Michigan Department of Health and Human Services

State Fiscal Year 2024 Validation of Performance Measures for Region 5—Mid-State Health Network

Behavioral and Physical Health and Aging Services Administration
Prepaid Inpatient Health Plans

October 2024

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 Title 42 of the Code of Federal Regulations (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 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' *External Quality Review (EQR) Protocols, February 2023*,[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. *External Quality Review (EQR) Protocols, February 2023*. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: September 6, 2024.

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:	Amy Dillon
Contact Telephone Number:	517.241.5116
Contact Email Address:	amy.dillon@midstatehealthnetwork.org
PMV Virtual Review Date:	July 30, 2024

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 (Q1) of state fiscal year (SFY) 2024, which began October 1, 2023, and ended December 31, 2023. 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 persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	• Children • Adults	Q1 SFY 2024
#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 2024
#3	The percentage of new persons during the quarter starting any medically necessary ongoing covered service within 14 days of completing a non-emergent biopsychosocial assessment.	• MI–Adults • MI–Children • I/DD–Adults • I/DD–Children	Q1 SFY 2024
#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	Q1 SFY 2024
#4b	The percent of discharges from a substance abuse detox unit who are seen for follow-up care within 7 days.	• Consumers	Q1 SFY 2024
#10	The percentage of readmissions of children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.	• Children • Adults	Q1 SFY 2024

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

Table 3—List of Performance Indicators Calculated by MDHHS

Indicator		Sub-Populations	Measurement Period
#2e	The percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of a non-emergency request for service for persons with substance use disorders (SUDs).	• Consumers	Q1 SFY 2024
#5	The percent of Medicaid recipients having received PIHP managed services.	• Medicaid Recipients	Q1 SFY 2024
#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	Q1 SFY 2024
#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 disability served by the CMHSPs and PIHPs who are employed competitively.	• MI–Adults • DD–Adults • MI and DD–Adults	SFY 2023
#9	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disability served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.	• MI–Adults • DD–Adults • MI and DD–Adults	SFY 2023
#13	The percent of adults with dual diagnosis (MI and DD) served, who live in a private residence alone, with spouse, or non-relatives.	• DD–Adults • MI and DD–Adults	SFY 2023
#14	The percent of adults with mental illness served, who live in a private residence alone, with spouse, or non-relatives.	• MI–Adults	SFY 2023

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 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. 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-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 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 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 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 indicators. Table 4 describes each team member's role and expertise.

Table 4—Validation Team

Name and Role	Skills and Expertise
Jacilyn Gatete, MAS, CHCA *Analytics Manager II*, *Data Science & Advanced Analytics (DSAA)*; *Lead Auditor*; *PIHP PMV Project Manager*	Multiple years of experience conducting audits, including Healthcare Effectiveness Data and Information Set (HEDIS®)[2] Compliance Audits™,[3] related to performance measurement, electronic health records (EHRs), medical billing, data integration and validation, and care management.
Naomi Abraha, MPH *Analytics Coordinator III, DSAA;* *Source Code Liaison*	Audit support team member; assists with PMV, including implementation, project coordination, analysis, and reporting.
Sarah Lemley *Source Code Reviewer*	Multiple years of experience in statistics, analysis, and source code/programming language knowledge.

[2] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[3] HEDIS Compliance Audit™ is a trademark of NCQA.

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)**—The PIHPs were required to submit a completed ISCAT that provided information on the PIHPs' and CMHSPs' information systems; 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 performance indicators**—PIHPs that calculated the performance indicators using computer programming language were required to submit source code for each performance indicator being validated. HSAG completed line-by-line review on the supplied source code to ensure compliance with the State-defined performance indicator specifications. HSAG identified areas of deviation from the specifications, evaluating the impact to the indicator and assessing the degree of bias (if any). PIHPs that did not use computer programming language to calculate the performance indicators were required to submit documentation describing the actions taken to calculate each indicator.
- **Performance indicator reports**—HSAG also reviewed the PIHPs' SFY 2023 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 demonstration, 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 indicators, including accurate numerator and denominator identification, and algorithmic compliance (which evaluated whether rate calculations were performed correctly, all data were combined appropriately, and numerator events were counted accurately). Based on the desk review of the ISCAT(s), HSAG conducted interviews with key PIHP 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 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 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-PMV and virtual 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 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 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 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 5 displays a list of **MSHN** virtual review participants:

Table 5—List of MSHN Virtual Review Participants

Name	Title
Amanda Ittner	Deputy Director, MSHN
Steve Grulke	Chief Information Officer, MSHN
Kim Zimmerman	Chief Compliance and Quality Officer, MSHN
Leslie Thomas	Chief Financial Officer, MSHN
Joseph Wager	Technology Project Manager, MSHN
Kyle Jaskulka	Contract Specialist, MSHN
Sandy Gettel	Quality Manager, MSHN
Amy Dillon	Compliance Administrator, MSHN
Dmitriy Katsman	Senior Systems Analyst, Peter Chang Enterprises, Inc. (PCE)
Adam Busenbark	Business Data Analyst, TBD Solutions, Inc. (TBD Solutions)
Joseph Torres	Data Science Consultant, TBD Solutions

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 **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 type of data used for reporting the MDHHS performance indicators. General findings, strengths, and areas for improvement for **MSHN** are indicated below.

Eligibility and Enrollment Data System Findings

HSAG had no concerns with **MSHN**'s receipt and processing of eligibility data.

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, Behavioral Health Treatment Episode Data Set (BH-TEDS) 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. Of the 12 CMHSPs, 11 affiliates used EMRs supported by PCE and subsequently received their eligibility extract files directly into their EMR systems; one CMHSP, Community Mental Health Authority of Clinton, Eaton, and Ingham Counties (CMHA-CEI), received its eligibility data through a secure file transfer protocol (FTP) site or downloaded the data from REMI. **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 that used PCE 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. Similarly, the CMHSP that did not use PCE checked the counts of segments at the end of the process and verified dates were in consecutive order. Providers, staff members, and PIHP affiliates performed real-time eligibility verification through the State's website, Community Health Automated Medicaid Processing System (CHAMPS). **MSHN** also convened councils in information technology, the Quality Improvement Council (QIC), and finance departments for monitoring, whose mandate 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** and its CMHSPs demonstrated that eligibility effective dates, termination dates, historical eligibility spans, and members were identified appropriately.

Medical Services Data System (Claims and Encounters) Findings

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

MSHN continued to delegate all claims processing except SUD data processing to its contracted CMHSPs; **MSHN** processed SUD data for all CMHSPs. 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, along with BH-TEDS data. 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 staging validation 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, 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 **MSHN**'s REMI system.

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 containing 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.

For performance metric production, **MSHN** 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 for review. The PIHP then reviewed any notable issues with the CMHSPs. Validated data were then placed into a calculation table to finalize the measure rates for reporting. During this process, duplicate records

across the CMHSPs were identified and eliminated from the file, with case precedence going to SUD cases. Due to the multiple validations in place at both 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.

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

MSHN continued to use REMI to collect, manage, and produce the BH-TEDS data for submission to MDHHS. Built to align with MDHHS specifications, core data validation edits and file requirements were incorporated into the implementation of REMI. 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 and receipt of properly formatted BH-TEDS files submitted by the CMHSPs. Both processes implemented all 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, clean BH-TEDS files to the State based on the State's requirements. After submission, the PIHP received detailed response files and error reports that 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 was able to log in to REMI and obtain its corresponding response file. 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. If the response files from the State included errors, the CMHSPs would work to resolve the errors and reach out to **MSHN** if they were unable to address the errors.

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 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 (CAP) 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

During the SFY 2023 audit, HSAG identified the following:

- For indicator #1, during CMHA-CEI's PSV, HSAG found a data entry error for one case which led to documenting an incorrect wait time. **MSHN** further researched the issue and reported an additional seven cases with similar documentation errors that needed correction. Review of the crisis screening showed a data entry error which resulted in an incorrect wait time being documented. While this finding did not significantly impact the rate, HSAG recommended that **MSHN** complete the proposed corrective action to review all abnormal disposition completed dates and times as part of its validation check. HSAG also recommended and supported **MSHN**'s efforts in continuing to meet with staff members to provide further training when errors occur, in addition to the PIHP's proposed corrective action to have the quality improvement (QI) team review all indicator #1 "out-of-compliance" items and check with the CMHSP for accuracy before submission. During the SFY 2024 audit, HSAG followed up on the recommendations, and **MSHN** indicated that it had completed the corrective actions and incorporated the improvement efforts as outlined by HSAG.
- For indicator #1, during Lifeways' PSV, HSAG identified one case that should have been reported as in compliance instead of out of compliance. After further review of this case, **MSHN** noted that two inpatient screenings were completed for the consumer. The second document that was completed and counted as out of compliance was completed in error and found to be a duplicate document. Rather than starting a new document, the CMHSP should have updated the initial inpatient screening to include the correct placement of the member. HSAG recommended that **MSHN** continue its efforts to meet with CMHSP staff members to provide further training when these and similar errors occur, in addition to having the QI team review all indicator #1 out-of-compliance items to check CMHSP reporting accuracy before submission. During the SFY 2024 audit, HSAG followed up on the recommendations, and **MSHN** indicated that it had incorporated the improvement efforts as outlined by HSAG.
- During Saginaw's PSV, HSAG found zero elapsed minutes documented and reported for one indicator #1 case. **MSHN** indicated that the staff member who entered this case was no longer available for follow up concerning the reason this case was incorrectly documented. While **MSHN** had since worked with PCE to develop a system update to help capture cases with zero elapsed minutes, HSAG recommended and supported **MSHN**'s efforts in monitoring for this particular issue until the PCE system update is in place. Additionally, HSAG recommended that **MSHN** continue to monitor for cases with unusual elapsed times after implementing the system update, to further ensure that the system edits are working as expected. During the SFY 2024 audit, HSAG followed up on the recommendations, and **MSHN** indicated that it had completed the corrective actions and incorporated the improvement efforts as outlined.
- After reviewing Bay-Arenac's proof-of-service documentation, HSAG found that one indicator #3 case was reported as in compliance when no valid follow-up service was documented. The logic captured this date in error because there was a "cost reconsideration" for the assessment on the date that was pulled for the follow-up date. This resulted in the logic capturing a single Current Procedural Terminology (CPT) code twice for both the assessment and the follow-up service on the same day. While PCE completed a logic update in June 2023 to prevent the specific CPT code from

being billed twice in the same day, HSAG recommended that **MSHN** and the CMHSP perform additional validation checks to ensure appropriate ongoing services are captured for compliant cases in future reporting. During the SFY 2024 audit, HSAG followed up on the recommendations, and **MSHN** indicated that it had completed the corrective actions and incorporated the improvement efforts outlined.

- After reviewing Huron's proof-of-service documentation, HSAG found that one case should have been counted as an exception rather than as compliant for indicator #4a. Huron confirmed that the consumer should have been counted as an exception originally, as the consumer had discharged to a residential care facility outside of the county. While this finding did not significantly impact the rate, HSAG recommended that **MSHN** and the CMHSP enhance the PIHP's validation process to ensure appropriate categorization of compliant cases and capture of exceptions. During the SFY 2024 audit, HSAG followed up on the recommendations, and **MSHN** indicated that it had incorporated the enhancements outlined by HSAG.
- After reviewing Shiawassee's proof-of-service documentation, HSAG found that one member for indicator #3 had an incorrect medically necessary ongoing service date documented and pulled for reporting. After further review of this case, HSAG noted that staff members submitted documentation for the incorrect date after overlooking notes that were scanned into the chart. HSAG requested that the CMHSP further research this issue, and the CMHSP noted that no other cases fell into the scenario, which was due to human error in extracting the wrong document from the EMR. While **MSHN** provided evidence of the correct date for the ongoing service that matched the reported date, HSAG recommended that **MSHN** and the CMHSP perform additional validation checks to ensure that appropriate ongoing services are captured for compliant cases in future reporting. During the SFY 2024 audit, HSAG followed up on the recommendations, and **MSHN** indicated that it had implemented staff member training on this issue due to turnover.

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 three 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

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 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 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 7 displays the indicator-specific review findings and designations for **MSHN**.

Table 7—Indicator-Specific Review Findings and Designations for MSHN

Performance Indicator		Key Review Findings	Indicator Designation
#1	The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	The PIHP/CMHSPs calculated this indicator in compliance with the MDHHS Codebook specifications.	R
#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
#2e	The percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of a non-emergency request for service for persons with SUDs.	The PIHPs were not required to report a rate for this indicator.	NA

Performance Indicator		Key Review Findings	Indicator Designation
#3	The percentage of new persons during the quarter starting any medically necessary ongoing covered service within 14 days of completing a non-emergent biopsychosocial assessment.	The PIHP/CMHSPs calculated this indicator in compliance with the MDHHS Codebook specifications.	R
#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 the MDHHS Codebook specifications.	R
#4b	The percent of discharges from a substance abuse detox unit who are seen for follow-up care within 7 days.	The PIHP/CMHSPs calculated this indicator in compliance with the MDHHS Codebook specifications.	R
#5	The percent of Medicaid recipients having received PIHP managed services.	MDHHS calculated this indicator in compliance with the MDHHS Codebook specifications.	R
#6	The percent of HSW enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	MDHHS calculated this indicator in compliance with the 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 disability served by the CMHSPs and PIHPs who are employed competitively.	MDHHS calculated this indicator in compliance with the 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 disability served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.	MDHHS calculated this indicator in compliance with the MDHHS Codebook specifications.	R
#10	The percentage of readmissions of 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 the MDHHS Codebook specifications.	R

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Performance Indicator		Key Review Findings	Indicator Designation
#13	The percent of adults with dual diagnosis (MI and DD) served, who live in a private residence alone, with spouse, or non-relatives.	MDHHS calculated this indicator in compliance with the MDHHS Codebook specifications.	R
#14	The percent of adults with mental illness served, who live in a private residence alone, with spouse, or non-relatives.	MDHHS calculated this indicator in compliance with the MDHHS Codebook specifications.	R

Strengths, Opportunities for Improvement, and Recommendations

By assessing **MSHN**'s performance and performance measure reporting process, HSAG identified the following areas of strength and opportunities for improvement as it relates 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's subcontracted CMHSPs continued to participate in discussion at QIC meetings to assist in identifying causal factors, barriers, and effective interventions. Best practices were also identified and shared with other CMHSPs and PIHPs, including processes, policies and procedures, and protocols used. [**Quality**, **Timeliness**, and **Access**]

Strength #2: MSHN implemented various improvement strategies such as increasing the number of staff members and network providers, incorporating the practice of "teach back" (i.e., having members repeat back what they are being told to confirm understanding) during care coordination and appointment reminders, performing appointment reminder phone calls to discuss any barriers and develop relationships with members, and expanding hours of operation. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: One case identified in indicator #10 for Tuscola did not involve a member who was a Medicaid beneficiary for at least one month during the reporting period. [**Quality**]

Why the weakness exists: Enrollment system information indicated that the member had a Family Planning Program waiver (Plan First) and was not eligible for Medicaid. **MSHN** confirmed that the member should be removed from indicator #10 and that, based on its review of all other reported indicator #10 cases, this was an isolated issue.

Recommendation: Although **MSHN** confirmed that this was an isolated issue, HSAG recommends that **MSHN** perform additional spot checks prior to submitting data to HSAG, such as performing PSV for a statistically significant sample of cases each quarter to ensure that the cases meet eligibility requirements. Data validation is a crucial step in ensuring an accurate submission.

Incorporating additional spot checks could add value, especially when data are being integrated from multiple sources.

Weakness #2: Two cases for CMHA-CEI in indicators #2 and #3 were identified as having the incorrect populations listed in the member-level detail file. [**Quality**]

Why the weakness exists: MSHN confirmed that this was due to the population designations changing after the original report was run and before the final report was submitted with final rates to MDHHS. **MSHN** indicated that it plans to put a remediation plan in place to crosswalk the initial report with the final report to identify any changes in population designations before submission. No other cases were identified with this issue.

Recommendation: Although this finding did not have a significant impact on the indicator #2 and #3 total rates, HSAG recommends that **MSHN** proceed with its outlined remediation plan. Additionally, HSAG recommends that **MSHN** continue to work with the CMHSP to enhance existing or implement additional processes when necessary to improve the accuracy of indicator #2 and #3 data. This should include implementing another level of validation for reviewing a statistically significant sample of cases each quarter to confirm that their associated population designations are accurately reported.

Weakness #3: HSAG identified one case in indicator #3 for Lifeways that should have been reported as out of compliance rather than in compliance. [**Quality**]

Why the weakness exists: MSHN confirmed that crisis transportation should not have been captured as an ongoing covered service and removed the case from indicator #3. **MSHN** also indicated that it will be working with PCE to update its programming logic to ensure that crisis transportation is not counted as an ongoing covered service. MSHN confirmed that this was an isolated issue after it reviewed all other reported indicator #3 cases.

Recommendation: Although **MSHN** confirmed that this was an isolated issue, HSAG recommends that **MSHN** implement the programming logic updates and also perform additional spot checks prior to submitting data to HSAG, such as performing PSV for a statistically significant sample of cases each quarter to ensure that the cases meet reporting requirements. Additionally, HSAG recommends that **MSHN** continue to work with the CMHSP to enhance existing or implement additional processes when necessary to improve the accuracy of indicator #3 data.

Weakness #4: HSAG identified one case in indicator #4a for Lifeways that should have been reported as an exception rather than in compliance. [**Quality**]

Why the weakness exists: MSHN confirmed that the case should not have been reported as incompliance for indicator #4a due to the follow-up appointment not being documented in the out-of-network area of the REMI system, and therefore it was not captured as an exception for indicator #4a. **MSHN** confirmed that this was an isolated issue after it reviewed of all other reported indicator #4a cases.

Recommendation: Although **MSHN** confirmed that this was an isolated issue, HSAG recommends that **MSHN** perform additional spot checks prior to submitting data to HSAG, such as performing PSV for a statistically significant sample of cases each quarter to ensure that the cases meet reporting requirements. Additionally, HSAG recommends that **MSHN** continue to work with the CMHSP to

enhance existing or implement additional processes when necessary to improve the accuracy of indicator #4a data. Retraining on how to appropriately document various scenarios in the REMI system should be provided if found necessary.

Weakness #5: MSHN’s indicator #2 total rate fell below the 75th percentile benchmark. [**Quality** and **Timeliness**]

Why the weakness exists: MSHN’s indicator #2 total rate fell below the 75th percentile benchmark, suggesting that some new persons may not have been able to get a timely biopsychosocial assessment completed following a nonemergency request for service.

Recommendation: HSAG recommends that **MSHN** continue with its improvement efforts related to indicator #2 so that it meets or exceeds the 75th percentile benchmark and further ensures timely and accessible treatments and supports for individuals. Timely assessments are critical for engagement and person-centered planning.

Weakness #6: MSHN’s indicator #3 total rate fell below the 50th percentile benchmark. [**Quality** and **Timeliness**]

Why the weakness exists: MSHN’s indicator #3 total rate fell below the 50th percentile benchmark, suggesting that some new persons may not have been able to receive timely ongoing covered services following completion of a non-emergent biopsychosocial assessment.

Recommendation: HSAG recommends that **MSHN** continue with its improvement efforts related to indicator #3 so that it meets or exceeds the 50th percentile benchmark and further ensures timely and accessible ongoing covered services following completion of a biopsychosocial assessment. The timeliness of ongoing services is critical to consumer engagement in treatment and services.

Documentation Worksheet

PIHP Name:	Mid-State Health Network
PMV Date:	July 30, 2024
Reviewers:	Jacilyn Gatete

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 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.	☒	☐	☐	

Data Integration and Control Element	Met	Not Met	NA	Comments
Proper linkage mechanisms are employed to join data from all necessary sources (e.g., identifying a member with a given disease/condition).	☒	☐	☐	
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 30, 2024
Reviewers:	Jacilyn Gatete

Denominator Validation Findings for MSHN				
Audit Element	Met	Not Met	NA	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 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.	☒	☐	☐	
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 indicators #1, #2, #2e, #3, #4a, #4b, #5, #6, and #10 is Q1 SFY 2024 (October 1, 2023–December 31, 2023). The measurement period for indicators #8, #9, #13, and #14 is SFY 2023 (October 1, 2022–September 30, 2023).

Indicator #1

The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. *Standard=95% within 3 hours*.

Table C-1—Indicator #1: Access—Timeliness/Inpatient Screening for MSHN

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—Indicator #1a	**915**	**902**	**98.58%**
Adults—Indicator #1b	**2,409**	**2,401**	**99.67%**

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%.*

Table C-2—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	**1,625**	**982**	**60.43%**
MI–Adults—Indicator #2b	**2,499**	**1,607**	**64.31%**
I/DD–Children—Indicator #2c	**262**	**114**	**43.51%**
I/DD–Adults—Indicator #2d	**115**	**78**	**67.83%**
Total—Indicator #2	**4,501**	**2,781**	**61.79%**

Indicator #2e

The percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of a non-emergency request for service for persons with SUDs. *50th Percentile = 68.2%. 75th Percentile = 75.3%.*

Table C-3—Indicator #2e: Access—Timeliness/First Request SUD for MSHN in Comparison to All PIHPs*

Medicaid SUD						
1. PIHP Name	2. # of Expired Requests Reported by the PIHP	3. # of Non-Urgent Admissions to a Licensed SUD Treatment Facility as Reported in BH-TEDS	4. Total Requests (Admissions + Expired Requests)	5. % of Expired Requests	6. # of Persons Receiving a Service for Treatment or Supports Within 14 Calendar Days of First Request	7. % of Persons Requesting a Service Who Received Treatment or Supports Within 14 Days
Mid-State Health Network	**503**	**2,479**	**2,982**	**16.87%**	**2,159**	**72.40%**
Northern Michigan Regional Entity	430	1,083	1,513	28.42%	910	60.15%
Lakeshore Regional Entity	247	1,234	1,481	16.68%	1,005	67.86%
Southwest Michigan Behavioral Health	410	959	1,369	29.95%	809	59.09%
NorthCare Network	118	415	533	22.14%	290	54.41%
Community Mental Health Partnership of Southeast Michigan	224	806	1,030	21.75%	610	59.22%
Detroit Wayne Integrated Health Network	995	2,901	3,896	25.54%	2,522	64.73%
Oakland Community Health Network	144	814	958	15.03%	766	79.96%
Macomb County Community Mental Health	301	1,387	1,688	17.83%	1,274	75.47%
Region 10 PIHP	330	1,620	1,950	16.92%	1,446	74.15%

*Please note that the PIHP data displayed for Indicator #2e are for informational purposes only, as the PIHPs were not required to report a rate to MDHHS. Data are presented to allow for identification of opportunities to improve rate accuracy for future reporting.

Indicator #3

The percentage of new persons during the quarter starting any medically necessary ongoing covered service within 14 days of completing a non-emergent biopsychosocial assessment. *50th Percentile = 72.9%. 75th Percentile = 83.8%.*

Table C-4—Indicator #3: Access—Timeliness/First Service for MSHN

1. Population	2. # of New Persons Who Completed a Biopsychosocial Assessment Within the Quarter and Are Determined Eligible for Ongoing Services	3. # of Persons From Col 2 Who Started a Face-to-Face Service Within 14 Calendar Days of the Completion of the Biopsychosocial Assessment	4. % of Persons Who Started Service Within 14 Days of a Biopsychosocial Assessment
MI–Children—Indicator #3a	**1,304**	**760**	**58.28%**
MI–Adults—Indicator #3b	**1,878**	**1,091**	**58.09%**
I/DD–Children—Indicator #3c	**263**	**200**	**76.05%**
I/DD–Adults—Indicator #3d	**108**	**71**	**65.74%**
Total—Indicator #3	**3,553**	**2,122**	**59.72%**

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-5—Indicator #4a: Access—Continuity of Care for MSHN

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	**201**	**51**	**150**	**142**	**94.67%**
Adults	**894**	**311**	**583**	**555**	**95.20%**

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Indicator #4b

The percent of discharges from a substance abuse detox unit that are seen for follow-up care within 7 days. *Standard=95%.*

Table C-6—Indicator #4b: Access—Continuity of Care for MSHN

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	**356**	**155**	**201**	**191**	**95.02%**

Indicator #5

The percent of Medicaid recipients having received PIHP managed services.

Table C-7—Indicator #5: Access—Penetration Rate for MSHN

1. Total Medicaid Beneficiaries Served	2. # of Area Medicaid Recipients	3. Penetration Rate
35,496	**482,723**	**7.35%**

Indicator #6

The percent of HSW enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.

Table C-8—Indicator #6: Adequacy/Appropriateness—Habilitation Supports Waiver for MSHN

1. Population	2. Total # of HSW Enrollees	3. # of HSW Enrollees Receiving at Least One HSW Service Other Than Supports Coordination	4. HSW Rate
HSW Enrollees	**1,465**	**1,419**	**96.86%**

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 disability served by the CMHSPs and PIHPs who are employed competitively.[4]

Table C-9—Indicator #8: Outcomes—Competitive Employment for MSHN

1. Population	2. Total # of Enrollees	3. # of Enrollees Who Are Competitively Employed	4. Competitive Employment Rate
MI–Adults—Indicator #8a	**23,016**	**5,374**	**23.35%**
DD–Adults—Indicator #8b	**3,378**	**308**	**9.12%**
MI and DD–Adults—Indicator #8c	**2,822**	**283**	**10.03%**

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 disability served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.[5]

Table C-10—Indicator #9: Outcomes—Minimum Wage for MSHN

1. Population	2. Total # of Enrollees	3. # of Enrollees Who Earn Minimum Wage or More	4. Minimum Wage Rate
MI–Adults—Indicator #9a	**5,397**	**5,379**	**99.67%**
DD–Adults—Indicator #9b	**464**	**321**	**69.18%**
MI and DD–Adults—Indicator #9c	**388**	**299**	**77.06%**

[4] Competitive employment includes: full time and part time. This indicator includes all adults by population no matter their employment status.

[5] Employed consumers include: full time and part time, enclave/mobile crew, or sheltered workshop. This indicator only includes the adults that meet the “employed” status.

Indicator #10

The percentage of readmissions of children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge. *Standard=15% or less within 30 days.*

Table C-11—Indicator #10: Outcomes—Inpatient Recidivism for MSHN

1. Population	2. # of Discharges From 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
Children—Indicator #10a	**225**	**22**	**203**	**19**	**9.36%**
Adults—Indicator #10b	**1,102**	**123**	**979**	**105**	**10.73%**

Indicator #13

The percent of adults with dual diagnosis (MI and DD) served, who live in a private residence alone, with spouse, or non-relatives.

Table C-12—Indicator #13: Outcomes—Private Residence for MSHN

1. Population	2. Total # of Enrollees	3. # of Enrollees Who Live in a Private Residence Alone, With Spouse, or Non-Relative(s)	4. Private Residence Rate
DD–Adults	**3,378**	**661**	**19.57%**
MI and DD–Adults	**2,825**	**738**	**26.12%**

Indicator #14

The percent of adults with mental illness served, who live in a private residence alone, with spouse, or non-relatives.

Table C-13—Indicator #14: Outcomes—Private Residence-MI for MSHN

1. Population	2. Total # of Enrollees	3. # of Enrollees Who Live in a Private Residence Alone, With Spouse, or Non-Relative(s)	4. Private Residence Rate
MI–Adults	**23,128**	**11,101**	**48.00%**

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-14. 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-14—BH-TEDS Data Elements in Performance Indicator Reporting for MSHN

BH-TEDS Data Element	Percent Complete SFY 2023	Percent Complete Q1 SFY 2024	Quarterly and Annual Indicators Impacted
Age*	**100.00%**	**100.00%**	**1, 4, 8, 9, 10, 13, 14**
Disability Designation*	**96.61%**	**97.50%**	**8, 9, 10, 13, 14**
Employment Status*	**99.06%**	**99.74%**	**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; no values are highlighted if all values are within acceptable ranges.