

**Michigan Department of Health and
Human Services**

**State Fiscal Year 2026
Validation of Performance Measures
for Region 5—Mid-State Health
Network**

Prepaid Inpatient Health Plans

September 2026



Table of Contents

Validation of Performance Measures.....	1
Validation Overview	1
Prepaid Inpatient Health Plan (PIHP) Information	2
Performance Indicator Validated.....	2
Description of Validation Activities.....	3
Pre-Audit Strategy	3
Validation Team	4
Technical Methods of Data Collection and Analysis	5
PMV Activities.....	5
Data Integration, Data Control, and Performance Indicator Documentation	8
Data Integration	8
Data Control	8
Performance Indicator Documentation	8
Validation Results	9
Eligibility and Enrollment Data System Findings.....	9
Medical Services Data System (Claims and Encounters) Findings	10
PIHP Oversight of Affiliate Community Mental Health Centers	11
Data Integration Findings.....	12
PIHP Actions Related to Previous Recommendations and Areas of Improvement.....	12
Performance Indicator Specific Findings and Recommendations	15
Strengths, Opportunities for Improvement, and Recommendations	16
Appendix A. Data Integration and Control Findings.....	A-1
Appendix B. Denominator and Numerator Validation Findings	B-1
Appendix C. Performance Measure Results	C-1

Validation of Performance Measures

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 Title 42 of the Code of Federal Regulations (42 CFR) §438.350(a) requires states that contract with MCOs to perform.

The purpose of performance measure validation (PMV) is to assess the accuracy of the performance indicator reported by the PIHPs and to determine the extent to which the performance indicator reported by the PIHPs follows state specifications and reporting requirements. According to the CMS EQR *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity, February 2023*¹ and 42 CFR §438.358(a), 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 selected a performance indicator that the PIHPs were required to calculate and report.²

¹ Department of Health and Human Services. Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity, February 2023*. Available at: <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf>. Accessed on: July 27, 2026.

² Please note, for SFY 2026, additional performance measures were included in the PMV activity; however, MDHHS calculated and reported these measures using encounter data submitted by the PIHPs. Therefore, the results for the MDHHS-calculated performance measures are presented in the MDHHS PMV report.

Prepaid Inpatient Health Plan (PIHP) Information

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

Table 1—MSHN Information

PIHP Name:	Mid-State Health Network
PIHP Location:	530 West Ionia Street, Lansing, MI 48933
PIHP Contact:	Compliance Administrator, MSHN
PMV Virtual Review Date:	July 7, 2026

Performance Indicator Validated

HSAG validated one performance indicator that was developed and selected by MDHHS for validation. The reporting cycle and measurement period were specified by MDHHS. Table 2 lists the performance indicator calculated by the PIHPs for specific populations for the first quarter (Q1) of state fiscal year (SFY) 2026, which began October 1, 2025, and ended December 31, 2025. The indicator is numbered as it appears in the MDHHS Codebook.

Table 2—Performance Indicator Calculated by PIHPs

Indicator		Sub-Populations	Measurement Period
#2	The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service.	- MI–Adults - MI–Children - I/DD–Adults - I/DD–Children	Q1 SFY 2026

MI = Mental Illness, I/DD = Intellectual and Developmental Disabilities

Description of Validation Activities

Pre-Audit Strategy

HSAG conducted the validation activities as outlined in the CMS EQR Protocol 2. HSAG obtained the indicator selected by MDHHS for validation. The indicator definition and reporting template 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 the 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 submit a member-level detail file for review.

Following the PIHPs' receipt of the documentation request letter and accompanying documents, HSAG convened a technical assistance webinar with the PIHPs. During this meeting, HSAG discussed the PMV purpose and objectives, reviewed the performance indicator 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-virtual review 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 file, 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 file and provided the selections to the PIHPs. The PIHPs were required to provide HSAG screenshots 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 PMV 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 PMV being conducted virtually.

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 indicator. Table 3 describes each team member’s role and expertise.

Table 3—Validation Team

Name, Title, and Role	Skills and Expertise
LaKeshau McBride, MSHA <i>Auditor I, Audits;</i> <i>Lead Auditor</i>	Multiple years of experience in quality health care industry and managed care organizations; exposure to various types of audits, such as Healthcare Effectiveness Data and Information Set (HEDIS®) ³ Compliance Audits™. ⁴
Jacilyn Gatete, MS, CHCA <i>Manager III, Audits;</i> <i>PIHP PMV Project Lead</i>	Multiple years of experience conducting audits, including HEDIS Compliance Audits related to performance measurement, electronic health records (EHRs), medical billing, data integration and validation, and care management.
Naomi Abraha, MPH <i>Senior Audits Coordinator, Audits;</i> <i>Source Code Liaison</i>	Audit support team member; assists with PMV, including implementation, project coordination, analysis, and reporting.
Sarah Lemley <i>Source Code Reviewer</i>	Multiple years of experience in statistics, analysis, and source code/programming language knowledge.

³ HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

⁴ HEDIS Compliance Audit™ is a trademark of NCQA.

Technical Methods of Data Collection and Analysis

The CMS EQR Protocol 2 identifies key data types 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)**—The PIHPs were required to submit a completed ISCAT that provided information on the PIHPs' and CMHSPs' information systems (as applicable); processes used for collecting, storing, and processing data; and processes used for performance measure calculation. Upon receipt by HSAG, the 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 the performance indicator**—PIHPs that calculated the performance indicator using computer programming language were required to submit source code for the performance indicator being validated. HSAG completed a line-by-line review of 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 on the indicator and assessing the degree of bias (if any). PIHPs that did not use computer programming language to calculate the performance indicator were required to submit documentation describing the actions taken to calculate the indicator.
- **Performance indicator reports**—HSAG also reviewed the PIHPs' SFY 2025 performance indicator reports. The 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.

PMV Activities

HSAG conducted PMV virtually with each PIHP. HSAG collected information using several methods including interviews, system demonstrations, review of data output files, primary source verification (PSV), observation of data processing, and review of data reports. The virtual review activities are described as follows:

- **Opening session**—The opening session included introductions of the validation team and key PIHP staff members involved in the PMV 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 indicator, 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 and CMHSP staff members familiar with the processing, monitoring, and calculation of the performance indicator. 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 indicator was generated. HSAG performed PSV 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.
- **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 provided HSAG with a measure-level detail file 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 screenshots that allowed for validation against the source data in the system. During the pre-PMV and virtual review, these data were also reviewed for verification, both live and using screenshots in the PIHPs' systems, which provided the PIHPs with an opportunity to explain processes regarding any exception processing or any unique, case-specific nuances that may or may not impact final indicator reporting. Instances could exist in which a sample case is acceptable based on clarification during the virtual review 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 from the indicator to verify that the PIHPs' system documentation supported appropriate inclusion 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 virtual meeting and reviewed the documentation requirements for any post-virtual review activities.

HSAG conducted several interviews with key **MSHN** staff members who were involved with any aspect of performance indicator reporting. Table 4 displays a list of **MSHN** virtual review participants.

Table 4—List of MSHN Virtual Review Participants

Position/Title	Department
Deputy Director	Administration/Leadership
Chief Compliance and Quality Officer	Compliance and Quality
Chief Financial Officer	Finance
Chief Information Officer	Information Technology
Quality Manager	Compliance and Quality
Technology Project Manager	Information Technology
Compliance Administrator	Compliance and Quality
Senior Systems Analyst	Peter Chang Enterprises, Inc. (PCE)

Data Integration, Data Control, and Performance Indicator Documentation

Several aspects involved in the calculation of the performance indicator 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 regarding the specific data integration and control elements assessed by HSAG, 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 **MSHN** 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 **MSHN**, 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 **MSHN** 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, workflow diagrams, narrative descriptions of performance indicator calculations, and other related documentation. Overall, HSAG determined that the documentation of performance indicator calculations by **MSHN** was:

- ☒ Acceptable
☐ Not acceptable

Validation Results

HSAG evaluated **MSHN**'s data systems for the processing of each data type used for reporting the MDHHS performance indicator. General findings, strengths, and areas for improvement for **MSHN** are indicated below.

Eligibility and Enrollment Data System Findings

HSAG evaluated the information systems and processes used by **MSHN** to capture enrollment data for members to confirm that the system was capable of collecting data on member characteristics as specified by MDHHS. HSAG's evaluation of **MSHN**'s enrollment system included the following findings:

- No major eligibility and enrollment system or process changes were noted for the measurement period. **MSHN** contracted with PCE for eligibility and encounter data processing within the PIHP's comprehensive electronic medical record (EMR) system, the Regional Electronic Medical Information (REMI) system. REMI was used for storing and producing the registry, performance indicator data, and encounter data files for submission to MDHHS.
- PCE retrieved the Electronic Data Interchange (EDI) 834 eligibility files from the State daily, uploaded the files to REMI, separated the eligibility and enrollment data by county, and distributed the data to the 12 CMHSPs. These daily 834 files were processed and sent to the CMHSPs as soon as they were separated by county.
- All 12 affiliated CMHSPs, with the exception of Community Mental Health Authority of Clinton, Eaton, and Ingham Counties (CMHA-CEI), used EMRs supported by PCE. All CMHSPs received their eligibility extract files directly into their EMR systems. **MSHN** reported that it used information obtained from a combination of EDI 270/271 Eligibility and Benefit Inquiry and Response files and 834 eligibility files as the source of truth for member eligibility.
- **MSHN**'s eligibility process incorporated standard pre- and post-processing edits to ensure the accuracy and completeness of incoming and outgoing files. Additionally, **MSHN** validated the EDI 834 eligibility files against the EDI 820 Payment Order and Remittance Advice files to ensure that each member for whom a payment was received had current, matching eligibility data.
- To support ongoing validation and verification of eligibility data, REMI included a series of monitoring reports to track eligibility trends. Moreover, control segment files helped **MSHN** determine whether all information was ingested correctly for the eligibility files or if any data were missed during the process.
- 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. Providers, staff members, and PIHP affiliates performed real-time eligibility verification through the State's web-based system, Community Health Automated Medicaid Processing System (CHAMPS).

- **MSHN** also convened councils in information technology, the Quality Improvement Council (QIC), and finance departments for monitoring. These councils' goals included review and resolution of reconciliation issues.
- 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.

MSHN demonstrated that eligibility effective dates, termination dates, historical eligibility spans, and members were identified appropriately.

HSAG identified no concerns with **MSHN**'s enrollment data capture, data processing, data integration, data storage, or data reporting.

Medical Services Data System (Claims and Encounters) Findings

HSAG evaluated the information systems and processes used by **MSHN** to capture claims/encounter data. HSAG's evaluation of **MSHN**'s claims system included the following findings:

- **MSHN** continued to delegate all claims processing, except SUD data processing, to its contracted CMHSPs. **MSHN**'s Access Department provided screening and access for SUD residential, withdrawal management, and recovery.
- Each CMHSP was responsible for collecting and processing claims and, subsequently, submitting encounter data using **MSHN**'s REMI system. The CMHSPs were required to submit EDI 837 professional and institutional encounters to **MSHN** each month for review, validation, and processing; however, some CMHSPs' submissions were more frequent (i.e., weekly) to support timely resolution of any issues. If errors were detected, each CMHSP had the ability to retrieve its error file for review and correction.
- Data files received from the CMHSPs were loaded into REMI via an automated process. REMI contained validation edits and processes that allowed **MSHN** and its CMHSPs to assess the accuracy of data at major transmission points (i.e., to **MSHN**, to REMI, and to MDHHS). Only after passing key validation stages were data files imported into production systems. The PIHP continued to perform a validation process on each encounter to ensure that all submitted files met the 837 file format requirements.
- Upon passing all validation processes, the data were submitted to the State weekly. The State generated a 999 response file that confirmed 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 was also provided with its response file for review.
- Performance indicator data were captured and submitted by each CMHSP quarterly. **MSHN** and the CMHSPs maintained comprehensive technical specifications that translated MDHHS Codebook requirements into CMHSP-specific system requirements. **MSHN** ensured consistency in the application and interpretation of performance indicators across its partners through the QIC, which

met regularly to review reporting requirements; address PIHP/CMHSP performance; and implement corrective actions, where appropriate. Additionally, **MSHN** maintained a Frequently Asked Questions (FAQ) document that contained all decisions and clarifications discussed by the QIC or received from MDHHS.

- Prior to submitting performance indicator data to the PIHP, each CMHSP had multiple validation processes in place, which included trending, outliers, and validation of exceptions. Each quarter, detailed information was submitted to **MSHN**. All data files were placed into a staging table, where several validations were applied to ensure data completeness and accuracy.
- To exclude members receiving Certified Community Behavioral Health Clinic (CCBHC)-only services from indicator #2, **MSHN** developed an encounter validation process that reported when individuals had any PIHP encounters in the Michigan Mission-Based Performance Indicator System (MMBPIS) reporting period. The CMHSPs crosschecked the information against their systems and removed any CCBHC-only individuals.
- For performance metric production, **MSHN** used the 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, or 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 for review.
- The PIHP reviewed any notable issues with the CMHSPs. Validated data were placed into a calculation table to finalize the indicator rates for reporting. During this process, duplicate records across the CMHSPs were identified and eliminated from the file. Due to multiple validations in place at both the CMHSP and PIHP levels, and due to the CMHSPs using the same PCE system, issues were rarely identified with the data submitted to the State for reporting.

HSAG had no concerns with how **MSHN** received and processed claims/encounter data for submission to MDHHS.

PIHP Oversight of Affiliate Community Mental Health Centers

HSAG found that **MSHN** had sufficient oversight of its 12 affiliated CMHSPs.

- **MSHN** 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 QIC meetings were held to facilitate the resolution of any issues and provided opportunities to discuss barriers and collaborate on solutions and interventions.
- Best practices and tools were also shared regionally to support systemic improvement. In addition, the PIHP performed a full evaluation for each CMHSP, which included on-site desk audits and chart reviews of 15–20 cases per CMHSP each quarter to ensure compliance with data capture and reporting requirements.

Data Integration Findings

HSAG evaluated **MSHN**'s processes for data integration, analytic file creation for performance indicator reporting, and rate production. HSAG's evaluation of **MSHN**'s data integration and rate calculation included the following findings:

- Performance indicator data were extracted and converted into a quarterly Michigan's Mission-Based Performance Indicator System (MMBPIS) reporting template, which was then submitted electronically to the PIHP.
- **MSHN** received performance indicator results quarterly from the CMHSPs.
- Completed CMHSP performance indicator data templates were reviewed for accuracy and compared to **MSHN** encounter reports to verify PIHP services provided.
- Discrepancies were shared with each respective CMHSP for review.
- **MSHN** employed several pre-submission validation checks as well as data comparison and quality checks on the data collected from the CMHSPs.
- The MMBPIS reporting template automatically calculated outcomes for the performance indicator.
- **MSHN**'s data exchange engine validated the data and collated the data into a set of databases prior to submission to MDHHS.
- **MSHN** compared accepted encounters to the data aggregated into the quarterly reporting template to ensure data accuracy.
- **MSHN** compiled all CMHSP performance indicator data into a singular MMBPIS template and data analysts compared the data to received encounters as a final validation.

HSAG identified no concerns with **MSHN**'s data integration, performance indicator calculation, and reporting processes.

PIHP Actions Related to Previous Recommendations and Areas of Improvement

During the SFY 2025 audit, HSAG identified the following:

- Cases were identified in indicators #1, #2, #3, and #4a for CMHA-CEI that were indicated as not being a Medicaid beneficiary for at least one month during the reporting period. HSAG recommended that MSHN and CMHA-CEI proceed with the outlined remediation plan. Additionally, HSAG recommended that CMHA-CEI increase its sample size for cases reviewed each quarter for these performance indicators to improve the accuracy of the reported data and ensure alignment with the reporting requirements. Testing should also be completed by MSHN once the warning error is programmed in REMI to ensure that it is appropriately being applied and capturing non-Medicaid individuals as expected. During the SFY 2026 audit, HSAG followed up on the recommendations, and MSHN indicated that it had incorporated the improvement efforts outlined by HSAG by implementing a warning error in REMI and ensuring up-to-date eligibility for reporting periods.

- Three cases were identified in indicator #4b for MSHN that were reported as compliant, but with a follow-up care date that was outside of the required seven-day time frame for compliance. Although MSHN confirmed that this was an isolated issue, HSAG recommended that MSHN perform increased spot checks prior to submitting data to HSAG, such as applying formulas to check member-level data for the appropriate categorization of cases and alignment with the reporting requirements or reviewing cases that have been overridden or corrected for accuracy. Additionally, HSAG recommended that MSHN continue to work on further enhancing existing processes, when necessary, to improve the accuracy of indicator #4b data. MSHN identified this as a user oversight issue; therefore, an MMBPIS submission checklist was implemented to assist in the process that was used for the remainder of SFY 2025 in the submission of indicator #4b data to ensure accurate categorization of MMBPIS indicators. The checklist was implemented and utilized for both the Q3 SFY 2025 submission on September 19, 2025, and the Q4 SFY 2025 submission in December 2025. As of the Q1 SFY 2026 MMBPIS submission, the checklist is no longer necessary due to the discontinuation of indicator #4b per MDHHS guidance and requirements.
- One case was identified in indicator #1 for Bay-Arenac that did not have the correct pre-admission screening request time and disposition time captured in the member-level detail file. Although MSHN confirmed that this was an isolated issue, HSAG recommended that MSHN perform increased spot checks on Bay-Arenac's indicator #1 reported data prior to submitting to HSAG. This process should include performing PSV on a statistically significant sample of cases each quarter to ensure that the cases meet reporting requirements and that the appropriate times are captured. Additionally, HSAG recommended that MSHN continue to work with the CMHSP to enhance existing or implement additional processes, when necessary, to improve the accuracy of indicator #1 data. Continued training or retraining with staff should be provided if found necessary. Bay-Arenac leadership provided targeted education to staff on the correct process for entering the disposition and screening times and emphasized the need for timely review of documentation prior to reporting. The targeted education ensured accurate capturing of time frames. The training was completed in August 2025.
- One case was identified in indicator #4a for CMHA-CEI that did not have the correct follow-up service date reported in the member-level detail file and was incorrectly categorized as compliant. HSAG recommended that MSHN and CMHA-CEI proceed with the outlined remediation plan. Additionally, HSAG recommended that CMHA-CEI increase its sample size for cases reviewed each quarter for this performance indicator to improve the accuracy of the reported data and ensure alignment with the reporting requirements. CMHA-CEI completed a remediation plan that was provided to and approved by MSHN on September 10, 2025, to ensure that this issue is addressed, ongoing validation is occurring prior to submission of MMBPIS indicators to REMI, and updated logic is working accurately. The corrective action plan (CAP) was completed for both the Q3 SFY 2025 submission (MSHN validation occurred in September 2025) and the Q4 SFY 2025 submission (MSHN validation occurred in December 2025). As of the Q1 SFY 2026 MMBPIS submission, this CAP is no longer necessary due to the discontinuation of indicator #4a per MDHHS guidance and requirements.
- One case was identified in indicator #1 for Lifeways that did not have the correct pre-admission screening disposition time captured in the member-level detail file. Although MSHN confirmed that this was an isolated issue, HSAG recommended that MSHN perform increased spot checks on

Lifeway's indicator #1 reported data prior to submitting to HSAG. This process should include performing PSV on a statistically significant sample of cases each quarter to ensure that the cases meet reporting requirements and that the appropriate times are captured. Additionally, HSAG recommended that **MSHN** continue to work with the CMHSP to enhance existing or implement additional processes, when necessary, to improve the accuracy of indicator #1 data. Continued training or retraining with staff should be provided if found necessary. During the SFY 2026 audit, HSAG followed up on the recommendations, and **MSHN** indicated that it had incorporated the improvement efforts outlined by HSAG by providing training to the clinician and including guidance in its CMHSP provider newsletter.

- **MSHN**'s indicator #2 total rate fell below the 75th percentile benchmark. HSAG recommended that **MSHN** continue with its improvement efforts related to indicator #2 to ensure that it meets or exceeds the 75th percentile benchmark and further ensures timely and accessible treatment and support for individuals. During the SFY 2026 audit, HSAG followed up on the recommendations, and **MSHN** indicated that it had reviewed data analysis summaries and improvement efforts with the QIC on a quarterly basis. These discussions included identifying barriers to meeting the benchmark standards for each CMHSP that was below the benchmark and highlighting local and regional improvement efforts that took place to increase compliance with this indicator. As of Q4 SFY 2025, **MSHN** met the MDHHS benchmarks set for indicator #2. Ongoing monitoring and improvement opportunities will continue to be discussed as necessary.

Performance Indicator Specific Findings and Recommendations

Based on all validation activities, HSAG determined the results for the performance indicator. The CMS EQR Protocol 2 identifies three possible validation finding designations for performance indicators, which are defined in Table 5. For more detailed information, please see Appendix B.

Table 5—Designation Categories for Performance Indicators

Reportable (R)	Indicator was compliant with the State’s specifications, and the rate can be reported.
Do Not Report (DNR)	This designation is assigned to indicators for which the PIHP rate was materially biased and should not be reported.
Not Applicable (NA)	The PIHPs were not required to report a rate for this indicator.

According to the protocol, the validation designation for an 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 DNR 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 [NA]*) can be found in Appendix A—Data Integration and Control Findings and Appendix B—Denominator and Numerator Validation Findings. Table 6 displays the indicator-specific review findings and designation for **MSHN**.

Table 6—Indicator-Specific Review Findings and Designations for MSHN

Performance Indicator		Key Review Findings	Indicator Designation
#2	The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service.	The PIHP/CMHSPs calculated this indicator in compliance with the MDHHS Codebook specifications.	R

Strengths, Opportunities for Improvement, and Recommendations

By assessing **MSHN**'s performance and performance indicator reporting process, HSAG identified the following areas of strength and opportunities for improvement related to the domains of quality, timeliness, and access. Along with each opportunity for improvement, HSAG has also provided a recommendation to help target improvement.

Strengths

Strength #1: MSHN and its subcontracted CMHSPs continued to engage in QIC meeting discussions to identify root causes, barriers, and effective interventions. Through these discussions, MSHN also identified and shared best practices with other CMHSPs and PIHPs, including relevant processes, policies, procedures, and protocols. This collaborative approach supports consistent reporting practices, promotes shared problem-solving across the region, and helps strengthen the quality, timeliness, and accessibility of services for members. **[Quality, Timeliness, and Access]**

Strength #2: MSHN continued to implement targeted improvement strategies to support timely access to services, including providing appointment reminders via text messages and phone calls and having peer support or care coordinator staff follow up with members after missed appointments. **[Quality, Timeliness, and Access]**

Strength #3: MSHN's reported total rate of 65.26 percent for indicator #2 exceeded the 75th percentile benchmark, which suggests that many new persons during the quarter received a biopsychosocial assessment within 14 calendar days of a non-emergency request for service. **[Quality and Timeliness]**

Weaknesses and Recommendations

Weakness #1: MSHN uses a manual encounter validation process to exclude CCBHC-only individuals. **[Quality]**

Why the weakness exists: Due to changes to the MDHHS Codebook between SFY 2025 and SFY 2026, CCBHC-only individuals are now excluded from the eligible population.

Recommendation: While no issues resulting from the manual exclusions process were identified for SFY 2026, HSAG recommends that **MSHN** develop and implement an automated system to identify CCBHC-only individuals and remove them from the system. Using an automated rather than a manual process can help to improve data accuracy and consistency, while minimizing submission errors, and ensure that only eligible individuals are included in the reporting criteria.

Appendix A. Data Integration and Control Findings

Documentation Worksheet

PIHP Name:	Mid-State Health Network
PMV Date:	July 7, 2026
Reviewer:	LaKeshau McBride

Data Integration and Control Element	Met	Not Met	NA	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 calculation of the performance indicator has been completed and validated.	☒	☐	☐	
Samples of data from the 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 facilitate any required programming necessary to calculate and report the required performance indicator.				
The performance indicator data repository's design, program flow charts, and source code enable 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	NA	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
PMV Date:	July 7, 2026
Reviewer:	LaKeshau McBride

Denominator Validation Findings for MSHN				
Audit Element	Met	Not Met	NA	Comments
For the performance indicator in scope of the review, 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 the performance indicator in scope of the review.	☒	☐	☐	
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 indicator 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 indicator under the scope of the audit.

Numerator Validation Findings for MSHN				
Audit Element	Met	Not Met	NA	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.	☐	☐	☒	MSHN did not use nonstandard codes.
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

The measurement period for indicator #2 is Q1 of SFY 2026 (October 1, 2025–December 31, 2025).

Indicator #2

The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service. *50th Percentile = 57.0%. 75th Percentile = 62.0%.⁵*

Table C-1—Indicator #2: Access—Timeliness/First Request for MSHN

1. Population	2. # of New Persons Who Requested Mental Health or I/DD Services and Supports and Are Referred for a Biopsychosocial Assessment	3. # of Persons Completing the Biopsychosocial Assessment Within 14 Calendar Days of First Request for Service	4. % of Persons Requesting a Service Who Received a Completed Biopsychosocial Assessment Within 14 Calendar Days
MI—Children—Indicator #2a	790	509	64.43%
MI—Adults—Indicator #2b	1,383	943	68.19%
I/DD—Children—Indicator #2c	242	119	49.17%
I/DD—Adults—Indicator #2d	69	50	72.46%
Total—Indicator #2	2,484	1,621	65.26%

⁵ Please note that the percentile benchmarks for indicator #2 are based on the cumulative percentage for the total eligibles within each population group. Therefore, percentile benchmark comparisons are only made for the total indicator population.