Michigan Department of Health and Human Services

State Fiscal Year 2019 Validation of Performance Measures for Region 5—Mid-State Health Network

Behavioral Health and Developmental Disabilities Administration
Prepaid Inpatient Health Plans

October 2019

HSAG HEALTH SERVICES ADVISORY GROUP

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Validation Overview

The Michigan Department of Health and Human Services (MDHHS) oversees and administers the Medicaid program in the state of Michigan. In 2013, MDHHS selected 10 behavioral health managed care organizations (MCOs) to serve as prepaid inpatient health plans (PIHPs). The PIHPs are responsible for managing Medicaid beneficiaries' behavioral healthcare, including authorization of services and monitoring of health outcomes and standards of care. The PIHPs serve members directly or through contracts with providers and community mental health services programs (CMHSPs).

The Centers for Medicare & Medicaid Services (CMS) requires that states, through their contracts with PIHPs, measure and report on performance to assess the quality and appropriateness of care and services provided to members. Validation of performance measures is one of the mandatory external quality review (EQR) activities that the Balanced Budget Act of 1997 (BBA) (as described in the Code of Federal Regulations [CFR], 42 CFR §438.358[b][2]) requires state Medicaid agencies to perform.

The purpose of performance measure validation (PMV) is to assess the accuracy of performance indicators reported by PIHPs and to determine the extent to which performance indicators reported by the PIHPs follow state specifications and reporting requirements. According to CMS' *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 1, 2012,[1] the mandatory PMV activity may be performed by the State Medicaid agency, an agent that is not a PIHP, or an external quality review organization (EQRO).

To meet the PMV requirements, MDHHS contracted with Health Services Advisory Group, Inc. (HSAG), the EQRO for MDHHS, to conduct the PMV for each PIHP. HSAG validated the PIHPs' data collection and reporting processes used to calculate performance indicator rates. MDHHS developed a set of performance indicators that the PIHPs were required to calculate and report.

[1] 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: Mar 25, 2019.

Prepaid Inpatient Health Plan (PIHP) Information

Information about **Mid-State Health Network** appears in Table 1.

Table 1—Mid-State Health Network Information

PIHP Name:	Mid-State Health Network
PIHP Site Visit Location:	530 West Ionia Street Lansing, Michigan 48933
PIHP Contact:	Sandy Gettel, Quality Manager
Contact Telephone Number:	517.220.2422
Contact Email Address:	sandy.gettel@midstatehealthnetwork.org
Site Visit Date:	July 24, 2019

Performance Indicators Validated

HSAG validated a set of performance indicators that were developed and selected by MDHHS for validation. The reporting cycle and measurement period were specified for each indicator by MDHHS. Table 2 lists the performance indicators calculated by the PIHPs for specific populations for the first quarter of SFY 2019, which began October 1, 2018, and ended December 31, 2018. Table 3 lists the performance indicators calculated by MDHHS, each with its specific measurement period. The indicators are numbered as they appear in the MDHHS Codebook.

Table 2—List of Performance Indicators Calculated by PIHPs

Indicator		Sub-Populations	Measurement Period
#1	The percentage of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	• Children • Adults	First Quarter SFY 2019
#2	The percentage of new Medicaid beneficiaries during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service.	• MI-Adults • MI-Children • DD-Adults • DD-Children • Medicaid SA	First Quarter SFY 2019
#3	The percentage of new Medicaid beneficiaries during the quarter starting any needed ongoing service within 14 days of a non-emergent face-to-face assessment with a professional.	• MI-Adults • MI-Children • DD-Adults • DD-Children • SA-Adult	First Quarter SFY 2019
#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	First Quarter SFY 2019
#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	First Quarter SFY 2019
#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.	• MI and DD-Adults • MI and DD-Children	First Quarter SFY 2019

MI = mental illness, DD = developmental disabilities, SA = substance abuse

Table 3—List of Performance Indicators Calculated by MDHHS

Indicator		Sub-Populations	Measurement Period
#5	The percent of Medicaid recipients having received PIHP managed services.	• Medicaid Recipients	First Quarter SFY 2019
#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.	• HSW Enrollees	First Quarter SFY 2019
#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 • DD-Adults • MI and DD Adults	SFY 2018
#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 • DD-Adults • MI and DD Adults	SFY 2018
#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 2018
#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 2018

Description of Validation Activities

Pre-Audit Strategy

HSAG conducted the validation activities as outlined in the CMS Performance Measure Validation Protocol. HSAG obtained a list of the indicators selected by MDHHS for validation. Indicator definitions and reporting templates were provided by MDHHS to HSAG.

In collaboration with MDHHS, HSAG prepared a documentation request letter that was submitted to the PIHPs. This documentation request letter outlined the steps in the PMV process. The documentation request letter included a request for the source code for each performance indicator calculated by the PIHP, a completed Information Systems Capabilities Assessment Tool (ISCAT), any additional supporting documentation necessary to complete the audit, a timeline for completion, and instructions for submission. HSAG also requested that each PIHP and related CMHSPs submit member-level detail files for review.

Following the PIHPs' receipt of the documentation request letter and accompanying documents, HSAG convened a technical assistance webinar with the PIHPs and CMHSPs. During this meeting, HSAG discussed the PMV purpose and objectives, reviewed the performance measures in the scope of the current year's PMV activities, and reviewed the documents provided to the PIHPs with the documentation request letter and PMV activities. Throughout the pre-on-site phase, HSAG also responded to any audit-related questions received directly from the PIHPs.

Upon submission of the requested source code, completed ISCAT, additional supporting documentation, and member-level detail files, HSAG began a desk review of the submitted documents to determine any follow-up questions, potential concerns related to information systems capabilities or measure calculations, and recommendations for improvement based on the PIHPs' and CMHSPs' current processes. HSAG also selected a sample of cases from the member-level detail files and provided the selections to the PIHPs. The PIHPs and/or CMHSPs were required to provide HSAG screen shots from the source system to confirm data accuracy. HSAG communicated any follow-up questions or required clarification to the PIHP during this process.

HSAG prepared an agenda describing all on-site visit activities and indicating the type of staff (by job function and title) required for each session. This included special requests for system reviews for PIHPs and related CMHSPs, especially when multiple systems were used to collect and track measure-related data. The agendas were sent to the respective PIHPs prior to the on-site visit. HSAG also conducted pre-on-site conference calls with the PIHPs to discuss on-site logistics and expectations, important deadlines, and outstanding documentation, as well as to answer any outstanding ISCAT questions.

Validation Team

HSAG's validation team was composed of a lead auditor and several validation team members. HSAG assembled the team based on the skills required for the validation of the PIHPs' performance indicators. Some team members, including the lead auditor, participated in the on-site meetings at the PIHP location; others conducted their work at HSAG offices. Table 4 describes each team member's role and expertise.

Table 4—Validation Team

Name and Role	Skills and Expertise
Mariyah Badani, JD, MBA, CHCA *Lead Auditor; Director, Audits/State & Corporate Services*	Management of audit department; multiple years auditing experience; certified HEDIS compliance auditor; data integration, systems review, and analysis experience.
Tammy GianFrancisco *Secondary Auditor; HEDIS Manager, Audits/State & Corporate Services*	Project management and coordination of audit-related activities.
Erica Poland, BS *Healthcare Quality Auditor, Audits/State & Corporate Services*	Liaison between audit team and clients; manages deliverables and timelines; coordinates review activities.
Ron Holcomb, AS *Source Code Reviewer*	Statistics, analysis, and source code/programming language knowledge.

Technical Methods of Data Collection and Analysis

The CMS PMV Protocol identifies key types of data that should be reviewed as part of the validation process. The list below indicates the type of data collected and how HSAG conducted an analysis of the data:

- **Information Systems Capabilities Assessment Tool (ISCAT) and Mini-ISCAT**—The PIHPs and CMHSPs were required to submit a completed ISCAT that provided information on their information systems; processes used for collecting, storing, and processing data; and processes used for performance measure calculation. Upon receipt by HSAG, the ISCAT(s) and Mini-ISCAT(s) underwent a cursory review to ensure each section was complete and all applicable attachments were present. HSAG then thoroughly reviewed all documentation, noting any potential issues, concerns, and items that needed additional clarification.
- **Source code (programming language) for performance indicators**—PIHPs and CMHSPs 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/CMHSPs that did not use computer programming language to calculate the performance indicators were required to submit documentation describing the actions taken to calculate each indicator.
- **Performance indicator reports**—HSAG also reviewed the PIHP performance indicator reports provided by MDHHS for the first quarter of SFY 2019. Previous year's reports were used along with the current reports to assess trending patterns and rate reasonability.
- **Supporting documentation**—The PIHPs and CMHSPs 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. This additional documentation also included measure-level detail files provided for each indicator for data verification.

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) and Mini-ISCAT(s), HSAG conducted interviews with key PIHP and CMHSP 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.
- **Primary Source Verification (PSV)—**HSAG performed additional validation using PSV to further validate the output files. PSV is a review technique used to confirm that the information from the primary source matches the output information used for reporting. Each PIHP and CMHSP provided HSAG with measure-level detail files which included the data the PIHPs had reported to MDHHS. HSAG selected a random sample from the submitted data, then requested that the PIHPs provide proof-of-service documents or system screen shots that allowed for validation against the source data in the system. During the pre-on-site and on-site review, these data were also reviewed for verification—both live and using screen shots in the PIHPs' systems—which provided the PIHPs an opportunity to explain processes regarding any exception processing or any unique, case-specific nuances that may not impact final indicator reporting. Instances could exist in which a sample case is acceptable based on on-site clarification and follow-up documentation provided by the PIHPs. Using this technique, HSAG assessed the PIHPs' processes used to input, transmit, and track the data; confirm entry; and detect errors. HSAG selected cases across indicators to verify that the PIHPs have system documentation which supports that the indicators appropriately include records for measure reporting. This technique does not rely on a specific number of cases for review to determine compliance; rather, it is used to detect errors from a small number of cases. If errors were detected, the outcome was determined based on the type of error. For example, the review of one case may have been sufficient in detecting a programming language error and, as a result, no additional cases related to that issue may have been reviewed. In other scenarios, one case error detected may have resulted in the selection of additional cases to better examine the extent of the issue and its impact on reporting.
- **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.

HSAG conducted several interviews with key **Mid-State Health Network** staff members who were involved with any aspect of performance indicator reporting. Table 5 displays a list of **Mid-State Health Network** on-site visit participants:

Table 5—List of Mid-State Health Network On-Site Visit Participants

Name	Title
Joanne Holland	Chief Information Officer (CIO), Community Mental Health Authority of Clinton, Eaton, and Ingham Counties
Dmitriy Katsman	Project Management, Peter Chang Enterprises, Inc. (PCE)
Forest Goodrich	CIO, Mid-State Health Network
Shyam Marar	Information Technology (IT) Project Manager, Mid-State Health Network
Kim Zimmerman	Director of Compliance & Quality, Mid-State Health Network
Sandy Gettel	Quality Manager, Mid-State Health Network
Kara Laferty	Chief Quality Officer (CQO), Mid-State Health Network
Jackie Shillinger	Lead, Tuscola Behavioral Health (off-site)
Katherine VanZwoll	Business Analyst Manager, Community Mental Health Authority of Clinton, Eaton, and Ingham Counties
Jason Manley	Business Analyst, Community Mental Health Authority of Clinton, Eaton, and Ingham Counties
Jane Cole	Systems Analyst, Community Mental Health for Central Michigan
Brian McNeill	CIO, Community Mental Health for Central Michigan
Julie McCulloch	Quality Supervisor, Saginaw County Community Mental Health Authority (off-site)
Steve Delong	CIO, Saginaw County Community Mental Health Authority (off-site)
Dave Dunham	System Analyst, Saginaw County Community Mental Health Authority (off-site)
Kim Hall	Administrative Assistance, Care Management, Saginaw County Community Mental Health Authority (off-site)
Laura Argyle	Director, Saginaw County Community Mental Health Authority (off-site)
Holli McGeshick	Quality Project Specialist, Saginaw County Community Mental Health Authority (off-site)
Linda Tilot	Quality Director, Saginaw County Community Mental Health Authority (off-site)

Data Integration, Data Control, and Performance Indicator Documentation

Several aspects involved in the calculation of performance indicators are crucial to the validation process. These include data integration, data control, and documentation of performance indicator calculations. Each of the following sections describes the validation processes used and the validation findings. For more detailed information, please see Appendix A.

Data Integration

Accurate data integration is essential to calculating valid performance indicators. The steps used to combine various data sources, including claims/encounter data, eligibility data, and other administrative data, must be carefully controlled and validated. HSAG validated the data integration process used by the PIHP, which included a review of file consolidations or extracts, a comparison of source data to warehouse files, data integration documentation, source code, production activity logs, and linking mechanisms. Overall, HSAG determined that the data integration processes in place at **Mid-State Health Network** were:

☒ Acceptable

☐ Not acceptable

Data Control

The organizational infrastructure of a PIHP must support all necessary information systems. Each PIHP's quality assurance practices and backup procedures must be sound to ensure timely and accurate processing of data and to provide data protection in the event of a disaster. HSAG reviewed the data control processes used by **Mid-State Health Network**, which included a review of disaster recovery procedures, data backup protocols, and related policies and procedures. Overall, HSAG determined that the data control processes in place at **Mid-State Health Network** were:

☒ Acceptable

☐ Not acceptable

Performance Indicator Documentation

Sufficient and complete documentation is necessary to support validation activities. While interviews and system demonstrations can provide supplementary information, HSAG based most of the validation review findings on documentation provided by the PIHP. HSAG reviewed all related documentation, which included the completed ISCAT, job logs, computer programming code, output files, work flow diagrams, narrative descriptions of performance indicator calculations, and other related documentation. Overall, HSAG determined that the documentation of performance indicator calculations by **Mid-State Health Network** was:

☒ Acceptable

☐ Not acceptable

Validation Results

HSAG evaluated **Mid-State Health Network**'s data systems for the processing of each type of data used for reporting the MDHHS performance indicators. General findings, strengths, and areas for improvement for **Mid-State Health Network** are indicated below.

Eligibility and Enrollment Data System Findings

HSAG had no concerns with how **Mid-State Health Network** received and processed eligibility and enrollment data.

Mid-State Health Network contracted with PCE for eligibility and encounter data processing. The PIHP implemented a new managed care information system, REMI, in February 2018, created by PCE. REMI is used for storing and producing the registry, performance indicator data, Behavioral Health Treatment Episode Data Set (BH-TEDS) data, and encounter data files for submission to MDHHS. PCE obtained the 834-eligibility files from the State daily and hourly, uploaded the files to REMI, and distributed to the 12 CMHSPs hourly. Each CMHSP received its eligibility files via the file transfer protocol (FTP) site. Providers, staff members, and PIHP affiliates performed real-time eligibility verification through the State's website, Community Health Automated Medicaid Processing System (CHAMPS). The 834-eligibility files were matched against the 820-payment files. This process helped to ensure that each member for whom a payment was received had current, matching eligibility data. Each CMHSP used its own validation process as an added quality check, which involved confirming whether a payment was received for a member to verify the accuracy of the enrollment files. In addition, REMI had a built-in 270/271-verification process the CMHSPs could use as an additional form of eligibility verification.

Adequate reconciliation and validation processes were in place to ensure that only accurate and complete eligibility and enrollment information was housed in the data system and communicated to the CMHSPs. **Mid-State Health Network** demonstrated that eligibility effective dates, termination dates, historical eligibility spans, and dual (Medicare-Medicaid) members were identified appropriately.

Medical Services Data System (Claims and Encounters) Findings

HSAG identified no concerns with how **Mid-State Health Network** received and processed claims and encounter data for submission to MDHHS.

The PIHP implemented a new claims processing system, REMI. With the exception of substance use disorder (SUD) data, each CMHSP was responsible for collecting and processing claims and encounter data using REMI. **Mid-State Health Network** processed SUD claims for all CMHSPs. REMI contained multiple validation edits that were applied to each file. After passing the validation, data files were moved to the production area.

Upon passing all validation processes, the data were submitted to the State. The State generated a 999-response file, confirming receipt of each submission. In addition, one week or more following the PIHP's file submission, the PIHP received a 4950-detailed response file, which included an explanation for each file and record rejection that occurred. Each CMHSP had the capability to download and review its response file from **Mid-State Health Network**'s REMI system**.**

The CMHSPs identified all cases based on the description provided in the MDHHS Codebook. Prior to submitting performance indicator data to the PIHP, each CMHSP has multiple validation processes in place, which include trending, outliers, and validation of exceptions. Each quarter, detailed information were submitted to **Mid-State Health Network** in a Microsoft Excel spreadsheet via a secure portal. All data files were placed into a staging table, where several validations were applied to ensure data completeness and accuracy.

For performance metric production, **Mid-State Health Network** used source code in the PCE system for aggregating the CMHSPs' data. 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 the PIHP. The files were reviewed by the PIHP, and any notable issues were reviewed with the CMHSPs. The PIHP implemented source code within the PCE system to use for aggregating the CMHSP data for performance indicator rate reporting. Validated data were then placed into a calculation table to finalize the measure rates for reporting. Due to the multiple validations in place at the CMHSP level as well as the PIHP level, and due to the CMHSPs using the same PCE system, there were rarely issues with the data submitted to the State for reporting.

Behavioral Health Treatment Episode Data Set (BH-TEDS) Data Production

Mid-State Health Network implemented a new managed care information system, REMI, developed by PCE for storing and producing the BH-TEDS data for submission to MDHHS. The PIHP worked with the CMHSPs to include BH-TEDS reporting into its processes and to provide validation regarding BH-TEDS completeness, and improve the quality of BH-TEDS reporting.

The PIHP's REMI system collected BH-TEDS data through direct data entry by the CMHSPs and receipt of properly formatted BH-TEDS files submitted by the CMHSPs. Both processes implemented all of the validations contained in the MDHHS BH-TEDS Coding Manual. All required validations, including data consistency and completeness, were enforced at the point where the data were submitted to the system.

The PIHP submitted validated and clean BH-TEDS files to the State based on the State's requirements. After submission, the PIHP received a 5874D-detailed response file, which included explanations for any file rejections that occurred. These response files were processed and loaded into the PIHP's REMI system. Once loaded, the response files were separated according to CMHSP and distributed to each CMHSP for review and correction. Each CMHSP had the ability to log into REMI and obtain its corresponding response file.

During the on-site review, **Mid-State Health Network** described processes to identify add, change, update, and delete actions to BH-TEDS records. The PIHP described the add process for BH-TEDS as new assessment records that required BH-TEDS information. The PIHP described the submission of BH-TEDS change records as any BH-TEDS related corrections to non-key fields that occurred after the initial assessment was completed by a clinician. The PIHP identified BH-TEDS records for deletion if the clinician identified a data entry error or if incorrect information was entered for a key field in the assessment.

Mid-State Health Network conducted training sessions for the CMHSPs to ensure that staff members and clinicians had a thorough understanding of all veteran-focused questions. The PIHP worked with PCE to ensure that electronic medical records were updated to include the veteran-focused BH-TEDS questions. HSAG identified no concerns with the incorporation of the new, veteran-focused fields into the assessment.

The PIHP and CMHSPs implemented additional data quality and reasonability checks of the BH-TEDS records, beyond the State-specified requirements, before the data were submitted to the State.

PIHP Oversight of Affiliate Community Mental Health Centers

HSAG found that **Mid-State Health Network** had sufficient oversight of its 12 CMHSPs.

Mid-State Health Network continued to demonstrate appropriate oversight processes for all CMHSPs. The PIHP continued to use a standard template document to ensure that the CMHSPs have the same understanding of how to report performance indicators and lessen the error threshold. Consistent communication and monthly committee meetings facilitated the resolution of any issues and provided opportunities to collaborate on solutions. In addition, the PIHP performed a full evaluation for each CMHSP, which included on-site desk audits and chart reviews for compliance with data capture and reporting requirements. A corrective action plan was implemented for any CMHSP that did not meet the required standard for a measure.

PIHP Actions Related to Previous Recommendations and Areas of Improvement

Based on the prior year's recommendations and challenges the PIHP had with its CMHSPs reporting consistently, **Mid-State Health Network** used a new system created by PCE for performance indicator, BH-TEDS, and claims and encounter data processing. All CMHSPs were converted to the new system, which resulted in more consistency with reporting amongst the 12 CMHSPs. In addition, the new system has multiple built-in edit checks at the CMHSP and PIHP levels beyond the State-required edits.

Performance Indicator Specific Findings and Recommendations

Based on all validation activities, HSAG determined results for each performance indicator. The CMS Performance Measure Validation Protocol identifies two possible validation finding designations for performance indicators, which are defined in Table 6. For more detailed information, please see Appendix B.

Table 6—Designation Categories for Performance Indicators

Report (R)	Indicator was compliant with the State's specifications and the rate can be reported.
Not Reported (NR)	This designation is assigned to measures for which: (1) the PIHP rate was materially biased or (2) the PIHP was not required to report.

According to the protocol, the validation designation for each indicator is determined by the magnitude of the errors detected for the audit elements, not by the number of audit elements determined to be not compliant based on the review findings. Consequently, an error for a single audit element may result in a designation of NR because the impact of the error biased the reported performance indicator by more than 5 percentage points. Conversely, it is also possible that several audit element errors may have little impact on the reported rate, and the indicator could be given a designation of R. Audit elements and their scoring designations (i.e., *Met*, *Not Met*, and *Not Applicable [N/A]*) can be found in Appendix A—Data Integration and Control Findings and Appendix B—Denominator and Numerator Validation Findings. Table 7 displays the indicator-specific review findings and designations for **Mid-State Health Network**.

Table 7—Indicator-Specific Review Findings and Designations for Mid-State Health Network

Performance Indicator		Key Review Findings	Indicator Designation
#1	The percentage of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	The PIHP/CMHSPs calculated this indicator in compliance with MDHHS Codebook specifications.	R
#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.	The PIHP/CMHSPs calculated this indicator in compliance with MDHHS Codebook specifications.	R
#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.	The PIHP/CMHSPs calculated this indicator in compliance with MDHHS Codebook specifications.	R

Performance Indicator		Key Review Findings	Indicator Designation
#4a	The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.	The PIHP/CMHSPs calculated this indicator in compliance with MDHHS Codebook specifications.	R
#4b	The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.	The PIHP/CMHSPs calculated this indicator in compliance with MDHHS Codebook specifications.	R
#5	The percent of Medicaid recipients having received PIHP managed services.	MDHHS calculated this indicator in compliance with MDHHS Codebook specifications.	R
#6	The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	MDHHS calculated this indicator in compliance with MDHHS Codebook specifications.	R
#8	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who are employed competitively.	MDHHS calculated this indicator in compliance with MDHHS Codebook specifications.	R
#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.	MDHHS calculated this indicator in compliance with MDHHS Codebook specifications.	R
#10	The percentage of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.	The PIHP/CMHSPs calculated this indicator in compliance with MDHHS Codebook specifications.	R
#13	The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	MDHHS calculated this indicator in compliance with MDHHS Codebook specifications.	R
#14	The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	MDHHS calculated this indicator in compliance with MDHHS Codebook specifications.	R

Appendix A. Data Integration and Control Findings

Documentation Worksheet

PIHP Name:	Mid-State Health Network
On-Site Visit Date:	July 24, 2019
Reviewers:	Mariyah Badani and Tammy GianFrancisco

Data Integration and Control Element	Met	Not Met	N/A	Comments
Accuracy of data transfers to assigned performance indicator data repository				
The PIHP accurately and completely processes transfer data from the transaction files (e.g., membership, provider, encounter/claims) into the performance indicator data repository used to keep the data until the calculations of the performance indicators have been completed and validated.	☒	☐	☐	
Samples of data from performance indicator data repository are complete and accurate.	☒	☐	☐	
Accuracy of file consolidations, extracts, and derivations				
The PIHP's processes to consolidate diversified files and to extract required information from the performance indicator data repository are appropriate.	☒	☐	☐	
Actual results of file consolidations or extracts are consistent with those that should have resulted according to documented algorithms or specifications.	☒	☐	☐	
Procedures for coordinating the activities of multiple subcontractors ensure the accurate, timely, and complete integration of data into the performance indicator database.	☒	☐	☐	
Computer program reports or documentation reflect vendor coordination activities, and no data necessary for performance indicator reporting are lost or inappropriately modified during transfer.	☒	☐	☐	
If the PIHP uses a performance indicator data repository, its structure and format facilitates any required programming necessary to calculate and report required performance indicators.				
The performance indicator data repository's design, program flow charts, and source code enables analyses and reports.	☒	☐	☐	
Proper linkage mechanisms are employed to join data from all necessary sources (e.g., identifying a member with a given disease/condition).	☒	☐	☐	

Data Integration and Control Element	Met	Not Met	N/A	Comments
Assurance of effective management of report production and of the reporting software.				
Documentation governing the production process, including PIHP production activity logs and the PIHP staff review of report runs, is adequate.	☒	☐	☐	
Prescribed data cutoff dates are followed.	☒	☐	☐	
The PIHP retains copies of files or databases used for performance indicator reporting in case results need to be reproduced.	☒	☐	☐	
The reporting software program is properly documented with respect to every aspect of the performance indicator data repository, including building, maintaining, managing, testing, and report production.	☒	☐	☐	
The PIHP's processes and documentation comply with the PIHP standards associated with reporting program specifications, code review, and testing.	☒	☐	☐	

Appendix B. Denominator and Numerator Validation Findings

Reviewer Worksheet

PIHP Name:	Mid-State Health Network
On-Site Visit Date:	July 24, 2019
Reviewers:	Mariyah Badani and Tammy GianFrancisco

Denominator Validation Findings for Mid-State Health Network				
Audit Element	**Met**	**Not Met**	**N/A**	**Comments**
For each of the performance indicators, all members of the relevant populations identified in the specifications are included in the population from which the denominator is produced.	☒	☐	☐	
Adequate programming logic or source code exists to appropriately identify all relevant members of the specified denominator population for each of the performance indicators.	☒	☐	☐	
The PIHP correctly calculates member months and member years if applicable to the performance indicator.	☐	☐	☒	Member month and member year calculations were not applicable to the indicators under the scope of the audit.
The PIHP properly evaluates the completeness and accuracy of any codes used to identify medical events, such as diagnoses, procedures, or prescriptions, and these codes are appropriately identified and applied as specified in each performance indicator.	☒	☐	☐	
If any time parameters are required by the specifications for the performance indicator, they are followed (e.g., cutoff dates for data collection, counting 30 calendar days after discharge from a hospital, etc.).	☒	☐	☐	
Exclusion criteria included in the performance indicator specifications are followed.	☒	☐	☐	
Systems or methods used by the PIHP to estimate populations when they cannot be accurately or completely counted (e.g., newborns) are valid.	☐	☐	☒	Population estimates were not applicable to the indicators under the scope of the audit.

Numerator Validation Findings for Mid-State Health Network				
Audit Element	**Met**	**Not Met**	**N/A**	**Comments**
The PIHP uses the appropriate data, including linked data from separate data sets, to identify the entire at-risk population.	☒	☐	☐	
Qualifying medical events (such as diagnoses, procedures, prescriptions, etc.) are properly identified and confirmed for inclusion in terms of time and services.	☒	☐	☐	
The PIHP avoids or eliminates all double-counted members or numerator events.	☒	☐	☐	
Any nonstandard codes used in determining the numerator are mapped to a standard coding scheme in a manner that is consistent, complete, and reproducible, as evidenced by a review of the programming logic or a demonstration of the program.	☐	☐	☒	No nonstandard codes were used.
If any time parameters are required by the specifications for the performance indicator, they are followed (i.e., the indicator event occurred during the period specified or defined in the specifications).	☒	☐	☐	

Appendix C. Performance Measure Results

Indicator #1

The percentage of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. *Standard=95%*

Table C-1—Indicator #1: Access—Timeliness/Inpatient Screening for Mid-State Health Network

1. Population	2. # of Emergency Referrals for Inpatient Screening During the Time Period	3. # of Dispositions About Emergency Referrals Completed Within Three Hours or Less	4. % of Emergency Referrals Completed Within the Time Standard
Children	**760**	**748**	**98.42%**
Adults	**2,650**	**2,609**	**98.45%**

Indicator #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. *Standard=95%*

Table C-2—Indicator #2: Access—Timeliness/First Request for Mid-State Health Network

1. Population	2. # of New Persons Receiving an Initial Non-Emergent Professional Assessment Following a First Request	3. # of New Persons From Col 2 Who Are Exceptions	4. Net # of New Persons Receiving an Initial Assessment (Col 2 Minus Col 3)	5. # of Persons From Col 4 Receiving an Initial Assessment Within 14 Calendar Days of First Request	6. % of Persons Receiving an Initial Assessment Within 14 Calendar Days of First Request
MI—Children	**1,273**	**133**	**1,140**	**1,119**	**98.16%**
MI—Adults	**1,760**	**189**	**1,571**	**1,548**	**98.54%**
DD—Children	**114**	**13**	**101**	**100**	**99.01%**
DD—Adults	**92**	**13**	**79**	**79**	**100.00%**
Medicaid SA	**1,731**	**57**	**1,674**	**1,643**	**98.15%**
TOTAL	**4,970**	**405**	**4,565**	**4,489**	**98.34%**

Indicator #3

The percentage of new Medicaid beneficiaries during the quarter starting any needed ongoing service within 14 days of a non-emergent face-to-face assessment with a professional. *Standard=95% within 14 days*

Table C-3—Indicator #3: Access—Timeliness/First Service for Mid-State Health Network

1. Population	2. # of New Persons Who Started Face-to-Face Service During the Period	3. # of New Persons From Col 2 Who Are Exceptions	4. Net # of Persons Who Started Service (Col 2 Minus Col 3)	5. # of Persons From Col 4 Who Started a Face-to-Face Service Within 14 Days of a Face-to-Face Assessment With a Professional	6. % of Persons Who Started Service Within 14 Days of Assessment
MI—Children	1,072	239	833	805	96.64%
MI—Adults	1,495	283	1,212	1,193	98.43%
DD—Children	105	29	76	69	90.79%
DD—Adults	81	20	61	59	96.72%
Medicaid SA	1,500	60	1,440	1,410	97.92%
TOTAL	4,253	631	3,622	3,536	97.63%

Indicator #4a

The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days. *Standard=95%*

Table C-4—Indicator #4a: Access—Continuity of Care for Mid-State Health Network

1. Population	2. # of Discharges From a Psychiatric Inpatient Unit	3. # of Discharges From Col 2 That Are Exceptions	4. # of Net Discharges (Col 2 Minus Col 3)	5. # of Discharges From Col 4 Followed Up by PIHP Within 7 Days	6. % of Persons Discharged Seen Within 7 Days
Children	214	58	156	153	98.08%
Adults	974	372	602	569	94.52%

Indicator #4b

The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days. *Standard=95%*

Table C-5—Indicator #4b: Access—Continuity of Care for Mid-State Health Network

1. Population	2. # of Discharges From a Substance Abuse Detox Unit	3. # of Discharges From Col 2 That Are Exceptions	4. # of Net Discharges (Col 2 Minus Col 3)	5. # of Discharges From Col 4 Followed Up by CMHSP/PIHP Within 7 Days	6. % of Persons Discharged Seen Within 7 Days
Consumers	**345**	**209**	**136**	**130**	**95.59%**

Indicator #5

The percent of Medicaid recipients having received PIHP managed services.

Table C-6—Indicator #5: Access—Penetration Rate for Mid-State Health Network

Total Medicaid Beneficiaries Served	# of Area Medicaid Recipients	Penetration Rate
33,074	**393,234**	**8.41%**

Indicator #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.

Table C-7—Indicator #6: Adequacy/Appropriateness—Habilitation Supports Waiver for Mid-State Health Network

Population	Total # of HSW Enrollees	# of HSW Enrollees Receiving at Least One HSW Service Other Than Supports Coordination	HSW Rate
HSW Enrollees	**1,606**	**1,563**	**97.32%**

Indicator #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.

Table C-8—Indicator #8: Outcomes—Competitive Employment for Mid-State Health Network

Population	Total # of Enrollees	# of Enrollees Who Are Competitively Employed	Competitive Employment Rate
MI—Adults	20,176	3,617	17.93%
DD—Adults	3,501	331	9.45%
MI and DD—Adults	2,601	225	8.65%

Indicator #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.

Table C-9—Indicator #9: Outcomes—Minimum Wage for Mid-State Health Network

Population	Total # of Enrollees	# of Enrollees Who Earn Minimum Wage or More	Minimum Wage Rate
MI—Adults	3,637	3,356	92.27%
DD—Adults	791	352	44.50%
MI and DD—Adults	519	209	40.27%

Indicator #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. *Standard=15% or less*

Table C-10—Indicator #10: Outcomes—Inpatient Readmissions for Mid-State Health Network

1. Population	2. # of Discharges From a Psychiatric Inpatient Care During the Reporting Period	3. # of Discharges From Col 2 That Are Exceptions	4. Net # of Discharges (Col 2 Minus Col 3)	5. # of Discharges (From Col 4) Readmitted to Inpatient Care Within 30 Days of Discharge	6. % of Discharges Readmitted to Inpatient Care Within 30 Days of Discharge
MI and DD—Children	216	1	215	21	9.77%
MI and DD—Adults	983	17	966	103	10.66%

Indicator #13

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

Table C-11—Indicator #13: Outcomes—Private Residence for Mid-State Health Network

Population	Total # of Enrollees	# of Enrollees Who Live in a Private Residence Alone, With Spouse, or Non-Relative(s)	Private Residence Rate
DD—Adults	3,501	668	19.08%

Indicator #14

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

Table C-12—Indicator #14: Outcomes—Private Residence-MI for Mid-State Health Network

Population	Total # of Enrollees	# of Enrollees Who Live in a Private Residence Alone, With Spouse, or Non-Relative(s)	Private Residence Rate
MI—Adults	20,176	10,458	51.83%

Behavioral Health Treatment Episode Data Set (BH-TEDS) Data Elements

The BH-TEDS data elements in Michigan PIHP performance indicator reporting are displayed in Table C-13. The table depicts the level of completion of specific data elements within the BH-TEDS data file that the PIHP submitted to MDHHS. Shown are the percent complete and the indicators for which the data elements were used. Data in the "Percent Complete" column were provided by MDHHS.

Table C-13—BH-TEDS Data Elements in Performance Indicator Reporting for Mid-State Health Network

BH-TEDS Data Element	Percent Complete SFY 2018	Percent Complete Q1 SFY 2019	Quarterly and Annual Indicators Impacted
Age*	**100.00%**	**100.00%**	**1, 2, 3, 4, 8, 9, 10, 13, 14**
Disability Designation*	**92.92%**	**88.42%**	**2, 3, 8, 9, 10, 13, 14**
Employment Status*	**96.45%**	**91.31%**	**8, 9**
Minimum Wage*	**100.00%**	**100.00%**	**9**

* Based on the PIHP/MDHHS contract, 90 percent of records must contain a value in this field, and the value must be within acceptable ranges. Values found to be outside of acceptable ranges have been highlighted in yellow.