	Study Indicator
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)	The percentage of members with schizophrenia and diabetes who had an HbA1c and LDL-C test during the measurement period.

Table 5-16 and Table 5-17 show **Lakeshore Regional Entity** scores based on HSAG's PIP evaluation. For additional details, refer to the 2017–2018 PIP validation report for **Lakeshore Regional Entity**.

Table 5-16—Performance Improvement Project Validation Results for Lakeshore Regional Entity

Stage	Step		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% (1/1)	0% (0/1)	0% (0/1)
	V.	Valid Sampling Techniques (if sampling was used)	*Not Applicable*		
	VI.	Accurate/Complete Data Collection	100% (3/3)	0% (0/3)	0% (0/3)
Design Total			**100% (8/8)**	**0% (0/8)**	**0% (0/8)**
Implementation	VII.	Sufficient Data Analysis and Interpretation	*Not Assessed*		
	VIII.	Appropriate Improvement Strategies	*Not Assessed*		
Implementation Total			***Not Assessed***		
Outcomes	IX.	Real Improvement Achieved	*Not Assessed*		
	X.	Sustained Improvement Achieved	*Not Assessed*		
Outcomes Total			***Not Assessed***		
Percentage Score of Applicable Evaluation Elements *Met*			**100% (8/8)**	**0% (0/8)**	**0% (0/8)**

Table 5-17—2017–2018 Performance Improvement Project Validation Scores for Lakeshore Regional Entity

Name of Project	Type of Annual Review	Percentage Score of Evaluation Elements *Met*	Percentage Score of Critical Elements *Met*	Overall Validation Status
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)	Submission	100%	100%	*Met*
	Resubmission	*NA*	*NA*	*NA*

Lakeshore Regional Entity submitted the Design stage of the PIP for this year's validation. Overall, 100 percent of all applicable evaluation elements received a score of *Met* for the first six steps of the PIP process. The PIP had not progressed to the Implementation and Outcomes stages during this validation cycle.

Lakeshore Regional Entity designed a scientifically sound study supported by key research principles and meeting all requirements in the Design stage. The technical design of the PIP was sufficient to measure and monitor PIP outcomes. **Lakeshore Regional Entity** indicated plans to include its entire eligible population in this PIP. A sound study design created the foundation for **Lakeshore Regional Entity** to progress to subsequent PIP stages—collecting data and implementing interventions with the potential to impact study indicator outcomes.

Strengths, Weaknesses, and Overall Conclusions

Lakeshore Regional Entity demonstrated both strengths and weaknesses based on the results of the 2017–2018 EQR activities. **Lakeshore Regional Entity** received a total compliance score of 79 percent across all standards reviewed during the 2017–2018 compliance monitoring review. **Lakeshore Regional Entity** scored above 90 percent in the Grievance Process, Provider Network, and Disclosure of Ownership, Control, and Criminal Convictions standards, indicating strong performance in these areas, but did not perform as well in the Customer Service, Subcontracts and Delegation, Access and Availability, Appeals, and Management Information Systems standards, as demonstrated by moderate to low performance scores (85 percent, 82 percent, 63 percent, 61 percent, and 83 percent respectively), reflecting that additional focus is needed in these areas. **Lakeshore Regional Entity**'s performance measure rates were deemed *Not Reported* for all 19 measure indicators with MPSs, indicating that **Lakeshore Regional Entity**/CMHSPs did not calculate the performance indicators in compliance with MDHHS Codebook specifications. HSAG identified gaps in **Lakeshore Regional Entity**'s process for validating the performance indicator data; therefore, the reported rates were considered materially biased and performance could not be determined.

Lakeshore Regional Entity's overall performance demonstrates the following impact to the Medicaid population's quality of, timeliness of, and access to care and services:

Table 5-18—Quality, Timeliness, and Access Performance Impact

Performance Area*	Overall Performance Impact
Quality	• Strength: Received a performance score of 100 percent in the Grievance Process standard, indicating that the PIHP had an effective grievance process in place for members to express dissatisfaction. • Strength: Received a performance score of 93 percent in the Disclosure of Ownership, Control, and Criminal Convictions standard, indicating a focus on program integrity, which includes appropriate screening of contracted providers. • Strength: Designed a scientifically sound study related to *Diabetes Monitoring for People With Diabetes and Schizophrenia*, which was supported by key research principles, meeting all requirements of the PIP Design stage. • Weakness: Received six deficiencies in the Customer Service standard related to the customer handbook and provider directory, indicating that members may have challenges navigating the Medicaid managed care program and knowing which providers can meet their unique healthcare needs.
Timeliness	• Weakness: Minimum performance standards related to timely assessments and timely follow-up care for children and adult members could not be assessed due to data issues.
Access	• Strength: Received a performance score of 92 percent in the Provider Network standard, indicating that the PIHP maintains a network of providers to provide behavioral health and substance use disorder services to members. • Weakness: Lowest performance score at 63 percent in the Access and Availability standard, suggesting that some members had challenges accessing providers and treatment when necessary. • Weakness: Received the second lowest score at 61 percent in the Appeals standard, suggesting that members may not be aware of all rights afforded to them under the appeal process, which may include opportunity to challenge denial of prescribed services.

*Performance impact may be applicable to one or more performance areas; however, for purposes of this report impact was aligned to either quality, timeliness, or access.

Follow-Up on Prior EQR Recommendations

CMS requires that EQROs report annually the degree to which PIHPs addressed the EQR recommendations made from the prior year's technical report. During the 2016–2017 EQR, HSAG made the following recommendations to **Lakeshore Regional Entity**; and **Lakeshore Regional Entity** addressed these recommendations by taking the following actions:

Compliance Monitoring

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 provided no recommendations

during the 2016–2017 review period; therefore, no actions were required of **Lakeshore Regional Entity**.

Validation of Performance Measures

The 2016–2017 validation of performance measures for **Lakeshore Regional Entity** identified opportunities for improvement, and recommendations were made by HSAG. For the 2016–2017 validation, HSAG had received **Lakeshore Regional Entity** performance measure rates from MDHHS; however, the rates did not include data from the PIHP's largest affiliated CMHSP, Network180. Although the CMHSP had implemented a new transactional system, lack of adequate system testing and data validation existed; therefore, the CMHSP was unable to produce valid and complete data timely. 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 recommended that **Lakeshore Regional Entity** monitor Network180's progress reporting complete and accurate performance indicator data. HSAG also recommended 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.

Network180, with oversight from the **Lakeshore Regional Entity**, conducted an "EHR Stabilization" project to stabilize and improve the performance of the CMHSP's EMR, Streamline. However, the EMR did not meet several key objectives; therefore, the **Lakeshore Regional Entity** employed the services of an independent subject matter expert to conduct a full information system review at Network180, including an evaluation of the EMR system. This review was completed in January 2018 and concluded with Network180 determining to replace the Streamline EMR software with PCE Systems in 2019. Although progress was made to address the recommendations, **Lakeshore Regional Entity**'s reporting reviewed during the 2017–2018 validation did not comply fully with measure specifications; and, gaps existed in the PIHP's process for validating the performance indicator data. Therefore, the performance indicator values submitted to MDHHS and reviewed during the 2017–2018 validation were considered materially biased and received *Not Reported* audit designations. **Lakeshore Regional Entity** must continue efforts to report complete and accurate data.

Validation of Performance Improvement Projects

For the 2016–2017 validation, **Lakeshore Regional Entity** provided its fourth-year submission on the 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*. 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, and recommended that the PIHP include a numeric percentage for the PIHP-specific Remeasurement 2 goal. HSAG also recommended that **Lakeshore Regional Entity** have mechanisms to ensure that the reported data and interpretation of results are accurate and consistent throughout the PIP Submission Form. Further, HSAG recommended that **Lakeshore Regional Entity** build on its momentum of improvement to ensure ability to sustain the improvement achieved; evaluate the effectiveness of each intervention; ensure that decisions made to

revise, continue, or discontinue an intervention are data driven; and 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. For the 2017–2018 validation, **Lakeshore Regional Entity** selected a new PIP topic; and as **Lakeshore Regional Entity** proceeds through each phase of the new PIP, HSAG will continue to assess **Lakeshore Regional Entity**'s performance related to improving upon the areas recommended in the previous PIP.

Recommendations

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Lakeshore Regional Entity** to members, HSAG recommends that **Lakeshore Regional Entity** incorporate efforts for improvement of the following performance indicators with an MPS as part of its quality improvement strategy within the QAPIP:

Not Reported Performance Measure Rates

- *#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, Total
- *#3: The percent of new Medicaid beneficiaries during the quarter starting any needed ongoing service within 14 days of a non-emergent face-to-face assessment with a professional*—MI Children, MI Adults, DD Children, DD Adults, Medicaid SA, 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

Lakeshore Regional Entity should include within its next annual QAPIP review the results of analyses for the performance indicators listed above that answer the following questions:

1. What were the root causes associated with low-performing rates?
2. What unexpected outcomes were found within the data?
3. What disparities were identified in the analyses?
4. What are the most significant areas of focus (or populations) for which improvement initiatives are planned? What is the highest impact area(s) to make an improvement(s) (low effort/high yield)?
5. What intervention(s) is **Lakeshore Regional Entity** considering or has already implemented to improve rates and performance for each identified indicator?

Based on the information presented above, **Lakeshore Regional Entity** should include the following within its quality improvement plan:

- Measurable goals and benchmarks for each indicator.
- Mechanisms to measure performance.
- Mechanisms to review data trends to identify improvement, decline, or stability in the performance rates.
- Identified opportunities for improvement.
- Ongoing analysis to identify factors that impact adequacy of rates.
- Quality improvement interventions that address the root cause of the deficiency.
- A plan to monitor the quality improvement interventions to detect whether they effect improvement.

Additionally, **Lakeshore Regional Entity** should have defined data entry processes, including its documented processes for data quality and data completeness checks.

HSAG also recommends that **Lakeshore Regional Entity** develop meaningful plans of action to bring into compliance each of the following deficient standards:

- Standard VI—Customer Service
- Standard IX—Subcontracts and Delegation
- Standard X—Provider Network
- Standard XII—Access and Availability
- Standard XIV—Appeals
- Standard XV—Disclosure of Ownership, Control, and Criminal Convictions
- Standard XVII—Management Information Systems

Lakeshore Regional Entity should include the following in each of its plans of action, and the plans of action should be provided to MDHHS within 30 days of receipt of required corrective action:

- Detailed narrative of the deficiency.
- Detailed corrective action steps to resolve each deficiency.
- Any resources required to resolve the deficiency.
- Due dates for completing each action step.
- Assigned party responsible for completing each action step.
- Any required deliverables to show that a deficiency has been resolved.
- Any dependencies to resolve deficiencies.

Finally, **Lakeshore Regional Entity** should take proactive steps to ensure a successful PIP. As the PIP progresses, **Lakeshore Regional Entity** should ensure doing the following:

- Follow the approved PIP methodology to calculate and report baseline data accurately in next year's annual submission.
- To impact the Remeasurement 1 study indicator rate, complete a causal/barrier analysis to identify barriers to desired outcomes and implement interventions to address those barriers timely. Interventions implemented late in the Remeasurement 1 study period will not have enough time to impact the study indicator rate.
- Document the process and steps used to determine barriers to improvement; and attach completed quality improvement tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis.
- Implement active, innovative improvement strategies with the potential to directly impact study indicator outcomes.
- Implement a process for evaluating the performance of each PIP intervention and its impact on the study indicators, and allow continual refinement of improvement strategies. The evaluation process should be ongoing and cyclical.

Region 4—Southwest Michigan Behavioral Health

To conduct the 2017–2018 EQR, HSAG reviewed **Southwest Michigan Behavioral Health**'s results for mandatory EQR activities. Those results were analyzed and evaluated to develop conclusions and make recommendations about the quality of, timeliness of, and access to care and services provided by **Southwest Michigan Behavioral Health**.

EQR Activity Results

This section provides the results and notable findings for the mandatory EQR activities performed for **Southwest Michigan Behavioral Health**.

Compliance Monitoring

Table 5-19 presents the total number of elements for each standard as well as the number of elements for each standard that received a score of *Met*, *Not Met*, or *Not Applicable (N/A*). Table 5-19 also presents **Southwest Michigan Behavioral Health**'s overall compliance score for each standard, the totals across the eight standards reviewed, and the total compliance score across all standards for the 2017–2018 compliance monitoring review.

Table 5-19—Summary of 2017–2018 Compliance Monitoring Review Results

Standard	Total # of Applicable Elements	Number of Elements			Total Compliance Score
		Met	*Not Met*	*N/A*	
Standard VI—Customer Service	39	34	5	0	**87%**
Standard VII—Grievance Process	26	21	5	0	**81%**
Standard IX—Subcontracts and Delegation	11	10	1	0	**91%**
Standard X—Provider Network	12	12	0	1	**100%**
Standard XII—Access and Availability	19	17	2	0	**89%**
Standard XIV—Appeals	54	47	7	0	**87%**
Standard XV—Disclosure of Ownership, Control, and Criminal Convictions	14	14	0	0	**100%**
Standard XVII—Management Information Systems	12	12	0	2	**100%**
Total Compliance Score	**187**	**167**	**20**	**3**	**89%**

Total # of Applicable Elements—The total number of elements within each standard minus any elements that received designations of *NA*.
Total Compliance Score—Elements scored *Met* were given full value (1 point). The point values were then totaled, and the sum was divided by the number of applicable elements to derive a percentage score.

Southwest Michigan Behavioral Health demonstrated compliance for 167 of 187 elements, with an overall compliance score of 89 percent. **Southwest Michigan Behavioral Health** demonstrated strong performance, scoring 90 percent or above in four standards, with three of those standards achieving full compliance. These areas of strength include Subcontracts and Delegation; Provider Network; Disclosure of Ownership, Control, and Criminal Convictions; and Management Information Systems.

Opportunities for improvement were identified in five of the eight standards, including deficiencies related to the following requirements:

- Content of the customer handbook.
- Content, maintenance, and/or dissemination of the provider directory.
- Grievance processes including but not limited to written consent from the member, acknowledgement of the grievance, and content and format or resolution letters.
- Subcontract provision specifying that the right to audit exists through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.
- Minimum performance standards for ongoing services (for the MI Children and MI Adults populations).
- Appeals processes, including but not limited to those related to obtaining a written, signed request for appeals; continuation or reinstatement of services; documentation of decision-makers; resolution time frames; and format and content of resolution letters.

Southwest Michigan Behavioral Health's lowest performing area was in Standard VII—Grievance Process with five *Not Met* findings and a compliance score of 81 percent. **Southwest Michigan Behavioral Health** was required to develop and implement a corrective action plan for each requirement in all standards scored *Not Met*. Refer to **Southwest Michigan Behavioral Health**'s 2017–2018 External Quality Review Compliance Monitoring Report for Prepaid Inpatient Health Plan for a detailed review of the findings.

Validation of Performance Measures

The purpose of the performance measure validation activity was to assess the accuracy of performance indicators reported by **Southwest Michigan Behavioral Health** and to determine the extent to which performance indicators reported by **Southwest Michigan Behavioral Health** followed State specifications and reporting requirements. HSAG evaluated **Southwest Michigan Behavioral Health**'s data systems for the processing of each type of data used for reporting MDHHS performance indicators. High-level findings are presented below. Refer to State Fiscal Year 2018 Validation of Performance Measures for Region 4—Southwest Michigan Behavioral Health report for a detailed review of the findings.

- Eligibility and Enrollment Data System Findings—HSAG identified no issues with how **Southwest Michigan Behavioral Health** received and processed eligibility data.
- Medical Services Data System (Claims and Encounters) Findings—HSAG identified no issues with **Southwest Michigan Behavioral Health**'s procedures for receiving and processing claims and encounters.
- Behavioral Health Treatment Episode Data Set (BH-TEDS) Data Production—Based on demonstrations of three CMHSPs' BH-TEDS data entry and submission processes during the on-site visit (i.e., Berrien Mental Health Authority [DBA Riverwood], Summit Pointe [CMHSP for Calhoun County], and Kalamazoo Community Mental Health & Substance Abuse Services), no concerns

were identified with the CMHSPs' adherence to the State-specified submission requirements. Note that **Southwest Michigan Behavioral Health** had low BH-TEDS completion rates for 2018, with BH-TEDS records reported for fewer than 85 percent of the members identified through 837-encounter reporting. Additionally, HSAG identified gaps indicating that **Southwest Michigan Behavioral Health** and the CMHSPs would benefit from employing more robust data quality and reasonability checks of the BH-TEDS records. Specifically, multiple BH-TEDS records in the CMHSPs' EMRs contained conflicting values (e.g., unemployed but listed as earning minimum wage or more) and the CMHSPs' EMRs could accept potentially incorrect values (e.g., clinician inadvertently selects the wrong drop-down value from a pick list); these values were not cross-checked for quality assurance before submission to MDHHS. Additionally, as mandatory fields were populated with the value of "not evaluated," the CMHSPs and **Southwest Michigan Behavioral Health** did not employ a clearly defined process to populate these fields with the true values after the answers were collected. For the records initially documented on paper or in the CMHSPs' EMRs, **Southwest Michigan Behavioral Health** and CMHSPs lacked processes to ensure that the data were input correctly into the **Southwest Michigan Behavioral Health** PIHP's system. Additionally, it was determined during the on-site visit that the BH-TEDS fields captured in the Peter Chang Enterprise, Inc. (PCE) systems (used by some CMHSPs) were not exact matches to the fields available in SmartCareEHR (system used by the PIHP); and **Southwest Michigan Behavioral Health** and the CMHSPs lacked a clear process for populating SmartCareEHR based on these system differences. For example, when entering in the PCE systems that the patient was not employed, the system dynamically changed so that the "Minimum Wage" value would not be collected. However, all values in SmartCareEHR were independent of one another; so, if the patient was not employed, the user would need to indicate the "Minimum Wage" value as "Not Working." Additionally, it was denoted that the total annual income populated in the PCE systems for unemployed members (e.g., child support) could be erroneously entered in the PIHP's EMR in the "Minimum Wage" field. This could lead to members being inadvertently reported to the State as unemployed but earning minimum wage.

- PIHP Oversight of Affiliate Community Mental Health Centers—HSAG found that **Southwest Michigan Behavioral Health** had sufficient oversight of its eight affiliated CMHSPs; but, as discussed in the BH-TEDS section above, areas for improvement still existed.

Based on all validation methods used to collect information during the Michigan SFY 2018 Validation of Performance Measures activity, HSAG determined results for each performance indicator and assigned each an indicator designation of *Report*, *Not Reported*, or *No Benefit*. **Southwest Michigan Behavioral Health** received an indicator designation of *Report* for all indicators, signifying that **Southwest Michigan Behavioral Health** had calculated all indicators in compliance with the MDHHS Codebook specifications and that rates could be reported. Table 5-20 presents **Southwest Michigan Behavioral Health**'s performance measure results and the corresponding MPS when an MPS was established by MDHHS.

Table 5-20—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	97.94%	95.00%
Adults	97.88%	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	97.43%	95.00%
MI Adults	99.52%	95.00%
DD Children	100.00%	95.00%
DD Adults	100.00%	95.00%
Medicaid SA	97.04%	95.00%
Total	98.09%	95.00%
#3: The percent of new Medicaid beneficiaries during the quarter starting any needed ongoing service within 14 days of a non-emergent face-to-face assessment with a professional.		
MI Children	95.67%	95.00%
MI Adults	96.06%	95.00%
DD Children	100.00%	95.00%
DD Adults	100.00%	95.00%
Medicaid SA	95.21%	95.00%
Total	95.70%	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	96.55%	95.00%
Adults	99.25%	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.	97.24%	95.00%
#5: The percent of Medicaid recipients having received PIHP managed services.		
The percent of Medicaid recipients having received PIHP managed services.	6.94%	—

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 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.	81.03%	—
#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	15.32%	—
DD Adults	9.01%	—
MI/DD Adults	7.80%	—
#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	91.63%	—
DD Adults	68.75%	—
MI/DD Adults	73.13%	—
#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	10.14%	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).	22.18%	—
#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).	48.66%	—

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.

Southwest Michigan Behavioral Health's performance exceeded their corresponding MPSs for all 19 measure indicators, suggesting strength in all areas.

Validation of Performance Improvement Projects

For the 2017–2018 validation, **Southwest Michigan Behavioral Health** provided its first-year submission on the new PIP topic: *Improving Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using An Antipsychotic Medication.* The goal of this PIP is to improve the proportion of members with schizophrenia or bipolar disorder and taking an antipsychotic medication who are screened for diabetes.

Table 5-21 outlines the study indicator for the PIP.

Table 5-21—Study Indicator

PIP Topic	Study Indicator
Improving Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using An Antipsychotic Medication	The proportion of members with schizophrenia or bipolar disorder taking an antipsychotic medication who are screened for diabetes during the measurement period.

Table 5-22 and Table 5-23 show **Southwest Michigan Behavioral Health** scores based on HSAG's PIP evaluation. For additional details, refer to the 2017–2018 PIP validation report for **Southwest Michigan Behavioral Health**.

Table 5-22—Performance Improvement Project Validation Results for Southwest Michigan Behavioral Health

Stage	Step		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% (1/1)	0% (0/1)	0% (0/1)
	V.	Valid Sampling Techniques (if sampling was used)	*Not Applicable*		
	VI.	Accurate/Complete Data Collection	100% (2/2)	0% (0/2)	0% (0/2)
Design Total			**100% (7/7)**	**0% (0/7)**	**0% (0/7)**

Stage	Step		Percentage of Applicable Elements		
			Met	*Partially Met*	*Not Met*
Implementation	VII.	Sufficient Data Analysis and Interpretation	*Not Assessed*		
	VIII.	Appropriate Improvement Strategies	*Not Assessed*		
Implementation Total			***Not Assessed***		
Outcomes	IX.	Real Improvement Achieved	*Not Assessed*		
	X.	Sustained Improvement Achieved	*Not Assessed*		
Outcomes Total			***Not Assessed***		
Percentage Score of Applicable Evaluation Elements *Met*			**100% (7/7)**	**0% (0/7)**	**0% (0/7)**

Table 5-23—2017–2018 Performance Improvement Project Validation Scores for Southwest Michigan Behavioral Health

Name of Project	Type of Annual Review	Percentage Score of Evaluation Elements *Met*	Percentage Score of Critical Elements *Met*	Overall Validation Status
Improving Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using An Antipsychotic Medication	Submission	100%	100%	*Met*
	Resubmission	*NA*	*NA*	*NA*

Southwest Michigan Behavioral Health submitted the Design stage of the PIP for this year's validation. Overall, 100 percent of all applicable evaluation elements received a score of *Met* for the first six steps of the PIP process. The PIP had not progressed to the Implementation and Outcomes stages during this validation cycle.

Southwest Michigan Behavioral Health designed a scientifically sound study supported by key research principles and meeting all requirements in the Design stage. The technical design of the PIP was sufficient to measure and monitor PIP outcomes. **Southwest Michigan Behavioral Health** indicated plans to include its entire eligible population in this PIP. A sound study design created the foundation for **Southwest Michigan Behavioral Health** to progress to subsequent PIP stages—collecting data and implementing interventions with the potential to impact study indicator outcomes.

Strengths, Weaknesses, and Overall Conclusions

Southwest Michigan Behavioral Health demonstrated both strengths and weaknesses based on the results of the 2017–2018 EQR activities. **Southwest Michigan Behavioral Health** received a total compliance score of 89 percent across all standards reviewed during the 2017–2018 compliance monitoring review. **Southwest Michigan Behavioral Health** scored above 90 percent in the Subcontracts and Delegation; Provider Network; Disclosure of Ownership, Control, and Criminal Convictions; and Management Information Systems standards, indicating strong performance in these areas, but did not perform as well in the Customer Service, Grievance Process, Access and Availability, and Appeals standards, as demonstrated by moderate to low performance scores (87 percent, 81 percent, 89 percent, and 87 percent respectively), reflecting that additional focus is needed in these areas. All 19 performance measure rates were above the MDHHS-established MPSs, indicating strength within all indicators.

Southwest Michigan Behavioral Health's overall performance demonstrates the following impact to the Medicaid population's quality of, timeliness of, and access to care and services:

Table 5-24—Quality, Timeliness, and Access Performance Impact

Performance Area*	Overall Performance Impact
Quality	• Strength: Received a performance score of 100 percent in the Disclosure of Ownership, Control, and Criminal Convictions standard, indicating a strong focus on program integrity, which includes appropriate screening of contracted providers. • Strength: Low percentage of readmission rates for children and adults discharged from inpatient psychiatric units, as indicated by performance of indicator #10. • Strength: Designed a scientifically sound study related to *Improving Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using An Antipsychotic Medication*, which was supported by key research principles, meeting all requirements of the PIP Design stage. • Weakness: Received five deficiencies in the Customer Service standard related to the customer handbook and provider directory, indicating that members may have challenges navigating the Medicaid managed care program and knowing which providers can meet their unique healthcare needs. • Weakness: Received a performance score of 81 percent in the Grievance Process standard, indicating that an effective grievance process may not be in place for members to express dissatisfaction.
Timeliness	• Strength: Minimum performance standards were met related to timely pre-admission screening for psychiatric inpatient care for children and adults; timely face-to-face assessments with a professional for non-emergency request for services for all populations; timely start of ongoing services for all populations; timely follow-up care after discharge from psychiatric inpatient unit for children and adults; and timely follow-up care after discharge from a substance abuse detox unit indicating that members can get services quickly.

Performance Area*	Overall Performance Impact
Access	• Strength: Received a performance score of 100 percent in the Provider Network standard, indicating that the PIHP maintains a network of providers to provide behavioral health and substance use disorder services to members. • Weakness: Received a performance score of 89 percent in the Access and Availability standard, indicating that some members may have challenges accessing providers and treatment when necessary, even when an appropriate network appears to exist and performance measure indicators are being met. • Weakness: Received an 87 percent in the Appeals standard, suggesting that members may not be aware of all rights afforded to them under the appeal process, which may include opportunity to challenge denial of prescribed services.

*Performance impact may be applicable to one or more performance areas; however, for purposes of this report impact was aligned to either quality, timeliness, or access.

Follow-Up on Prior EQR Recommendations

CMS requires that EQROs report annually the degree to which PIHPs addressed the EQR recommendations made from the prior year's technical report. During the 2016–2017 EQR, HSAG made the following recommendations to **Southwest Michigan Behavioral Health**; and **Southwest Michigan Behavioral Health** addressed these recommendations by taking the following actions:

Compliance Monitoring

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 provided no recommendations during the 2016–2017 review period; therefore, no actions were required of **Southwest Michigan Behavioral Health**.

Validation of Performance Measures

The 2016–2017 validation of performance measures for **Southwest Michigan Behavioral Health** identified opportunities for improvement in the following performance indicators:

- #3: *The percent of new Medicaid beneficiaries during the quarter starting any needed ongoing service within 14 days of a non-emergent face-to-face assessment with a professional—DD Children, DD Adults, Medicaid SA, and Total*

HSAG recommended that **Southwest Michigan Behavioral Health** identify reasons for positive performance for members in the MI Children and MI Adults populations as well as potential opportunities for leveraging these strategies for improved timely ongoing services for children and adults with developmental disabilities and for members receiving substance abuse services. Based upon

the results of the 2017–2018 validation, **Southwest Michigan Behavioral Health** has fully addressed the prior recommendations.

Validation of Performance Improvement Projects

For the 2016–2017 validation, **Southwest Michigan Behavioral Health** provided its fourth-year submission on the PIP topic: *Improving Diabetes Treatment for Consumers With a Co-morbid Mental Health Condition*. 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 and recommended that **Southwest Michigan Behavioral Health** ensure that the reported data and interpretation of results are accurate and consistent throughout the PIP Submission Form. HSAG also recommended that **Southwest Michigan Behavioral Health** build on its momentum of improvement to ensure ability to sustain the improvement achieved; evaluate the effectiveness of each intervention; ensure that decisions made to revise, continue, or discontinue an intervention are data driven; and 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. For the 2017–2018 validation, **Southwest Michigan Behavioral Health** selected a new PIP topic; and as **Southwest Michigan Behavioral Health** proceeds through each phase of the new PIP, HSAG will continue to assess **Southwest Michigan Behavioral Health**'s performance related to improving upon the areas recommended in the previous PIP.

Recommendations

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Southwest Michigan Behavioral Health** to members, HSAG recommends that **Southwest Michigan Behavioral Health** develop a quality improvement strategy within the QAPIP to ensure that all performance indicators remain stable.

Southwest Michigan Behavioral Health should focus on the lowest-performing indicators with an MPS, and should include within its next annual QAPIP review the results of analyses for these performance indicators that answer the following questions:

1. What were the root causes associated with lower-performing areas?
2. What unexpected outcomes were found within the data?
3. What disparities were identified in the analyses?
4. What are the most significant areas of focus (or populations) for which improvement initiatives are planned? What is the highest impact area(s) to make an improvement(s) (low effort/high yield)?
5. What intervention(s) is **Southwest Michigan Behavioral Health** considering or has already implemented to improve rates and performance for each identified indicator?

Based on the information presented above, **Southwest Michigan Behavioral Health** should include the following within its quality improvement plan:

- Measurable goals and benchmarks for each indicator.
- Mechanisms to measure performance.
- Mechanisms to review data trends to identify improvement, decline, or stability in the performance rates.
- Identified opportunities for improvement.
- Ongoing analysis to identify factors that impact adequacy of rates.
- Quality improvement interventions that address the root cause of the deficiency.
- A plan to monitor the quality improvement interventions to detect whether they effect improvement.

Additionally, **Southwest Michigan Behavioral Health** should have defined data entry processes, including documented processes for data quality and data completeness checks.

HSAG also recommends that **Southwest Michigan Behavioral Health** develop meaningful plans of action to bring into compliance each of the following deficient standards:

- Standard VI—Customer Service
- Standard VII—Grievance Process
- Standard IX—Subcontracts and Delegation
- Standard XII—Access and Availability
- Standard XIV—Appeals

Southwest Michigan Behavioral Health should include the following in each of its plans of action, and the plans of action should be provided to MDHHS within 30 days of receipt of required corrective action:

- Detailed narrative of the deficiency.
- Detailed corrective action steps to resolve each deficiency.
- Any resources required to resolve the deficiency.
- Due dates for completing each action step.
- Assigned party responsible for completing each action step.
- Any required deliverables to show that a deficiency has been resolved.
- Any dependencies to resolve deficiencies.

Finally, **Southwest Michigan Behavioral Health** should take proactive steps to ensure a successful PIP. As the PIP progresses, **Southwest Michigan Behavioral Health** should ensure the following:

- Follow the approved PIP methodology to calculate and report baseline data accurately in next year's annual submission.
- To impact the Remeasurement 1 study indicator rate, complete a causal/barrier analysis to identify barriers to desired outcomes and implement interventions to address those barriers timely. Interventions implemented late in the Remeasurement 1 study period will not have enough time to impact the study indicator rate.
- Document the process and steps used to determine barriers to improvement and attach completed quality improvement tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis.
- Implement active, innovative improvement strategies with the potential to directly impact study indicator outcomes.
- Implement a process for evaluating the performance of each PIP intervention and its impact on the study indicators and allow continual refinement of improvement strategies. The evaluation process should be ongoing and cyclical.

Region 5—Mid-State Health Network

To conduct the 2017–2018 EQR, HSAG reviewed **Mid-State Health Network**'s results for mandatory EQR activities. Those results were analyzed and evaluated to develop conclusions and make recommendations about the quality of, timeliness of, and access to care and services provided by **Mid-State Health Network**.

EQR Activity Results

This section provides the results and notable findings for the mandatory EQR activities performed for **Mid-State Health Network**.

Compliance Monitoring

Table 5-25 presents the total number of elements for each standard as well as the number of elements for each standard that received a score of *Met*, *Not Met*, or *Not Applicable (N/A*). Table 5-25 also presents **Mid-State Health Network**'s overall compliance score for each standard, the totals across the eight standards reviewed, and the total compliance score across all standards for the 2017–2018 compliance monitoring review.

Table 5-25—Summary of 2017–2018 Compliance Monitoring Review Results

Standard	Total # of Applicable Elements	Number of Elements			Total Compliance Score
		Met	*Not Met*	*N/A*	
Standard VI—Customer Service	39	34	5	0	**87%**
Standard VII—Grievance Process	26	24	2	0	**92%**
Standard IX—Subcontracts and Delegation	11	10	1	0	**91%**
Standard X—Provider Network	12	12	0	1	**100%**
Standard XII—Access and Availability	19	18	1	0	**95%**
Standard XIV—Appeals	54	50	4	0	**93%**
Standard XV—Disclosure of Ownership, Control, and Criminal Convictions	14	14	0	0	**100%**
Standard XVII—Management Information Systems	14	14	0	0	**100%**
Total Compliance Score	**189**	**176**	**13**	**1**	**93%**

Total # of Applicable Elements—The total number of elements within each standard minus any elements that received designations of *NA*.
Total Compliance Score—Elements scored *Met* were given full value (1 point). The point values were then totaled, and the sum was divided by the number of applicable elements to derive a percentage score.

Mid-State Health Network demonstrated compliance for 176 of 189 elements, with an overall compliance score of 93 percent. **Mid-State Health Network** demonstrated strong performance, scoring 90 percent or above in seven standards, with three of those standards achieving full compliance. These areas of strength include Grievance Process; Subcontracts and Delegation; Provider Network; Access

and Availability; Appeals; Disclosure of Ownership, Control, and Criminal Convictions; and Management Information Systems.

Opportunities for improvement were identified in five of the eight standards, including deficiencies related to the following requirements:

- Content of the customer handbook.
- Content, maintenance, and/or dissemination of the provider directory.
- Grievance processes including but not limited to accountable entity for resolving SUD-related grievances, and format of resolution letters.
- Subcontract provision specifying that the right to audit exists through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.
- Minimum performance standards for ongoing services (for the DD Children population).
- Appeal processes including but not limited to those related to obtaining a written, signed request for an appeal, resolution time frames, and format and content of resolution letters.

Mid-State Health Network's lowest performing areas were in Standard VI—Customer Services with five *Not Met* findings and a compliance score of 87 percent. **Mid-State Health Network** was required to develop and implement a corrective action plan for each requirement in all standards scored *Not Met*. Refer to **Mid-State Health Network**'s 2017–2018 External Quality Review Compliance Monitoring Report for Prepaid Inpatient Health Plan for a detailed review of the findings.

Validation of Performance Measures

The purpose of the performance measure validation activity was to assess the accuracy of performance indicators reported by **Mid-State Health Network** and to determine the extent to which performance indicators reported by **Mid-State Health Network** followed State specifications and reporting requirements. HSAG evaluated **Mid-State Health Network**'s data systems for the processing of each type of data used for reporting MDHHS performance indicators. High-level findings are presented below. Refer to State Fiscal Year 2018 Validation of Performance Measures for Region 5—Mid-State Health Network report for a detailed review of the findings.

- Eligibility and Enrollment Data System Findings—HSAG had no concerns with how **Mid-State Health Network** received and processed eligibility data.
- Medical Services Data System (Claims and Encounters) Findings—HSAG identified no concerns with how **Mid-State Health Network** received and processed claims and encounters for submission to MDHHS. HSAG identified that data completeness and data quality processes used for performance indicator reporting presented some concerns; however, none of these concerns materially impacted the **Mid-State Health Network**'s ability to report performance measure data.
- Behavioral Health Treatment Episode Data Set (BH-TEDS) Data Production—HSAG identified no concerns related to the preparation, validation, and submission of BH-TEDS data files to the State. Monthly, each CMHSP logged in to the BH-TEDS portion of the **Mid-State Health Network** data

warehouse test area and uploaded its data file. Validations were performed by each CMHSP prior to moving the file to the production area of the data warehouse. For data completeness**, Mid-State Health Network**'s vendor, CEI, validated BH-TEDS data based on the State's requirements. The PIHP submitted validated and clean BH-TEDS files to the State based on the State's requirements.

- PIHP Oversight of Affiliate Community Mental Health Centers—HSAG found that **Mid-State Health Network** had sufficient oversight of its 12 CMHSPs.

Based on all validation methods used to collect information during the Michigan SFY 2018 Validation of Performance Measures activity, HSAG determined results for each performance indicator and assigned each an indicator designation of *Report*, *Not Reported*, or *No Benefit*. **Mid-State Health Network** received an indicator designation of *Report* for all indicators, signifying that **Mid-State Health Network** calculated all indicators in compliance with the MDHHS Codebook specifications and that rates could be reported. Table 5-26 presents **Mid-State Health Network**'s performance measure results and the corresponding MPS when an MPS was established by MDHHS.

Table 5-26—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	99.72%	95.00%
Adults	99.31%	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	98.77%	95.00%
MI Adults	99.10%	95.00%
DD Children	100.00%	95.00%
DD Adults	100.00%	95.00%
Medicaid SA	98.65%	95.00%
Total	98.92%	95.00%
#3: The percent of new Medicaid beneficiaries during the quarter starting any needed ongoing service within 14 days of a non-emergent face-to-face assessment with a professional.		
MI Children	95.55%	95.00%
MI Adults	97.90%	95.00%
DD Children	83.05%	95.00%
DD Adults	100.00%	95.00%
Medicaid SA	99.80%	95.00%
Total	97.68%	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	100.00%	95.00%
Adults	97.17%	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.	97.90%	95.00%
#5: The percent of Medicaid recipients having received PIHP managed services.		
The percent of Medicaid recipients having received PIHP managed services.	7.99%	—
#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 HSW enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	96.51%	—
#8: The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who are employed competitively.		
MI Adults	15.37%	—
DD Adults	9.02%	—
MI/DD Adults	8.60%	—
#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	91.84%	—
DD Adults	79.90%	—
MI/DD Adults	80.89%	—
#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	10.12%	15.00%
Adults	9.09%	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).	19.98%	—

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).		
The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	50.48%	—

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.

Rates exceeded their corresponding MPSs for 18 of the 19 measure indicators with MPSs, indicating high performance overall for **Mid-State Health Network.**

One measure rate, indicator *#3: The percent of new Medicaid beneficiaries during the quarter starting any needed ongoing service within 14 days of a non-emergent face-to-face assessment with a professional*—DD Children, fell below the MPS, indicating an opportunity for improvement.

Validation of Performance Improvement Projects

For the 2017–2018 validation, **Mid-State Health Network** provided its first-year submission on the new PIP topic: *Patients With Schizophrenia and Diabetes Who Had an HbA1c and LDL-C Test.* The goal of this PIP is to increase annual hemoglobin A1c (HbA1c) and low-density lipoprotein cholesterol (LDL-C) testing among Medicaid members with diabetes and schizophrenia.

Table 5-27 outlines the study indicators for the PIP.

Table 5-27—Study Indicator

PIP Topic	Study Indicator
Patients With Schizophrenia and Diabetes Who Had an HbA1c and LDL-C Test	The percentage of members with schizophrenia and diabetes who had an HbA1c and LDL-C test during the measurement period.

Table 5-28 and Table 5-29 show **Mid-State Health Network** scores based on HSAG's PIP evaluation. For additional details, refer to the 2017–2018 PIP validation report for **Mid-State Health Network**.

Table 5-28—Performance Improvement Project Validation Results for Mid-State Health Network

Stage	Step		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% (2/2)	0% (0/2)	0% (0/2)
	V.	Valid Sampling Techniques (if sampling was used)	*Not Applicable*		
	VI.	Accurate/Complete Data Collection	100% (2/2)	0% (0/2)	0% (0/2)
Design Total			**100% (8/8)**	**0% (0/8)**	**0% (0/8)**
Implementation	VII.	Sufficient Data Analysis and Interpretation	*Not Assessed*		
	VIII.	Appropriate Improvement Strategies	*Not Assessed*		
Implementation Total			***Not Assessed***		
Outcomes	IX.	Real Improvement Achieved	*Not Assessed*		
	X.	Sustained Improvement Achieved	*Not Assessed*		
Outcomes Total			***Not Assessed***		
Percentage Score of Applicable Evaluation Elements *Met*			**100% (8/8)**	**0% (0/8)**	**0% (0/8)**

Table 5-29—2017–2018 Performance Improvement Project Validation Scores for Mid-State Health Network

Name of Project	Type of Annual Review	Percentage Score of Evaluation Elements *Met*	Percentage Score of Critical Elements *Met*	Overall Validation Status
Patients With Schizophrenia and Diabetes Who Had an HbA1c and LDL-C Test	Submission	88%	80%	*Partially Met*
	Resubmission	100%	100%	*Met*

Mid-State Health Network submitted the Design stage of the PIP for this year's validation. Overall, 100 percent of all applicable evaluation elements received a score of *Met* for the first six steps of the PIP process. The PIP had not progressed to the Implementation and Outcomes stages during this validation cycle.

Mid-State Health Network designed a scientifically sound study supported by key research principles and meeting all requirements in the Design stage. The technical design of the PIP was sufficient to measure and monitor PIP outcomes. **Mid-State Health Network** indicated plans to include its entire eligible population in this PIP. A sound study design created the foundation for **Mid-State Health Network** to progress to subsequent PIP stages—collecting data and implementing interventions with the potential to impact study indicator outcomes.

Strengths, Weaknesses, and Overall Conclusions

Mid-State Health Network demonstrated both strengths and weaknesses based on the results of the 2017–2018 EQR activities. **Mid-State Health Network** received a total compliance score of 93 percent across all standards reviewed during the 2017–2018 compliance monitoring review, which was the highest score achieved during the review. **Mid-State Health Network** scored above 90 percent in the Grievance Process; Subcontracts and Delegation; Provider Network; Access and Availability; Appeals; Disclosure of Ownership, Control, and Criminal Convictions; and Management Information Systems standards, indicating strong performance in these areas, but did not perform as well in the Customer Service standard, as demonstrated by a performance score of 87 percent, reflecting that additional focus is needed in this area. While 18 of the 19 performance measure rates were above the MDHHS-established MPSs, indicating strengths in these areas, **Mid-State Health Network**'s rate for indicator #3*: The percent of new Medicaid beneficiaries during the quarter starting any needed ongoing service within 14 days of a non-emergent face-to-face assessment with a professional—DD Children* fell below its corresponding MPS, indicating opportunities for improvement for this measure.

Mid-State Health Network's overall performance demonstrates the following impact to the Medicaid population's quality of, timeliness of, and access to care and services:

Table 5-30—Quality, Timeliness, and Access Performance Impact

Performance Area*	Overall Performance Impact
Quality	• Strength: Received a performance score of 92 percent in the Grievance Process standard, indicating that the PIHP had an effective grievance process in place for members to express dissatisfaction. • Strength: Received a performance score of 100 percent in the Disclosure of Ownership, Control, and Criminal Convictions standard, indicating a strong focus on program integrity, which includes appropriate screening of its contracted providers. • Strength: Low percentage of readmission rates for children and adults discharged from inpatient psychiatric units, as indicated by performance of indicator #10. • Strength: Designed a scientifically sound study related to *Patients With Schizophrenia and Diabetes Who Had an HbA1c and LDL-C Test,* which was supported by key research principles, meeting all requirements of the PIP Design stage. • Weakness: Received five deficiencies in the Customer Service standard related to the customer handbook and provider directory, indicating that members may have challenges navigating the Medicaid managed care program and knowing which providers can meet their unique healthcare needs.
Timeliness	• Strength: Minimum performance standards were met related to timely pre-admission screening for psychiatric inpatient care for children and adults; timely face-to-face assessments with a professional for non-emergency request for services for MI Children, MI Adults, DD Children, DD Adults, and Medicaid SA; and receiving timely needed ongoing services for MI Children, MI Adults, DD Adults, and Medicaid SA. • Weakness: Minimum performance standard related to receiving timely needed ongoing services for DD Children, indicating that children with developmental disabilities were not always receiving services as soon as needed.
Access	• Strength: Received a performance score of 100 percent in the Provider Network standard, indicating that the PIHP maintains a network of providers to provide behavioral health and substance use disorder services to members. • Strength: Tied for second-highest performance score at 95 percent in the Access and Availability standard, indicating that most members had access to providers and treatment when necessary. • Strength: As indicated by the performance measure rate, 100 percent of children discharged from a psychiatric inpatient unit were seen for follow-up care within seven days. • Strength: Received a 93 percent in the Appeals standard, suggesting that members are receiving most rights afforded to them under the appeal process, including giving members opportunity to challenge denial of prescribed services.

*Performance impact may be applicable to one or more performance areas; however, for purposes of this report impact was aligned to either quality, timeliness, or access.

Follow-Up on Prior EQR Recommendations

CMS requires that EQROs report annually the degree to which PIHPs addressed the EQR recommendations made from the prior year's technical report. During the 2016–2017 EQR, HSAG made the following recommendations to **Mid-State Health Network**; and **Mid-State Health Network** addressed these recommendations by taking the following actions:

Compliance Monitoring

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 provided no recommendations during the 2016–2017 review period; therefore, no actions were required of **Mid-State Health Network**.

Validation of Performance Measures

The 2016–2017 validation of performance measures for **Mid-State Health Network** identified opportunities for improvement in the following performance indicators:

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

HSAG recommended that **Mid-State Health Network** evaluate contributing factors that led to timely ongoing services for members in the MI Children, MI Adults, DD Children, and Medicaid SA populations and leverage those factors to achieve timely ongoing services for adults with developmental disabilities. Based on the results of the 2017–2018 validation, **Mid-State Health Network** fully addressed the prior recommendations; however, opportunities still exist in this indicator as DD Children did not meet the established minimum performance threshold.

Validation of Performance Improvement Projects

For the 2016–2017 validation, **Mid-State Health Network** provided its fourth-year submission on the PIP topic: *Increasing Diabetes Screening for Consumers With Schizophrenia or Bipolar Disorder Prescribed Antipsychotic Medications*. HSAG identified no opportunities for improvement in the annual PIP validation tool for **Mid-State Health Network**, however recommended that **Mid-State Health Network** continue to evaluate and monitor interventions to ensure continuing to sustain the improvement achieved. For the 2017–2018 validation, **Mid-State Health Network** selected a new PIP topic; and as **Mid-State Health Network** proceeds through each phase of the new PIP, HSAG will continue to assess **Mid-State Health Network**'s performance related to evaluating and monitoring interventions as recommended in the previous PIP.

Recommendations

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Mid-State Health Network** to members, HSAG recommends that **Mid-State Health Network** incorporate efforts for improvement of the following performance indicators with an MPS as part of its quality improvement strategy within the QAPIP:

Ratings Below the MPS[5-3]

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

Performance Declined >2 Percent From Previous Year

- *#3: The percent of new Medicaid beneficiaries during the quarter starting any needed ongoing service within 14 days of a non-emergent face-to-face assessment with a professional*—MI Children
- *#4b: The percent of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days*

Mid-State Health Network should include within its next annual QAPIP review the results of analyses for the performance indicators listed above that answer the following questions:

1. What were the root causes associated with low-performing rates?
2. What unexpected outcomes were found within the data?
3. What disparities were identified in the analyses?
4. What are the most significant areas of focus (or populations) for which improvement initiatives are planned? What is the highest impact area(s) to make an improvement(s) (low effort/high yield)?
5. What intervention(s) is **Mid-State Health Network** considering or has already implemented to improve rates and performance for each identified indicator?

Based on the information presented above, **Mid-State Health Network** should include the following within its quality improvement plan:

- Measurable goals and benchmarks for each indicator.
- Mechanisms to measure performance.
- Mechanisms to review data trends to identify improvement, decline, or stability in the performance rates.
- Identified opportunities for improvement.
- Ongoing analysis to identify factors that impact adequacy of rates.

[5-3] Performance indicators listed under "Ratings Below the MPS" could have demonstrated a greater than 2 percent decline from the previous year, but they were not repeated under "Performance Declined >2 Percent From Previous Year."

- Quality improvement interventions that address the root cause of the deficiency.
- A plan to monitor the quality improvement interventions to detect whether they effect improvement.

Additionally, **Mid-State Health Network** should have defined data entry processes, including documented processes for data quality and data completeness checks.

HSAG also recommends that **Mid-State Health Network** develop meaningful plans of action to bring into compliance each of the following deficient standards:

- Standard VI—Customer Service
- Standard VII—Grievance Process
- Standard IX—Subcontracts and Delegation
- Standard XII—Access and Availability
- Standard XIV—Appeals

Mid-State Health Network should include the following in each of its plans of action, and the plans of action should be provided to MDHHS within 30 days of receipt of required corrective action:

- Detailed narrative of the deficiency.
- Detailed corrective action steps to resolve each deficiency.
- Any resources required to resolve the deficiency.
- Due dates for completing each action step.
- Assigned party responsible for completing each action step.
- Any required deliverables to show that a deficiency has been resolved.
- Any dependencies to resolve deficiencies

Finally, **Mid-State Health Network** should take proactive steps to ensure a successful PIP. As the PIP progresses, **Mid-State Health Network** should ensure the following:

- Follow the approved PIP methodology to calculate and report baseline data accurately in next year's annual submission.
- To impact the Remeasurement 1 study indicator rate, complete a causal/barrier analysis to identify barriers to desired outcomes and implement interventions to address those barriers timely. Interventions implemented late in the Remeasurement 1 study period will not have enough time to impact the study indicator rate.
- Document the process and steps used to determine barriers to improvement; and attach completed quality improvement tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis.
- Implement active, innovative improvement strategies with the potential to directly impact study indicator outcomes.
- Implement a process for evaluating the performance of each PIP intervention and its impact on the study indicators, and allow continual refinement of improvement strategies. The evaluation process should be ongoing and cyclical.

Region 6—CMH Partnership of Southeast Michigan

To conduct the 2017–2018 EQR, HSAG reviewed **CMH Partnership of Southeast Michigan**'s results for mandatory EQR activities. Those results were analyzed and evaluated to develop conclusions and make recommendations about the quality of, timeliness of, and access to care and services provided by **CMH Partnership of Southeast Michigan**.

EQR Activity Results

This section provides the results and notable findings for the mandatory EQR activities performed for **CMH Partnership of Southeast Michigan**.

Compliance Monitoring

Table 5-31 presents the total number of elements for each standard as well as the number of elements for each standard that received a score of *Met*, *Not Met*, or *Not Applicable (N/A*). Table 5-31 also presents **CMH Partnership of Southeast Michigan**'s overall compliance score for each standard, the totals across the eight standards reviewed, and the total compliance score across all standards for the 2017–2018 compliance monitoring review.

Table 5-31—Summary of 2017–2018 Compliance Monitoring Review Results

Standard	Total # of Applicable Elements	Number of Elements			Total Compliance Score
		Met	*Not Met*	*N/A*	
Standard VI—Customer Service	39	34	5	0	**87%**
Standard VII—Grievance Process	26	26	0	0	**100%**
Standard IX—Subcontracts and Delegation	11	10	1	0	**91%**
Standard X—Provider Network	12	10	2	1	**83%**
Standard XII—Access and Availability	19	17	2	0	**89%**
Standard XIV—Appeals	54	47	7	0	**87%**
Standard XV—Disclosure of Ownership, Control, and Criminal Convictions	14	14	0	0	**100%**
Standard XVII—Management Information Systems	12	12	0	2	**100%**
Total Compliance Score	**187**	**170**	**17**	**3**	**91%**

Total # of Applicable Elements—The total number of elements within each standard minus any elements that received designations of *NA*.
Total Compliance Score—Elements scored *Met* were given full value (1 point). The point values were then totaled, and the sum was divided by the number of applicable elements to derive a percentage score.

CMH Partnership of Southeast Michigan demonstrated compliance for 170 of 187 elements, with an overall compliance score of 91 percent. **CMH Partnership of Southeast Michigan** demonstrated strong performance, scoring 90 percent or above in four standards, with three of those standards achieving full compliance. These areas of strength include Grievance Process; Subcontracts and

Delegation; Disclosure of Ownership, Control, and Criminal Convictions; and Management Information Systems.

Opportunities for improvement were identified in five of the eight standards, including deficiencies related to the following requirements:

- Content of the customer handbook.
- Content, maintenance, and/or dissemination of the provider directory.
- Subcontract provision specifying that the right to audit exists through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.
- Giving providers not selected for inclusion in the network written notice of the reason for the decision.
- Process to ensure that MDHHS is notified within seven days of any changes to the composition of the provider network organizations which negatively affect access to care.
- Minimum performance standards for ongoing services (for the DD Adults population), and follow-up after discharge from a detoxication unit.
- Appeal processes including but not limited to continuation or reinstatement of services as well as ensuring documentation that decision makers were not involved in any previous level of review or decision making.

CMH Partnership of Southeast Michigan's lowest performing areas were in Standard X—Provider Network with two *Not Met* findings and a compliance score of 83 percent. **CMH Partnership of Southeast Michigan** was required to develop and implement a corrective action plan for each requirement in all standards scored *Not Met*. Refer to **CMH Partnership of Southeast Michigan**'s 2017–2018 External Quality Review Compliance Monitoring Report for Prepaid Inpatient Health Plan for a detailed review of the findings.

Validation of Performance Measures

The purpose of the performance measure validation activity was to assess the accuracy of performance indicators reported by **CMH Partnership of Southeast Michigan** and to determine the extent to which performance indicators reported by **CMH Partnership of Southeast Michigan** followed State specifications and reporting requirements. HSAG evaluated **CMH Partnership of Southeast Michigan's** data systems for the processing of each type of data used for reporting MDHHS performance indicators. High-level findings are presented below. Refer to State Fiscal Year 2018 Validation of Performance Measures for Region 6—CMH Partnership of Southeast Michigan report for a detailed review of the findings.

- Eligibility and Enrollment Data System Findings—HSAG identified no concerns with **CMH Partnership of Southeast Michigan**'s process for receiving and processing eligibility data.

- Medical Services Data System (Claims and Encounters) Findings—HSAG identified no concerns with the process used by **CMH Partnership of Southeast Michigan** to receive and process claims and encounters.
- Behavioral Health Treatment Episode Data Set (BH-TEDS) Data Production—Built-in validation processes and additional manual verification ensured accuracy and completeness of the data prior to State submission. BH-TEDS data files were created by the CMHSPs, reviewed for accuracy, and submitted to **CMH Partnership of Southeast Michigan** for submission to the State monthly. After submission, the State provided a 5847d BH-TEDS response file containing explanation for any file rejections. HSAG identified gaps, indicating that **CMH Partnership of Southeast Michigan** and the CMHSPs would benefit from employing more robust data quality and reasonability checks of the BH-TEDS records. Specifically, multiple BH-TEDS records in the CMHSPs' EMRs contained conflicting values (for example, unemployed, but listed as earning minimum wage or more), and the CMHSPs' EMRs could accept potentially incorrect values (e.g., clinician inadvertently selects the wrong drop-down value from a pick list); but these values were not cross-checked for quality assurance before submission to MDHHS. Additionally, as mandatory fields were populated with the value of "not evaluated," the CMHSPs and **CMH Partnership of Southeast Michigan** did not employ a clearly defined process to populate these fields with the true values after the answers were collected. It should also be noted that for 2017–2018 **CMH Partnership of Southeast Michigan** reported BH-TEDS records for fewer than 85 percent of the members identified through 837-encounter submissions to the State.
- PIHP Oversight of Affiliate Community Mental Health Centers—HSAG found that **CMH Partnership of Southeast Michigan** had sufficient oversight of its four affiliated CMHSPs; but, as discussed in the section above, areas for improvement still existed.

Based on all validation methods used to collect information during the Michigan SFY 2018 validation of performance measures activity, HSAG determined results for each performance indicator and assigned each an indicator designation of *Report*, *Not Reported*, or *No Benefit*. **CMH Partnership of Southeast Michigan** received an indicator designation of *Report* for all indicators, signifying that **CMH Partnership of Southeast Michigan** had calculated all indicators in compliance with the MDHHS Codebook specifications and that rates could be reported. Table 5-32 presents **CMH Partnership of Southeast Michigan**'s performance measure results and the corresponding MPS when an MPS was established by MDHHS.

Table 5-32—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.		
Children	100.00%	95.00%
Adults	99.63%	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	99.37%	95.00%
MI Adults	99.65%	95.00%
DD Children	100.00%	95.00%
DD Adults	100.00%	95.00%
Medicaid SA	97.58%	95.00%
Total	98.75%	95.00%
#3: The percent of new Medicaid beneficiaries during the quarter starting any needed ongoing service within 14 days of a non-emergent face-to-face assessment with a professional.		
MI Children	97.94%	95.00%
MI Adults	97.55%	95.00%
DD Children	96.77%	95.00%
DD Adults	96.30%	95.00%
Medicaid SA	95.15%	95.00%
Total	96.30%	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	97.79%	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.	92.13%	95.00%
#5: The percent of Medicaid recipients having received PIHP managed services.		
The percent of Medicaid recipients having received PIHP managed services.	6.59%	—

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 HSW enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	96.86%	—
#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	14.40%	—
DD Adults	9.20%	—
MI/DD Adults	9.31%	—
#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	89.41%	—
DD Adults	60.96%	—
MI/DD Adults	68.64%	—
#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	12.20%	15.00%
Adults	9.38%	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).	26.00%	—
#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).	29.81%	—

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.

Rates for 18 of 19 measure indicators exceeded their corresponding MPSs, indicating positive performance for **CMH Partnership of Southeast Michigan**.

One measure, 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*, fell below the MPS, indicating an opportunity for improvement.

Validation of Performance Improvement Projects

For the 2017–2018 validation, **CMH Partnership of Southeast Michigan** provided its first-year submission on the new PIP topic: *Patients With Schizophrenia and Diabetes Who Had an HbA1c and LDL-C Test.* The goal of this PIP is to increase annual HbA1c and LDL-C testing among Medicaid members with diabetes and schizophrenia.

Table 5-33 outlines the study indicators for the PIP.

Table 5-33—Study Indicator

PIP Topic	Study Indicators
Patients With Schizophrenia and Diabetes Who Had an HbA1c and LDL-C Test	The percentage of members aged 18–64 with schizophrenia and diabetes who had an HbA1c and LDL-C test during the measurement year.

Table 5-34 and Table 5-35 show **CMH Partnership of Southeast Michigan** scores based on HSAG's PIP evaluation. For additional details, refer to the 2017–2018 PIP validation report for **CMH Partnership of Southeast Michigan**.

Table 5-34—Performance Improvement Project Validation Results for CMH Partnership of Southeast Michigan

Stage	Step		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% (2/2)	0% (0/2)	0% (0/2)
	V.	Valid Sampling Techniques (if sampling was used)	*Not Applicable*		
	VI.	Accurate/Complete Data Collection	100% (3/3)	0% (0/3)	0% (0/3)
Design Total			**100% (9/9)**	**0% (0/9)**	**0% (0/9)**

Stage		Step	Percentage of Applicable Elements		
			Met	*Partially Met*	*Not Met*
Implementation	VII.	Sufficient Data Analysis and Interpretation	*Not Assessed*		
	VIII.	Appropriate Improvement Strategies	*Not Assessed*		
Implementation Total			***Not Assessed***		
Outcomes	IX.	Real Improvement Achieved	*Not Assessed*		
	X.	Sustained Improvement Achieved	*Not Assessed*		
Outcomes Total			***Not Assessed***		
Percentage Score of Applicable Evaluation Elements *Met*			**100% (9/9)**	**0% (0/9)**	**0% (0/9)**

Table 5-35—2017–2018 Performance Improvement Project Validation Scores for CMH Partnership of Southeast Michigan

Name of Project	Type of Annual Review	Percentage Score of Evaluation Elements *Met*	Percentage Score of Critical Elements *Met*	Overall Validation Status
Patients With Schizophrenia and Diabetes Who Had an HbA1c and LDL-C Test	Submission	100%	100%	*Met*
	Resubmission	*NA*	*NA*	*NA*

CMH Partnership of Southeast Michigan submitted the Design stage of the PIP for this year's validation. Overall, 100 percent of all applicable evaluation elements received a score of *Met* for the first six steps of the PIP process. The PIP had not progressed to the Implementation and Outcomes stages during this validation cycle.

CMH Partnership of Southeast Michigan designed a scientifically sound study supported by key research principles and meeting all requirements in the Design stage. The technical design of the PIP was sufficient to measure and monitor PIP outcomes. **CMH Partnership of Southeast Michigan** indicated plans to include its entire eligible population in this PIP. A sound study design created the foundation for **CMH Partnership of Southeast Michigan** to progress to subsequent PIP stages—collecting data and implementing interventions with the potential to impact study indicator outcomes.

Strengths, Weaknesses, and Overall Conclusions

CMH Partnership of Southeast Michigan demonstrated both strengths and weaknesses based on the results of the 2017–2018 EQR activities. **CMH Partnership of Southeast Michigan** received a total compliance score of 91 percent across all standards reviewed during the 2017–2018 compliance monitoring review, which was the second-highest performing score across all PIHPs. **CMH Partnership of Southeast Michigan** scored above 90 percent in the Grievance Process; Subcontracts and Delegation; Disclosure of Ownership, Control, and Criminal Convictions; and Management Information Systems standards, indicating strong performance in these areas, but did not perform as well in the Customer Service, Provider Network, Access and Availability, and Appeals standards, as demonstrated by moderate to low performance scores (87 percent, 83 percent, 89 percent, and 87 percent respectively), reflecting that additional focus is needed in these areas. While 18 of the 19 performance measure rates were above the MDHHS-established MPSs, indicating strengths in these areas, **CMH Partnership of Southeast Michigan**'s rate 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*, fell below the corresponding MPS, indicating opportunities for improvement for this measure.

CMH Partnership of Southeast Michigan's overall performance demonstrates the following impact to the Medicaid population's quality of, timeliness of, and access to care and services:

Table 5-36—Quality, Timeliness, and Access Performance Impact

Performance Area*	Overall Performance Impact
Quality	• Strength: Received a performance score of 100 percent in the Grievance Process standard, indicating that the PIHP had an effective grievance process in place for members to express dissatisfaction. • Strength: Received a performance score of 100 percent in the Disclosure of Ownership, Control, and Criminal Convictions standard, indicating a strong focus on program integrity, which includes appropriate screening of contracted providers. • Strength: Low percentage of readmission rates for children and adults discharged from inpatient psychiatric units, as indicated by performance of indicator #10. • Strength: Designed a scientifically sound study related to *Patients With Schizophrenia and Diabetes Who Had an HbA1c and LDL-C Test*, which was supported by key research principles, meeting all requirements of the PIP Design stage. • Weakness: Received five deficiencies in the Customer Service standard related to the customer handbook and provider directory, indicating that members may have challenges navigating the Medicaid managed care program and knowing which providers can meet their unique healthcare needs.

Performance Area*	Overall Performance Impact
Timeliness	• Strength: Minimum performance standards were met related to timely pre-admission screening for psychiatric inpatient care for children and adults; timely face-to-face assessments with a professional for non-emergency requests for services for MI Children, MI Adults, DD Children, DD Adults, and Medicaid SA; and receiving timely needed ongoing services for MI Children, MI Adults, DD Children, DD Adults, and Medicaid SA. • Weakness: Minimum performance standard related to timely substance abuse detox follow-up care was not met, indicating that members were not always receiving services as soon as needed.
Access	• Strength: As indicated by the performance measure rate, 100 percent of children and 97.79 percent of adults discharged from a psychiatric inpatient unit were seen for follow-up care within seven days. • Weakness: Received an 87 percent in the Appeals standard, suggesting that members may not be aware of all rights afforded to them under the appeal process, which may include opportunity to challenge denial of prescribed services.

*Performance impact may be applicable to one or more performance areas; however, for purposes of this report impact was aligned to either quality, timeliness, or access.

Follow-Up on Prior EQR Recommendations

CMS requires EQROs to report annually the degree to which PIHPs addressed the EQR recommendations made from the prior year's technical report. During the 2016–2017 EQR, HSAG made the following recommendations to **CMH Partnership of Southeast Michigan**; and **CMH Partnership of Southeast Michigan** addressed these recommendations by taking the following actions:

Compliance Monitoring

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 provided no recommendations during the 2016–2017 review period; therefore, no actions were required of **CMH Partnership of Southeast Michigan**.

Validation of Performance Measures

The 2016–2017 validation of performance measures for **CMH Partnership of Southeast Michigan** identified opportunities for improvement in the following performance indicators due to these rates being deemed *Not Reported*:

- *#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: The percent of new Medicaid beneficiaries during the quarter starting any needed ongoing service within 14 days of a non-emergent face-to-face assessment with a professional*
- *#4b: The percent of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days*

HSAG recommended that **CMH Partnership of Southeast Michigan** create a locked, consumer-level detail file at the time of reporting of rates for each quarter. HSAG also recommended that **CMH Partnership of Southeast Michigan** follow up with MDHHS to resolve discrepancies between MDHHS rate calculations and the PIHP's rate calculations. Further, HSAG recommended that **CMH Partnership of Southeast Michigan** enhance its processes to create, across all providers, uniformity in documenting appointment-offered dates and continue to monitor exclusions and exceptions data for all performance indicators, to ensure proper alignment with the measure specifications. Based upon the results of the 2017–2018 validation, **CMH Partnership of Southeast Michigan** fully addressed the prior recommendations.

Validation of Performance Improvement Projects

For the 2016–2017 validation, **CMH Partnership of Southeast Michigan** provided its fourth-year submission on the PIP topic: *Medication Labs*. HSAG identified *Points of Clarification* as an area of opportunity in Activity VIII—Appropriate Improvement Strategies, and recommended that **CMH Partnership of Southeast Michigan** evaluate the effectiveness of each intervention; ensure that decisions made to revise, continue, or discontinue an intervention are data driven; and continue to identify barriers and monitor interventions to ensure sustaining improvement achieved. For the 2017–2018 validation, **CMH Partnership of Southeast Michigan** selected a new PIP topic; and, as **CMH Partnership of Southeast Michigan** proceeds through each phase of the new PIP, HSAG will continue to assess **CMH Partnership of Southeast Michigan**'s performance related to improving upon the areas recommended in the previous PIP.

Recommendations

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **CMH Partnership of Southeast Michigan** to members, HSAG recommends that **CMH Partnership of Southeast Michigan** incorporate efforts for improvement of the following performance indicators with an MPS as part of its quality improvement strategy within the QAPIP:

Rating Below the MPS[5-4]

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

Increase in Readmissions >5 Percent From Previous Year

- *#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

CMH Partnership of Southeast Michigan should include within its next annual QAPIP review the results of analyses for the performance indicators listed above that answer the following questions:

1. What were the root causes associated with low-performing rates?
2. What unexpected outcomes were found within the data?
3. What disparities were identified in the analyses?
4. What are the most significant areas of focus (or populations) for which improvement initiatives are planned? What is the highest impact area(s) to make an improvement(s) (low effort/high yield)?
5. What intervention(s) is **CMH Partnership of Southeast Michigan** considering or has already implemented to improve rates and performance for each identified indicator?

Based on the information presented above, **CMH Partnership of Southeast Michigan** should include the following within its quality improvement plan:

- Measurable goals and benchmarks for each indicator.
- Mechanisms to measure performance.
- Mechanisms to review data trends to identify improvement, decline, or stability in the performance rates.
- Identified opportunities for improvement.
- Ongoing analysis to identify factors that impact adequacy of rates.
- Quality improvement interventions that address the root cause of the deficiency.
- A plan to monitor the quality improvement interventions to detect whether they effect improvement.

[5-4] Performance indicators listed under "Ratings Below the MPS" could have demonstrated a greater than 5 percent increase from the previous year, but they were not repeated under "Increase in Readmissions >5 Percent From Previous Year."

Additionally, **CMH Partnership of Southeast Michigan** should have defined data entry processes, including documented processes for data quality and data completeness checks.

HSAG also recommends that **CMH Partnership of Southeast Michigan** develop meaningful plans of action to bring into compliance each of the following deficient standards:

- Standard VI—Customer Service
- Standard IX—Subcontracts and Delegation
- Standard X—Provider Network
- Standard XII—Access and Availability
- Standard XIV—Appeals

CMH Partnership of Southeast Michigan should include the following in each of its plans of action, and the plans of action should be provided to MDHHS within 30 days of receipt of required corrective action:

- Detailed narrative of the deficiency.
- Detailed corrective action steps to resolve each deficiency.
- Any resources required to resolve the deficiency.
- Due dates for completing each action step.
- Assigned party responsible for completing each action step.
- Any required deliverables to show that a deficiency has been resolved.
- Any dependencies to resolve deficiencies.

Finally, **CMH Partnership of Southeast Michigan** should take proactive steps to ensure a successful PIP. As the PIP progresses, **CMH Partnership of Southeast Michigan** should ensure the following:

- Follow the approved PIP methodology to calculate and report baseline data accurately in next year's annual submission.
- To impact the Remeasurement 1 study indicator rate, complete a causal/barrier analysis to identify barriers to desired outcomes and implement interventions to address those barriers timely. Interventions implemented late in the Remeasurement 1 study period will not have enough time to impact the study indicator rate.
- Document the process and steps used to determine barriers to improvement; and attach completed quality improvement tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis.
- Implement active, innovative improvement strategies with the potential to directly impact study indicator outcomes.
- Implement a process for evaluating the performance of each PIP intervention and its impact on the study indicators and allow continual refinement of improvement strategies. The evaluation process should be ongoing and cyclical.

Region 7—Detroit Wayne Mental Health Authority

To conduct the 2017–2018 EQR, HSAG reviewed **Detroit Wayne Mental Health Authority**'s results for mandatory EQR activities. Those results were analyzed and evaluated to develop conclusions and make recommendations about the quality of, timeliness of, and access to care and services provided by **Detroit Wayne Mental Health Authority**.

EQR Activity Results

This section provides the results and notable findings for the mandatory EQR activities performed for **Detroit Wayne Mental Health Authority**.

Compliance Monitoring

Table 5-37 presents the total number of elements for each standard as well as the number of elements for each standard that received a score of *Met*, *Not Met*, or *Not Applicable (N/A*). Table 5-37 also presents **Detroit Wayne Mental Health Authority**'s overall compliance score for each standard, the totals across the eight standards reviewed, and the total compliance score across all standards for the 2017–2018 compliance monitoring review.

Table 5-37—Summary of 2017–2018 Compliance Monitoring Review Results

Standard	Total # of Applicable Elements	Number of Elements			Total Compliance Score
		Met	*Not Met*	*N/A*	
Standard VI—Customer Service	39	34	5	0	**87%**
Standard VII—Grievance Process	26	26	0	0	**100%**
Standard IX—Subcontracts and Delegation	11	9	2	0	**82%**
Standard X—Provider Network	12	12	0	1	**100%**
Standard XII—Access and Availability	19	17	2	0	**89%**
Standard XIV—Appeals	54	45	9	0	**83%**
Standard XV—Disclosure of Ownership, Control, and Criminal Convictions	14	14	0	0	**100%**
Standard XVII—Management Information Systems	12	9	3	2	**75%**
Total Compliance Score	**187**	**166**	**21**	**3**	**89%**

Total # of Applicable Elements—The total number of elements within each standard minus any elements that received designations of *NA*.
Total Compliance Score—Elements scored *Met* were given full value (1 point). The point values were then totaled, and the sum was divided by the number of applicable elements to derive a percentage score.

Detroit Wayne Mental Health Authority demonstrated compliance for 166 of 187 elements, with an overall compliance score of 89 percent. **Detroit Wayne Mental Health Authority** demonstrated strong performance, scoring 90 percent or above in three standards, with all three of those standards achieving full compliance. These areas of strength include Grievance Process; Provider Network; Disclosure of Ownership, Control, and Criminal Convictions.

Opportunities for improvement were identified in five of the eight standards, including deficiencies related to the following requirements:

- Content of the customer handbook.
- Content, maintenance, and/or dissemination of the provider directory.
- Annual monitoring of subcontractors.
- Subcontract provision specifying that the right to audit exists through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.
- Minimum performance standards for preadmission screening (for the Adults population); and face-to-face assessments (for the Children population).
- Appeal processes including but not limited to continuation or reinstatement of services, denial of expedited appeal request provisions, extension of time frame provisions, and content of resolution notices.
- Annual certification to attest to the accuracy, completeness, and truthfulness of information in data sets submitted to MDHHS.
- Providing utilization reports to each CMHSP as to how the CMHSP compares to the PIHP's region as a whole.

Detroit Wayne Mental Health Authority's lowest performing areas were in Standard XVII—Management Information Systems with three *Not Met* findings and a compliance score of 75 percent. **Detroit Wayne Mental Health Authority** was required to develop and implement a corrective action plan for each requirement in all standards scored *Not Met*. Refer to **Detroit Wayne Mental Health Authority**'s 2017–2018 External Quality Review Compliance Monitoring Report for Prepaid Inpatient Health Plan for a detailed review of the findings.

Validation of Performance Measures

The purpose of the performance measure validation activity was to assess the accuracy of performance indicators reported by **Detroit Wayne Mental Health Authority** and to determine the extent to which performance indicators reported by **Detroit Wayne Mental Health Authority** followed State specifications and reporting requirements. HSAG evaluated **Detroit Wayne Mental Health Authority**'s data systems for the processing of each type of data used for reporting MDHHS performance indicators. High-level findings are presented below. Refer to State Fiscal Year 2018 Validation of Performance Measures for Region 7—Detroit Wayne Mental Health Authority report for a detailed review of the findings.

- Eligibility and Enrollment Data System Findings—HSAG had no concerns with how **Detroit Wayne Mental Health Authority**'s received and processed eligibility data.
- Medical Services Data System (Claims and Encounters) Findings—HSAG identified no concerns with how **Detroit Wayne Mental Health Authority** received and processed claims and encounters. For HSAG's review, the PIHP provided a patient-level detail file; however, the data needed to be

filtered and modified to drill down to the exact denominator, numerator, and exception counts reported to the State; and **Detroit Wayne Mental Health Authority** was unable to filter the files to arrive at the reported data counts. Due to this, it was not possible to validate the counts reported to the State by **Detroit Wayne Mental Health Authority**. Gaps existed in the **Detroit Wayne Mental Health Authority**'s process for evaluating and validating the performance indicator data; therefore, the performance indicator values submitted to MDHHS were considered materially biased and received *Not Reported* audit designations.

- Behavioral Health Treatment Episode Data Set (BH-TEDS) Data Production—BH-TEDS were completed at an initial assessment and annually thereafter or if any major change occurred in member information. Adequate validation processes were in place to ensure data accuracy and completeness. However, lengthy lag times appeared to exist between when the BH-TEDS record was entered into MH-WIN, **Detroit Wayne Mental Health Authority**'s EMR, and when the record was submitted to the State (more than one year, in some cases). Also, multiple BH-TEDS records in the CMHSPs' EMRs contained conflicting values (for example, unemployed but listed as earning minimum wage or more); and the providers' EMRs could accept potentially incorrect values (e.g., clinician inadvertently selects the wrong drop-down value from a pick list), but these values were not cross-checked for quality assurance before submission to MDHHS. Additionally, as mandatory fields were populated with the value of "not evaluated," neither the providers nor **Detroit Wayne Mental Health Authority**'s employed clearly defined processes to populate these fields with the true values after the answers were collected. Additionally, for the records initially documented on paper, **Detroit Wayne Mental Health Authority**'s and the providers lacked processes to ensure that the data were input correctly into the **Detroit Wayne Mental Health Authority**'s system. Additionally, it was noted that the "Total Annual Income" populated in the system for unemployed members (e.g., child support) could lead to members being inadvertently reported to the State as unemployed but earning minimum wage. It should also be noted that for 2017–2018, **Detroit Wayne Mental Health Authority** reported BH-TEDS records for fewer than 85 percent of the members identified through 837-encounter submissions to the State.
- PIHP Oversight of Affiliate Community Mental Health Centers—HSAG found that **Detroit Wayne Mental Health Authority** had sufficient oversight of its four contracted Managers of Comprehensive Provider Networks (MCPNs).

Based on all validation methods used to collect information during the Michigan SFY 2018 Validation of Performance Measures activity, HSAG determined results for each performance indicator and assigned each an indicator designation of *Report*, *Not Reported*, or *No Benefit*. **Detroit Wayne Mental Health Authority** received an indicator designation of *Report* for six indicators, signifying that **Detroit Wayne Mental Health Authority** had calculated these indicators in compliance with the MDHHS Codebook specifications and that rates could be reported. For the remaining six indicators, **Detroit Wayne Mental Health Authority** received indicator designations of *Not Reported*, indicating that gaps were identified in **Detroit Wayne Mental Health Authority**'s process for validating the performance indicator data; therefore, the reported rates were considered materially biased. Table 5-38 presents **Detroit Wayne Mental Health Authority**'s performance measure results and the corresponding MPS when an MPS was established by MDHHS.

Table 5-38—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.		
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 ongoing 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.	6.42%	—

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 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.	98.43%	—
#8: The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who are employed competitively.		
MI Adults	9.84%	—
DD Adults	8.45%	—
MI/DD Adults	6.02%	—
#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	86.43%	—
DD Adults	83.96%	—
MI/DD Adults	77.65%	—
#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).	19.13%	—
#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).	30.80%	—

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)*. 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.

Detroit Wayne Mental Health Authority's rates were deemed *Not Reported* (*NR*) for all 19 measure indicators with MPSs; therefore, HSAG could not determine any performance measure strengths.

Validation of Performance Improvement Projects

For the 2017–2018 validation, **Detroit Wayne Mental Health Authority** provided its first-year submission on the new PIP topic: *Improving Diabetes Screening Rates for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications.* The goal of this PIP is to increase diabetes screening for members with schizophrenia or bipolar disorder who are dispensed atypical antipsychotic medications.

Table 5-39 outlines the study indicators for the PIP.

Table 5-39—Study Indicator

PIP Topic	Study Indicator
Diabetes Screening Rates for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	The percentage of diabetes screenings completed during the measurement year for members with schizophrenia or bipolar disorder taking an antipsychotic medication.

Table 5-40 and Table 5-41 show **Detroit Wayne Mental Health Authority** scores based on HSAG's PIP evaluation. For additional details, refer to the 2017–2018 PIP validation report for **Detroit Wayne Mental Health Authority**.

Table 5-40—Performance Improvement Project Validation Results for Detroit Wayne Mental Health Authority

Stage	Step		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% (1/1)	0% (0/1)	0% (0/1)
	V.	Valid Sampling Techniques (if sampling was used)	*Not Applicable*		
	VI.	Accurate/Complete Data Collection	100% (3/3)	0% (0/3)	0% (0/3)
Design Total			**100% (8/8)**	**0% (0/8)**	**0% (0/8)**

Stage	Step		Percentage of Applicable Elements		
			Met	*Partially Met*	*Not Met*
Implementation	VII.	Sufficient Data Analysis and Interpretation	*Not Assessed*		
	VIII.	Appropriate Improvement Strategies	*Not Assessed*		
Implementation Total			***Not Assessed***		
Outcomes	IX.	Real Improvement Achieved	*Not Assessed*		
	X.	Sustained Improvement Achieved	*Not Assessed*		
Outcomes Total			***Not Assessed***		
Percentage Score of Applicable Evaluation Elements *Met*			**100% (8/8)**	**0% (0/8)**	**0% (0/8)**

Table 5-41—2017–2018 Performance Improvement Project Validation Scores for Detroit Wayne Mental Health Authority

Name of Project	Type of Annual Review	Percentage Score of Evaluation Elements *Met*	Percentage Score of Critical Elements *Met*	Overall Validation Status
Diabetes Screening Rates for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	Submission	88%	80%	*Partially Met*
	Resubmission	100%	100%	*Met*

Detroit Wayne Mental Health Authority submitted the Design stage of the PIP for this year's validation. Overall, 100 percent of all applicable evaluation elements received a score of *Met* for the first six steps of the PIP process. The PIP had not progressed to the Implementation and Outcomes stages during this validation cycle.

Detroit Wayne Mental Health Authority designed a scientifically sound study supported by key research principles and meeting all requirements in the Design stage. The technical design of the PIP was sufficient to measure and monitor PIP outcomes. **Detroit Wayne Mental Health Authority** indicated plans to include its entire eligible population in this PIP. A sound study design created the foundation for **Detroit Wayne Mental Health Authority** to progress to subsequent PIP stages—collecting data and implementing interventions with the potential to impact study indicator outcomes.

Strengths, Weaknesses, and Overall Conclusions

Detroit Wayne Mental Health Authority demonstrated both strengths and weaknesses based on the results of the 2017–2018 EQR activities. **Detroit Wayne Mental Health Authority** received a total compliance score of 89 percent across all standards reviewed during the 2017–2018 compliance monitoring review. **Detroit Wayne Mental Health Authority** scored above 90 percent in the Grievance Process; Provider Network; and Disclosure of Ownership, Control, and Criminal Convictions standards, indicating strong performance in these areas, but did not perform as well in the Customer Service, Subcontracts and Delegation, Access and Availability, Appeals, and Management Information Systems standards, as demonstrated by moderate to low performance scores (87 percent, 82 percent, 89 percent, 83 percent, and 75 percent respectively), reflecting that additional focus is needed in these areas. **Detroit Wayne Mental Health Authority**'s performance measure rates were deemed *Not Reported* for all 19 measure indicators with corresponding MPSs, indicating opportunities for improvement in all measures.

Detroit Wayne Mental Health Authority's overall performance demonstrates the following impact to the Medicaid population's quality of, timeliness of, and access to care and services:

Table 5-42—Quality, Timeliness, and Access Performance Impact

Performance Area*	Overall Performance Impact
Quality	• Strength: Received a performance score of 100 percent in the Grievance Process standard, indicating that the PIHP had an effective grievance process in place for members to express dissatisfaction. • Strength: Received a performance score of 100 percent in the Disclosure of Ownership, Control, and Criminal Convictions standard, indicating a strong focus on program integrity, which includes appropriate screening of contracted providers. • Strength: Designed a scientifically sound study related to *Improving Diabetes Screening Rates for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*, which was supported by key research principles, meeting all requirements of the PIP Design stage. • Weakness: Received five deficiencies in the Customer Service standard related to the customer handbook and provider directory, indicating that members may have challenges navigating the Medicaid managed care program and knowing which providers can meet their unique healthcare needs.
Timeliness	• Weakness: Minimum performance standards related to timely assessments and timely follow-up care for children and adult members could not be assessed due to data issues.

Performance Area*	Overall Performance Impact
Access	• Strength: Received a performance score of 100 percent in the Provider Network standard, indicating that the PIHP maintains a network of providers to provide behavioral health and substance use disorder services to members. • Weakness: Received an 89 percent in the Access and Availability standard, indicating that some members may have challenges accessing providers and treatment when necessary. • Weakness: Received an 83 percent in the Appeals standard, suggesting that members may not be aware of all rights afforded to them under the appeal process, which may include opportunity to challenge denial of prescribed services.

*Performance impact may be applicable to one or more performance areas; however, for purposes of this report impact was aligned to either quality, timeliness, or access.

Follow-Up on Prior EQR Recommendations

CMS requires EQROs to report annually the degree to which PIHPs addressed the EQR recommendations made from the prior year's technical report. During the 2016–2017 EQR, HSAG made the following recommendations to **Detroit Wayne Mental Health Authority**; and **Detroit Wayne Mental Health Authority** addressed these recommendations by taking the following actions:

Compliance Monitoring

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 provided no recommendations during the 2016–2017 review period; therefore, no actions were required of **Detroit Wayne Mental Health Authority**.

Validation of Performance Measures

The 2016–2017 validation of performance measures for **Detroit Wayne Mental Health Authority** identified opportunities for improvement in the following performance indicators:

- *#3: The percent of new Medicaid beneficiaries during the quarter starting any needed ongoing service within 14 days of a non-emergent face-to-face assessment with a professional*—DD 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 (Not Reported)
- *#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 recommended that **Detroit Wayne Mental Health Authority** evaluate any contributing factors that led to timely ongoing services for members 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 recommended 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** also had challenges with two indicators, resulting in those indicators being deemed *Not Reported.* HSAG recommended 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 rate numerator. Based upon the results of the 2017–2018 validation, rates for all 19 measure indicators with MPSs were deemed *Not Reported,* indicating that **Detroit Wayne Mental Health Authority** has not fully addressed prior recommendations.

Validation of Performance Improvement Projects

For the 2016–2017 validation, **Detroit Wayne Mental Health Authority** provided its fourth-year submission on the PIP topic: *Improving Wellness Self-Management of SMI Consumers with Chronic Health Conditions*. HSAG identified opportunities for improvement in Activity VII—Sufficient Data Analysis and Interpretation, and recommended that **Detroit Wayne Mental Health Authority** ensure that reported data and interpretation of results are accurate and consistent throughout the PIP Submission Form. HSAG also identified *Points of Clarification* as opportunities for improvement in Activity VII—Sufficient Data Analysis and Interpretation and Activity VIII—Appropriate Improvement Strategies and recommended that **Detroit Wayne Mental Health Authority** calculate the *p* values for its statistical testing results accurately and provide Plan-Do-Study-Act worksheets as supporting documents for evaluation of interventions of effectiveness. HSAG also recommended that **Detroit Wayne Mental Health Authority** 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. For the 2017–2018 validation, **Detroit Wayne Mental Health Authority** selected a new PIP topic; and as **Detroit Wayne Mental Health Authority** proceeds through each phase of the new PIP, HSAG will continue to assess **Detroit Wayne Mental Health Authority**'s performance related to improving upon the areas recommended in the previous PIP.

Recommendations

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Detroit Wayne Mental Health Authority** to members, HSAG recommends that **Detroit Wayne Mental Health Authority** incorporate efforts for improvement of the following performance indicators with an MPS as part of its quality improvement strategy within the QAPIP:

Not Reported Performance Measure Rates

- *#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 ongoing 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
- *#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

Detroit Wayne Mental Health Authority should include within its next annual QAPIP review the results of analyses for the performance indicators listed above that answer the following questions:

1. What were the root causes associated with low-performing rates?
2. What unexpected outcomes were found within the data?
3. What disparities were identified in the analyses?
4. What are the most significant areas of focus (or populations) for which improvement initiatives are planned? What is the highest impact area(s) to make an improvement(s) (low effort/high yield)?
5. What intervention(s) is **Detroit Wayne Mental Health Authority** considering or has already implemented to improve rates and performance for each identified indicator?

Based on the information presented above, **Detroit Wayne Mental Health Authority** should include the following within its quality improvement plan:

- Measurable goals and benchmarks for each indicator.
- Mechanisms to measure performance.
- Mechanisms to review data trends to identify improvement, decline, or stability in the performance rates.
- Identified opportunities for improvement.
- Ongoing analysis to identify factors that impact adequacy of rates.
- Quality improvement interventions that address the root cause of the deficiency.
- A plan to monitor the quality improvement interventions to detect whether they effect improvement.

Additionally, **Detroit Wayne Mental Health Authority** should have defined data entry processes, including documented processes for data quality and data completeness checks.

HSAG also recommends that **Detroit Wayne Mental Health Authority** develop meaningful plans of action to bring into compliance each of the following deficient standards:

- Standard VI—Customer Service
- Standard IX—Subcontracts and Delegation
- Standard XII—Access and Availability
- Standard XIV—Appeals
- Standard XVII—Management Information Systems

Detroit Wayne Mental Health Authority should include the following in each of its plans of action, and the plans of action should be provided to MDHHS within 30 days of receipt of required corrective action:

- Detailed narrative of the deficiency.
- Detailed corrective action steps to resolve each deficiency.
- Any resources required to resolve the deficiency.
- Due dates for completing each action step.
- Assigned party responsible for completing each action step.
- Any required deliverables to show that a deficiency has been resolved.
- Any dependencies to resolve deficiencies.

Finally, **Detroit Wayne Mental Health Authority** should take proactive steps to ensure a successful PIP. As the PIP progresses, **Detroit Wayne Mental Health Authority** should ensure the following:

- Follow the approved PIP methodology to calculate and report baseline data accurately in next year's annual submission.
- To impact the Remeasurement 1 study indicator rate, complete a causal/barrier analysis to identify barriers to desired outcomes and implement interventions to address those barriers timely. Interventions implemented late in the Remeasurement 1 study period will not have enough time to impact the study indicator rate.
- Document the process and steps used to determine barriers to improvement; and attach completed quality improvement tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis.
- Implement active, innovative improvement strategies with the potential to directly impact study indicator outcomes.
- Implement a process for evaluating the performance of each PIP intervention and its impact on the study indicators, and allow continual refinement of improvement strategies. The evaluation process should be ongoing and cyclical.

Region 8—Oakland County CMH Authority

To conduct the 2017–2018 EQR, HSAG reviewed **Oakland County CMH Authority**'s results for mandatory EQR activities. Those results were analyzed and evaluated to develop conclusions and make recommendations about the quality of, timeliness of, and access to care and services provided by **Oakland County CMH Authority**.

EQR Activity Results

This section provides the results and notable findings for the mandatory EQR activities performed for **Oakland County CMH Authority**.

Compliance Monitoring

Table 5-43 presents the total number of elements for each standard as well as the number of elements for each standard that received a score of *Met*, *Not Met*, or *Not Applicable (N/A*). Table 5-43 also presents **Oakland County CMH Authority**'s overall compliance score for each standard, the totals across the eight standards reviewed, and the total compliance score across all standards for the 2017–2018 compliance monitoring review.

Table 5-43—Summary of 2017–2018 Compliance Monitoring Review Results

Standard	Total # of Applicable Elements	Number of Elements			Total Compliance Score
		Met	*Not Met*	*N/A*	
Standard VI—Customer Service	39	32	7	0	**82%**
Standard VII—Grievance Process	26	23	3	0	**88%**
Standard IX—Subcontracts and Delegation	11	9	2	0	**82%**
Standard X—Provider Network	12	10	2	1	**83%**
Standard XII—Access and Availability	19	17	2	0	**89%**
Standard XIV—Appeals	54	46	8	0	**85%**
Standard XV—Disclosure of Ownership, Control, and Criminal Convictions	14	14	0	0	**100%**
Standard XVII—Management Information Systems	12	10	2	2	**83%**
Total Compliance Score	**187**	**161**	**26**	**3**	**86%**

Total # of Applicable Elements—The total number of elements within each standard minus any elements that received designations of *NA*.
Total Compliance Score—Elements scored *Met* were given full value (1 point). The point values were then totaled, and the sum was divided by the number of applicable elements to derive a percentage score.

Oakland County CMH Authority demonstrated compliance for 161 of 187 elements, with an overall compliance score of 86 percent. **Oakland County CMH Authority** demonstrated strong performance, scoring 90 percent or above in one standard, with that standard achieving full compliance. This area of strength includes Disclosure of Ownership, Control, and Criminal Convictions.

Opportunities for improvement were identified in seven of the eight standards, including deficiencies related to the following requirements:

- Content of the customer handbook.
- Content, maintenance, and/or dissemination of the provider directory.
- Grievance processes including but not limited to filing grievances, and written consent from the member.
- Subcontract provisions related to the delegated activities or obligations and reporting responsibilities.
- Subcontract provision specifying that the right to audit exists through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.
- Providing providers not selected for inclusion in the network written notice of the reason for the decision.
- Procedures to address changes in its network which negatively affect access to care.
- Minimum performance standards for follow-up care after discharge from a psychiatric inpatient unit (for the Adults population).
- Monitoring of corrective action plans related to the MMBPIS.
- Appeal processes including but not limited to continuation or reinstatement of services, denial of expedited appeal request provisions, extension of time frame provisions, and format of resolution notices.
- Annual certification to attest to the accuracy, completeness, and truthfulness of information in data sets submitted to MDHHS.

Oakland County CMH Authority's lowest performing areas were in Standard VI—Customer Service with seven *Not Met* findings and a compliance score of 82 percent, and Standard IX—Subcontracts and Delegation with two *Not Met* findings and a compliance score of 82 percent. **Oakland County CMH Authority** was required to develop and implement a corrective action plan for each requirement in all standards scored *Not Met*. Refer to **Oakland County CMH Authority**'s 2017–2018 External Quality Review Compliance Monitoring Report for Prepaid Inpatient Health Plan for a detailed review of the findings.

Validation of Performance Measures

The purpose of the performance measure validation activity was to assess the accuracy of performance indicators reported by **Oakland County CMH Authority** and to determine the extent to which performance indicators reported by **Oakland County CMH Authority** followed State specifications and reporting requirements. HSAG evaluated **Oakland County CMH Authority**'s data systems for the processing of each type of data used for reporting MDHHS performance indicators. High-level findings are presented below. Refer to State Fiscal Year 2018 Validation of Performance Measures for Region 8—Oakland County CMH Authority report for a detailed review of the findings.

- Eligibility and Enrollment Data System Findings—HSAG identified no concerns with how the **Oakland County CMH Authority** received and processed eligibility data.
- Medical Services Data System (Claims and Encounters) Findings—HSAG identified no concerns with how **Oakland County CMH Authority** received and processed claims and encounters.
- Behavioral Health Treatment Episode Data Set (BH-TEDS) Data Production—Data validation for BH-TEDS file uploads aligned with State validations to ensure data accuracy. **Oakland County CMH Authority** submitted BH-TEDS files to the State via a secure file transfer protocol site monthly at minimum. Adequate validation processes were in place to ensure data accuracy and completeness.
- PIHP Oversight of Affiliate Community Mental Health Centers—**Oakland County CMH Authority** is a stand-alone PIHP; therefore, this section is not applicable.

Based on all validation methods used to collect information during the Michigan SFY 2018 validation of performance measures activity, HSAG determined results for all performance indicators and assigned each an indicator designation of *Report*, *Not Reported*, or *No Benefit*. **Oakland County CMH Authority** received an indicator designation of *Report* for all indicators, signifying that **Oakland County CMH Authority** had calculated all indicators in compliance with the MDHHS Codebook specifications and that rates could be reported. Table 5-44 presents **Oakland County CMH Authority**'s performance measure results and the corresponding MPS when an MPS was established by MDHHS.

Table 5-44—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	92.76%	95.00%
Adults	90.98%	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	96.50%	95.00%
MI Adults	98.26%	95.00%
DD Children	96.15%	95.00%
DD Adults	96.00%	95.00%
Medicaid SA	99.45%	95.00%
Total	98.35%	95.00%
#3: The percent of new Medicaid beneficiaries during the quarter starting any needed ongoing service within 14 days of a non-emergent face-to-face assessment with a professional.		
MI Children	100.00%	95.00%

Performance Indicator	Rate	Minimum Performance Standard
MI Adults	99.67%	95.00%
DD Children	100.00%	95.00%
DD Adults	100.00%	95.00%
Medicaid SA	98.73%	95.00%
Total	99.43%	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	97.14%	95.00%
Adults	95.26%	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.	7.31%	—
#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 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.	97.80%	—
#8: The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who are employed competitively.		
MI Adults	15.46%	—
DD Adults	11.03%	—
MI/DD Adults	10.49%	—
#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	86.51%	—
DD Adults	41.88%	—
MI/DD Adults	81.82%	—
#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	5.88%	15.00%
Adults	14.25%	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).		
The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	21.29%	—
#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).	33.71%	—

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.

Oakland County CMH Authority's rates exceeded their corresponding MPSs for 17 of 19 measure indicators, indicating strength in these areas.

Although most of **Oakland County CMH Authority**'s rates were above the corresponding MPSs, the two rates under 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*, for the Children and Adults populations fell below the MPSs, indicating opportunities for improvement.

Validation of Performance Improvement Projects

For the 2017–2018 validation, **Oakland County CMH Authority** provided its first-year submission on the new PIP topic: *Improving Diabetes Screening Rates for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications.* The goal of this PIP is to increase diabetes screening for members with schizophrenia or bipolar disorder who are dispensed atypical antipsychotic medications.

Table 5-45 outlines the study indicator for the PIP.

Table 5-45—Study Indicator

PIP Topic	Study Indicator
Improving Diabetes Screening Rates for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	The percentage of diabetes screenings completed during the measurement year for members with schizophrenia or bipolar disorder taking an antipsychotic medication.

Table 5-46 and Table 5-47 show **Oakland County CMH Authority** scores based on HSAG's PIP evaluation. For additional details, refer to the 2017–2018 PIP validation report for **Oakland County CMH Authority**.

Table 5-46—Performance Improvement Project Validation Results for Oakland County CMH Authority

Stage	Step		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% (1/1)	0% (0/1)	0% (0/1)
	V.	Valid Sampling Techniques (if sampling was used)	*Not Applicable*		
	VI.	Accurate/Complete Data Collection	100% (3/3)	0% (0/3)	0% (0/3)
Design Total			**100% (8/8)**	**0% (0/8)**	**0% (0/8)**
Implementation	VII.	Sufficient Data Analysis and Interpretation	*Not Assessed*		
	VIII.	Appropriate Improvement Strategies	*Not Assessed*		
Implementation Total			***Not Assessed***		
Outcomes	IX.	Real Improvement Achieved	*Not Assessed*		
	X.	Sustained Improvement Achieved	*Not Assessed*		
Outcomes Total			***Not Assessed***		
Percentage Score of Applicable Evaluation Elements *Met*			**100% (8/8)**	**0% (0/8)**	**0% (0/8)**

Table 5-47—2017–2018 Performance Improvement Project Validation Scores for Oakland County CMH Authority

Name of Project	Type of Annual Review	Percentage Score of Evaluation Elements *Met*	Percentage Score of Critical Elements *Met*	Overall Validation Status
Improving Diabetes Screening Rates for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	Submission	75%	60%	*Partially Met*
	Resubmission	100%	100%	*Met*

Oakland County CMH Authority submitted the Design stage of the PIP for this year's validation. Overall, 100 percent of all applicable evaluation elements received a score of *Met* for the first six steps of the PIP process. The PIP had not progressed to the Implementation and Outcomes stages during this validation cycle.

Oakland County CMH Authority designed a scientifically sound study supported by key research principles and meeting all requirements in the Design stage. The technical design of the PIP was sufficient to measure and monitor PIP outcomes. **Oakland County CMH Authority** indicated plans to include its entire eligible population in this PIP. A sound study design created the foundation for **Oakland County CMH Authority** to progress to subsequent PIP stages—collecting data and implementing interventions with the potential to impact study indicator outcomes.

Strengths, Weaknesses, and Overall Conclusions

Oakland County CMH Authority demonstrated both strengths and weaknesses based on the results of the 2017–2018 EQR activities. **Oakland County CMH Authority** received a total compliance score of 86 percent across all standards reviewed during the 2017–2018 compliance monitoring review. **Oakland County CMH Authority** scored 100 percent in the Disclosure of Ownership, Control, and Criminal Convictions standard, indicating strong performance in this area, but did not perform as well in the Customer Service, Grievance Process, Subcontracts and Delegation, Provider Network, Access and Availability, Appeals, and Management Information Systems standards, as demonstrated by moderate performance scores (82 percent, 88 percent, 82 percent, 83 percent, 89 percent, 85 percent, and 83 percent respectively), reflecting that additional focus is needed in these areas. While 17 of the 19 performance measure rates were above the MDHHS-established MPSs, indicating strengths in these areas, **Oakland County CMH Authority**'s rates under 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* fell below their corresponding MPSs, indicating opportunities for improvement in these measures.

Oakland County CMH Authority's overall performance demonstrates the following impact to the Medicaid population's quality of, timeliness of, and access to care and services:

Table 5-48—Quality, Timeliness, and Access Performance Impact

Performance Area*	Overall Performance Impact
Quality	• Strength: Received a performance score of 100 percent in the Disclosure of Ownership, Control, and Criminal Convictions standard, indicating a strong focus on program integrity, which includes appropriate screening of contracted providers. • Strength: Low percentage of readmission rates for children and adults discharged from inpatient psychiatric units, as indicated by performance of indicator #10. • Strength: Designed a scientifically sound study related to *Improving Diabetes Screening Rates for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*, which was supported by key research principles, meeting all requirements of the PIP Design stage. • Weakness: Received a performance score of 88 percent in the Grievance Process standard, indicating that an effective grievance process may not be in place for members to express dissatisfaction. • Weakness: Received seven deficiencies in the Customer Service standard related to the customer handbook and provider directory, indicating that members may have challenges navigating the Medicaid managed care program and knowing which providers can meet their unique healthcare needs.
Timeliness	• Strength: Minimum performance standards were met related to timely face-to-face assessments with a professional for non-emergency request for services for MI Children, MI Adults, DD Children, DD Adults, and Medicaid SA as well as for receiving timely needed ongoing services for MI Children, MI Adults, DD Children, DD Adults, and Medicaid SA. • Weakness: Minimum performance standards related to timely pre-admission screening for psychiatric inpatient care for children and adults were not met, indicating that members were not always receiving services as soon as needed.
Access	• Strength: As indicated by the performance measure rate, 100 percent of members discharged from a substance abuse detox unit were seen for follow-up care within seven days. • Weakness: Received a performance score of 89 percent in the Access and Availability standard, indicating that some members had challenges accessing providers and treatment when necessary. • Weakness: Received a performance score of 83 percent in the Provider Network standard, indicating that the PIHP may have challenges with managing its network of behavioral health and substance use disorder providers. • Weakness: Received an 85 percent in the Appeals standard, suggesting that members may not be aware of all rights afforded to them under the appeal process, which may include opportunity to challenge denial of prescribed services.

*Performance impact may be applicable to one or more performance areas; however, for purposes of this report impact was aligned to either quality, timeliness, or access.

Follow-Up on Prior EQR Recommendations

CMS requires EQROs to report annually the degree to which PIHPs addressed the EQR recommendations made from the prior year's technical report. During the 2016–2017 EQR, HSAG made the following recommendations to **Oakland County CMH Authority**; and **Oakland County CMH Authority** addressed these recommendations by taking the following actions:

Compliance Monitoring

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 provided no recommendations during the 2016–2017 review period; therefore, no actions were required of **Oakland County CMH Authority**.

Validation of Performance Measures

The 2016–2017 validation of performance measures for **Oakland County CMH Authority** identified opportunities for improvement in the following performance indicators:

- *#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 recommended 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 recommended 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. For validation purposes, HSAG recommended that **Oakland County CMH Authority** establish a formal process to track manual changes made to consumer-level detail files. Based upon the results of the 2017–2018 validation, **Oakland County CMH Authority** fully addressed the prior recommendations.

Validation of Performance Improvement Projects

For the 2016–2017 validation, **Oakland County CMH Authority** provided its fourth-year submission on the 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*. HSAG identified *Points of Clarification* as opportunities for improvement in Activity VIII—Appropriate Improvement Strategies and recommended that **Oakland County CMH Authority** ensure that all interventions are documented and evaluated for effectiveness. HSAG also recommended that **Oakland County CMH Authority** build on its momentum of improvement to ensure ability to sustain the

improvement achieved, revisit its causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers, and see if any new barriers exist that require the development of interventions. For the 2017–2018 validation, **Oakland County CMH Authority** selected a new PIP topic; and, as **Oakland County CMH Authority** proceeds through each phase of the new PIP, HSAG will continue to assess **Oakland County CMH Authority**'s performance related to improving upon the areas recommended in the previous PIP.

Recommendations

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Oakland County CMH Authority** to members, HSAG recommends that **Oakland County CMH Authority** incorporate efforts for improvement of the following performance indicators with an MPS as part of its quality improvement strategy within the QAPIP:

Ratings Below the MPS[5-5]

- *#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

Performance Declined >2 Percent From Previous Year

- *#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*—DD Children

Increase in Readmissions >5 Percent From Previous Year

- *#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

Oakland County CMH Authority should include within its next annual QAPIP review the results of analyses for the performance indicators listed above that answer the following questions:

1. What were the root causes associated with low-performing rates?
2. What unexpected outcomes were found within the data?
3. What disparities were identified in the analyses?
4. What are the most significant areas of focus (or populations) for which improvement initiatives are planned? What is the highest impact area(s) to make an improvement(s) (low effort/high yield)?
5. What intervention(s) is **Oakland County CMH Authority** considering or has already implemented to improve rates and performance for each identified indicator?

[5-5] Performance indicators listed under "Ratings Below the MPS" could have demonstrated either a greater than 2 percent decline or a greater than 5 percent increase from the previous year, but they were not repeated under "Performance Declined >2 Percent From Previous Year" or "Increase in Readmissions >5 Percent From Previous Year," respectively.

Based on the information presented above, **Oakland County CMH Authority** should include the following within its quality improvement plan:

- Measurable goals and benchmarks for each indicator.
- Mechanisms to measure performance.
- Mechanisms to review data trends to identify improvement, decline, or stability in the performance rates.
- Identified opportunities for improvement.
- Ongoing analysis to identify factors that impact adequacy of rates.
- Quality improvement interventions that address the root cause of the deficiency.
- A plan to monitor the quality improvement interventions to detect whether they effect improvement.

Additionally, **Oakland County CMH Authority** should have defined data entry processes, including documented processes for data quality and data completeness checks.

HSAG also recommends that **Oakland County CMH Authority** develop meaningful plans of action to bring into compliance each of the following deficient standards:

- Standard VI—Customer Service
- Standard VII—Grievance Process
- Standard IX—Subcontracts and Delegation
- Standard X—Provider Network
- Standard XII—Access and Availability
- Standard XIV—Appeals
- Standard XVII—Management Information Systems

Oakland County CMH Authority should include the following in each of its plans of action, and the plans of action should be provided to MDHHS within 30 days of receipt of required corrective action:

- Detailed narrative of the deficiency.
- Detailed corrective action steps to resolve each deficiency.
- Any resources required to resolve the deficiency.
- Due dates for completing each action step.
- Assigned party responsible for completing each action step.
- Any required deliverables to show that a deficiency has been resolved.
- Any dependencies to resolve deficiencies.

Finally, **Oakland County CMH Authority** should take proactive steps to ensure a successful PIP. As the PIP progresses, **Oakland County CMH Authority** should ensure the following:

- Follow the approved PIP methodology to calculate and report baseline data accurately in next year's annual submission.
- To impact the Remeasurement 1 study indicator rate, complete a causal/barrier analysis to identify barriers to desired outcomes and implement interventions to address those barriers timely. Interventions implemented late in the Remeasurement 1 study period will not have enough time to impact the study indicator rate.
- Document the process and steps used to determine barriers to improvement; and attach completed quality improvement tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis.
- Implement active, innovative improvement strategies with the potential to directly impact study indicator outcomes.
- Implement a process for evaluating the performance of each PIP intervention and its impact on the study indicators, and allow continual refinement of improvement strategies. The evaluation process should be ongoing and cyclical.

Region 9—Macomb County CMH Services

To conduct the 2017–2018 EQR, HSAG reviewed **Macomb County CMH Services**' results for mandatory EQR activities. Those results were analyzed and evaluated to develop conclusions and make recommendations about the quality of, timeliness of, and access to care and services provided by **Macomb County CMH Services**.

EQR Activity Results

This section provides the results and notable findings for the mandatory EQR activities performed for **Macomb County CMH Services**.

Compliance Monitoring

Table 5-49 presents the total number of elements for each standard as well as the number of elements for each standard that received a score of *Met*, *Not Met*, or *Not Applicable (N/A*). Table 5-49 also presents **Macomb County CMH Services**' overall compliance score for each standard, the totals across the eight standards reviewed, and the total compliance score across all standards for the 2017–2018 compliance monitoring review.

Table 5-49—Summary of 2017–2018 Compliance Monitoring Review Results

Standard	Total # of Applicable Elements	Number of Elements			Total Compliance Score
		Met	*Not Met*	*N/A*	
Standard VI—Customer Service	39	34	5	0	**87%**
Standard VII—Grievance Process	26	26	0	0	**100%**
Standard IX—Subcontracts and Delegation	11	6	5	0	**55%**
Standard X—Provider Network	12	12	0	1	**100%**
Standard XII—Access and Availability	19	16	3	0	**84%**
Standard XIV—Appeals	54	53	1	0	**98%**
Standard XV—Disclosure of Ownership, Control, and Criminal Convictions	14	14	0	0	**100%**
Standard XVII—Management Information Systems	12	12	0	2	**100%**
Total Compliance Score	**187**	**173**	**14**	**3**	**93%**

Total # of Applicable Elements—The total number of elements within each standard minus any elements that received designations of *NA*.
Total Compliance Score—Elements scored *Met* were given full value (1 point). The point values were then totaled, and the sum was divided by the number of applicable elements to derive a percentage score.

Macomb County CMH Services demonstrated compliance for 173 of 187 elements, with an overall compliance score of 93 percent. **Macomb County CMH Services** demonstrated strong performance, scoring 90 percent or above in five standards, with four of those standards achieving full compliance. These areas of strength include Grievance Process; Provider Network; Appeals; Disclosure of Ownership, Control, and Criminal Convictions; and Management Information Systems.

Opportunities for improvement were identified in four of the eight standards, including deficiencies related to the following requirements:

- Content of the customer handbook.
- Content, maintenance, and/or dissemination of the provider directory.
- Annual monitoring of subcontractors.
- Subcontract provisions related to the right to audit.
- Minimum performance standards for face-to-face assessments (for the DD Children population); ongoing services (for the DD Adults population); follow-up care after discharge from a psychiatric inpatient unit (for the Children population).
- Monitoring of corrective action plans related to access standards.
- Appeal processes including but not limited to the format of resolution notices.

Macomb County CMH Services' lowest performing areas were in Standard IX—Subcontracts and Delegation with five *Not Met* findings and a compliance score of 55 percent. **Macomb County CMH Services** was required to develop and implement a corrective action plan for each requirement in all standards scored *Not Met*. Refer to **Macomb County CMH Services**' 2017–2018 External Quality Review Compliance Monitoring Report for Prepaid Inpatient Health Plan for a detailed review of the findings.

Validation of Performance Measures

The purpose of the performance measure validation activity was to assess the accuracy of performance indicators reported by **Macomb County CMH Services** and to determine the extent to which performance indicators reported by **Macomb County CMH Services** followed State specifications and reporting requirements. HSAG evaluated **Macomb County CMH Services**' data systems for the processing of each type of data used for reporting MDHHS performance indicators. High-level findings are presented below. Refer to State Fiscal Year 2018 Validation of Performance Measures for Region 9—Macomb County CMH Services report for a detailed review of the findings.

- Eligibility and Enrollment Data System Findings—HSAG had no concerns with how **Macomb County CMH Services** received and processed eligibility data.
- Medical Services Data System (Claims and Encounters) Findings—HSAG identified no concerns with **Macomb County CMH Services** claims and encounter data processing.
- Behavioral Health Treatment Episode Data Set (BH-TEDS) Data Production—BH-TEDS data from contracted providers were entered directly into **Macomb County CMH Services'** EMR. Once entered, edits were performed to ensure accuracy and completeness. In addition, reports were available on demand to identify for providers any missing or incomplete data. **Macomb County CMH Services** also ran reports to check for missing information prior to submitting data to the State. If any information was missing, a request was sent to the provider. **Macomb County CMH Services** did not conduct any additional checks on these data, relying solely on the system edits.

Macomb County CMH Services submitted validated and clean BH-TEDS files to the State based on the State's requirements.

- PIHP Oversight of Affiliate Community Mental Health Centers—HSAG found that **Macomb County CMH Services** staff members implemented additional oversight as a result of the change in contractual arrangement with Macomb-Oakland Regional Center (MORC). **Macomb County CMH Services** transitioned the relationship with MORC from CMHSP to provider network.

Based on all validation methods used to collect information during the Michigan SFY 2018 validation of performance measures activity, HSAG determined results for each performance indicator and assigned each an indicator designation of *Report*, *Not Reported*, or *No Benefit*. **Macomb County CMH Services** received an indicator designation of *Report* for all indicators, signifying that **Macomb County CMH Services** had calculated all indicators in compliance with the MDHHS Codebook specifications and that rates could be reported. Table 5-50 presents **Macomb County CMH Services**' performance measure results and the corresponding MPS when an MPS was established by MDHHS.

Table 5-50—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	99.82%	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	91.61%	95.00%
MI Adults	95.65%	95.00%
DD Children	89.58%	95.00%
DD Adults	94.59%	95.00%
Medicaid SA	97.82%	95.00%
Total	96.31%	95.00%
#3: The percent of new Medicaid beneficiaries during the quarter starting any needed ongoing service within 14 days of a non-emergent face-to-face assessment with a professional.		
MI Children	97.71%	95.00%
MI Adults	100.00%	95.00%
DD Children	93.02%	95.00%
DD Adults	100.00%	95.00%
Medicaid SA	99.89%	95.00%
Total	99.47%	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	86.30%	95.00%
Adults	94.75%	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.	99.34%	95.00%
#5: The percent of Medicaid recipients having received PIHP managed services.		
The percent of Medicaid recipients having received PIHP managed services.	5.48%	—
#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 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.	97.68%	—
#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	14.43%	—
DD Adults	5.99%	—
MI/DD Adults	5.86%	—
#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	91.16%	—
DD Adults	98.06%	—
MI/DD Adults	90.14%	—
#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	11.90%	15.00%
Adults	15.23%	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).	12.18%	—

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).		
The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	31.58%	—

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.

Macomb County CMH Services' rates exceeded their corresponding MPSs for 12 of the 19 measure indicators, suggesting strength in these areas.

Although most of **Macomb County CMH Services**' rates were above their corresponding MPSs, rates for at least one population under indicators #2, #3, #4a, and #10 fell below the MPSs, indicating opportunities for improvement.

Validation of Performance Improvement Projects

For the 2017–2018 validation, **Macomb County CMH Services** provided its first-year submission on the new PIP topic: *Reducing Acute Inpatient Recidivism for Adults With Serious Mental Illness.* The goal of this PIP is to decrease members recidivating within 30 days post discharge to acute inpatient behavior health services.

Table 5-51 outlines the study indicator for the PIP.

Table 5-51—Study Indicator

PIP Topic	Study Indicator
Reducing Acute Inpatient Recidivism for Adults With Serious Mental Illness	30-day hospital readmission

Table 5-52 and Table 5-53 show **Macomb County CMH Services** scores based on HSAG's PIP evaluation. For additional details, refer to the 2017–2018 PIP validation report for **Macomb County CMH Services**.

Table 5-52—Performance Improvement Project Validation Results for Macomb County CMH Services

Stage	Step		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% (1/1)	0% (0/1)	0% (0/1)
	V.	Valid Sampling Techniques (if sampling was used)	*Not Applicable*		
	VI.	Accurate/Complete Data Collection	100% (3/3)	0% (0/3)	0% (0/3)
Design Total			**100% (8/8)**	**0% (0/8)**	**0% (0/8)**
Implementation	VII.	Sufficient Data Analysis and Interpretation	*Not Assessed*		
	VIII.	Appropriate Improvement Strategies	*Not Assessed*		
Implementation Total			***Not Assessed***		
Outcomes	IX.	Real Improvement Achieved	*Not Assessed*		
	X.	Sustained Improvement Achieved	*Not Assessed*		
Outcomes Total			***Not Assessed***		
Percentage Score of Applicable Evaluation Elements *Met*			**100% (8/8)**	**0% (0/8)**	**0% (0/8)**

Table 5-53—2017–2018 Performance Improvement Project Validation Scores for Macomb County CMH Services

Name of Project	Type of Annual Review	Percentage Score of Evaluation Elements *Met*	Percentage Score of Critical Elements *Met*	Overall Validation Status
Reducing Acute Inpatient Recidivism for Adults With Serious Mental Illness	Submission	100%	100%	*Met*
	Resubmission	*NA*	*NA*	*NA*

Macomb County CMH Services submitted the Design stage of the PIP for this year's validation. Overall, 100 percent of all applicable evaluation elements received a score of *Met* for the first six steps of the PIP process. The PIP had not progressed to the Implementation and Outcomes stages during this validation cycle.

Macomb County CMH Services designed a scientifically sound study supported by key research principles and meeting all requirements in the Design stage. The technical design of the PIP was sufficient to measure and monitor PIP outcomes. **Macomb County CMH Services** indicated that it plans to include its entire eligible population in this PIP. A sound study design created the foundation for **Macomb County CMH Services** to progress to subsequent PIP stages—collecting data and implementing interventions with the potential to impact study indicator outcomes.

Strengths, Weaknesses, and Overall Conclusions

Macomb County CMH Services demonstrated both strengths and weaknesses based on the results of the 2017–2018 EQR activities. **Macomb County CMH Services** received a total compliance score of 93 percent across all standards reviewed during the 2017–2018 compliance monitoring review, which was the highest score achieved during the review. **Macomb County CMH Services** scored above 90 percent in the Grievance Process; Provider Network; Appeals; Disclosure of Ownership, Control, and Criminal Convictions; and Management Information Systems standards, indicating strong performance in these areas, but did not perform as well in the Customer Service, Subcontracts and Delegation, and Access and Availability standards, as demonstrated by moderate to low performance scores (87 percent, 55 percent, and 84 percent respectively), reflecting that additional focus is needed in these areas. While 12of the 19 performance measure rates were above the MDHHS-established MPSs, indicating strengths in these areas, **Macomb County CMH Services**' rates for indicators *#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, DD Children, and DD Adults*; *#3: The percent of new Medicaid beneficiaries during the quarter starting any needed ongoing service within 14 days of a non-emergent face-to-face assessment with a professional—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—Children and Adults*; and *#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 fell below their corresponding MPSs, indicating opportunities for improvement in these measures.

Macomb County CMH Services' overall performance demonstrates the following impact to the Medicaid population's quality of, timeliness of, and access to care and services:

Table 5-54—Quality, Timeliness, and Access Performance Impact

Performance Area*	Overall Performance Impact
Quality	• Strength: Received a performance score of 100 percent in the Grievance Process standard, indicating that the PIHP had an effective grievance process in place for members to express dissatisfaction. • Strength: Received a performance score of 100 percent in the Disclosure of Ownership, Control, and Criminal Convictions standard, indicating a strong focus on program integrity, which includes appropriate screening of contracted providers. • Strength: Low percentage of readmission rates for children discharged from inpatient psychiatric units, as indicated by performance of indicator #10. • Strength: Designed a scientifically sound study related to *Reducing Acute Inpatient Recidivism for Adults With Serious Mental Illness*, which was supported by key research principles, meeting all requirements of the PIP Design stage. • Weakness: Received five deficiencies in the Customer Service standard related to the customer handbook and provider directory, indicating that members may have challenges navigating the Medicaid managed care program and knowing which providers can meet their unique healthcare needs.
Timeliness	• Strength: Minimum performance standards were met related to timely pre-admission screening for psychiatric inpatient care for children and adults; timely face-to-face assessments with a professional for non-emergency request for services for MI Adults and Medicaid SA; and receiving timely needed ongoing services for MI Children, MI Adults, DD Adults, and Medicaid SA. • Weakness: Minimum performance standards related to face-to-face timely assessments for new Medicaid members in the MI Children, DD Children, and DD Adults populations and timely follow-up care for children and adults following psychiatric inpatient discharge were not met, indicating that members were not always receiving services as soon as needed.
Access	• Strength: Received a performance score of 100 percent in the Provider Network standard, indicating that the PIHP maintains a network of providers to provide behavioral health and substance use disorder services to members. • Strength: Received the highest score,98 percent, in the Appeals standard, suggesting that members are receiving all rights afforded to them under the appeal process, including opportunity to challenge denial of prescribed services. • Weakness: Received a performance score of 84 percent in the Access and Availability standard, indicating that some members may have challenges accessing providers and treatment when necessary.

Performance Area*	Overall Performance Impact
	• Weakness: As indicated by the performance measure rate, children and adults discharged from psychiatric inpatient units were not always seen for follow-up care within seven days.

*Performance impact may be applicable to one or more performance areas; however, for purposes of this report impact was aligned to either quality, timeliness, or access.

Follow-Up on Prior EQR Recommendations

CMS requires EQROs report annually the degree to which PIHPs addressed the EQR recommendations made from the prior year's technical report. During the 2016–2017 EQR, HSAG made the following recommendations to **Macomb County CMH Services**; and **Macomb County CMH Services** addressed these recommendations by taking the following actions:

Compliance Monitoring

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 provided no recommendations during the 2016–2017 review period; therefore, no actions were required of **Macomb County CMH Services**.

Validation of Performance Measures

The 2016–2017 validation of performance measures for **Macomb County CMH Services** identified opportunities for improvement in the following performance indicators:

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

HSAG recommended 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. Additionally, HSAG made recommendations for **Macomb County CMH Services** to improve compliance with MDHHS Codebook specifications. Based upon the results of the 2017–2018 validation, **Macomb County CMH Services** improved its rates for indicator #3 for DD Adults and achieved the MPS. **Macomb County CMH Services** did not; however, meet MPS for indicator #4a for Adults and indicator #10 for Adults, indicating that **Macomb County CMH Services** partially addressed prior recommendations but needs to improve upon the remaining measures still not meeting the MPS.

Validation of Performance Improvement Projects

For the 2016–2017 validation, **Macomb County CMH Services** provided its fourth-year submission on the PIP topic: *Increasing Metabolic Syndrome Screening for Adults With Severe Mental Illness*. HSAG identified opportunities for improvement in Activity VII—Sufficient Data Analysis and Interpretation, and recommended that, within its 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. HSAG also identified *Points of Clarification* as opportunities for improvement in Activity IV—Clearly Defined Study Indicator(s) and Activity VII—Sufficient Data Analysis and Interpretation, and recommended documenting the Remeasurement 2 goal accurately and consistently throughout the PIP Submission Form. Further, HSAG recommended that **Macomb County CMH Services** build on its momentum of improvement to ensure ability to sustain the improvement achieved; and revisit its causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers as well as to see if any new barriers exist that require the development of interventions. For the 2017–2018 validation, **Macomb County CMH Services** selected a new PIP topic; and as **Macomb County CMH Services** proceeds through each phase of the new PIP, HSAG will continue to assess **Macomb County CMH Services**' performance related to improving upon the areas recommended in the previous PIP.

Recommendations

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Macomb County CMH Services** to members, HSAG recommends that **Macomb County CMH Services** incorporate efforts for improvement of the following performance indicators with an MPS as part of its quality improvement strategy within the QAPIP:

Ratings Below the MPS

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

Macomb County CMH Services should include within its next annual QAPIP review the results of analyses for the performance indicators listed above that answer the following questions:

1. What were the root causes associated with low-performing rates?
2. What unexpected outcomes were found within the data?
3. What disparities were identified in the analyses?
4. What are the most significant areas of focus (or populations) for which improvement initiatives are planned? What is the highest impact area(s) to make an improvement(s) (low effort/high yield)?
5. What intervention(s) is **Macomb County CMH Services** considering or has already implemented to improve rates and performance for each identified indicator?

Based on the information presented above, **Macomb County CMH Services** should include the following within its quality improvement plan:

- Measurable goals and benchmarks for each indicator.
- Mechanisms to measure performance.
- Mechanisms to review data trends to identify improvement, decline, or stability in the performance rates.
- Identified opportunities for improvement.
- Ongoing analysis to identify factors that impact adequacy of rates.
- Quality improvement interventions that address the root cause of the deficiency.
- A plan to monitor the quality improvement interventions to detect whether they effect improvement.

Additionally, **Macomb County CMH Services** should have defined data entry processes, including documented processes for data quality and data completeness checks.

HSAG also recommends that **Macomb County CMH Services** develop meaningful plans of action to bring into compliance each of the following deficient standards:

- Standard VI—Customer Service
- Standard IX—Subcontracts and Delegation
- Standard XII—Access and Availability
- Standard XIV—Appeals

Macomb County CMH Services should include the following in each of its plans of action, and the plans of action should be provided to MDHHS within 30 days of receipt of required corrective action:

- Detailed narrative of the deficiency.
- Detailed corrective action steps to resolve each deficiency.
- Any resources required to resolve the deficiency.

- Due dates for completing each action step
- Assigned party responsible for completing each action step.
- Any required deliverables to show that a deficiency has been resolved.
- Any dependencies to resolve deficiencies.

Finally, **Macomb County CMH Services** should take proactive steps to ensure a successful PIP. As the PIP progresses, **Macomb County CMH Services** should ensure the following:

- Follow the approved PIP methodology to calculate and report baseline data accurately in next year's annual submission.
- To impact the Remeasurement 1 study indicator rate, complete a causal/barrier analysis to identify barriers to desired outcomes and implement interventions to address those barriers timely. Interventions implemented late in the Remeasurement 1 study period will not have enough time to impact the study indicator rate.
- Document the process and steps used to determine barriers to improvement; and attach completed quality improvement tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis.
- Implement active, innovative improvement strategies with the potential to directly impact study indicator outcomes.
- Implement a process for evaluating the performance of each PIP intervention and its impact on the study indicators and allow continual refinement of improvement strategies. The evaluation process should be ongoing and cyclical.

Region 10 PIHP

To conduct the 2017–2018 EQR, HSAG reviewed **Region 10 PIHP**'s results for mandatory EQR activities. Those results were analyzed and evaluated to develop conclusions and make recommendations about the quality of, timeliness of, and access to care and services provided by **Region 10 PIHP**.

EQR Activity Results

This section provides the results and notable findings for the mandatory EQR activities performed for **Region 10 PIHP**.

Compliance Monitoring

Table 5-55 presents the total number of elements for each standard as well as the number of elements for each standard that received a score of *Met*, *Not Met*, or *Not Applicable (N/A*). Table 5-55 also presents **Region 10 PIHP**'s overall compliance score for each standard, the totals across the eight standards reviewed, and the total compliance score across all standards for the 2017–2018 compliance monitoring review.

Table 5-55—Summary of 2017–2018 Compliance Monitoring Review Results

Standard	Total # of Applicable Elements	Number of Elements			Total Compliance Score
		Met	*Not Met*	*N/A*	
Standard VI—Customer Service	39	34	5	0	**87%**
Standard VII—Grievance Process	26	20	6	0	**77%**
Standard IX—Subcontracts and Delegation	11	9	2	0	**82%**
Standard X—Provider Network	12	12	0	1	**100%**
Standard XII—Access and Availability	19	19	0	0	**100%**
Standard XIV—Appeals	54	23	31	0	**43%**
Standard XV—Disclosure of Ownership, Control, and Criminal Convictions	14	14	0	0	**100%**
Standard XVII—Management Information Systems	12	10	2	2	**83%**
Total Compliance Score	**187**	**141**	**46**	**3**	**75%**

Total # of Applicable Elements—The total number of elements within each standard minus any elements that received designations of *NA*.
Total Compliance Score—Elements scored *Met* were given full value (1 point). The point values were then totaled, and the sum was divided by the number of applicable elements to derive a percentage score.

Region 10 PIHP demonstrated compliance for 141 of 187 elements, with an overall compliance score of 75 percent. **Region 10 PIHP** demonstrated strong performance, scoring 90 percent or above in three standards, with all three of those standards achieving full compliance. These areas of strength include Provider Network; Access and Availability; and Disclosure of Ownership, Control, and Criminal Convictions.

Opportunities for improvement were identified in five of the eight standards, including deficiencies related to the following requirements:

- Content of the customer handbook.
- Content, maintenance, and/or dissemination of the provider directory.
- Grievance processes including not but limited to access to the State fair hearing process for untimely resolution of grievances, written consent from the member, resolution of grievances, and content of resolution notices.
- Monitoring of subcontractors.
- Subcontract provision specifying that the right to audit exists through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.
- Appeal processes including but not limited to those related to providing information to providers and subcontractors at the time they enter into a contract; obtaining a written, signed request for an appeal; obtaining written consent from the member; continuation or reinstatement of benefits; acknowledgement of the appeal; record maintenance; documentation of appropriate clinical decision makers; member access to records; denial of an expedited appeal request provision; extension of time frame provisions; format and content of resolution notices; and State fair hearing filing requirements.
- Annual certification to attest to the accuracy, completeness, and truthfulness of information in data sets submitted to MDHHS.

Region 10 PIHP's lowest performing areas were in Standard XIV—Appeals with 31 *Not Met* findings and a compliance score of 43 percent. **Region 10 PIHP** was required to develop and implement a corrective action plan for each requirement in all standards scored *Not Met*. Refer to **Region 10 PIHP**'s 2017–2018 External Quality Review Compliance Monitoring Report for Prepaid Inpatient Health Plan for a detailed review of the findings.

Validation of Performance Measures

The purpose of the performance measure validation activity was to assess the accuracy of performance indicators reported by **Region 10 PIHP** and to determine the extent to which performance indicators reported by **Region 10 PIHP** followed State specifications and reporting requirements. HSAG evaluated **Region 10 PIHP**'s data systems for the processing of each type of data used for reporting MDHHS performance indicators. High-level findings are presented below. Refer to State Fiscal Year 2018 Validation of Performance Measures for Region 10—PIHP report for a detailed review of the findings.

- Eligibility and Enrollment Data System Findings—HSAG identified no concerns with how **Region 10 PIHP** received and processed eligibility data.
- Medical Services Data System (Claims and Encounters) Findings—HSAG identified no major concerns with how **Region 10 PIHP** received and processed claims and encounter data for State submission and performance indicator reporting. Performance indicators were verified prior to submission to the State. Additional issues were identified by **Region 10 PIHP** after the measures

were reported to the State; however, these issues did not materially impact the rates, and **Region 10 PIHP** was able to report the performance measure rates.

- Behavioral Health Treatment Episode Data Set (BH-TEDS) Data Production—The required BH-TEDS fields were programmed into the CMHSPs' EHR systems for streamlined data collection via fillable fields and drop-down fields. The CMHSPs, via an automated process, extracted BH-TEDS information from their internal EHRs and uploaded it to **Region 10 PIHP** EHR system. Adequate validation processes were in place to ensure that all BH-TEDS-related questions were given responses. For data completeness, **Region 10 PIHP** validated BH-TEDS data based on the State's requirements. **Region 10 PIHP** submitted validated and clean BH-TEDS files to the State based on the State's requirements.
- PIHP Oversight of Affiliate Community Mental Health Centers—HSAG identified no major concerns regarding **Region 10 PIHP**'s oversight of its four CMHSPs.

Based on all validation methods used to collect information during the Michigan SFY 2018 Validation of Performance Measures activity, HSAG determined results for each performance indicator and assigned each an indicator designation of *Report*, *Not Reported*, or *No Benefit*. **Region 10 PIHP** received an indicator designation of *Report* for all indicators, signifying that **Region 10 PIHP** had calculated all indicators in compliance with the MDHHS Codebook specifications and that rates could be reported. Table 5-56 presents **Region 10 PIHP**'s performance measure results and the corresponding MPS when an MPS was established by MDHHS.

Table 5-56—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.		
Children	99.51%	95.00%
Adults	99.83%	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	100.00%	95.00%
MI Adults	100.00%	95.00%
DD Children	100.00%	95.00%
DD Adults	100.00%	95.00%
Medicaid SA	96.64%	95.00%
Total	98.47%	95.00%
#3: The percent of new Medicaid beneficiaries during the quarter starting any needed ongoing service within 14 days of a non-emergent face-to-face assessment with a professional.		
MI Children	98.05%	95.00%

Performance Indicator	Rate	Minimum Performance Standard
MI Adults	99.37%	95.00%
DD Children	98.81%	95.00%
DD Adults	96.61%	95.00%
Medicaid SA	99.38%	95.00%
Total	98.94%	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	97.35%	95.00%
Adults	97.63%	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 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.	98.13%	—
#8: The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who are employed competitively.		
MI Adults	9.82%	—
DD Adults	5.99%	—
MI/DD Adults	6.28%	—
#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	90.03%	—
DD Adults	75.26%	—
MI/DD Adults	71.21%	—

Performance Indicator	Rate	Minimum Performance Standard
#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	12.00%	15.00%
Adults	15.22%	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).	16.42%	—
#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).	45.50%	—

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.

Region 10 PIHP's performance exceeded corresponding MPSs for 18 of 19 indicators with MPSs, indicating strength in these areas.

Although almost all of **Region 10 PIHP**'s rates exceeded their corresponding MPSs, one rate for indicator #10 fell below the MPS, indicating opportunities for improvement in reducing inpatient psychiatric readmissions for adults.

Validation of Performance Improvement Projects

For the 2017–2018 validation, **Region 10 PIHP** provided its first-year submission on the new PIP topic: *Medical Assistance for Tobacco Use Cessation.* The goal of this PIP is to improve the medical assistance services pertaining to tobacco use cessation for PIHP members with serious mental illness and who have been identified as tobacco users. Medical assistance for this PIP is defined as a medical prescription to assist with tobacco cessation.

Table 5-57 outlines the study indicators for the PIP.

Table 5-57—Study Indicator

PIP Topic	Study Indicator
Medical Assistance for Tobacco Use Cessation	The proportion of adult Medicaid beneficiaries with serious mental illness (SMI) identified by the PIHP as tobacco users who have at least one medical assistance service event pertaining to tobacco use cessation during the measurement year.

Table 5-58 and Table 5-59 show **Region 10 PIHP** scores based on HSAG's PIP evaluation. For additional details, refer to the 2017–2018 PIP validation report for **Region 10 PIHP**.

Table 5-58—Performance Improvement Project Validation Results for Region 10 PIHP

Stage	Step		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% (2/2)	0% (0/2)	0% (0/2)
	V.	Valid Sampling Techniques (if sampling was used)	*Not Applicable*		
	VI.	Accurate/Complete Data Collection	100% (3/3)	0% (0/3)	0% (0/3)
Design Total			**100% (9/9)**	**0% (0/9)**	**0% (0/9)**
Implementation	VII.	Sufficient Data Analysis and Interpretation	*Not Assessed*		
	VIII.	Appropriate Improvement Strategies	*Not Assessed*		
Implementation Total			***Not Assessed***		
Outcomes	IX.	Real Improvement Achieved	*Not Assessed*		
	X.	Sustained Improvement Achieved	*Not Assessed*		
Outcomes Total			***Not Assessed***		
Percentage Score of Applicable Evaluation Elements *Met*			**100% (9/9)**	**0% (0/9)**	**0% (0/9)**

Table 5-59—2017–2018 Performance Improvement Project Validation Scores for Region 10 PIHP

Name of Project	Type of Annual Review	Percentage Score of Evaluation Elements *Met*	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Medical Assistance for Tobacco Use Cessation	Submission	89%	88%	*Partially Met*
	Resubmission	100%	100%	*Met*

Region 10 PIHP submitted the Design stage of the PIP for this year's validation. Overall, 100 percent of all applicable evaluation elements received a score of *Met* for the first six steps of the PIP process. The PIP had not progressed to the Implementation and Outcomes stages during this validation cycle.

Region 10 PIHP designed a scientifically sound study supported by key research principles and meeting all requirements in the Design stage. The technical design of the PIP was sufficient to measure and monitor PIP outcomes. **Region 10 PIHP** indicated plans to include its entire eligible population in this PIP. A sound study design created the foundation for **Region 10 PIHP** to progress to subsequent PIP stages—collecting data and implementing interventions with the potential to impact study indicator outcomes.

Strengths, Weaknesses, and Overall Conclusions

Region 10 PIHP demonstrated both strengths and weaknesses based on the results of the 2017–2018 EQR activities. **Region 10 PIHP** received a total compliance score of 75 percent across all standards reviewed during the 2017–2018 compliance monitoring review, which was the lowest aggregated score across all PIHPs. **Region 10 PIHP** scored above 90 percent in the Provider Network; Access and Availability; and Disclosure of Ownership, Control, and Criminal Convictions standards, indicating strong performance in these areas, but did not perform as well in the Customer Service, Grievance Process, Subcontracts and Delegation, Appeals, and Management Information Systems standards, as demonstrated by moderate to low performance scores (87 percent, 77 percent, 82 percent, 43 percent, and 83 percent respectively), reflecting that additional focus is needed in these areas. While 18 of the 19 performance measure rates were above the MDHHS-established MPSs, indicating strengths in these areas, **Region 10 PIHP**'s 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* fell below its corresponding MPS, indicating opportunities for improvement for this measure.

Region 10 PIHP's overall performance demonstrates the following impact to the Medicaid population's quality of, timeliness of, and access to care and services:

Table 5-60—Quality, Timeliness, and Access Performance Impact

Performance Area*	Overall Performance Impact
Quality	• Strength: Received a performance score of 100 percent in the Disclosure of Ownership, Control, and Criminal Convictions standard, indicating a strong focus on program integrity, which includes appropriate screening of contracted providers. • Strength: Low percentage of readmission rates for children discharged from inpatient psychiatric units, as indicated by performance of indicator #10. • Strength: Designed a scientifically sound study related to *Medical Assistance for Tobacco Use Cessation*, which was supported by key research principles, meeting all requirements of the PIP Design stage. • Weakness: High percentage of readmission rates for adults discharged from inpatient psychiatric units, suggesting that these adult members need assistance obtaining follow-up care. • Weakness: Received a performance score of 77 percent in the Grievance Process standard, indicating that the PIHP may not have an effective grievance process in place for members to express dissatisfaction. • Weakness: Received five deficiencies in the Customer Service standard related to the customer handbook and provider directory, indicating that members may have challenges navigating the Medicaid managed care program and knowing which providers can meet their unique healthcare needs.
Timeliness	• Strength: Minimum performance standards were met related to timely pre-admission screening for psychiatric inpatient care for children and adults; timely face-to-face assessments with a professional for non-emergency request for services for MI Children, MI Adults, DD Children, DD Adults, and Medicaid SA; and receiving timely needed, ongoing services for MI Children, MI Adults, DD Children, DD Adults, and Medicaid SA.
Access	• Strength: Received a performance score of 100 percent in the Provider Network standard, indicating that the PIHP maintains a network of providers to provide behavioral health and substance use disorder services to members. • Strength: Received the highest performance score, 100 percent, in the Access and Availability standard, indicating that members had access to providers and treatment when necessary. • Strength: As indicated by the performance measure rate, 100 percent of members discharged from a substance abuse detox unit were seen for follow-up care within seven days. • Weakness: Received the lowest score, at 43 percent, in the Appeals standard, suggesting that members are not receiving all rights afforded to them under the appeal process, which may include opportunity to challenge denial of prescribed services.

*Performance impact may be applicable to one or more performance areas; however, for purposes of this report impact was aligned to either quality, timeliness, or access.

Follow-Up on Prior EQR Recommendations

CMS requires EQROs report annually the degree to which PIHPs addressed the EQR recommendations made from the prior year's technical report. During the 2016–2017 EQR, HSAG made the following recommendations to **Region 10 PIHP**, and **Region 10 PIHP** addressed these recommendations by taking the following actions:

Compliance Monitoring

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 provided no recommendations during the 2016–2017 review period; therefore, no actions were required of **Region 10 PIHP**.

Validation of Performance Measures

Region 10 PIHP's performance exceeded the minimum performance standards for all 19 indicators with MPSs during the 2016–2017 validation; therefore, no performance measure recommendations were identified.

Validation of Performance Improvement Projects

For the 2016–2017 validation, **Region 10 PIHP** provided its fourth-year submission on the PIP topic: *Behavioral and Physical Health Care Integration*. HSAG identified no opportunities for improvement in the annual PIP validation tool for **Region 10 PIHP**; however, HSAG recommended that **Region 10 PIHP** build on its momentum of improvement to ensure it can sustain the improvement achieved; revisit its causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers, and determine whether any new barriers exist that require the development of interventions. For the 2017–2018 validation, **Region 10 PIHP** selected a new PIP topic, and as **Region 10 PIHP** proceeds through each phase of the new PIP, HSAG will continue to assess **Region 10 PIHP**'s performance related to improving upon the areas recommended in the previous PIP.

Recommendations

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Region 10 PIHP** to members, HSAG recommends that **Region 10 PIHP** incorporate efforts for improvement of the following performance indicators with an MPS as part of its quality improvement strategy within the QAPIP:

Ratings Below the MPS[5-6]

- *#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

Performance Declined >2 Percent From Previous Year

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

Region 10 PIHP should include within its next annual QAPIP review the results of analyses for the performance indicators listed above that answer the following questions:

1. What were the root causes associated with low-performing rates?
2. What unexpected outcomes were found within the data?
3. What disparities were identified in the analyses?
4. What are the most significant areas of focus (or populations) for which improvement initiatives are planned? What is the highest impact area(s) to make an improvement(s) (low effort/high yield)?
5. What intervention(s) is **Region 10 PIHP** considering or has already implemented to improve rates and performance for each identified indicator?

Based on the information presented above, **Region 10 PIHP** should include the following within its quality improvement plan:

- Measurable goals and benchmarks for each indicator.
- Mechanisms to measure performance.
- Mechanisms to review data trends to identify improvement, decline, or stability in the performance rates.
- Identified opportunities for improvement.
- Ongoing analysis to identify factors that impact adequacy of rates.
- Quality improvement interventions that address the root cause of the deficiency.
- A plan to monitor the quality improvement interventions to detect whether they effect improvement.

Additionally, **Region 10 PIHP** should have defined data entry processes, including documented processes for data quality and data completeness checks.

[5-6] Performance indicators listed under "Ratings Below the MPS" could have demonstrated a greater than 2 percent decline from the previous year, but they were not repeated under "Performance Declined >2 Percent From Previous Year."

HSAG also recommends that **Region 10 PIHP** develop meaningful plans of action to bring into compliance each of the following deficient standards:

- Standard VI—Customer Service
- Standard VII—Grievance Process
- Standard IX—Subcontracts and Delegation
- Standard XIV—Appeals
- Standard XVII—Management Information Systems

Region 10 PIHP should include the following in each of its plans of action, and the plans of action should be provided to MDHHS within 30 days of receipt of required corrective action:

- Detailed narrative of the deficiency.
- Detailed corrective action steps to resolve each deficiency.
- Any resources required to resolve the deficiency.
- Due dates for completing each action step.
- Assigned party responsible for completing each action step.
- Any required deliverables to show that a deficiency has been resolved.
- Any dependencies to resolve deficiencies.

Finally, **Region 10 PIHP** should take proactive steps to ensure a successful PIP. As the PIP progresses, **Region 10 PIHP** should ensure the following:

- Follow the approved PIP methodology to calculate and report baseline data accurately in next year's annual submission.
- To impact the Remeasurement 1 study indicator rate, complete a causal/barrier analysis to identify barriers to desired outcomes and implement interventions to address those barriers timely. Interventions implemented late in the Remeasurement 1 study period will not have enough time to impact the study indicator rate.
- Document the process and steps used to determine barriers to improvement; and attach completed quality improvement tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis.
- Implement active, innovative improvement strategies with the potential to directly impact study indicator outcomes.
- Implement a process for evaluating the performance of each PIP intervention and its impact on the study indicators, and allow continual refinement of improvement strategies. The evaluation process should be ongoing and cyclical.

6. PIHP Comparative Information With Recommendations for Michigan Department of Health and Human Services

In addition to performing a comprehensive assessment of the performance of each PIHP, HSAG compared the findings and conclusions established for each PIHP to assess the Michigan Medicaid managed care program as a whole. The overall findings of the 10 PIHPs were used to identify the overall strengths and weaknesses of the Michigan Medicaid managed care program and to identify areas in which MDHHS could leverage or modify Michigan's Quality Strategy to promote improvement.

EQR Activity Results

This section provides the summarized results for the mandatory EQR activities across the 10 PIHPs.

Compliance Monitoring

Table 6-1 presents a summary of performance results for the Medicaid programs of the PIHPs as well as Statewide aggregated performance. The percentage of requirements met for each of the eight compliance standards reviewed during the 2017–2018 compliance monitoring review are provided.

Table 6-1—Compliance Monitoring Comparative Results

Standard	R1	R2	R3	R4	R5	R6	R7	R8	R9	R10	Statewide
VI	87%	90%	85%	87%	87%	87%	87%	82%	87%	87%	**87%**
VII	92%	81%	100%	81%	92%	100%	100%	88%	100%	77%	**91%**
IX	91%	91%	82%	91%	91%	91%	82%	82%	55%	82%	**84%**
X	92%	100%	92%	100%	100%	83%	100%	83%	100%	100%	**95%**
XII	95%	63%	63%	89%	95%	89%	89%	89%	84%	100%	**86%**
XIV	78%	81%	61%	87%	93%	87%	83%	85%	98%	43%	**80%**
XV	100%	100%	93%	100%	100%	100%	100%	100%	100%	100%	**99%**
XVII	83%	100%	83%	100%	100%	100%	75%	83%	100%	83%	**91%**
Total	**87%**	**86%**	**79%**	**89%**	**93%**	**91%**	**89%**	**86%**	**93%**	**75%**	**87%**

Standard VI—Customer Service
Standard VII—Grievance Process
Standard IX—Subcontracts and Delegation
Standard X—Provider Network
Standard XII—Access and Availability
Standard XIV—Appeals
Standard XV—Disclosure of Ownership, Control, and Criminal Convictions
Standard XVII—Management Information Systems

The Michigan Medicaid managed care program under BHDDA received an average total performance score across the 10 PIHPs of 87 percent. The program as a whole demonstrated strong performance, scoring 90 percent or above in four standards. These areas of strength include Grievance Process; Provider Network; Disclosure of Ownership, Control, and Criminal Convictions; and Management

Information Systems. All but one PIHP received 100 percent compliance in the Disclosure of Ownership, Control, and Criminal Convictions standard. Additionally, six PIHPs scored 100 percent compliance in the Provider Network standard.

While opportunities for improvement were identified in all eight standards, areas of the program with the greatest opportunities include Customer Service, Subcontracts and Delegation, Access and Availability, and Appeals. Although **Northern Michigan Regional Entity** scored 90 percent in the Customer Service standard, the remaining nine PIHPs scored under 90 percent. Additionally, five PIHPs scored below 90 percent in the Subcontracts and Delegation standard, with one of those PIHPs scoring 55 percent compliance. While **Region 10 PIHP**, **NorthCare Network**, and **Mid-State Health Network** received compliance scores of 95 percent or higher, seven PIHPs scored below 90 percent, with two PIHPs scoring 63 percent each in the Access and Availability standard. The lowest-performing standard across the State was Appeals. Two PIHPs, **Macomb County CMH Services** and **Mid-State Health Network**, demonstrated being greater than 90 percent compliant; however, three PIHPs scored below 80 percent compliant, with one PIHP receiving a performance score of 61 percent while another PIHP received a performance score of 43 percent.

Performance Measures

Statewide rates were calculated by summing the number of cases that met the requirements of the performance measure 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 *Not Reported* validation finding designations; therefore, the number of PIHPs included in the statewide rates was reduced to eight PIHPs for all indicators, due to **Lakeshore Regional Entity** and **Detroit Wayne Mental Health Authority** reporting rates with *Not Reported* for all indicators with an MPS.

Table 6-2 displays the statewide scores and the lowest and highest scores among the PIHPs for validated performance measure indicators.

Table 6-2—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	98.90%	95.00%	92.76%	100.00%
Adults	98.24%	95.00%	90.98%	99.83%
#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	97.98%	95.00%	91.61%	100.00%
MI Adults	98.92%	95.00%	95.65%	100.00%

Performance Indicator	Statewide Score	Minimum Performance Standard	PIHP Low Score	PIHP High Score
DD Children	97.77%	95.00%	89.58%	100.00%
DD Adults	98.49%	95.00%	93.33%	100.00%
Medicaid SA	97.53%	95.00%	91.24%	99.45%
Total	98.13%	95.00%	95.86%	98.92%
#3: The percent of new Medicaid beneficiaries during the quarter starting any needed ongoing service within 14 days of a non-emergent face-to-face assessment with a professional.				
MI Children	96.82%	95.00%	95.55%	100.00%
MI Adults	98.26%	95.00%	96.06%	100.00%
DD Children	95.39%	95.00%	83.05%	100.00%
DD Adults	98.44%	95.00%	90.00%	100.00%
Medicaid SA	98.25%	95.00%	95.15%	99.89%
Total	97.89%	95.00%	95.70%	99.47%
#4a: The percent of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.				
Children	95.58%	95.00%	82.14%	100.00%
Adults	96.70%	95.00%	94.00%	99.25%
#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.	95.95%	95.00%	76.19%	100.00%
#5: The percent of Medicaid recipients having received PIHP managed services.				
The percent of Medicaid recipients having received PIHP managed services.	6.75%	—	5.27%	7.99%
#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 HSW enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	96.04%	—	81.03%	98.66%
#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	12.50%	—	9.82%	15.93%
DD Adults	8.96%	—	5.18%	12.18%
MI/DD Adults	8.35%	—	5.86%	13.73%

Performance Indicator	Statewide Score	Minimum Performance Standard	PIHP Low Score	PIHP High Score
#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	81.02%	—	80.24%	92.09%
DD Adults	36.34%	—	41.88%	98.06%
MI/DD Adults	38.68%	—	55.43%	90.91%
#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	10.10%	15.00%	14.71%	0.00%
Adults	11.88%	15.00%	15.23%	4.71%
#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).	19.45%	—	12.18%	26.00%
#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).	40.05%	—	29.81%	55.29%

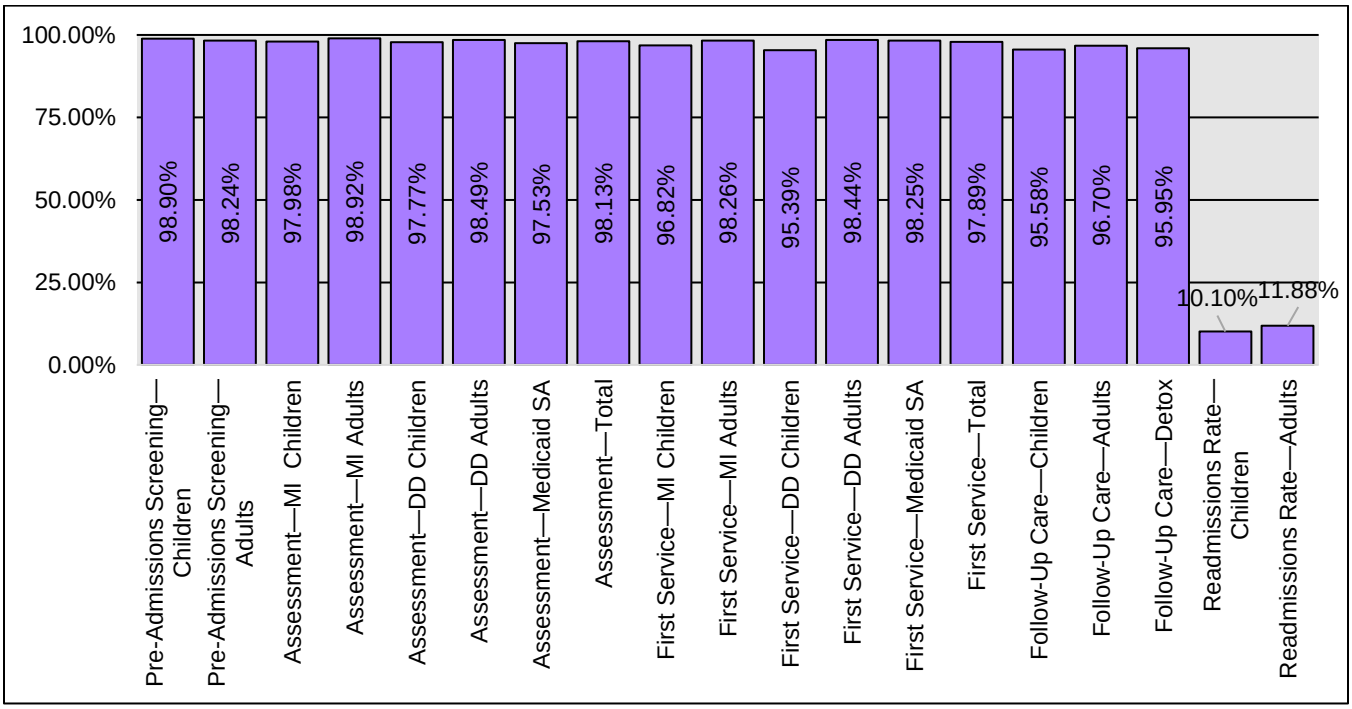
Indicates that the reported rate was better than the minimum performance standard.

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

* A lower rate indicates better performance.

MDHHS does not specify a minimum performance standard for all performance indicators, as demonstrated in Table 6-2. Statewide performance exceeded the MDHHS-established MPSs for all indicators with specified standards, as shown in Figure 6-1.

Figure 6-1—Statewide Rates for Performance Measures



Timeliness of care and access to care are demonstrated as statewide strengths for the PIHPs. The statewide scores exceeded the corresponding MPSs 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 ongoing 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 scores for the following performance indicators also exceeded the corresponding MPSs, 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*

Performance on the following statewide scores exceeded the corresponding MPSs as lower rates for these measures indicate better performance, demonstrating statewide strengths in quality of care:

- *#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

As displayed in Figure 6-1, continued strong performance resulted in statewide rates that exceeded the MDHHS benchmark for all indicators. One PIHP, **Southwest Michigan Behavioral Health**, exceeded all MPSs; while three additional PIHPs, **Mid-State Health Network**, **CMH Partnership of Southeast Michigan**, and **Region 10 PIHP** exceeded all but one indicator.

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 showed the highest statewide rate at 98.92 percent for MI Adults. 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* represented another statewide area of strength, with statewide performance exceeding the MPS of 15 percent for both children and adults.

Compared to performance in the prior validation cycle, most statewide rates for indicators remained essentially unchanged, with most rates changing by less than 2 percentage points each. Refer to Appendix A, Table A–2. Indicator *#3: The percent of new Medicaid beneficiaries during the quarter starting any needed ongoing service within 14 days of a non-emergent face-to-face assessment with a professional—DD Adults* achieved an improvement in performance of greater than 3 percent, which may indicate a statewide strength.

Although a few performance measures had decreases of slightly more than 2 percent each, no statewide measure rates were below the established MPSs. However, for most measures at least one PIHP did not meet the MPS, indicating opportunities for improvement for those individual PIHPs. Additionally, three various PIHPs each did not meet the MPS for at least one population under each of the following indicators, indicating the most prevalent opportunities for improvement statewide:

- *#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: The percent of new Medicaid beneficiaries during the quarter starting any needed ongoing service within 14 days of a non-emergent face-to-face assessment with a professional*
- *#4a: The 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*

Performance Improvement Project

For 2017–2018 validation, the PIHPs provided first-year PIP submissions for their new PIP topics. Table 6-3 presents a list of the PIP topics selected by each PIHP.

Table 6-3—PIHP PIP Topics

PIHP	PIP Topic
Region 1—NorthCare Network	*Follow-up After Hospitalization for Mental Illness Within Seven Days of Discharge for Members 6 Years and Older*
Region 2—Northern Michigan Regional Entity	*Follow-up Care for Children Prescribed ADHD Medication*
Region 3—Lakeshore Regional Entity	*Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)*
Region 4—Southwest Michigan Behavioral Health	*Improving Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication*
Region 5—Mid-State Health Network	*Patients with Schizophrenia and Diabetes Who Had an HbA1c and LDL-C Test*
Region 6—CMH Partnership of Southeast Michigan	*Patients with Schizophrenia and Diabetes Who Had an HbA1c and LDL-C Test*
Region 7—Detroit Wayne Mental Health Authority	*Improving Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication*
Region 8—Oakland County CMH Authority	*Improving Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication*
Region 9—Macomb County CMH Services	*Reducing Acute Inpatient Recidivism for Adults with Serious Mental Illness*
Region 10 PIHP	*Medical Assistance for Tobacco Use Cessation*

For this year's validation, the PIHPs included information on the PIP study Design stage (Steps I through VI) only. Once the data collection begins and improvement strategies are implemented, the PIPs will be assessed for the remaining steps. The PIHPs will report baseline data in next year's annual PIP submission. Figure 6-2 and Table 6-4 provide comparison of the study design validation scores and overall PIP validation status, by PIHPs.

Figure 6-2—Comparison of Study Design Validation Scores

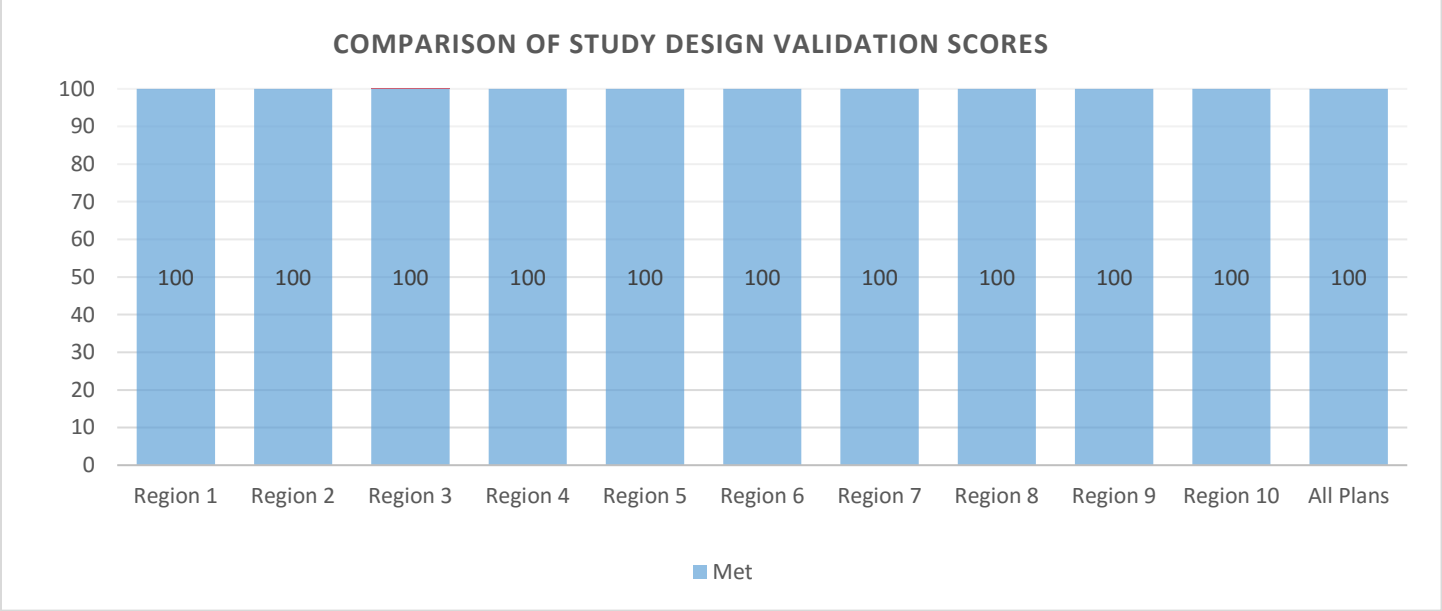


Table 6-4 presents a comparison of PIP validation results by each PIHP, showing how many of the PIPs reviewed for each activity received *Met* scores for all applicable evaluation or critical elements.

Table 6-4—Comparison of PIP Validation Status

PIHP	Percentage of All Applicable Evaluation Elements Met	Percentage of Critical Elements Met	Validation Status
Region 1—NorthCare Network	100	100	*Met*
Region 2—Northern Michigan Regional Entity	100	100	*Met*
Region 3—Lakeshore Regional Entity	100	100	*Met*
Region 4—Southwest Michigan Behavioral Health	100	100	*Met*
Region 5—Mid-State Health Network	100	100	*Met*
Region 6—CMH Partnership of Southeast Michigan	100	100	*Met*
Region 7—Detroit Wayne Mental Health Authority	100	100	*Met*
Region 8—Oakland County CMH Authority	100	100	*Met*
Region 9—Macomb County CMH Services	100	100	*Met*
Region 10 PIHP	100	100	*Met*

The results from the 2017–2018 validation reflected strong performance in the Design phase (Steps I through VI) of the PIPs. All 10 PIHPs each received an overall *Met* validation status, each with a score of 100 percent in all applicable evaluation elements in Steps I through VI.

Summary, Conclusions, and Recommendations

HSAG performed a comprehensive assessment of the performance of each PIHP and of the overall strengths and weaknesses of the Michigan Medicaid managed care program related to behavioral health, developmental disability, and substance abuse services. All components of each EQR activity and the resulting findings were thoroughly analyzed and reviewed across the continuum of program areas and activities that comprise BHDDA under the Michigan Medicaid managed care program.

Strengths and Associated Conclusions

Through this all-inclusive assessment of aggregated performance, HSAG identified several areas of strength in the program.

Compliance Monitoring

Through the 2017–2018 compliance monitoring review, overall, BHDDA under the Michigan Medicaid managed care program demonstrated areas of strength in managing and adhering to expectations established for the Medicaid program through State and federal requirements. Most of these requirements relate to or impact the quality of, timeliness of, and access to care and services provided by each PIHP to their members. The highest-performing plans were **Mid-State Health Network** and **Macomb County CMH Services**, each with an overall average performance score of 93 percent. **CMH Partnership of Southeast Michigan** followed closely behind with a score of 91 percent. An additional five PIHPs scored between 89 percent and 86 percent. Additionally, statewide average scores in each of the following standards were at 91 percent or above, demonstrating strong performance:

- Grievance Process—the PIHPs had effective systems in place for members to express dissatisfaction related to services or other areas of the program.
- Provider Network—the PIHPs maintained and continually evaluated their network of providers to ensure that all members, including those with limited English proficiency, physical, and/or mental disabilities, had adequate access to services covered by Medicaid.
- Disclosure of Ownership, Control, and Criminal Convictions—the PIHPs had implemented robust monitoring processes to ensure that network providers, contractors, and employees were not excluded from providing services under federal programs and met the PIHPs' established expectations for network providers, contractors, and employees.
- Management Information Systems—the PIHPs maintained sufficient health information systems and processes, ensuring that enrollees' claims data were accurate and complete and that the PIHPs could meet obligations under their contracts with MDHHS.

Performance Measures

The individual PIHPs were evaluated against State benchmarks for measures related to quality of, access to, and timeliness of services. When the individual PIHP scores were aggregated, statewide average scores exceeded all corresponding MDHHS-established performance standards. On a statewide average, more than 95 percent of adult and child members were each able to:

- Receive a pre-admission screening for psychiatric inpatient care, for those for whom the disposition was completed within three hours.
- Receive a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service.
- Start needed ongoing service within 14 days of a non-emergent face-to-face assessment with a professional.
- Be seen for follow-up care within seven days of being discharged from a psychiatric inpatient unit.
- Be seen for follow-up care within seven days of being discharged from a substance abuse detox unit.

Additionally, the percentage of MI and DD children and adults being readmitted to inpatient psychiatric units within 30 days of discharge was under the 15 percent performance standard threshold, which may indicate that PIHPs are quickly and effectively coordinating care for members after discharge.

Performance Improvement Project

Through their participation in the PIP, the PIHPs will focus their efforts on specific quality outcomes—particularly quality and access to care and services—which should result in better health outcomes for Michigan Medicaid members.

During the 2017–2018 review period, all 10 PIHPs completed the Design stage of the PIP by successfully identifying an appropriate study topic; defining study questions; identifying the study population; defining study indicators to measure improvement over time; and collecting valid and reliable data on selected study indicators in order to effectively measure and monitor PIP outcomes. As the PIP progresses, the PIHPs will establish interventions to improve the health of their identified populations by:

- Increasing the prevalence of follow-up visits with a mental health practitioner within seven days after an inpatient discharge for members with selected mental health diagnoses. Follow-up after inpatient discharge is important in continuity of care between treatment settings and in ensuring that members receive care and services. Members receiving appropriate follow-up care with a mental health practitioner can reduce risk of repeat hospitalization.
- Increasing the percentage of child members, with newly prescribed attention/hyperactivity disorder (ADHD) medication, who have two follow-up care visits within a 10 month-period, one within 30 days of when the first ADHD medication was dispensed. Follow-up care visits are important in continuity of care to ensure that children's medications are prescribed and managed correctly.

- Increasing hemoglobin A1c and low-density lipoprotein cholesterol testing among Medicaid members with diabetes and schizophrenia. Monitoring these test results can assist in controlling diabetes; prevent serious health complications such as blindness, kidney disease, and amputations; and lead to improvement in health and functional outcomes of members.
- Improving the proportion of members with schizophrenia or bipolar disorder taking an antipsychotic medication who are screened for diabetes. Individuals with a mental health illness are at increased risk for developing diabetes. Uncontrolled diabetes can lead to adverse health problems.
- Decreasing members recidivating within 30 days post discharge to acute inpatient behavior health services. Timely follow-up care after inpatient stay and adequate treatment after discharge can help to identify risk factors for readmission and monitor risks, reducing the need for additional hospital services.
- Improving the medical assistance services (e.g., prescriptions) pertaining to tobacco use cessation for members with serious mental illness and who have been identified as tobacco users. Promoting tobacco cessation is expected to reduce smoking-related health hazards in members and improve members' health, functional status, satisfaction, and overall well-being.

Weaknesses and Associated Conclusions

HSAG's comprehensive assessment of the PIHPs and BHDDA under the Michigan Medicaid managed care program also identified areas of focus that represent significant opportunities for improvement within the program. These primary areas of focus are access and availability of services and information, management of the appeal process, and oversight of delegated entities.

Access and Availability of Services and Information

Although statewide average performance measure scores exceeded their MDHHS-established MPSs, access to and availability of services remain an area of opportunity for the Michigan Medicaid managed care program. As demonstrated through the 2017–2018 compliance monitoring review, statewide average performance in the Access and Availability standard was 86 percent, with seven of the 10 PIHPs performing under 90 percent, indicating that some members may be experiencing challenges accessing non-emergency and follow-up care timely. Additionally, two PIHPs received lower than average performance scores of 63 percent in this area for not meeting MDHHS-established performance thresholds, suggesting that network deficiencies may exist in these PIHPs' specific regions.

In addition to having an adequate network of providers available to see members timely, the PIHPs must also ensure that members have sufficient access to information to help them maximize their benefits, have awareness of available providers, and have knowledge of treatment options. The 2017–2018 compliance monitoring review revealed an opportunity to improve upon the information available and being distributed to Medicaid members receiving behavioral health and substance use disorder services. Statewide average performance in the Customer Service standard was 87 percent, with nine of the 10 PIHPs performing under 90 percent. Each of the 10 PIHPs was noted to have deficiencies in customer handbooks and provider directories.

Many customer handbooks distributed to members contained limited information about the grievance and appeal systems and, specifically, did not include pertinent details for members to understand the time frames and processes associated with filing grievances and appeals. Additionally, handbooks did not always inform members how to report fraud and abuse and were missing comprehensive information about members' rights and responsibilities, including the right to use any hospital or other setting for emergency care as well as how members could obtain access to out-of-network services, when necessary.

Most of the PIHP's provider directories included provider names, provider locations, and telephone numbers; but they did not always include provider website URLs. Additionally, the directories did not always inform members of the services available at each location; whether accommodations were available for members with physical disabilities; include a listing of the non-English languages spoken by providers and/or their staff members at each location; or include providers' cultural and linguistic capabilities, including any completed cultural competency training. Further, many directories did not specify whether providers were accepting new patients.

Management of the Appeal Process

With the May 6, 2016, publishing of the Medicaid Managed Care Final Rule, changes were made to activities related to EQR under 42 CFR §438.358 effective July 1, 2018. With CMS' revisions to the timeliness components within the appeal process, MDHHS substantially revised contract language to ensure that PIHPs were compliant with updated regulations. As demonstrated through the 2017–2018 compliance monitoring review, the appeal process was determined to be an area of weakness for most PIHPs, with many deficiencies resulting from noncompliance with updated program requirements. Statewide average performance in the Appeals standard was 80 percent, which was the lowest scoring standard evaluated during the review. Although two PIHPs exhibited high performance with scores of 98 percent and 93 percent, three PIHPs had remarkably low performance scores (43 percent, 61 percent, and 78 percent), and the remaining five PIHPs scored under 90 percent. Medicaid members are entitled to adequate notices of adverse benefit determinations and must be given a chance to appeal those decisions when their requests for medical services have been denied or not acted on within a reasonable time period. As indicated by low statewide performance in the Appeals standard, the PIHPs have significant opportunities to improve their internal appeal processes to ensure that members can challenge the denial of coverage of prescribed services, receive notice of resolution timely, and have an opportunity to request a State fair hearing when the internal PIHP appeal process has been exhausted.

Oversight of Delegated Entities

All 10 PIHPs have entered into delegation agreements with multiple CMHSPs, MCPNs, behavioral health providers, and/or SUD providers to meet their contract obligations with MDHHS. Through the 2017–2018 compliance monitoring review, all PIHPs provided evidence to support that they are held solely and are fully responsible for executing all provisions documented within their contracts with MDHHS, regardless whether an entity other than the PIHP is performing activities to meet those obligations. Additionally, the PIHPs' contracts with their delegates supported that the subcontractor agrees to perform the delegated activities and reporting responsibilities specified in compliance with the

PIHP's contract obligations. Although five of the PIHPs scored above 90 percent in the Subcontracts and Delegation standard during the compliance monitoring review, the remaining five PIHPs scored below 90 percent, with one PIHP scoring 55 percent. Additionally, concerns and deficiencies were noted in other standards due to a lack of oversight of delegated entities, which indicates opportunities for improvement in the oversight of delegated entities. Specifically, although effective processes were in place at most PIHPs to manage grievances, limited grievances were reported by delegated entities, suggesting the possibility that not all complaints were being tracked and managed through the grievance process. Similar to the grievance process, HSAG also noted potential concerns that some PIHPs were not able to access all appeal-related information to monitor delegates' compliance with the appeal process. Statewide, challenges existed with consistency in how the grievance and appeal processes were handled across each PIHP's multitude of delegates. Overall, processes and procedures and member materials, including acknowledgment and resolution notices, applicable to the appeal and grievance system were not consistent across the PIHP's delegates, suggesting risk of noncompliance in these areas. Additionally, in the Customer Service standard, several PIHPs lacked oversight of their delegates' provider directories and other member materials posted on the delegates' websites and/or available hard copy, which resulted in non-compliant and outdated directories and member materials being available for access by Medicaid managed care members.

Quality Strategy Recommendations for Michigan

Based on a comprehensive assessment of the PIHPs' performance in providing quality, timely, and accessible behavioral healthcare and SUD services to Michigan's Medicaid managed care members, HSAG concludes that the following prevalent areas of the program demonstrate the most opportunities for improvement:

- Member Access to and Availability of Services
- Member Access to Information
- Oversight of the Grievance and Appeal System

Michigan's quality strategy is designed to improve the health outcomes of its Medicaid members, including children and adults receiving behavioral health and SUD services, by measuring access, efficiency, and outcomes through standardized performance indicators; initiating PIPs that can be expected to have a positive effect on health outcomes and member satisfaction; and close monitoring of provider networks, affiliates, and subcontractors to ensure that quality healthcare and services are being provided to Michigan residents receiving Medicaid benefits. In consideration of the goals of the quality strategy and the comparative review of findings for all activities, HSAG recommends the following quality improvement initiatives, which target the identified specific areas of opportunity.

Member Access to and Availability of Services

One way to gauge the effectiveness of a Medicaid managed care program is to determine whether it provides members access to medically-necessary and high-quality healthcare services in a timely manner. MDHHS, as a State-Medicaid agency, is required to monitor access to care. Through its

MMBPIS, MDHHS has a mechanism to assess access to care and quality of the service delivery system statewide for behavioral health and SUD services. To further assess member access to and availability of services, HSAG recommends that MDHHS consider requiring PIHPs, as applicable, to incorporate efforts for improvement as part of its quality improvement strategy within the QAPIP to address performance indicators not meeting the MDHHS standards. The quality improvement plan should be provided to MDHHS at least bi-annually, and should include the following:

- Measurable goals and benchmarks for each indicator.
- Mechanisms to measure performance.
- Mechanisms to review data trends to identify improvement, decline, or stability in the performance rates.
- Identified opportunities for improvement.
- Ongoing analysis to identify factors that impact adequacy of rates.
- Quality improvement interventions that address the root cause of the deficiency.
- A plan to monitor the quality improvement interventions to detect whether they effect improvement.

At least annually, the PIHP should provide MDHHS with a summary report that includes an analysis of the interventions and the impact that the interventions had on the rates for each performance indicator not meeting MPS.

Additionally, since the statewide average performance score consistently meets the 95 percent MPS for each indicator, MDHHS could also consider doing the following:

- Increase the MPS for each indicator to 98 percent.
- Continue efforts to evaluate performance measures to determine whether any measures can be retired or if additional measures should be added to better assess access to care and availability of services from behavioral health and SUD providers.

Member Access to Information

To help members maximize Medicaid services and improve member overall health, it is important that members have access to information that outlines the processes to get services, clearly and comprehensively explains benefits and rights, and assists in finding providers that can meet members' unique needs.

To ensure that all materials being distributed to members meet State and federal requirements and include the necessary information to help navigate the Medicaid managed care program, HSAG recommends that MDHHS initiate a workgroup to specifically target member materials. The workgroup should consist of staff from MDHHS and representatives from each of the PIHPS. The goals of the workgroup should be to:

- Review all customer handbook templates, and revise to include all mandated federal requirements.

- Consider whether adopting a single customer handbook that can be customized only to include PIHP-specific information, such as contact information, would be appropriate.
- Discuss best practices for developing compliant provider directories.
- Consider the appropriateness of PIHPs having sole responsibility for maintaining provider directories.

Oversight of the Grievance and Appeal System

Medicaid members have the right to express dissatisfaction with any aspect of the operations, activities, or behavior of a PIHP or its providers as well as to request reconsideration of an adverse coverage determination. PIHPs have the responsibility to ensure that procedures are in place for timely notification of members' rights to file a grievance and/or an appeal as well as for timely resolution of a filed grievance and/or appeal. To ensure that members' rights are not impeded and that they can effectively navigate the grievance and appeal system, PIHPs must have adequate grievance and appeal processes in place. With the concerns noted during the 2017–2018 compliance monitoring review related to delegates' management of grievances and, most prevalently, appeals, HSAG recommends that MDHHS consider the following:

- Prohibit the delegation of grievances and appeals.
- Require the PIHPs to have staff available to manage the intake and processing of all grievances and appeals.
- Require the CMHSPs, MCPNs, and other providers to have a process in place for referring all grievances and appeals to the PIHP department responsible for the management of grievances and appeals.
- Require de-delegation of the grievance and appeal system and all related program requirements, allowing a six-month transition period to complete full de-delegation (in accordance with PIHPs' executed delegation agreements).

Appendix A. Summary Tables of External Quality Review Activity Results

Introduction

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

Results for Compliance Monitoring

Compliance monitoring activities were not required to be conducted in 2016–2017 as they were completed during the previous two years. The new cycle of reviews began in the 2017–2018 review period. Therefore, no comparative year-over-year data exist for the compliance monitoring activity.

Results for Validation of Performance Measures

Table A-1 presents the 2016–2017 and 2017–2018 statewide results for the validated performance indicators.

Table A-1—2016–2017 and 2017–2018 Statewide Performance Measure Rates

Performance Indicator	2016–2017 Rate	2017–2018 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	98.96%	98.90%
Adults	98.27%	98.24%
#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%	97.98%
MI Adults	98.09%	98.92%
DD Children	99.13%	97.77%
DD Adults	99.09%	98.49%
Medicaid SA	97.61%	97.53%
Total	97.87%	98.13%

Performance Indicator	2016–2017 Rate	2017–2018 Rate
#3: The percent of new Medicaid beneficiaries during the quarter starting any needed ongoing service within 14 days of a non-emergent face-to-face assessment with a professional.		
MI Children	97.37%	96.82%
MI Adults	97.64%	98.26%
DD Children	95.37%	95.39%
DD Adults	95.24%	98.44%
Medicaid SA	97.67%	98.25%
Total	97.48%	97.89%
#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%	95.58%
Adults	95.16%	96.70%
#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%	95.95%
#5: The percent of Medicaid recipients having received PIHP managed services.		
The percent of Medicaid recipients having received PIHP managed services.	6.90%	6.75%
#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 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%	96.04%
#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%	12.50%
DD Adults	9.51%	8.96%
MI/DD Adults	8.68%	8.35%
#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%	81.02%
DD Adults	39.90%	36.34%
MI/DD Adults	39.84%	38.68%

Performance Indicator	2016–2017 Rate	2017–2018 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.*		
Children	7.87%	10.10%
Adults	13.70%	11.88%
#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%	19.45%
#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).	42.14%	40.05%

* A lower rate indicates better performance.

Table A–2 and Table A–3 present two-year comparisons of the PIHP-specific results for the validated performance indicators.

Table A-2—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 Network	CY	100.00	99.54	98.80	99.52	100.00	93.33	91.24	95.86	96.80	100.00	100.00	100.00	99.68	99.17	100.00	94.00	86.67
	PY	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 Michigan Regional Entity	CY	97.14	96.71	96.93	98.36	93.94	100.00	98.12	97.91	96.74	97.20	96.43	90.00	98.17	97.20	82.14	94.07	76.19
	PY	93.02	97.31	98.20	99.53	98.55	100.00	96.30	98.01	91.80	95.26	90.20	92.00	95.05	94.10	100.00	91.96	95.41
Region 3—Lakeshore Regional Entity	CY	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*
	PY	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*
Region 4—Southwest Michigan Behavioral Health	CY	97.94	97.88	97.43	99.52	100.00	100.00	97.04	98.09	95.67	96.06	100.00	100.00	95.21	95.70	96.55	99.25	97.24
	PY	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 Health Network	CY	99.72	99.31	98.77	99.10	100.00	100.00	98.65	98.92	95.55	97.90	83.05	100.00	99.80	97.68	100.00	97.17	97.90
	PY	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

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—CMH Partnership of Southeast Michigan	CY	100.00	99.63	99.37	99.65	100.00	100.00	97.58	98.75	97.94	97.55	96.77	96.30	95.15	96.30	100.00	97.79	92.13
	PY	100.00	99.66	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	100.00	96.27	*NR*
Region 7—Detroit Wayne Mental Health Authority	CY	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*
	PY	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 County CMH Authority	CY	92.76	90.98	96.50	98.26	96.15	96.00	99.45	98.35	100.00	99.67	100.00	100.00	98.73	99.43	97.14	95.26	100.00
	PY	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 County CMH Services	CY	100.00	99.82	91.61	95.65	89.58	94.59	97.82	96.31	97.71	100.00	93.02	100.00	99.89	99.47	86.30	94.75	99.34
	PY	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	CY	99.51	99.83	100.00	100.00	100.00	100.00	96.64	98.47	98.05	99.37	98.81	96.61	99.38	98.94	97.35	97.63	100.00
	PY	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

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

Table A-3—Current Year (CY) and Prior Year (PY) PIHP-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 Network	CY	7.08	98.66	15.93	5.18	7.05	92.09	92.11	90.91	5.26	4.71	16.05	50.56
	PY	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 Michigan Regional Entity	CY	7.90	96.78	15.25	12.18	13.73	90.60	50.29	82.35	14.71	9.89	25.82	55.29
	PY	8.10	98.49	12.97	13.95	13.03	86.25	44.53	52.80	5.41	8.19	29.06	53.80
Region 3—Lakeshore Regional Entity	CY	5.27	98.05	13.21	11.87	12.60	80.24	65.73	55.43	*NR*	*NR*	14.40	51.40
	PY	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 Michigan Behavioral Health	CY	6.94	81.03	15.32	9.01	7.80	91.63	68.75	73.13	0.00	10.14	22.18	48.66
	PY	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 Health Network	CY	7.99	96.51	15.37	9.02	8.60	91.84	79.90	80.89	10.12	9.09	19.98	50.48
	PY	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—CMH Partnership of Southeast Michigan	CY	6.59	96.86	14.40	9.20	9.31	89.41	60.96	68.64	12.20	9.38	26.00	29.81
	PY	6.87	97.74	13.83	10.06	9.84	82.95	50.76	55.30	2.17	14.76	25.38	29.67

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 Mental Health Authority	CY	6.42	98.43	9.84	8.45	6.02	86.43	83.96	77.65	NR	NR	19.13	30.80
	PY	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 County CMH Authority	CY	7.31	97.80	15.46	11.03	10.49	86.51	41.88	81.82	5.88	14.25	21.29	33.71
	PY	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 County CMH Services	CY	5.48	97.68	14.43	5.99	5.86	91.16	98.06	90.14	11.90	15.23	12.18	31.58
	PY	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	CY	7.17	98.13	9.82	5.99	6.28	90.03	75.26	71.21	12.00	15.22	16.42	45.50
	PY	7.17	98.64	10.15	6.07	6.74	82.99	16.02	23.46	8.82	12.05	16.90	49.93

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

* A lower rate indicates better performance.

Results for Validation of Performance Improvement Projects

For the 2016–2017 review period and PIP validation cycle, the PIHPs provided the fourth-year submissions for topics that each selected related to behavioral and physical healthcare integration. All 10 PIHPs' PIPs each 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 over time. In 2017–2018, the PIHPs implemented a new PIP on one of the 10 State-recommended PIP topics. HSAG performed validation activities on the PIP study design of the newly selected PIP topic for each PIHP. Therefore, no comparative year-over-year data are available.

Behavioral Health and Developmental Disabilities Administration

Review Tools for the 2017–2018 External Quality Review Activities *for* Prepaid Inpatient Health Plans

March 2019

HSAG HEALTH SERVICES ADVISORY GROUP

Review Tools for the 2017–2018 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. 2017–2018 Documentation Request and Evaluation Tool
Michigan Department of Health and Human Services
Prepaid Inpatient Health Plans (PIHPs)
for <Region>—<Health Plan Name>

Standard VI—Customer Service		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
1. Designated Unit MDHHS Contract Part IIA-6.3 Attachment P6.3.1		
a. The PIHP has a designated unit called "Customer Services", with a minimum of one full-time equivalent (FTE) performing the customer services function, within the customer services unit or elsewhere within the PIHP. Attachment P6.3.1(1-2)		☐ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement		
HSAG Findings		
2. Phone Access Attachment P6.3.1		
a. 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.). Attachment P6.3.1(3)		☐ Met ☐ Not Met ☐ Not Applicable
b. The customer services numbers are displayed in agency brochures and public information material. Attachment P6.3.1(3)		☐ Met ☐ Not Met ☐ Not Applicable

Standard VI—Customer Service		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
c. The PIHP ensures that the customer services telephone line is answered by a live voice during business hours. Telephone menus are not acceptable. Attachment P6.3.1(4)		☐ Met ☐ Not Met ☐ Not Applicable
d. A variety of alternatives may be employed to triage high volumes of calls as long as there is response to each call within one business day. Attachment P6.3.1(4)		☐ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement		
HSAG Findings		
3. Hours of Operation Attachment P6.3.1		
a. The hours of customer service unit operations and the process for accessing information from customer services outside those hours shall be publicized. Attachment P6.3.1(5)		☐ Met ☐ Not Met ☐ Not Applicable
b. The customer services unit or function will operate minimally eight hours daily, Monday through Friday, except for holidays. Attachment P6.3.1(5)		☐ Met ☐ Not Met ☐ Not Applicable

Standard VI—Customer Service		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement		
HSAG Findings		
4. Customer Handbook 42 CFR 438.10(g) Attachment P6.3.1		
a. The customer handbook includes:		
i. The state-required topics (See P.6.3.1.1.A) including Templates #1-#12, other required contract topics, and all CFR requirements specified in 438.10(g) – refer to the Customer Handbook Checklist. 42 CFR438.10(g)(2) Attachment P6.3.1(6)		☐ Met ☐ Not Met ☐ Not Applicable
ii. The Medicaid coverage name and the State's description of each services. Attachment P6.3.1(7)		☐ Met ☐ Not Met ☐ Not Applicable
iii. The date of the publication and revision(s). Attachment P6.3.1(8)		☐ Met ☐ Not Met ☐ Not Applicable
iv. Information about how to contact the Medicaid Health Plans or Medicaid fee-for-service programs in the PIHP service area, including plan or program name, locations, and telephone numbers. Attachment P6.3.1(10)		☐ Met ☐ Not Met ☐ Not Applicable

Standard VI—Customer Service		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
b. The PIHP or delegate entity must provide each customer a customer handbook within a reasonable time after receiving notice of the beneficiary's enrollment. This may be provided by: 42 CFR 438.10(g) Attachment P6.3.1		
i. Mailing a printed copy to the customer's mailing address. 42 CFR 438.10(g)(3)(i) Attachment P6.3.1(9)(a)		☐ Met ☐ Not Met ☐ Not Applicable
ii. Emailed after obtaining the customer's agreement to receive information by email. 42 CFR 438.10(g)(3)(ii) Attachment P6.3.1(9)(b)		☐ Met ☐ Not Met ☐ Not Applicable
iii. If the PIHP posts the information on the website and advises the customer in paper or electronic form that the information is available on the internet provided that persons with disabilities who cannot access the information online are provided auxiliary aids and services upon request at no cost. 42 CFR 438.10(g)(3)(iii) Attachment P6.3.1(9)(c)		☐ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement		

Standard VI—Customer Service		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
HSAG Findings		
5. Provider Listing 42 CFR 438.10(h) Attachment P6.3.1		
a. The PIHP or delegate unit shall maintain a current listing of all providers, practitioners and organizations with whom the PIHP has contracts – refer to the Provider Directory Checklist. 42 CFR 438.10(h)(1)(i-viii) Attachment P6.3.1(11)		☐ Met ☐ Not Met ☐ Not Applicable
b. The PIHP must make this available in paper form upon request and electronic form such as the PIHP, CMHSP, or network provider's website as applicable. 42 CFR 438.10(h)(1) Attachment P6.3.1(11)		☐ Met ☐ Not Met ☐ Not Applicable
c. Beneficiaries shall be given this list annually unless the beneficiary has expressly informed the PIHP that accessing the listing through an available website or customer services line is acceptable. Attachment P6.3.1(11)		☐ Met ☐ Not Met ☐ Not Applicable
d. The provider directory must be made available in paper form upon request and electronic form. It must also be made available on the PIHP's website in a machine readable file and format. 42 CFR 438.10(h)(1,4) Attachment P6.3.1(12)		☐ Met ☐ Not Met ☐ Not Applicable

Standard VI—Customer Service		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
e. The paper provider directory must be updated at least monthly and electronic provider directories must be updated no later than 30 calendar days after the PIHP receives updated provider information. 42 CFR 438.10(h)(3) Attachment P6.3.1(13)		☐ Met ☐ Not Met ☐ Not Applicable
f. If the PIHP provides information electronically, it must inform the customer that the information is available in paper form without charge and upon request and provides it upon request within 5 business days. Attachment P6.3.1(14)		☐ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement		
HSAG Findings		
6. Access to Information The customer services unit has access to information about the PIHP, including: Attachment P6.3.1		
a. CMHSP affiliate annual report. Attachment P6.3.1(15)		☐ Met ☐ Not Met ☐ Not Applicable
b. Current organizational chart.		☐ Met

Standard VI—Customer Service		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
Attachment P6.3.1(15)		☐ Not Met ☐ Not Applicable
c. CMHSP board member list. Attachment P6.3.1(15)		☐ Met ☐ Not Met ☐ Not Applicable
d. Meeting schedule, and minutes. Attachment P6.3.1(15)		☐ Met ☐ Not Met ☐ Not Applicable
e. Customer services provides this information in a timely manner to individuals upon their requests. Attachment P6.3.1(15)		☐ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement		
HSAG Findings		
7. Assistance with Grievances and Appeals MDHHS Contract Part IIA-6.3 Attachment P6.3.1		
a. Upon request, the customer services unit assists beneficiaries with the grievance, appeals, and local dispute resolution processes and coordinates, as appropriate, with the Fair Hearing Officer and the local Office of Recipient Rights. Attachment P6.3.1(16)		☐ Met ☐ Not Met ☐ Not Applicable

Standard VI—Customer Service		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement		
HSAG Findings		
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		
Working Knowledge About:		
a. 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). Attachment P6.3.1(17)(a)		☐ Met ☐ Not Met ☐ Not Applicable
b. Service array (including substance abuse treatment services), medical necessity requirements, and eligibility for and referral to specialty services. Attachment P6.3.1(17)(b)		☐ Met ☐ Not Met ☐ Not Applicable
c. Grievance and appeals, fair hearings, local dispute resolution processes, and recipient rights. Attachment P6.3.1(17)(g)		☐ Met ☐ Not Met ☐ Not Applicable

Standard VI—Customer Service		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
d. Information and referral about Medicaid-covered services within the PIHP as well as outside to Medicaid health plans, fee-for-service practitioners, and the Department of Human Services. Attachment P6.3.1(17)(i)		☐ Met ☐ Not Met ☐ Not Applicable
Knowledge Where to Obtain Information About:		
e. Person-centered planning. Attachment P6.3.1(17)(c)		☐ Met ☐ Not Met ☐ Not Applicable
f. Self-determination. Attachment P6.3.1(17)(d)		☐ Met ☐ Not Met ☐ Not Applicable
g. Recovery and resiliency. Attachment P6.3.1(17)(e)		☐ Met ☐ Not Met ☐ Not Applicable
h. Peer specialists. Attachment P6.3.1(17)(f)		☐ Met ☐ Not Met ☐ Not Applicable
i. Limited English proficiency and cultural competency. Attachment P6.3.1(17)(h)		☐ Met ☐ Not Met ☐ Not Applicable
j. The organization of the public mental health system. Attachment P6.3.1(17)(j)		☐ Met ☐ Not Met ☐ Not Applicable
k. Balanced Budget Act relative to the customer services functions and beneficiary rights and protections.		☐ Met ☐ Not Met

Standard VI—Customer Service		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
Attachment P6.3.1(17)(k)		☐ Not Applicable
l. Community resources (e.g., advocacy organizations, housing options, schools, public health agencies). Attachment P6.3.1(17)(l)		☐ Met ☐ Not Met ☐ Not Applicable
m. Public Health Code (for substance abuse treatment recipients if not delegated to the PIHP). Attachment P6.3.1(17)(m)		☐ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement		
HSAG Findings		

Results—Standard VI						
Met	=		X	1.0	=	
Not Met	=		X	.00	=	
Not Applicable	=					
Total Applicable	=		**Total Score**		=	
Total Score ÷ Total Applicable					=	

Standard VII—Enrollee Grievance Process		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
1. General Requirement 42 CFR 438.402 MDHHS Contract Part II A-6.3.1 Attachment P6.3.1.1		
a. The PIHP has a grievance system in place for Enrollee's that complies with Subpart F of Part 438. 42 CFR 438.402(a) MDHHS Contract Part II A-6.3.1 Attachment P6.3.1.1(III)		☐ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement		
HSAG Findings		
2. 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: 42 CFR 438.414 42 CFR 438.10 MDHHS Contract Part II A-7.0(4)		
a. The right to file grievances. 42 CFR 438.10(g)(2)(xi)(A)		☐ Met ☐ Not Met ☐ Not Applicable

Standard VII—Enrollee Grievance Process		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
b. The requirement and timeframes for filing a grievance. 42 CFR 438.10(g)(2)(xi)(B)		☐ Met ☐ Not Met ☐ Not Applicable
c. The availability of assistance in the filing process. 42 CFR 438.10(g)(2)(xi)(C)		☐ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement		
HSAG Findings		
3. General 42 CFR 438.402 Attachment P6.3.1.1		
a. Enrollees must file Grievances with the PIHP organizational unit approved and administratively responsible for facilitating resolution of Grievances. Attachment P6.3.1.1(VII)(B)(1)		☐ Met ☐ Not Met ☐ Not Applicable
b. Grievances may be filed at any time by the Enrollee, guardian, or parent of a minor child or his/her legal representative. 42 CFR 438.402(c)(2)(i) Attachment P6.3.1(VII)(B)(2)		☐ Met ☐ Not Met ☐ Not Applicable

Standard VII—Enrollee Grievance Process		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
c. The enrollee may file a grievance either orally or in writing. 42 CFR 438.402(c)(3)(i)		☐ Met ☐ Not Met ☐ Not Applicable
d. Enrollee's access to the State Fair Hearing process respecting Grievances is only available when the PIHP fails to resolve the grievance and provide resolution within 90 calendar days of the date of the request. 42 CFR 438.400(b)(5) 42 CFR 438.408(b)(1) Attachment P6.3.1(VII)(B)(3)		☐ Met ☐ Not Met ☐ Not Applicable
e. The Grievance System must provide Enrollees:		
i. The right to concurrently file an Appeal of an Adverse Benefit Determination and a Grievance regarding other service complaints.		☐ Met ☐ Not Met ☐ Not Applicable
ii. With the written consent from the Enrollee, the right to have a provider or other authorized representative, acting on the Enrollee's behalf, file Grievance to the PIHP. 42 CFR 438.402(c)(1)(ii) Attachment P6.3.1.1(III)		☐ Met ☐ Not Met ☐ Not Applicable
iii. The provider may file a grievance or request a state fair hearing on behalf of the Enrollee since the State permits the provider to act as the Enrollee's authorized representative in doing so. 42 CFR 438.402(c)(1)(ii) Attachment P6.3.1.1(III)		☐ Met ☐ Not Met ☐ Not Applicable

Standard VII—Enrollee Grievance Process		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
iv. Punitive action may not be taken by the PIHP against a provider who acts on the Enrollee's behalf with the Enrollee's written consent to do so. Attachment P6.3.1.1(III)		☐ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement		
HSAG Findings		
4. The PIHP Responsibility When Enrollee Files a Grievance 42 CFR 438.406 Attachment P6.3.1.1		
a. Provide Enrollees reasonable assistance to complete forms and to take other procedural steps. This includes but is not limited to auxiliary aids and services upon request, such as providing interpreter services and toll free numbers that have adequate TTY/TTD and interpreter capability 42 CFR 438.406(a) Attachment P6.3.1.1(VII)(C)(1)		☐ Met ☐ Not Met ☐ Not Applicable
b. Acknowledge receipt of the grievance. 42 CFR 438.406(b)(1) Attachment P6.3.1.1(VII)(C)(2)		☐ Met ☐ Not Met ☐ Not Applicable

Standard VII—Enrollee Grievance Process		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
c. Maintain a record of grievances for review by the State as part of its quality strategy. Attachment P6.3.1.1(VII)(C)(3)		☐ Met ☐ Not Met ☐ Not Applicable
d. Submit the written grievance to appropriate staff including a PIHP administrator with the authority to require corrective action. Attachment P6.3.1.1(VII)(C)(4)		☐ Met ☐ Not Met ☐ Not Applicable
e. Coordinates as appropriate with Fair Hearing Officers and the local Office of Recipient Rights. Attachment P6.3.1(13)		☐ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement		
HSAG Findings		
5. Individuals Making Decisions Ensure that the individual(s) who make the decisions on the Grievance: 42 CFR 438.406 Attachment P6.3.1.1		
a. Were not involved in any previous level review or decision-making, nor a subordinate of any such individual. 42 CFR 438.406(b)(2)(i) Attachment P6.3.1.1(VII)(C)(5)(a)		☐ Met ☐ Not Met ☐ Not Applicable

Standard VII—Enrollee Grievance Process		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
b. When the Grievance involves either (i) clinical issues, or (ii) denial of expedited resolution of an Appeal, are individual(s) who have appropriate clinical expertise, as determined by the State, in treating the Enrollee's condition or disease. 42 CFR 438.406(b)(2)(ii)(B-C) Attachment P6.3.1.1(VII)(C)(5)(b)		☐ Met ☐ Not Met ☐ Not Applicable
c. Take into account all comments, documents, records, and other information submitted by the Enrollee or their representative without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination. 42 CFR 438.406(b)(2)(iii) Attachment P6.3.1.1(VII)(C)(5)(c)		☐ Met ☐ Not Met ☐ Not Applicable
HSAG Findings		
6. Timing of Grievance Resolution 42 CFR 438.408 Attachment P6.3.1.1		
a. Provide the Enrollee a written notice of resolution not to exceed 90 calendar days from the day the PIHP received the Grievance.		☐ Met ☐ Not Met ☐ Not Applicable

Standard VII—Enrollee Grievance Process		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
42 CFR 438.408(b)(1) Attachment P6.3.1.1(VII)(D)(1)		
PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement		
HSAG Findings		
7. Format of Notice of Grievance Resolution 42 CFR 438.408 Attachment P6.3.1.1		
a. Enrollee notice of Grievance resolution must meet the requirements of 42 CFR 438.10 (i.e., "…in a manner and format that may be easily understood and is readily accessible by such enrollees and potential enrollees," meets the needs of those with limited English proficiency and or limited reading proficiency). 42 CFR 438.10 42 CFR 438.408(d)(1) Attachment P6.3.1.1(VII)(D)(2)(a)		☐ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement		
HSAG Findings		

Standard VII—Enrollee Grievance Process		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
8. Content of Notice of Grievance Resolution The notice of Grievance resolution must include: 42 CFR 438.408(d)(1) Attachment P6.3.1.1		
a. The results of the grievance process. Attachment P6.3.1.1(VII)(D)(2)(b)(i)		☐ Met ☐ Not Met ☐ Not Applicable
b. The date the grievance process was concluded. Attachment P6.3.1.1(VII)(D)(2)(b)(ii)		☐ Met ☐ Not Met ☐ Not Applicable
c. Notice of the Enrollee's right to request a State Fair Hearing, if the notice of resolution is more than 90-days from the date of the Grievance Attachment P6.3.1.1(VII)(D)(2)(b)(iii)		☐ Met ☐ Not Met ☐ Not Applicable
d. Instructions on how to access the State Fair Hearing process, if applicable. Attachment P6.3.1.1(VII)(D)(2)(b)(iv)		☐ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement		
HSAG Findings		

Results—Standard VII						
Met	=		X	1.0	=	
Not Met	=		X	.00	=	
Not Applicable	=					
Total Applicable	=		Total Score		=	
Total Score ÷ Total Applicable					=	

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
1. Delegation 42 CFR 438.230 MDHHS Contract Part I-38.0		
a. The PIHP shall be held solely and fully responsible to execute all provisions of contract, whether or not said provisions are directly pursued by the PIHP, or pursued by the PIHP through a subcontract vendor. 42 CFR 438.230(b)(1) MDHHS Contract Part I-38.0		☐ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement		
HSAG Findings		
2. Written Contract Each contract or written arrangement must specify: 42 CFR 438.230 MDHHS Contract Part I-38.0		
a. The delegated activities or obligations, and related reporting responsibilities. 42 CFR 438.230(c)(1)(i)		☐ Met ☐ Not Met ☐ Not Applicable

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
b. The subcontractor agrees to perform the delegated activities and reporting responsibilities specified in compliance with the PIHP's contract obligations. 42 CFR 438.230(c)(1)(ii)		☐ Met ☐ Not Met ☐ Not Applicable
c. The contract or written arrangement must either provide for revocation of the delegation of activities or obligations, or specify other remedies in instances where the State or the PIHP determine that the subcontractor has not performed satisfactorily. 42 CFR 438.230(c)(1)(iii)		☐ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement		
HSAG Findings		
3. Agree to Comply 42 CFR 438.230 MDHHS Contract Part I-38.0		
a. The subcontractor agrees to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions. 42 CFR 438.230(c)(2)		☐ Met ☐ Not Met ☐ Not Applicable

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement		
HSAG Findings		
4. Monitoring of Delegates 42 CFR 438.230 MDHHS Contract Part I-38.0 Attachment P7.9.1		
a. The PIHP annually monitors its provider network(s), including any affiliates or subcontractors to which it has delegated managed care functions, including service and support provision. Attachment P7.9.1(XV)		☐ Met ☐ Not Met ☐ Not Applicable
b. The PIHP shall review and follow up on any provider network monitoring of its subcontractors. Attachment P7.9.1(XV)		☐ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement		
HSAG Findings		

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
5. Right to Audit The subcontractor agrees that: 42 CFR 438.230		
a. MDHHS, CMS, the HHS Inspector General, the Controller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the PIHP's contract with MDHHS. 42 CFR 438.230(c)(3)(i)		☐ Met ☐ Not Met ☐ Not Applicable
b. The subcontractor makes available, for purposes of an audit, evaluation, or inspection, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid enrollees. 42 CFR 438.230(c)(3)(ii)		☐ Met ☐ Not Met ☐ Not Applicable
c. The right to audit exists through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. 42 CFR 438.230(c)(3)(iii)		☐ Met ☐ Not Met ☐ Not Applicable
d. If MDHHS, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, MDHHS, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time. 42 CFR 438.230(c)(3)(iv)		☐ Met ☐ Not Met ☐ Not Applicable

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement		
HSAG Findings		

Results—Standard IX						
Met	=		X	1.0	=	
Not Met	=		X	.00	=	
Not Applicable	=					
Total Applicable	=		Total Score		=	
Total Score ÷ Total Applicable					=	

Standard X—Provider Network		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
1. Provider Written Agreement 42 CFR 438.206 MDHHS Contract Part II A-7.0		
a. The PIHP is responsible for maintaining and continually evaluating an effective provider network supported by written agreements to fulfill the obligations of its contract. 42 CFR 438.206(b)(1) MDHHS Contract Part II A-7.0		☐ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement		
HSAG Findings		
2. Sufficiency of Agreements 42 CFR 438.206		
a. Written agreements provide adequate access to all services covered under the contract for all enrollees, including those with limited English proficiency or physical or mental disabilities. 42 CFR 438.206(b)(1)		☐ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement		

Standard X—Provider Network		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
HSAG Findings		
3. Liability for Payment 42 CFR 438.106		
a. The PIHP's providers may not bill individuals for the difference between the provider's charge and the PIHP's payment for services. 42 CFR 438.106(b)(2) MDHHS Contract Part II A-7.8.2.2		☐ Met ☐ Not Met ☐ Not Applicable
b. Providers shall not seek nor accept any additional payment for covered services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the beneficiary would owe if the PIHP provided the services directly. 42 CFR 438.106(c) MDHHS Contract Part II A-7.8.2.2		☐ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement		
HSAG Findings		
4. Reason for Decision to Decline 42 CFR 438.12 MDHHS Contract Part I-37.0		

Standard X—Provider Network		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
a. Must give those providers not selected for inclusion in the network written notice of the reason for its decision. 42 CFR 438.12(a)(1) MDHHS Contract Part I-37.0 Attachment P7.1.1(H)		☐ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement		
HSAG Findings		
5. Network Changes The PIHP submits supporting documentation to MDHHS that demonstrates that it has the capacity to serve the expected enrollment in its service area: 42 CFR 438.207 Attachment P7.7.1.1		
a. On an annual basis.* 42 CFR 438.207(c)(2) *Effective for contracts beginning on or after July 1, 2018.		☐ Met ☐ Not Met ☒ Not Applicable
b. The PIHP shall notify MDHHS within 7 days of any changes to the composition of the provider network organizations that negatively affect access to care. 42 CFR 438.207(c)(3)		☐ Met ☐ Not Met ☐ Not Applicable

Standard X—Provider Network		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
Attachment P7.7.1.1		
c. PIHPs shall have procedures to address changes in its network that negatively affect access to care. Attachment P7.7.1.1		☐ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement		
HSAG Findings		
6. Out-of-Network Responsibility 42 CFR 438.206 MDHHS Contract Part II A-4.10		
a. If the PIHP is unable to provide necessary medical services covered under the contract to a particular beneficiary the PIHP must adequately and timely cover these services out of network for the beneficiary, for as long as the entity is unable to provide them within the network. 42 CFR 438.206(b)(4) MDHHS Contract Part II A-4.10		☐ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement		
HSAG Findings		

Standard X—Provider Network		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
7. Requirements Related to Payment 42 CFR 438.206 MDHHS Contract Part II A-4.10		
a. Since there is no cost to the beneficiary for the PIHP's in-network services, there may be no cost to beneficiary for medically-necessary specialty services provided out-of-network. 42 CFR 438.206(b)(5) MDHHS Contract Part II A-4.10		☐ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement		
HSAG Findings		
8. Second Opinion 42 CFR 438.206 MDHHS Contract Part II A-4.9		
a. If the beneficiary requests, the PIHP must provide for a second opinion from a qualified health care professional within the network, or arrange for the ability of the beneficiary to obtain one outside the network, at no cost to the beneficiary. 42 CFR 438.206(b)(3) MDHHS Contract Part II A-4.9		☐ Met ☐ Not Met ☐ Not Applicable

Standard X—Provider Network		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement		
HSAG Findings		
9. Cultural Considerations 42 CFR 438.206 MDHHS Contract Part II A-4.5		
a. The PIHP promotes the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity. 42 CFR 438.206(c)(2) MDHHS Contract Part II A-4.5		☐ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement		
HSAG Findings		
10. Accessibility Considerations The PIHP ensures that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities.		

Standard X—Provider Network		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
42 CFR 438.206(c)(3) Attachment P4.1.1		
a. The access system shall maintain the capacity to immediately accommodate individuals who present with: LEP and other linguistic needs, diverse cultural and demographic backgrounds, visual impairments, alternative needs for communication, and mobility challenges. 42 CFR 438.206(c)(3) Attachment P4.1.1(I)(c)		☐ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement		
HSAG Findings		

Results—Standard X						
Met	=		X	1.0	=	
Not Met	=		X	.00	=	
Not Applicable	=					
Total Applicable	=		Total Score		=	
Total Score ÷ Total Applicable					=	

Standard XII—Access and Availability		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
Findings were derived from the Michigan Mission-Based Performance Indicator System—Access Domain, Indicators 1 through 4b. MDHHS provided data directly to HSAG for April 1, 2017 – December 31, 2017. The PIHP's performance was evaluated and scored based on data across the reported quarters.		
1. Access Standards MDHHS Contract Part II A-4.1 Attachment P7.7.1.1		
a. The PIHP shall ensure timely access to supports and services in accordance with the Access Standards in Attachment P4.1.1 and the following timeliness standards, and report its performance on the standards in accordance with Attachment P7.7.1.1 of the contract. MDHHS Contract Part II A-4.1		☐ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement		
HSAG Findings		
2. Access Standards—Preadmission Screening The percent of all Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. **Standard = 95% in three hours** MDHHS Contract Part II A-4.1 Attachment P7.7.1.1		
a. Children		☐ Met ☐ Not Met ☐ Not Applicable

Standard XII—Access and Availability		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
b. Adult		☐ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement		
HSAG Findings		
3. Access Standards—Face-to-Face Assessment The percent of new Medicaid beneficiaries receiving a face-to-face meeting with a professional within 14 calendar days of a non-emergency request for service. **Standard = 95% in 14 days** MDHHS Contract Part II A-4.1 Attachment P7.7.1.1		
a. Children		☐ Met ☐ Not Met ☐ Not Applicable
b. Adult		☐ Met ☐ Not Met ☐ Not Applicable
c. Developmentally Disabled—Children		☐ Met ☐ Not Met ☐ Not Applicable
d. Developmentally Disabled—Adult		☐ Met ☐ Not Met ☐ Not Applicable

Standard XII—Access and Availability		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
e. Substance Abuse		☐ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement		
HSAG Findings		
4. Access Standards—Ongoing Services The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional. **Standard = 95% in 14 days** MDHHS Contract Part II A-4.1 Attachment P7.7.1.1		
a. Mentally Ill—Children		☐ Met ☐ Not Met ☐ Not Applicable
b. Mentally Ill—Adult		☐ Met ☐ Not Met ☐ Not Applicable
c. Developmentally Disabled—Children		☐ Met ☐ Not Met ☐ Not Applicable
d. Developmentally Disabled—Adult		☐ Met ☐ Not Met ☐ Not Applicable

Standard XII—Access and Availability		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
e. Substance Abuse		☐ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement		
HSAG Findings		
5. Access Standards—Follow-up Care After Discharge/Inpatient The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days. **Standard = 95% in seven days** MDHHS Contract Part II A-4.1 Attachment P7.7.1.1		
a. Children		☐ Met ☐ Not Met ☐ Not Applicable
b. Adults		☐ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement		
HSAG Findings		

Standard XII—Access and Availability		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
6. Access Standards— Follow-up After Discharge/Detox The percent of discharges from a detoxification unit who are seen for follow-up care within seven days. **Standard = 95% in seven days** MDHHS Contract Part II A-4.1 Attachment P7.7.1.1		
a. Substance Abuse		☐ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement		
HSAG Findings		
7. Providers Required to Meet Access Standards 42 CFR 438.206 MDHHS Contract Part I-38.0 MDHHS Contract Part II A-4.1, 7.11 Attachment P7.7.1.1		
a. The PIHP requires its providers to meet Medicaid accessibility standards. 42 CFR 438.206(c)(1)(i) MDHHS Contract Part II A-4.1 MDHHS Contract Part I-38.0(16) Attachment P7.7.1.1		☐ Met ☐ Not Met ☐ Not Applicable

Standard XII—Access and Availability		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
b. The PIHP shall establish ongoing internal monitoring and auditing to assure that the standards are enforced, to identify other high-risk compliance areas, and to identify where improvements must be made. 42 CFR 438.206(c)(1)(iv) MDHHS Contract Part II A-7.11		☐ Met ☐ Not Met ☐ Not Applicable
c. There are procedures for prompt response to identified problems and development of corrective actions. 42 CFR 438.206(c)(1)(vi) MDHHS Contract Part II A-7.11		☐ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement		
HSAG Findings		

Results—Standard XII						
Met	=		X	1.0	=	
Not Met	=		X	.00	=	
Not Applicable	=					
Total Applicable	=		**Total Score**		=	
Total Score ÷ Total Applicable					=	

Standard XIV—Appeals		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
1. Appeals 42 CFR 438.402 Attachment P6.3.1.1		
a. The PIHP has an appeal system in place for Enrollee's that complies with Subpart F of Part 438. Attachment P6.3.1.1(III)		☐ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement		
HSAG Findings		
2. Information to Subcontractors and Providers The PIHP provides information about the appeal system to all providers and subcontractors at the time they enter into a contract. The information includes: 42 CFR 438.414 42 CFR 438.10 MDHHS Contract Part II A-7.0(4)		
a. The right to file appeals. 42 CFR 438.10(g)(2)(xi)(A)		☐ Met ☐ Not Met ☐ Not Applicable
b. The requirement and timeframes for filing an appeal. 42 CFR 438.10(g)(2)(xi)(B)		☐ Met ☐ Not Met ☐ Not Applicable

Standard XIV—Appeals		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
c. The availability of assistance in the filing process. 42 CFR 438.10(g)(2)(xi)(C)		☐ Met ☐ Not Met ☐ Not Applicable
d. The right to request a State fair hearing after the PIHP has made a determination on an enrollee's appeal which is adverse to the enrollee. 42 CFR 438.10(g)(2)(xi)(D)		☐ Met ☐ Not Met ☐ Not Applicable
e. The fact that, when requested by the enrollee, benefits that the PIHP seeks to reduce or terminate will continue if the enrollee files an appeal or a request for State fair hearing within the timeframes specified for filing. 42 CFR 438.10(g)(2)(xi)(E)		☐ Met ☐ Not Met ☐ Not Applicable
f. The fact that, the enrollee may be required to pay the cost of services furnished while the appeal or state fair hearing is pending if the final decision is adverse to the enrollee. 42 CFR 438.10(g)(2)(xi)(E)		☐ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement		
HSAG Findings		
3. Appeal Process 42 CFR 438.402 42 CFR 438.406 Attachment P6.3.1.1		

Standard XIV—Appeals		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
a. The Enrollee has 60 calendar days from the date of the notice of Adverse Benefit Determination to request an Appeal. 42 CFR 438.402(c)(2)(ii) Attachment P6.3.1.1(VI)(A)(1)		☐ Met ☐ Not Met ☐ Not Applicable
b. The Enrollee may request an Appeal either orally or in writing. 42 CFR 438.402(c)(3)(ii) Attachment P6.3.1.1(VI)(A)(2)		☐ Met ☐ Not Met ☐ Not Applicable
c. Unless the Enrollee requests and expedited resolution, an oral request for Appeal must be followed by a written, signed request for Appeal. 42 CFR 438.402(c)(3)(ii) Attachment P6.3.1.1(VI)(A)(2)		☐ Met ☐ Not Met ☐ Not Applicable
d. Oral inquiries seeking to appeal an Adverse Benefit Determination are treated as Appeals (to establish the earliest possible filing date for the Appeal). 42 CFR 438.406(b)(3) Attachment P6.3.1.1(VI)(A)(2)		☐ Met ☐ Not Met ☐ Not Applicable
e. The Appeal System must provide Enrollees:		
i. With the written consent from the Enrollee, the right to have a provider or other authorized representative, acting on the Enrollee's behalf, file an Appeal. 42 CFR 438.402(c)(1)(ii) Attachment P6.3.1.1(III)		☐ Met ☐ Not Met ☐ Not Applicable

Standard XIV—Appeals		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
ii. Punitive action may not be taken by the PIHP against a provider who acts on the Enrollee's behalf with the Enrollee's written consent to do so. Attachment P6.3.1.1(III)		☐ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement		
HSAG Findings		
4. Medicaid Services Continuation or Reinstatement 42 CFR 438.420 42 CFR 438.424 Attachment P6.3.1.1		
a. If an Appeal involves the termination, suspension, or reduction of previously authorized services that were ordered by an authorized provider, the PIHP MUST continue the Enrollee's benefits if all of the following occur:		
i. The Enrollee files the request for Appeal timely (within 60 calendar days). 42 CFR 438.420(b)(1) Attachment P6.3.1.1(V)(A)(1)		☐ Met ☐ Not Met ☐ Not Applicable
ii. The Enrollee files the request for continuation of benefits timely (on or before the latter of (i) 10 calendar days from the date of the notice of Adverse Benefit Determination, or (ii) the intended effective date of the proposed Adverse Benefit Determination).		☐ Met ☐ Not Met ☐ Not Applicable

Standard XIV—Appeals		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
42 CFR 438.420(b)(5) Attachment P6.3.1.1(V)(A)(2)		
iii. The period covered by the original authorization has not expired. 42 CFR 438.420(b)(4) Attachment P6.3.1.1(V)(A)(3)		☐ Met ☐ Not Met ☐ Not Applicable
b. If the PIHP continues or reinstates the Enrollee's benefits, at the Enrollee's request, while the Appeal or State Fair Hearing is pending, the PIHP must continue the benefits until one of following occurs:		
i. The Enrollee withdraws the Appeal or request for State Fair Hearing; a record of appeals for review by the State as part of its quality strategy. 42 CFR 438.420(c)(1) Attachment P6.3.1.1(V)(B)(1)		☐ Met ☐ Not Met ☐ Not Applicable
ii. The Enrollee fails to request a State Fair Hearing and continuation of benefits within 10 calendar days after PIHP sends the Enrollee notice of an adverse resolution to the Enrollee's Appeal. 42 CFR 438.420(c)(2) Attachment P6.3.1.1(V)(B)(2)		☐ Met ☐ Not Met ☐ Not Applicable
iii. A State Fair Hearing office issues a decision adverse to the Enrollee. 42 CFR 438.420(c)(3) Attachment P6.3.1.1(V)(B)(3)		☐ Met ☐ Not Met ☐ Not Applicable

Standard XIV—Appeals		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
c. If the final resolution of the Appeal or State Fair Hearing upholds the PIHP's Adverse Benefit Determination, the PIHP may, consistent with the state's usual policy on recoveries and as specified in the PIHP's contract, recover the cost of services furnished to the Enrollee while the Appeal and State Fair Hearing was pending, to the extent that they were furnished solely because of these requirements. 42 CFR 438.420(d) Attachment P6.3.1.1(V)(C)		☐ Met ☐ Not Met ☐ Not Applicable
d. If the Enrollee's services were reduced, terminated or suspended without an advance notice, the PIHP must reinstate services to the level before the action. Attachment P6.3.1.1(V)(D)		☐ Met ☐ Not Met ☐ Not Applicable
e. If the PIHP, or the MDHHS fair hearing administrative law judge reverses a decision to deny authorization of services, and the Enrollee received the disputed services while the appeal was pending, the PIHP or the State must pay for those services in accordance with State policy and regulations. 42 CFR 438.424(b) Attachment P6.3.1.1(V)(E)		☐ Met ☐ Not Met ☐ Not Applicable
f. If the PIHP, or the MDHHS fair hearing administrative law judge reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the PIHP must authorize or provide the disputed services promptly, and as expeditiously as the Enrollee's health condition requires, but no later than 72 hours from the date it receives notice reversing the determination. 42 CFR 438.424(a) Attachment P6.3.1.1(V)(F)		☐ Met ☐ Not Met ☐ Not Applicable

Standard XIV—Appeals		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement		
HSAG Findings		
5. PIHP Responsibilities When Enrollee Requests an Appeal 42 CFR 438.406 Attachment P6.3.1.1		
a. Provide Enrollees reasonable assistance to complete forms and to take other procedural steps. This includes but is not limited to auxiliary aids and services upon request, such as providing interpreter services and toll free numbers that have adequate TTY/TTD and interpreter capability. 42 CFR 438.406(a) Attachment P6.3.1.1(VI)(B)(1)		☐ Met ☐ Not Met ☐ Not Applicable
b. Acknowledge receipt of each appeal. 42 CFR 438.406(b)(1) Attachment P6.3.1.1(VI)(B)(2)		☐ Met ☐ Not Met ☐ Not Applicable
c. Maintain a record of appeals for review by the State as part of its quality strategy. Attachment P6.3.1.1(VI)(B)(3)		☐ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement		

Standard XIV—Appeals		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
HSAG Findings		
6. Individuals Making Decisions Ensure that the individual(s) who make the decisions on Appeals: 42 CFR 438.406 Attachment P6.3.1.1		
a. Were not involved in any previous level of review or decision-making, nor a subordinate of any such individual. 42 CFR 438.406(b)(2)(i) Attachment P6.3.1.1(VI)(B)(4)(a)		☐ Met ☐ Not Met ☐ Not Applicable
b. When deciding an Appeal that involves either (i) clinical issues, or (ii) a denial based on lack of medical necessity, are individual(s) who have the appropriate clinical expertise, as determined by the State, in treating the Enrollee's condition or disease. 42 CFR 438.406(b)(2)(ii)(A, C) Attachment P6.3.1.1(VI)(B)(4)(b)		☐ Met ☐ Not Met ☐ Not Applicable
c. Take into account all comments, documents, records, and other information submitted by the Enrollee or their representative without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination. 42 CFR 438.406(b)(2)(iii) Attachment P6.3.1.1(VI)(B)(4)(c)		☐ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement		

Standard XIV—Appeals		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
HSAG Findings		
7. Right to Examine Records 42 CFR 438.406 Attachment P6.3.1.1		
a. Provide the Enrollee a reasonable opportunity to present evidence, testimony and allegations of fact or law in person and in writing. 42 CFR 438.406(b)(4) Attachment P6.3.1.1(VI)(B)(5)		☐ Met ☐ Not Met ☐ Not Applicable
i. Inform the Enrollee of the limited time available for this sufficiently in advance of the resolution timeframe for Appeals. 42 CFR 438.406(b)(4) Attachment P6.3.1.1(VI)(B)(5)		☐ Met ☐ Not Met ☐ Not Applicable
b. Provide the Enrollee and his/her representative the Enrollee's case file, including medical records and any other documents or records considered, relied upon, or generated by or at the direction of the PIHP in connection with the Appeal of the Adverse Benefit Determination. 42 CFR 438.406(b)(5) Attachment P6.3.1.1(VI)(B)(6)		☐ Met ☐ Not Met ☐ Not Applicable
i. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for the appeal. 42 CFR 438.406(b)(5) Attachment P6.3.1.1(VI)(B)(6)		☐ Met ☐ Not Met ☐ Not Applicable

Standard XIV—Appeals		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
c. Provide opportunity to include as parties to the appeal the Enrollee and his or her representative, or the legal representative of a deceased Enrollee's estate. 42 CFR 438.406(b)(6) Attachment P6.3.1.1(VI)(B)(7)		☐ Met ☐ Not Met ☐ Not Applicable
d. Provide the Enrollee with information regarding the right to request a State Fair Hearing and the process to be used to request one. Attachment P6.3.1.1(VI)(B)(7)		☐ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement		
HSAG Findings		
8. Standard Appeal Resolution 42 CFR 438.408 Attachment P6.3.1.1		
a. The PIHP must resolve the Appeal and provide notice of resolution to the affected parties as expeditiously as the Enrollee's health condition requires, but not to exceed 30 calendar days from the day the PIHP receives the Appeal. 42 CFR 438.408(b)(2) Attachment P6.3.1.1(VI)(C)(1)		☐ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement		

Standard XIV—Appeals		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
HSAG Findings		
9. Expedited Appeal Resolution 42 CFR 438.408 42 CFR 438.410 Attachment P6.3.1.1		
a. Available where the PIHP determines (for a request from the Enrollee) or the provider indicates (in making a request on the Enrollee's behalf or supporting the Enrollee's request) that the time for a standard resolution could seriously jeopardize the Enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function. 42 CFR 438.410(a) Attachment P6.3.1.1(VI)(C)(2)(a)		☐ Met ☐ Not Met ☐ Not Applicable
b. The PIHP may not take punitive action against a provider who requests an expedited resolution or supports an Enrollee's appeal. 42 CFR 438.410(b) Attachment P6.3.1.1(VI)(C)(2)(b)		☐ Met ☐ Not Met ☐ Not Applicable
c. If a request for expedited resolution is denied, the PIHP must:		
i. Transfer the appeal to the timeframe for standard resolution. 42 CFR 438.410(c)(1) Attachment P6.3.1.1(VI)(C)(2)(c)(i)		☐ Met ☐ Not Met ☐ Not Applicable

Standard XIV—Appeals		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
ii. Make reasonable efforts to give the Enrollee prompt oral notice of the denial. 42 CFR 438.408(c)(2)(i) 42 CFR 438.410(c)(2) Attachment P6.3.1.1(VI)(C)(2)(c)(ii)		☐ Met ☐ Not Met ☐ Not Applicable
iii. Within 2 calendar days, give the Enrollee written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a Grievance if they disagree with the decision. 42 CFR 438.408(c)(2)(ii) 42 CFR 438.410(c)(2) Attachment P6.3.1.1(VI)(C)(2)(c)(iii)		☐ Met ☐ Not Met ☐ Not Applicable
iv. Resolve the Appeal as expeditiously as the Enrollee's health condition requires but not to exceed 30 calendar days. 42 CFR 438.408(c)(2)(iii) 42 CFR 438.410(c)(2) Attachment P6.3.1.1(VI)(C)(2)(c)(iv)		☐ Met ☐ Not Met ☐ Not Applicable
d. If a request for expedited resolution is granted, the PIHP must resolve the Appeal and provide notice of resolution to the affected parties no longer than 72 hours after the PIHP receives the request for expedited resolution of the Appeal. 42 CFR 438.408(b)(3) Attachment P6.3.1.1(VI)(C)(2)(d)		☐ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement		

Standard XIV—Appeals		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
HSAG Findings		
10. Extension of Timeframes 42 CFR 438.408 Attachment P6.3.1.1		
a. The PIHP may extend the resolution and notice timeframe by up to 14 calendar days if the Enrollee requests an extension, or if the PIHP shows to the satisfaction of the State that there is a need for additional information and how the delay is in the Enrollee's interest 42 CFR 438.408(c)(1)(i-ii) Attachment P6.3.1.1(VI)(C)(3)		☐ Met ☐ Not Met ☐ Not Applicable
b. If the PIHP extends resolution/notice timeframes, it must complete all of the following:		
i. Make reasonable efforts to give the Enrollee prompt oral notice of the delay; 42 CFR 438.408(c)(2)(i) Attachment P6.3.1.1(VI)(C)(3)(a)(i)		☐ Met ☐ Not Met ☐ Not Applicable
ii. Within 2 calendar days, give the Enrollee written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a Grievance if they disagree with the decision. 42 CFR 438.408(c)(2)(ii) Attachment P6.3.1.1(VI)(C)(3)(a)(ii)		☐ Met ☐ Not Met ☐ Not Applicable

Standard XIV—Appeals		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
iii. Resolve the Appeal as expeditiously as the Enrollee's health condition requires and not later than the date the extension expires. 42 CFR 438.408(c)(2)(iii) Attachment P6.3.1.1(VI)(C)(3)(a)(iii)		☐ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement		
HSAG Findings		
11. Appeal Resolution Notice Format 42 CFR 438.408 Attachment P6.3.1.1		
a. The PIHP must provide Enrollees with written notice of the resolution of their Appeal, and must also make reasonable efforts to provide oral notice in the case of an expedited resolution. 42 CFR 438.408(d)(2)(ii) Attachment P6.3.1.1(VI)(C)(4)(a)		☐ Met ☐ Not Met ☐ Not Applicable
b. Enrollee notice must meet the requirements of 42 CFR 438.10 (i.e., "…in a manner and format that may be easily understood and is readily accessible by such enrollees and potential enrollees," meets the needs of those with limited English proficiency and or limited reading proficiency). 42 CFR438.10		☐ Met ☐ Not Met ☐ Not Applicable

Standard XIV—Appeals		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
42 CFR 438.408(d)(2)(i) Attachment P6.3.1.1(VI)(C)(4)(a)		
PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement		
HSAG Findings		
12. Appeal Resolution Notice Content 42 CFR 438.408 Attachment P6.3.1.1		
a. The notice of resolution must include the results of the resolution and the date it was completed. 42 CFR 438.408(e)(1) Attachment P6.3.1.1(VI)(C)(5)(a)		☐ Met ☐ Not Met ☐ Not Applicable
b. When the appeal is not resolved wholly in favor of the Enrollee, the notice of disposition must also include notice of the Enrollee's:		
i. Right to request a state fair hearing, and how to do so. 42 CFR 438.408(e)(2)(i) Attachment P6.3.1.1(VI)(C)(5)(b)(i)		☐ Met ☐ Not Met ☐ Not Applicable
ii. Right to request to receive benefits while the state fair hearing is pending, and how to make the request. 42 CFR 438.408(e)(2)(ii) Attachment P6.3.1.1(VI)(C)(5)(b)(ii)		☐ Met ☐ Not Met ☐ Not Applicable

Standard XIV—Appeals		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
c. Potential liability for the cost of those benefits if the hearing decision upholds the PIHP's Adverse Benefit Determination. 42 CFR 438.408(e)(2)(iii) Attachment P6.3.1.1(VI)(C)(5)(b)(iii)		☐ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement		
HSAG Findings		
13. State Fair Hearing 42 CFR 438.408 Attachment P6.3.1.1		
a. Enrollees are given 120 calendar days from the date of the applicable notice of resolution to file a request for a State Fair Hearing. 42 CFR 438.408(f)(2) Attachment P6.3.1.1(VIII)(D)		☐ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement		
HSAG Findings		

Results—Standard XIV						
Met	=		X	1.0	=	
Not Met	=		X	.00	=	
Not Applicable	=					
Total Applicable	=		Total Score		=	
Total Score ÷ Total Applicable					=	

Standard XV—Disclosure of Ownership, Control, and Criminal Convictions		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
1. Disclosure of Ownership, Controlling Interest and Management Statement and Attestation of Criminal Convictions, Sanctions, Exclusions, Debarment or Termination The PIHP ensures that its providers and contractors submit full disclosures identified in 42 CFR Part 455 Subpart B. Disclosures include: 42 CFR 455.104 42 CFR 455.106 MDHHS Contract Part I-34.0–34.1		
a. 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. 42 CFR 455.104(b)(1)(i)		☐ Met ☐ Not Met ☐ Not Applicable
b. Date of birth and Social Security number of each person with an ownership or control interest in the disclosing entity. 42 CFR 455.104(b)(1)(ii)		☐ Met ☐ Not Met ☐ Not Applicable
c. 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. 42 CFR 455.104(b)(1)(iii)		☐ Met ☐ Not Met ☐ Not Applicable

Standard XV—Disclosure of Ownership, Control, and Criminal Convictions		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
d. 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. 42 CFR 455.104(b)(2)		☐ Met ☐ Not Met ☐ Not Applicable
e. The name of any other disclosing entity in which an owner of the disclosing entity has an ownership or control interest. 42 CFR 455.104(b)(3)		☐ Met ☐ Not Met ☐ Not Applicable
f. The name, address, date of birth, and Social Security number of any managing employee of the disclosing entity. 42 CFR 455.104(b)(3)		☐ Met ☐ Not Met ☐ Not Applicable
g. 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 455.106(a)(1-2)		☐ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement		

Standard XV—Disclosure of Ownership, Control, and Criminal Convictions		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
HSAG Findings		
2. Time of Disclosure Disclosure from any provider or disclosing entity is due at any of the following times: 42 CFR 455.104 MDHHS Contract Part I-34.2		
a. Upon the provider or disclosing entity submitting the provider application. 42 CFR 455.104(c)(1)(i)		☐ Met ☐ Not Met ☐ Not Applicable
b. Upon the provider or disclosing entity executing the provider agreement. 42 CFR 455.104(c)(1)(ii)		☐ Met ☐ Not Met ☐ Not Applicable
c. Upon request of the Medicaid agency during the re-validation of enrollment process under §455.414. 42 CFR 455.104(c)(1)(iii)		☐ Met ☐ Not Met ☐ Not Applicable
d. Within 35 days of any change in ownership of a disclosing entity. 42 CFR 455.104(c)(1)(iv)		☐ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement		

Standard XV—Disclosure of Ownership, Control, and Criminal Convictions		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
HSAG Findings		
3. Monitoring Provider Networks MDHHS Contract Part I-34.1		
a. 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. MDHHS Contract Part I-34.1		☐ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement		
HSAG Findings		
4. Reporting Criminal Convictions Involved The PIHP is required to promptly notify the Division of Program Development, Consultation and Contracts, Behavioral Health and Developmental Disabilities Administration in MDHHS if: 42 CFR 1001.1001 42 CFR 455.106 MDHHS Contract Part I-34.2		
a. Any disclosures made by providers with regard to 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		☐ Met ☐ Not Met ☐ Not Applicable

Standard XV—Disclosure of Ownership, Control, and Criminal Convictions		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
had civil money penalties or assessments imposed under section 1128A of the Act. MDHHS Contract Part I-34.2(a)		
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. MDHHS Contract Part I-34.2(b)		☐ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement		
HSAG Findings		

Results—Standard XV						
Met	=		X	1.0	=	
Not Met	=		X	.00	=	
Not Applicable	=					
Total Applicable	=		Total Score		=	
Total Score ÷ Total Applicable					=	

Standard XVII—Management Information Systems		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
1. Management Information Systems (MIS) 42 CFR 438.242 MDHHS Contract Part II A-7.7		
a. The PIHP shall ensure that Management Information Systems and practices have the capacity that the obligations of its contract are fulfilled by the entity and/or its subcontractors. 42 CFR 438.242 MDHHS Contract Part II A-7.7		☐ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement		
HSAG Findings		
2. Uniform Data and Information 42 CFR 438.242 MDHHS Contract Part II A-7.7.1		
a. To measure the PIHP's accomplishments in the areas of access to care, utilization, service outcomes, recipient satisfactions, and to provide sufficient information to track expenditures and calculate future capitation rates, the PIHP must provide MDHHS with uniform data and information specified by MDHHS. MDHHS Contract Part II A-7.7.1		☐ Met ☐ Not Met ☐ Not Applicable

Standard XVII—Management Information Systems		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
b. The PIHP must certify that the data they submit are accurate, complete and truthful:		
i. An annual certification from and signed by the Chief Executive Officer or the Chief Financial Officer, or a designee who reports directly to either must be submitted annually. MDHHS Contract Part II A-7.7.1		☐ Met ☐ Not Met ☐ Not Applicable
ii. The certification must attest to the accuracy, completeness, and truthfulness of the information in each of the sets of data. MDHHS Contract Part II A-7.7.1		☐ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement		
HSAG Findings		
3. Information System Management The PIHP must have an information management system that supports the core administrative activities of the region including: Attachment P13.0.B		
a. The ability to detect and correct errors in data receipt, transmissions and analyses. Attachment P13.0.B-2.3(g)		☐ Met ☐ Not Met ☐ Not Applicable

Standard XVII—Management Information Systems		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
b. This includes screening for completeness, logic, and consistency; and identifying and tracking fraud and abuse. Attachment P13.0.B-2.3(g)		☐ Met ☐ Not Met ☐ Not Applicable
c. The ability (within limits of law) to safely and securely send and receive data to and from other systems which includes, but is not limited to, the State of Michigan, health plans and providers systems including physical health and non-healthcare support systems of care. Attachment P13.0.B-2.3(h)		☐ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement		
HSAG Findings		
3. Enrollee Encounter Data 42 CFR 438.242 MDHHS Contract Part II A-7.7.2 Attachment P7.7.1.1		
a. In order to assess quality of care, determine utilization patterns and access to care for various health care services, affirm capitation rate calculations and estimates, the PIHP shall submit encounter data containing detail for each recipient encounter reflecting all services provided by the PIHP. 42 CFR 438.242(c)(2) MDHHS Contract Part II A-7.7.2		☐ Met ☐ Not Met ☐ Not Applicable

Standard XVII—Management Information Systems		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
b. The PIHP collects and maintains sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees: 42 CFR 438.242(c)(1) Attachment P7.7.1.1		
i. The encounter requires a small set of specific demographic data: gender, diagnosis, Medicaid number, race, social security number and name of the consumer, and the provider name and identification number, place of service, and amount paid. Attachment P7.7.1.1		☐ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement		
HSAG Findings		
4. Oversight of CMHSPs MDHHS Contract Part II A-7.7		
a. A PIHP organized as a regional entity may have a single CMHSP perform PIHP health plan information technology functions on behalf of the regional entity if each of the following requirements are met: MDHHS Contract Part II A-7.7(2)		

Standard XVII—Management Information Systems		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
i. The contract between the PIHP and the CMHSP clearly describes the CMHSP's contractual responsibility to the PIHP for the health plan information technology related functions. MDHHS Contract Part II A-7.7(2)		☐ Met ☐ Not Met ☐ Not Applicable
ii. The contract between the PIHP and the CMHSP for PIHP health plan information technology functions shall be separate from other EHR functions performed as a CMHSP. MDHHS Contract Part II A-7.7(2)		☐ Met ☐ Not Met ☐ Not Applicable
b. The PIHP shall analyze claims and encounter data to create information about region wide and CMHSP specific service utilization. MDHHS Contract Part II A-7.7(3)		☐ Met ☐ Not Met ☐ Not Applicable
c. The PIHP shall provide regular reports to each CMHSP as to how the CMHSP's individual utilization compares to the PIHP's region as a whole. MDHHS Contract Part II A-7.7(3)		☐ Met ☐ Not Met ☐ Not Applicable
d. The PIHP shall utilize this information to inform risk management strategies and other health plan functions. MDHHS Contract Part II A-7.7(3)		☐ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement		

Standard XVII—Management Information Systems		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
HSAG Findings		

Results—Standard XVII						
Met	=		X	1.0	=	
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 only in the context of the performance indicators reported to MDHHS and the Behavioral Health Treatment Episode Data Set (BH-TEDS) and encounter data submitted to MDHHS. If a question does not apply to the performance indicator calculation and reporting, BH-TEDS data, or encounter data submission, enter an N/A response. A Community Mental Health Service Program (CMHSP) or a Managed Comprehensive Provider Network (MCPN) should be considered a subcontractor.

A. Contact Information

Please insert the PIHP identification information below, including the PIHP name, PIHP contact name and title, mailing address, telephone and fax numbers, and email address, if applicable.

PIHP Name: Enter text	
Mailing Address: Enter text	
PMV Contact Name and Title: Enter text	
PMV Contact Email Address: Enter text	
PMV Contact Phone Number: Enter text	PMV Contact Fax Number: Enter text
Chief Information Officer (CIO) Name and Title: Enter text	
CIO Phone Number: Enter text	
CIO Email Address: Enter text	

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): Enter text

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): Enter text

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:

Enter text

D. Count of Medicaid Consumers Receiving Services as of:

October 2016	Enter count		June 2017	Enter count
November 2016	Enter count		July 2017	Enter count
December 2016	Enter count		August 2017	Enter count
January 2017	Enter count		September 2017	Enter count
February 2017	Enter count		October 2017	Enter count
March 2017	Enter count		November 2017	Enter count
April 2017	Enter count		December 2017	Enter count
May 2017	Enter count			

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? Enter text When was the assessment completed? Enter text

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 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 the names of each CMHSP contracted with your plan and the percentage of your plans total data that comes from each CMHSP.

CMHSP name	Percentage of total data received
Enter text	%
Enter text	%
Enter text	%
Enter text	%
Enter text	%
Enter text	%
Enter text	%
Enter text	%
Enter text	%
Enter text	%
Enter text	%
Enter text	%
Total	**100%**

H. Did any CMHSPs require Corrective Action Plans (CAPs)? If yes, please provide the reasons for the need for CAPs. Were any CAPs implemented during the measurement period?

Enter text

I. General Information

I. Please describe any system changes made by the CMHSPs since the prior measurement period.

Enter text

J. Please provide a summary of your PIHP's experience in working with the state CHAMPS system in the past year, specifically as it relates to data reporting/data acquisition through CHAMPS.

Enter text

K. Describe any quality improvement interventions or activities your PIHP implemented and/or conducted to improve measure indicator rates.

Enter text

L. Describe your data analysis methodology in place to review data for accuracy and to determine appropriate improvement interventions and identify best practices.

Enter text

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?

Enter text

2. How would you characterize this/these DBMS(s)? *(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?

Enter text

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 (BH-TEDS 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.

Enter text

How many programmers (internal staff or external vendors) are trained and capable of modifying these programs?

Enter text

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.

Enter percentage %

7. What is the average experience, in years, of programmers in your organization?

Enter number 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.

Enter text

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.

Enter text

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: Enter text

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).

Enter text

11b. Describe claims and/or service/encounter data processor training from new hire to refresher courses for seasoned processors:

Enter text

11c. What is the average tenure of the staff? Enter text

11d. What is the annual turnover? Enter text

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?

Enter text

How frequently are system back-ups being performed? Enter text

Where are back-up data stored? Enter text

12b. What is done to minimize the corruption of Medicaid data due to system failure or program error?

Enter text

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.

Enter text

12d. Describe the provisions in place for physical security of the computer system and manual files:

Enter text

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

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.

Enter text

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 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)	☐	☐	Enter text
Sub-Panel Provider (for a CMH contract agency)	☐	☐	Enter text
Off-Panel Provider (for out-of-network providers, incl. County of Financial Responsibility (COFR)	☐	☐	Enter text
Hospital	☐	☐	Enter text
Other: Enter text	☐	☐	Enter text
Other: Enter text	☐	☐	Enter text

III. Data Acquisition Capabilities

2. Explain how claims or service/encounter data are submitted to your plan. Provide an estimate of the percentage (if any) of services provided to your consumers by providers serving your Medicaid enrollees that 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:

Enter text

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	Enter text	Enter text	Enter text	Enter text	Enter text
Diagnosis	Enter text	Enter text	Enter text	Enter text	Enter text
Procedure	Enter text	Enter text	Enter text	Enter text	Enter text
First Date of Service	Enter text	Enter text	Enter text	Enter text	Enter text
Last Date of Service	Enter text	Enter text	Enter text	Enter text	Enter text
# of Units	Enter text	Enter text	Enter text	Enter text	Enter text
Revenue Code	Enter text	Enter text	Enter text	Enter text	Enter text
Provider ID	Enter text	Enter text	Enter text	Enter text	Enter text
Place of Service	Enter text	Enter text	Enter text	Enter text	Enter text

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.

Enter text

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—Inpatient Data		ENCOUNTER—Inpatient Data	
Diagnoses: Enter #	Procedures: Enter #	Diagnoses: Enter #	Procedures: Enter #
CLAIM—Ambulatory/Outpatient Data		**ENCOUNTER—Ambulatory/Outpatient Data**	
Diagnoses: Enter #	Procedures: Enter #	Diagnoses: Enter #	Procedures: Enter #

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?

Enter text

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?

Inpatient Data: Enter text

Ambulatory/Outpatient Data: Enter text

III. Data Acquisition Capabilities

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

Enter text

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?

Enter text

9. Medicaid Claims/Encounters

9a. How are Medicaid claims/encounters received?

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

Source	Received Directly	Submitted Through an Intermediary
CMH/MCPN (for direct-run providers)	☐	☐
Sub-Panel Provider (for a CMH contract agency)	☐	☐
Off-Panel Provider (for out-of-network providers, incl. COFR)	☐	☐
Hospital	☐	☐
Other: Enter text	☐	☐

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

Enter text

III. Data Acquisition Capabilities

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

Coding Scheme	Inpatient Diagnosis	Inpatient Procedure	Ambulatory/ Outpatient Diagnosis	Ambulatory/ Outpatient Procedure
ICD-10	%	%	%	%
CPT-4		%		%
HCPCS		%		%
DSM-IV	%		%	
Internally Developed	%	%	%	%
Other (Specify): Enter text	%	%	%	%
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.

Enter text

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 Enter text

☐ New system purchased and installed to replace most of old system; old system still used.
Description/implementation dates Enter text

☐ Major enhancements made to old system. (If *yes*, please describe the enhancements.)
Description/implementation dates Enter text

☐ New product line adjudicated (processed) on old system.
Description/implementation dates Enter text

☐ Conversion of a product line from one system to another.
Description/implementation dates Enter text

Comments:

Enter text

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?

Enter text

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

Enter text

15. What percentage 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.

Enter text

If batch, how often is it run? Enter text

III. Data Acquisition Capabilities

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

Enter text

How is completeness estimated? How is completeness defined?

Enter text

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

Enter text

Are Medicaid encounters audited regularly? Randomly?

Enter text

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

Enter text

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.

Enter text

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 BH-TEDS or encounter 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	BH-TEDS Data
Percent of Total Service Volume	%	%	
Percent Complete	%	%	%
Other Administrative Data (list types)	Enter text		
How Are the Above Statistics Quantified?	Enter text		
Incentives for Data Submission	Enter text		

Comments:

Enter text

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.

Enter text

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?

Enter text

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?

Enter text

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.

Enter text

With what frequency are performance indicator data merged?

Enter text

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.

Enter text

III. Data Acquisition Capabilities

24c. Discuss which decisions in processing a Medicaid claim and encounter (service data) are automated, which are prompted by automated messages appearing on the screen, and which are manual. Document the opportunities a processor has for overriding the system manually.

Is there a report documenting overrides or "exceptions" generated on each processor and reviewed by the claim supervisor? Please describe this report.

The intent of this question is to understand how much manual intervention is required to either data-enter a claim/encounter or to adjudicate a claim. The less manual intervention there is, the less room there is for error.

Enter text

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?

Enter text

III. Data Acquisition Capabilities

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 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.

Enter text

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.)?

Enter text

24g. Describe how your systems and procedures handle validation and payment of Medicaid claims and encounters (service data) when procedure codes are not provided.

Enter text

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?

Enter text

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.

Enter text

III. Data Acquisition Capabilities

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.

Enter text

27. Describe the process for submitting data to the State on the total number of Medicaid members who have received PIHP services.

Enter text

28. Describe the process for submitting data to the State on the total number of Habilitation Supports Waiver (HSW) enrolled members. How does your organization identify and report the services HSW enrolled members receive?

Enter text

29. Identify and describe where data are captured to identify the mental illness (MI), developmental disabilities (DD), and dual MI/DD populations.

Enter text

30. Describe the process for ensuring information entered into BH-TEDS is accurate and complete.

Enter text

31. Please provide counts for members who were not assessed for a diagnosis of serious emotional disturbance (SED) and serious mental illness (SMI).

Please fill in the following table with the appropriate counts and percentages of members who were not assessed for these diagnoses.

Diagnosis	Count	Percentage
SMI	Enter count	**%**
SED	Enter count	**%**

III. Data Acquisition Capabilities

32. Of those individuals not assessed/evaluated for SED or SMI, please describe the reason(s) the assessment/evaluation did not occur.

Enter text

33. Please describe what would trigger a "Change Record" versus an "Update Record."

Enter text

34. Please describe whether a "Change Record" or an "Update Record" is completed when an individual's place of residence changes.

Enter text

35. Other Administrative Data Used for Performance Indicator Reporting

35a. 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

☐ BH-TEDS 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: Enter text

III. Data Acquisition Capabilities
35b. 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. Enter text
35c. 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: Enter text
35d. For each data source identified above, describe the validation activities performed by your PIHP to ensure the data in the administrative database are accurate. Enter text

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

Enter text

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?

Enter text

3. How does your PIHP uniquely identify consumers?

Enter text

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?

Enter text

5. How do you track consumer eligibility? Does the individual retain the same ID (unique consumer ID)?

Enter text

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?

Enter text

8. How often is Medicaid enrollment information updated (e.g., how often does your PIHP receive eligibility updates)?

Enter text

9. Can you track and maintain Medicaid eligibility over time, including retro-active eligibility?

Enter text

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, subcontract 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. (1st Quarter SFY 2018)	Enter text
#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. (1st Quarter SFY 2018)	Enter text
#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. (1st Quarter SFY 2018)	Enter text
#4a	The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days. (1st Quarter SFY 2018)	Enter text
#4b	The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days. (1st Quarter SFY 2018)	Enter text
#5	The percent of Medicaid recipients having received PIHP managed services. (1st Quarter SFY 2018)	Enter text
#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. (1st Quarter SFY 2018)	Enter text
#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 2017)	Enter text
#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 2017)	Enter text
#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. (1st Quarter SFY 2018)	Enter text
#13	The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s). (SFY 2017)	Enter text
#14	The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s). (SFY 2017)	Enter text

III. Data Acquisition Capabilities

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

Enter text

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

Enter text

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

Enter text

5. Do you evaluate the quality of this information?

If so, how?

Enter text

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

Enter text

III. Data Acquisition Capabilities

D. Integration and Control of Data for Performance Measure Reporting

File Consolidation

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.

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.

Enter text

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?

  Enter text

- 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?

  Enter text

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?

Enter text

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?

Enter text

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)?

Enter text

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)?

Enter text

3e. Describe your processes 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?

Enter text

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.

Enter text

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:

Enter text

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?

Enter text

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
EXAMPLE: CMHSP #1—All mental health services for blank population	☒ Yes ☐ No	☒ Yes ☐ No	☐ A ☒ B ☐ C	☒ A ☐ B ☐ C	*Volumes of encounters not consistent from month to month.*
Enter text	☐ Yes ☐ No	☐ Yes ☐ No	☐ A ☐ B ☐ C	☐ A ☐ B ☐ C	Enter text
Enter text	☐ Yes ☐ No	☐ Yes ☐ No	☐ A ☐ B ☐ C	☐ A ☐ B ☐ C	Enter text
Enter text	☐ Yes ☐ No	☐ Yes ☐ No	☐ A ☐ B ☐ C	☐ A ☐ B ☐ C	Enter text
Enter text	☐ Yes ☐ No	☐ Yes ☐ No	☐ A ☐ B ☐ C	☐ A ☐ B ☐ C	Enter text
Enter text	☐ Yes ☐ No	☐ Yes ☐ No	☐ A ☐ B ☐ C	☐ A ☐ B ☐ C	Enter text
Enter text	☐ Yes ☐ No	☐ Yes ☐ No	☐ A ☐ B ☐ C	☐ A ☐ B ☐ C	Enter text
Enter text	☐ Yes ☐ No	☐ Yes ☐ No	☐ A ☐ B ☐ C	☐ A ☐ B ☐ C	Enter text

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.

Enter text

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

Enter text

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

Enter text

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

Enter text

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?

Enter text

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:** Enter text	%	%	%	%
3. Fee-for-Service with bonus **Bonus range:** Enter text	%	%	%	%
4. Capitated—no withhold or bonus	%	%	%	%
5. Capitated with withhold **Please specify % withhold:** Enter text	%	%	%	%
6. Capitated with bonus **Bonus range:** Enter text	%	%	%	%
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?**

   Enter text

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

   Enter text

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

A. 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.

a. How many entities are responsible for reporting administrative data to the PIHP? Describe each entities role in the collection of claims and encounter data.

Enter text

b. Describe how these administrative data are provided to the PIHP (if applicable).

Enter text

c. Describe how claims and encounter data submitted are integrated into your data respository.

Enter text

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

Enter text

B. 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.

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

Enter text

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

Enter text

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

Enter text

IV. Outsourced or Delegated Functions

C. 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?

Enter text

Vendor Oversight

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

Enter text

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

☐ Yes ☐ No

If so, please answer the following questions.

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

Enter text

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

Enter text

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

Enter text

IV. Outsourced or Delegated Functions

F. 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.

a. Please describe your external entities' data accuracy, completeness, and timeliness standards/requirements. Include examples of language from vendor contracts.

Enter text

b. How is delegated entity performance measured against those standards? Provide documentation of periodic monitoring of the accuracy and completeness of reporting.

Enter text

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

Enter text

G. Primary Source Verification

The purpose of this section is to conduct validation to confirm that the information from the primary source matches the output information used for reporting the selected performance indicators. **In an attachment to the ISCAT submit measure level detail files to include a list of all denominator and numerator compliant members by performance indicator. Label as Attachment 12.**

a. Describe the validation activities performed to ensure the accuracy of the data submitted to the PIHP.

Enter text

b. Are audit and/or quality checks performed on the data submitted to the PIHP? If yes, what is the schedule of these activities?

Enter text

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 ISCAT.	**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**

Requested Document	Details	Label Number
Measure Level Detail Data	List of denominator and numerator compliant members included in each performance indicator under the scope of the audit. Include member name or ID number, member DOB and date of service.	**12**
Other/Describe: Enter text	Enter text	**13**

Comments:

Enter text

Attachment B2. Michigan Department of Health and Human Services (MDHHS)
Mini-Information Systems Capabilities Assessment Tool (ISCAT) for Prepaid Inpatient Health Plans (PIHPs)
Community Mental Health Services Program (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 only in the context of the performance measures reported to MDHHS, and the Behavioral Health Treatment Episode Data Set (BH-TEDS) and encounter data submitted to MDHHS only. If a question does not apply to the performance measure calculation and reporting, BH-TEDS data, or encounter data submission, enter an "N/A" response.

A. Contact Information

Please insert the PIHP subcontractor identification information below, including the organization name, contact name and title, mailing address, telephone and fax numbers, and email address, if applicable.

Organization Name: Enter text	
Mailing Address: Enter text	
Contact Name and Title: Enter text	
Contact Email Address: Enter text	
Contact Phone Number: Enter text	Contact Fax Number: Enter text
Chief Information Officer (CIO) Name and Title: Enter text	
CIO Phone Number: Enter text	
CIO Email Address: Enter text	

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): Enter text

Please indicate model type (if other, please specify):

☐ Group model

☐ Network model

☐ Mixed model

☐ Other (describe): Enter text

Please provide a brief description of your organization structure:

Enter text

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:

Enter text

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 *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. 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?

Enter text

2. How would you characterize this/these DBMS(s)? *(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?

Enter text

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 BH-TEDS or encounter data submission or performance measure reporting.

How many programmers (internal staff or external vendors) are trained and capable of modifying these programs?

Enter text

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.

Enter percentage %

7. What is the average experience, in years, of programmers in your organization?

Enter number 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.

Enter text

II. Information Systems: Data Processing Procedures and Personnel

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).

Enter text

9b. Describe claims/encounter data processor training from new hire to refresher courses for seasoned processors:

Enter text

9c. What is the average tenure of the staff? Enter text

9d. What is the annual turnover? Enter text

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 service/encounter data prevented in the event of system failure?

Enter text

How frequently are system back-ups performed? Enter text

Where are back-up data stored? Enter text

10b. What is done to minimize the corruption of Medicaid data due to system failure or program error?

Enter text

II. Information Systems: Data Processing Procedures and Personnel

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.

Enter text

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

Enter text

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.

Enter text

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 CMHSP Programs	☐	☐	Enter text
Sub-Panel/Contract Agency	☐	☐	Enter text
Off-Panel/County of Financial Responsibility (COFR) Providers	☐	☐	Enter text
Hospitals	☐	☐	Enter text
Other: Enter text	☐	☐	Enter text

III. Data Acquisition Capabilities

2. Explain how claims or encounters are submitted to your organization. Provide an estimate of the percentage (if any) of services provided to your consumers by providers serving your Medicaid enrollees that 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:

Enter text

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	Enter text	Enter text	Enter text	Enter text	Enter text
Diagnosis	Enter text	Enter text	Enter text	Enter text	Enter text
Procedure	Enter text	Enter text	Enter text	Enter text	Enter text
First Date of Service	Enter text	Enter text	Enter text	Enter text	Enter text
Last Date of Service	Enter text	Enter text	Enter text	Enter text	Enter text
# of Units	Enter text	Enter text	Enter text	Enter text	Enter text
Revenue Code	Enter text	Enter text	Enter text	Enter text	Enter text
Provider ID	Enter text	Enter text	Enter text	Enter text	Enter text
Place of Service	Enter text	Enter text	Enter text	Enter text	Enter text

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.

Enter text

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—Inpatient Data		ENCOUNTER—Inpatient Data	
Diagnoses: Enter #	Procedures: Enter #	Diagnoses: Enter #	Procedures: Enter #
CLAIM—Ambulatory/Outpatient Data		**ENCOUNTER—Ambulatory/Outpatient Data**	
Diagnoses: Enter #	Procedures: Enter #	Diagnoses: Enter #	Procedures: Enter #

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?

Enter text

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 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?

Inpatient Data: Enter text

Ambulatory/Outpatient Data: Enter text

III. Data Acquisition Capabilities

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

Enter text

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?

Enter text

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	☐	☐
Sub-Panel/Contract Agency	☐	☐
Off-Panel/COFR Providers	☐	☐
Hospital	☐	☐
Other: Enter text	☐	☐

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

Enter text

III. Data Acquisition Capabilities

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

Coding Scheme	Inpatient Diagnosis	Inpatient Procedure	Ambulatory/ Outpatient Diagnosis	Ambulatory/ Outpatient Procedure
ICD-10	%	%	%	%
CPT-4		%		%
HCPCS		%		%
DSM-IV	%		%	
Internally Developed	%	%	%	%
Other (Specify): Enter text	%	%	%	%
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 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.

Enter text

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 Enter text

☐ New system purchased and installed to replace most of old system; old system still used.
Description/implementation dates Enter text

☐ Major enhancements made to old system. (If *yes*, please describe the enhancements.)
Description/implementation dates Enter text

☐ New product line adjudicated (processed) on old system.
Description/implementation dates Enter text

☐ Conversion of a product line from one system to another.
Description/implementation dates Enter text

Comments:

Enter text

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?

Enter text

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

Enter text

15. What percentage 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.

Enter text

If batch, how often is it run? Enter text

III. Data Acquisition Capabilities

16. How complete are the Medicaid data three months after the close of the reporting period?

Enter text

How is completeness estimated? How is completeness defined?

Enter text

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

Enter text

Are Medicaid encounters audited regularly? Randomly?

Enter text

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

Enter text

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.

Enter text

III. Data Acquisition Capabilities

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	BH-TEDS Data
Percent of Total Service Volume	**%**	**%**	
Percent Complete	**%**	**%**	**%**
Other Administrative Data (list types)	Enter text		
How Are the Above Statistics Quantified?	Enter text		
Incentives for Data Submission	Enter text		

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.

Enter text

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?

Enter text

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?

Enter text

24. If no providers are paid via capitation, how do you ensure that all services are represented within the information system?

Enter text

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.

Enter text

25b. Please provide a detailed description of each system or process that is involved in adjudicating:

- Professional encounter(s) for a capitated service

  For example, how do you confirm encounter reporting when processing the reimbursement of a capitated claim?

  Enter text

III. Data Acquisition Capabilities

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?

Enter text

- Inpatient stays (with or without authorization)

  Enter text

25c. Discuss which decisions in processing a Medicaid claim/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.

Enter text

Is there a report that documented overrides or "exceptions" generated on each processor and reviewed by the claim supervisor? Please describe this report.

Enter text

The intent of this question is to understand how much manual intervention is required to either data-enter a claim/encounter or to adjudicate a claim. The less manual intervention there is, the less room there is for error.

25d. Are there any outside parties or contractors used to complete adjudication, including but not limited to:

- Bill auditors (hospital claims, claims over a certain dollar amount)

  ☐ Yes

  ☐ No

- Peer or medical reviewers

  ☐ Yes

  ☐ No

- Sources for additional charge data (usual and customary)

  ☐ Yes

  ☐ No

- Bill "re-pricing" for any services provided

  ☐ Yes

  ☐ No

III. Data Acquisition Capabilities

How are these data incorporated into your organization's data?

Enter text

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 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.

Enter text

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.)?

Enter text

25g. Describe how your systems and procedures handle validation and payment of Medicaid claims and encounters (service data) when procedure codes are not provided.

Enter text

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?

Enter text

III. Data Acquisition Capabilities

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.

Enter text

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.

Enter text

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)

☐ 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: Enter text

III. Data Acquisition Capabilities
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. Enter text
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: Enter text
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. Enter text

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

Enter text

2. How does your organization uniquely identify consumers?

Enter text

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?

Enter text

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—F. Provider Data* 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. (1st Quarter SFY 2018)	Enter text
#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. (1st Quarter SFY 2018)	Enter text
#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. (1st Quarter SFY 2018)	Enter text
#4a	The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days. (1st Quarter SFY 2018)	Enter text
#4b	The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days. (1st Quarter SFY 2018)	Enter text
#5	The percent of Medicaid recipients having received PIHP managed services. (1st Quarter SFY 2018)	Enter text
#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. (1st Quarter SFY 2018)	Enter text
#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 2017)	Enter text
#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 2017)	Enter text
#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. (1st Quarter SFY 2018)	Enter text

III. Data Acquisition Capabilities		
#13	The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s). (SFY 2017)	Enter text
#14	The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s). (SFY 2017)	Enter text

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

Enter text

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

Enter text

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

Enter text

5. Do you evaluate the quality of this information?

If so, how?

Enter text

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

Enter text

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.**

   Enter text

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?

     Enter text

   - 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

III. Data Acquisition Capabilities

3. Describe how your organization receives Medicaid eligibility data, and tracks Medicaid eligibility over time.

Enter text

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?

Enter text

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?

Enter text

4c. What control processes are in place to ensure that no extraneous data are captured (e.g., lack of specificity in consumer identifiers may lead to inclusion of non-eligible members or to double-counting)?

Enter text

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)?

Enter text

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?

Enter text

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.

Enter text

III. Data Acquisition Capabilities

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

☐ Yes

☐ No

If yes, please describe:

Enter text

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?

Enter text

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
EXAMPLE: Large provider group #1	☒ Yes ☐ No	☒ Yes ☐ No	☐ A ☒ B ☐ C	☒ A ☐ B ☐ C	*Volumes of encounters not consistent from month to month.*
Enter text	☐ Yes ☐ No	☐ Yes ☐ No	☐ A ☐ B ☐ C	☐ A ☐ B ☐ C	Enter text
Enter text	☐ Yes ☐ No	☐ Yes ☐ No	☐ A ☐ B ☐ C	☐ A ☐ B ☐ C	Enter text
Enter text	☐ Yes ☐ No	☐ Yes ☐ No	☐ A ☐ B ☐ C	☐ A ☐ B ☐ C	Enter text
Enter text	☐ Yes ☐ No	☐ Yes ☐ No	☐ A ☐ B ☐ C	☐ A ☐ B ☐ C	Enter text
Enter text	☐ Yes ☐ No	☐ Yes ☐ No	☐ A ☐ B ☐ C	☐ A ☐ B ☐ C	Enter text
Enter text	☐ Yes ☐ No	☐ Yes ☐ No	☐ A ☐ B ☐ C	☐ A ☐ B ☐ C	Enter text
Enter text	☐ Yes ☐ No	☐ Yes ☐ No	☐ A ☐ B ☐ C	☐ A ☐ B ☐ C	Enter text

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.

Enter text

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

Enter text

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

Enter text

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

Enter text

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?

Enter text

III. Data Acquisition Capabilities

E. Primary Source Verification

The purpose of this section is to conduct validation to confirm that the information from the primary source matches the output information used for reporting the selected performance indicators. **In an attachment to the ISCAT, submit measure level detail files to include a list of all denominator and numerator compliant members by performance indicator. Label as Attachment 9.**

1. Describe the validation activities performed to ensure the accuracy of the data submitted to the PIHP.

Enter text

2. Are audit and/or quality checks performed on the data submitted to the PIHP? If yes, what is the schedule of these activities?

Enter text

III. Data Acquisition Capabilities

F. 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:** Enter text	%	%	%	%	%
4. Fee-for-Service with bonus **Bonus range:** Enter text	%	%	%	%	%
5. Capitated—no withhold or bonus	%	%	%	%	%
6. Capitated with withhold **Please specify % withhold:** Enter text	%	%	%	%	%
7. Capitated with bonus **Bonus range:** Enter text	%	%	%	%	%
8. Other	%	%	%	%	%
Total	100%	100%	100%	100%	100%

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

Enter text

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

Enter text

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**
Measure Level Detail Data	List of denominator and numerator compliant members included in each performance indicator under the scope of the audit. Include member name or ID number, member DOB and date of service.	**9**
Other: Enter text	Enter text	**10**

Comments:

Enter text

Attachment C1. State of Michigan 2017-18 PIP Validation Tool
<PIP Topic>
for <Health Plan Name>

Demographic Information	
Plan Name: **<Health Plan Name>**	
Project Leader Name: _____	Title: _____
Telephone Number: _____	Email Address: _____
Name of Project: ***<PIP Topic>***	
Submission Date: _____	Type of Delivery System: _____

Attachment C1. State of Michigan 2017-18 PIP Validation Tool
<PIP Topic>
for <Health Plan Name>

Evaluation Elements		Scoring	Comments
Performance Improvement Project/Healthcare Study Evaluation			
I.	**Select the Study Topic(s): The study topic should be selected based on data that identify an opportunity for improvement. The goal of the project should be to improve processes and outcomes of healthcare. The topic may also be specified by the State. The study topic:**		
C*	1. Was selected following collection and analysis of data. ***NA*** is not applicable to this element for scoring.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
	2. Has the potential to affect consumer health, functional status, or satisfaction. The scoring for this element will be ***Met*** or ***Not Met.***	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	

Results for Step I

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

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

* "C" in this column denotes a *critical* evaluation element.
** This is the total number of *all* evaluation elements for this review step.
*** This is the total number of critical evaluation elements for this review step.

Attachment C1. State of Michigan 2017-18 PIP Validation Tool
<PIP Topic>
for <Health Plan Name>

Evaluation Elements		Scoring	Comments
Performance Improvement Project/Healthcare Study 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:**		
C*	1. Was stated in simple terms and in the recommended X/Y format. ***NA*** is not applicable to this element for scoring.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	

Results for Step II

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

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

* "C" in this column denotes a *critical* evaluation element.
** This is the total number of *all* evaluation elements for this review step.
*** This is the total number of critical evaluation elements for this review step.

Evaluation Elements		Scoring	Comments
Performance Improvement Project/Healthcare Study Evaluation			
III.	**Define the Study Population: The study population should be clearly defined to represent the population to which the study question and indicators apply, without excluding comsumerss with special healthcare needs. The study population:**		
C*	1. Was accurately and completely defined and captured all consumers to whom the study question(s) applied. ***NA*** is not applicable to this element for scoring.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	

Results for Step III

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

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

* "C" in this column denotes a *critical* evaluation element.
** This is the total number of *all* evaluation elements for this review step.
*** This is the total number of critical evaluation elements for this review step.

Evaluation Elements		Scoring	Comments
Performance Improvement Project/Healthcare Study Evaluation			
IV.	**Select the Study Indicator(s): A study indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status 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. Study indicator goals should be specific, measurable, attainable, relevant, and time-bound. The study indicator(s):**		
C*	1. Were well-defined, objective, and measured changes in health or functional status, consumer satisfaction, or valid process alternatives.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
	2. Included the basis on which the indicator(s) was adopted, if internally developed.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	

Results for Step IV

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

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

* "C" in this column denotes a *critical* evaluation element.
** This is the total number of *all* evaluation elements for this review step.
*** This is the total number of critical evaluation elements for this review step.

Evaluation Elements		Scoring	Comments
Performance Improvement Project/Healthcare Study Evaluation			
V.	**Use Sound Sampling Techniques: (If sampling is not used, each evaluation element will be scored Not Applicable [NA]). If sampling is used to select consumers in the study, proper sampling techniques are necessary to provide valid and reliable information on the quality of care provided. Sampling methods:**		
	1. Included the measurement period for the sampling methods used (e.g., baseline, Remeasurement 1).	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
	2. Included the title of the applicable study indicator(s).	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
	3. Included the population size.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
C*	4. Included the sample size.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
	5. Included the margin of error and confidence level.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
	6. Described in detail the method used to select the sample.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
C*	7. Allowed for the generalization of results to the study population.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	

Results for Step V

Total Evaluation Elements				
Total Evaluation Elements**	*Met*	*Partially Met*	*Not Met*	*NA*
7	0	0	0	0

Critical Elements				
Critical Elements***	*Met*	*Partially Met*	*Not Met*	*NA*
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 step.
*** This is the total number of critical evaluation elements for this review step.

Evaluation Elements		Scoring	Comments
Performance Improvement Project/Healthcare Study Evaluation			
VI.	**Reliably Collect Data: The data collection process must ensure that the data collected on the study indicators are valid and reliable. Validity is an indication of the accuracy of the information obtained. Reliability is an indication of the repeatability or reproducibility of a measurement. Data collection procedures include:**		
	1. Clearly defined sources of data and data elements to be collected. ***NA*** is not applicable to this element for scoring.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
C*	2. A clearly defined and systematic process for collecting data that included how baseline and remeasurement data were collected. ***NA*** is not applicable to this element for scoring.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
C*	3. A manual data collection tool that ensured consistent and accurate collection of data according to indicator specifications.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
	4. An estimated degree of administrative data completeness percentage. *Met* = 80–100 percent *Partially Met* = 50–79 percent *Not Met* = <50 percent or not provided	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	

Results for Step VI

Total Evaluation Elements					Critical Elements				
Total Evaluation Elements**	*Met*	*Partially Met*	*Not Met*	*NA*	Critical Elements***	*Met*	*Partially Met*	*Not Met*	*NA*
4	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 step.
*** This is the total number of critical evaluation elements for this review step.

Evaluation Elements		Scoring	Comments
Performance Improvement Project/Healthcare Study Evaluation			
VII.	**Analyze Data and Interpret Study Results: Clearly present the results for each study indicator(s). Describe the data analysis performed and the results of the statistical analysis, if applicable, and interpret the results. Through data analysis and interpretation, real improvement as well as sustained improvement can be determined. The data analysis and interpretation of the study indicator outcomes:**		
C*	1. Included accurate, clear, consistent, and easily understood information in the data table.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
	2. Include a narrative interpretation that addresses all required components of data analysis and statistical testing.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
	3. Identified factors that threatened the validity of the data reported and ability to compare the initial measurement with the remeasurement.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	

Results for Step VII

Total Evaluation Elements

Total Evaluation Elements**	*Met*	*Partially Met*	*Not Met*	*NA*
3	0	0	0	0

Critical Elements

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

* "C" in this column denotes a *critical* evaluation element.
** This is the total number of *all* evaluation elements for this review step.
*** This is the total number of critical evaluation elements for this review step.

Evaluation Elements		Scoring	Comments
Performance Improvement Project/Healthcare Study Evaluation			
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. The improvement strategies are developed from an ongoing quality improvement process that included:**		
C*	1. A causal/barrier analysis with a clearly documented team, process/steps, and quality improvement tools.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
	2. Barriers that were identified and prioritized based on results of data analysis and/or other quality improvement processes.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
C*	3. Interventions that were logically linked to identified barriers and will directly impact study indicator outcomes.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
	4. Interventions that were implemented in a timely manner to allow for impact of study indicator outcomes.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
C*	5. Evaluation of individual interventions for effectiveness.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
	6. Interventions that were continued, revised, or discontinued based on evaluation results.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	

Results for Step VIII

Total Evaluation Elements				
Total Evaluation Elements**	*Met*	*Partially Met*	*Not Met*	*NA*
6	0	0	0	0

Critical Elements				
Critical Elements***	*Met*	*Partially Met*	*Not Met*	*NA*
3	0	0	0	0

* "C" in this column denotes a *critical* evaluation element.
** This is the total number of *all* evaluation elements for this review step.
*** This is the total number of critical evaluation elements for this review step.

Evaluation Elements		Scoring	Comments
Performance Improvement Project/Healthcare Study Evaluation			
IX.	**Assess for Real Improvement: Real improvement or meaningful change in performance is evaluated based on study indicator(s) results.**		
	1. The remeasurement methodology was the same as the baseline methodology.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
	2. The documented improvement meets the State- or plan-specific goal.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
C*	3. There was statistically significant improvement over the baseline across all study indicators.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	

Results for Step IX

Total Evaluation Elements				
Total Evaluation Elements**	*Met*	*Partially Met*	*Not Met*	*NA*
3	0	0	0	0

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

* "C" in this column denotes a *critical* evaluation element.
** This is the total number of *all* evaluation elements for this review step.
*** This is the total number of critical evaluation elements for this review step.

Evaluation Elements		Scoring	Comments
Performance Improvement Project/Healthcare Study Evaluation			
X.	**Assess for Sustained Improvement: Sustained improvement is demonstrated through repeated measurements over comparable time periods.**		
C*	1. Repeated measurements over comparable time periods demonstrated sustained improvement over the baseline.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	

Results for Step X

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

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

* "C" in this column denotes a *critical* evaluation element.
** This is the total number of *all* evaluation elements for this review step.
*** This is the total number of critical evaluation elements for this review step.

Attachment C1. State of Michigan 2017-18 PIP Validation Tool
<PIP Topic>
for <Health Plan Name>

Table B-1—2017-18 PIP Validation Tool Scores for <PIP Topic> for <Health Plan 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(s)	2					1				
II. Define the Study Question(s)	1					1				
III. Define the Study Population	1					1				
IV. Select the Study Indicator(s)	2					1				
V. Use Sound Sampling Techniques	7					2				
VI. Reliably Collect Data	4					2				
VII. Analyze Data and Interpret Study Results	3					1				
VIII. Improvement Strategies	6					3				
IX. Assess for Real Improvement	3					1				
X. Assess for Sustained Improvement	1					1				
Totals for All Steps	**30**					**14**				

Table B-2—2017-18 PIP Validation Tool Overall Score for <PIP Topic> for <Health Plan 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 Not Assessed and Not Applicable scores have been removed from the scoring calculations.

** 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.

EVALUATION OF THE OVERALL VALIDITY AND RELIABILITY OF PIP RESULTS
HSAG assessed the validity and reliability of the results based on CMS validation protocols and determined whether the State and key stakeholders can have confidence in the reported PIP findings. Based on the validation of this PIP, HSAG's assessment determined the following:
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.***
Summary of Aggregate Validation Findings ☐ ***Met*** ☐ ***Partially Met*** ☐ ***Not Met***

Attachment C2. State of Michigan 2017-18 PIP Summary Form
<PIP Topic>
for <Health Plan Name>

Demographic Information	
Plan Name: **<Health Plan Name>**	Type of Delivery System: _____
Project Leader Name: _____	Title: _____
Telephone Number: _____	Email Address: _____
Name of Project: ***<PIP Topic>***	
Submission Date: _____	

Step I: Select the Study Topic. The study topic should be selected based on data that identify an opportunity for improvement. The goal of the project should be to improve processes and outcomes of healthcare. The topic may also be specified by the State.
Study Topic: **Provide plan-specific data:** **Describe how the study topic has the potential to improve consumer health, functional status, or satisfaction:**

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).

Study Question(s):

Step III: Define the 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 healthcare needs.

The study population definition should:

- Include the requirements for the length of enrollment, continuous enrollment, new enrollment, and allowable gap criteria.
- Include the age range and the anchor dates used to identify age criteria, if applicable.
- Include 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 and ethnicity will be identified, if applicable.

Study Population:

Enrollment requirements (if applicable):

Consumer age criteria (if applicable):

Inclusion, exclusion, and diagnosis criteria:

Diagnosis/procedure/pharmacy/billing codes (if applicable):

Step IV: Select the Study Indicator(s). A study indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status 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. Study indicator goals should be specific, measurable, attainable, relevant, and time-bound.

The description of the study Indicator(s) should:

- Include the complete title of the study indicator(s).
- Include a narrative description of the numerator(s) and denominator(s).
- 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.
- Include complete dates for all measurement periods (with the day, month, and year).
- Include plan-specific goals for the remeasurement periods that are specific, measurable, attainable, relevant, and time-bound.
- Include the State-designated goal, if applicable.

Study Indicator 1: [Enter title]	**Provide a narrative description and the rationale for selection of the study indicator. Describe the basis on which the indicator was adopted, if internally developed.**
Numerator Description:	
Denominator Description:	
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	
Remeasurement 1 Period Goal	

Step IV: Select the Study Indicator(s). A study indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status 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. Study indicator goals should be specific, measurable, attainable, relevant, and time-bound.

The description of the study Indicator(s) should:

- Include the complete title of the study indicator(s).
- Include a narrative description of the numerator(s) and denominator(s).
- 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.
- Include complete dates for all measurement periods (with the day, month, and year).
- Include plan-specific goals for the remeasurement periods that are specific, measurable, attainable, relevant, and time-bound.
- Include the State-designated goal, if applicable.

Remeasurement 2 Period (include date range) MM/DD/YYYY to MM/DD/YYYY	
Remeasurement 2 Period Goal	
State-Designated Goal or Benchmark	
Source of Benchmark	
Study Indicator 2: [Enter title]	**Provide a narrative description and the rationale for selection of the study indicator. Describe the basis on which the indicator was adopted, if internally developed.**
Numerator Description:	
Denominator Description:	

Step IV: Select the Study Indicator(s). A study indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status 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. Study indicator goals should be specific, measurable, attainable, relevant, and time-bound. **The description of the study Indicator(s) should:** • Include the complete title of the study indicator(s). • Include a narrative description of the numerator(s) and denominator(s). • 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. • Include complete dates for all measurement periods (with the day, month, and year). • Include plan-specific goals for the remeasurement periods that are specific, measurable, attainable, relevant, and time-bound. • Include the State-designated goal, if applicable.	
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	
Remeasurement 1 Period Goal	
Remeasurement 2 Period (include date range) MM/DD/YYYY to MM/DD/YYYY	
Remeasurement 2 Period Goal	

Step IV: Select the Study Indicator(s). A study indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status 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. Study indicator goals should be specific, measurable, attainable, relevant, and time-bound.

The description of the study Indicator(s) should:

- Include the complete title of the study indicator(s).
- Include a narrative description of the numerator(s) and denominator(s).
- 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.
- Include complete dates for all measurement periods (with the day, month, and year).
- Include plan-specific goals for the remeasurement periods that are specific, measurable, attainable, relevant, and time-bound.
- Include the State-designated goal, if applicable.

State-Designated Goal or Benchmark	
Source of Benchmark	
Study Indicator 3: [Enter title]	**Provide a narrative description and the rationale for selection of the study indicator. Describe the basis on which the indicator was adopted, if internally developed.**
Numerator Description:	
Denominator Description:	
Baseline Measurement Period (include date range) MM/DD/YYYY to MM/DD/YYYY	

Step IV: Select the Study Indicator(s). A study indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status 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. Study indicator goals should be specific, measurable, attainable, relevant, and time-bound.

The description of the study Indicator(s) should:

- Include the complete title of the study indicator(s).
- Include a narrative description of the numerator(s) and denominator(s).
- 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.
- Include complete dates for all measurement periods (with the day, month, and year).
- Include plan-specific goals for the remeasurement periods that are specific, measurable, attainable, relevant, and time-bound.
- Include the State-designated goal, if applicable.

Remeasurement 1 Period (include date range) MM/DD/YYYY to MM/DD/YYYY	
Remeasurement 1 Period Goal	
Remeasurement 2 Period (include date range) MM/DD/YYYY to MM/DD/YYYY	
Remeasurement 2 Period Goal	
State-Designated Goal or Benchmark	
Source of Benchmark	

Step IV: Select the Study Indicator(s). A study indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status 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. Study indicator goals should be specific, measurable, attainable, relevant, and time-bound.

The description of the study Indicator(s) should:

- Include the complete title of the study indicator(s).
- Include a narrative description of the numerator(s) and denominator(s).
- 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.
- Include complete dates for all measurement periods (with the day, month, and year).
- Include plan-specific goals for the remeasurement periods that are specific, measurable, attainable, relevant, and time-bound.
- Include the State-designated goal, if applicable.

Use this area to provide additional information, if necessary.

Step V: Use Sound Sampling Techniques. If sampling is 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.

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 and ensure sampling techniques support generalizable results.

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:

Attachment C2. State of Michigan 2017-18 PIP Summary Form
<PIP Topic>
for <Health Plan Name>

Step VI: Reliably Collect Data. The data collection process must ensure that data collected for the study indicators are valid and reliable.

The 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.
- A copy of the manual data collection tool, if applicable.
- An estimate of the administrative data completeness percentage and the process used to determine this percentage.

Data Sources (Select all that apply)

[ ] Hybrid—Both medical/treatment record review (manual data collection) and administrative data.

[ ] Medical/Treatment Record Abstraction

Record Type

[ ] Outpatient
[ ] Inpatient
[ ] Other

_____

Other Requirements

[ ] Data collection tool attached
[ ] Other data

_____

[ ] 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/ICD-10, CPT codes)_____
[ ] Data completeness assessment attached
[ ] Coding verification 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 _____

Step VI: Determine the Data Collection Cycle.	Determine the Data Analysis Cycle.
[ ] Once a year [ ] Twice a year [ ] Once a season [ ] Once a quarter [ ] Once a month [ ] Once a week [ ] Once a day [ ] Continuous [ ] Other (list and describe):	[ ] Once a year [ ] Once a season [ ] Once a quarter [ ] Once a month [ ] Continuous [ ] Other (list and describe):

Describe the data collection process:

Step VII: Study Indicator Results. Enter the results of the study indicator(s) in the table below. For HEDIS-based PIPs, the data reported in the PIP Summary Form should match the validated performance measure rate(s).

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 *p* 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 *p* Value
MM/DD/YYYY–MM/DD/YYYY	Baseline					
	Remeasurement 1					
	Remeasurement 2					
	Remeasurement 3					

Step VII: Data Analysis and Interpretation of Study Results. Clearly document the results for each of the study indicator(s). Describe the data analysis performed and the results of the statistical analysis, and interpret the results. 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:

- Data presented clearly, accurately, and consistently in both table and narrative format.
- A clear and comprehensive narrative description of the data analysis process, including a comparison of the results to the goal and the type of statistical test completed. Statistical testing *p* value results should be calculated and reported to four decimal places (e.g., 0.0235).
- Discussion of any random, year-to-year variations; population changes; sampling errors; or statistically significant increases or decreases that occurred during the remeasurement process.
- A statement indicating whether or not factors that could threaten (a) the validity of the findings for each measurement period and/or (b) the comparability of measurement periods were identified. If there were no factors identified, this should be documented in Step VII.

Describe the data analysis process and provide an interpretation of the results for each measurement period.

Baseline Measurement:

Baseline to Remeasurement 1:

Baseline to Remeasurement 2:

Baseline to Remeasurement 3:

Baseline to Final Remeasurement:

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.

This step should include the following:

- Processes used to identify barriers/interventions.
- Processes used to prioritize barriers.
- Prioritized list of barriers with corresponding interventions.
- Processes used to evaluate the effectiveness each intervention and the evaluation results.
- For remeasurement periods, how evaluation and analysis results guided continuation, revision, or discontinuation of interventions.

Please describe the process used to identify barriers and develop corresponding interventions. Include the team/committee/group that conducted the causal/barrier analysis and the QI tools used to identify barriers, such as data mining, key driver diagram, fishbone diagram, process-level data, etc. Describe the process used to prioritize the barriers and designate high-priority barriers. Lastly, describe the process used to evaluate the effectiveness of each intervention. The documentation should be dated to identify when steps in the ongoing quality improvement process were initiated and revisited.

Describe the causal/barrier analysis process, quality improvement team consumers, and quality improvement tools:

Describe the processes, tools, and/or data analysis results used to identify and prioritize barriers:

Describe the processes and measures used to evaluate the effectiveness of each intervention:

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Barriers/Interventions Table:

Use the table below to list barriers, corresponding intervention descriptions, intervention type, target population, and implementation date. For each intervention, select if the intervention was (1) new, continued, or revised, and (2) consumer, provider, or system. Update the table as interventions are added, discontinued, or revised.

Date Implemented (MM/YY)	Select if Continued, New, or Revised	Select if Consumer, Provider, or System Intervention	Priority Ranking	Barrier	Intervention That Addresses the Barrier Listed in the Previous Column
	Click to select status	Click to select status			
	Click to select status	Click to select status			
	Click to select status	Click to select status			
	Click to select status	Click to select status			

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- For remeasurement periods, how evaluation and analysis results guided continuation, revision, or discontinuation of interventions.

Report the evaluation results for each intervention and describe the steps taken based on the evaluation results. Was each intervention successful? How were successful interventions continued or implemented on a larger scale? How were less-successful interventions revised or discontinued?

Describe evaluation results for each intervention:

Describe next steps for each intervention based on evaluation results: