Michigan Department of Health and Human Services

State Fiscal Year 2022 Validation of Performance Measures for Region 5—Mid-State Health Network

Behavioral Health and Developmental Disabilities Administration
Prepaid Inpatient Health Plans

September 2022

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 managed care organizations 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 and federal specifications and reporting requirements. According to CMS' *External Quality Review (EQR) Protocols, October 2019*,[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] The Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols, October 2019.* Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/quality-of-care-external-quality-review/index.html. Accessed on: Mar 25, 2022.

Prepaid Inpatient Health Plan (PIHP) Information

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

Table 1—Mid-State Health Network Information

PIHP Name:	Mid-State Health Network
PIHP Location:	530 W. Ionia St., Lansing, MI 48933
PIHP Contact:	Sandy Gettel
Contact Telephone Number:	517.220.2422
Contact Email Address:	sandy.gettel@midstatehealthnetwork.org
PMV Virtual Review Date:	June 17, 2022

Performance Indicators Validated

HSAG validated a set of performance indicators that were developed and selected by MDHHS for validation. The reporting cycle and measurement period were specified for each indicator by MDHHS. Table 2 lists the performance indicators calculated by the PIHPs for specific populations for the first quarter of state fiscal year (SFY) 2022, which began October 1, 2021, and ended December 31, 2021. 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	1st Quarter SFY 2022
#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	1st Quarter SFY 2022
#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	1st Quarter SFY 2022
#4a	The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.	• Children • Adults	1st Quarter SFY 2022
#4b	The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.	• Consumers	1st Quarter SFY 2022
#10	The percentage of readmissions of MI and I/DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.	• MI & I/DD–Adults • MI & I/DD–Children	1st Quarter SFY 2022

MI = Mental Illness, I/DD = Intellectual and 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	1st Quarter SFY 2022
#5	The percent of Medicaid recipients having received PIHP managed services.	• Medicaid Recipients	1st Quarter SFY 2022
#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	1st Quarter SFY 2022
#8	The percent of (a) adults with mental illness, and the percent of (b) adults with intellectual or developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/intellectual or developmental disability served by the CMHSPs and PIHPs who are employed competitively.	• MI–Adults • I/DD–Adults • MI & I/DD–Adults	SFY 2021
#9	The percent of (a) adults with mental illness, the percent of (b) adults with intellectual or developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/ intellectual or developmental disability served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.	• MI–Adults • I/DD–Adults • MI & I/DD–Adults	SFY 2021
#13	The percent of adults with intellectual or developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	• I/DD–Adults • MI & I/DD–Adults	SFY 2021
#14	The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	• MI–Adults	SFY 2021

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
Emily Higgins, MA, LPCC-S *Analytics Manager, Data Science & Advanced Analytics (DSAA);* *Lead Auditor*	Multiple years of auditing experience related to performance measurement, quality improvement, data review and analysis, data integration and validation, care management, and healthcare industry experience.
Jacilyn Daniel, BS *Analytics Manager, DSAA;* *PIHP PMV Project Manager*	Multiple years of auditing experience related to performance measurement, electronic health records (EHRs), medical billing, data integration and validation, and care management.
Matt Kelly, MBA *Manager, DSAA;* *Source Code Liaison*	Multiple years of systems analysis, quality improvement, data review and analysis, and healthcare industry experience.
Sarah Lemley *Source Code Reviewer*	Statistics, analysis, and source code/programming language knowledge.

Technical Methods of Data Collection and Analysis

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

- **Information Systems Capabilities Assessment Tool (ISCAT)**—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 2021 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, 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 performance measure validation activities. Discussion during the session covered the review purpose, the required documentation, basic meeting logistics, and queries to be performed.

- **Evaluation of system compliance**—The evaluation included a review of the information systems, focusing on the processing of enrollment and disenrollment data. Additionally, HSAG evaluated the processes used to collect and calculate the performance indicators, including accurate numerator and denominator identification, and algorithmic compliance (which evaluated whether rate calculations were performed correctly, all data were combined appropriately, and numerator events were counted accurately). Based on the desk review of the ISCAT(s), HSAG conducted interviews with key PIHP and CMHSP staff members familiar with the processing, monitoring, and calculation of the performance indicators. HSAG used interviews to confirm findings from the documentation review, expand or clarify outstanding issues, and verify that written policies and procedures were used and followed in daily practice.
- **Overview of data integration and control procedures**—The overview included discussion and observation of source code logic, a review of how all data sources were combined, and how the analytic file used for reporting the performance indicators was generated. HSAG performed primary source verification to further validate the output files. HSAG also reviewed any supporting documentation provided for data integration. This session addressed data control and security procedures as well.
- **Primary Source Verification (PSV)**—HSAG performed additional validation using PSV to further validate the output files. PSV is a review technique used to confirm that the information from the primary source matches the output information used for reporting. Each PIHP 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 **Mid-State Health Network** staff members who were involved with any aspect of performance indicator reporting. Table 5 displays a list of **Mid-State Health Network** virtual review participants:

Table 5—List of Mid-State Health Network Virtual Review Participants

Name	Title
Sandra Gettel	Quality Manager, Mid-State Health Network
Kim Zimmerman	Chief Compliance and Quality Officer, Mid-State Health Network
Steve Grulke	Chief Information Officer (CIO), Mid-State Health Network
Shyam Marar	Systems Analyst and Project Manager, Mid-State Health Network
Dmitriy Katsman	Project Management, Peter Chang Enterprises, Inc. (PCE)
JoAnn Holland	CIO, Clinton, Eaton, and Ingham
Sue Panetta	Chief Financial Officer, Clinton, Eaton, and Ingham
Elise Magen	Quality Improvement (QI)/Utilization Management Coordinator, Clinton, Eaton, and Ingham
Bradley Allen	QI Specialist, Clinton, Eaton, and Ingham
Pam Flory	Reimbursement Supervisor, Clinton, Eaton, and Ingham
Katherine VanZwoll	Business Analyst Manager, Clinton, Eaton, and Ingham
Jason Manley	Senior Business Analyst, Clinton, Eaton, and Ingham
Andrea Fletcher	QI/Corporate Compliance Director, Newaygo
Jill McKay	Recipient Rights Officer, Data Coordinator, Newaygo
Jay Hollinger	CIO, Newaygo
Lynn Martin	Coder/Medical Records Coordinator, Newaygo
Sally Culey	Quality and Information Services Director, Montcalm
Joe Cappon	Quality Analyst, Montcalm
Terry Reihl	Information Technology Manager, Montcalm
Brian McNeill	Data Analyst, Gratiot
Natalie Nugent	Chief Operating Officer, Huron
Jackie Shillinger	Performance Improvement Coordinator, Tuscola Behavioral Health Systems

Data Integration, Data Control, and Performance Indicator Documentation

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

Data Integration

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

☒ Acceptable

☐ Not acceptable

Data Control

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

☒ Acceptable

☐ Not acceptable

Performance Indicator Documentation

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

☒ Acceptable

☐ Not acceptable

Validation Results

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

Eligibility and Enrollment Data System Findings

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

No major eligibility and enrollment system or process changes were noted for the measurement period. **Mid-State Health Network** contracted with Peter Chang Enterprises (PCE) for eligibility and encounter data processing within the PIHP's comprehensive electronic medical record (EMR) system, the Regional Electronic Medical Record (REMI). 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, split the eligibility and enrollment data by county, and distributed the data to the 12 CMHSPs hourly. Of the 12 CMHSPs, 11 organizations used EMRs supported by PCE and subsequently received their eligibility extract files directly into their EMR systems; one CMHSP received its eligibility data through secure file transfer protocol (FTP). **Mid-State Health Network** 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 its source of truth for member eligibility.

Mid-State Health Network's eligibility process incorporated standard pre- and post-processing edits to ensure the accuracy and completeness of incoming and outgoing files. Additionally, **Mid-State Health Network** 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. Similarly, 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 website, Community Health Automated Medicaid Processing System (CHAMPS). **Mid-State Health Network** also convened an Information Technology Council 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. **Mid-State Health Network** demonstrated that eligibility effective dates, termination dates, historical eligibility spans, and dual (Medicare-Medicaid) members were identified appropriately.

Medical Services Data System (Claims and Encounters) Findings

HSAG had no major concerns with how **Mid-State Health Network** received and processed claims and encounter data for performance indicator reporting.

Mid-State Health Network delegated claims processing to its contracted CMHSPs, with the exception of SUD data, which was processed by **Mid-State Health Network** for all CMHSPs. Each CMHSP was responsible for collecting and processing claims and, subsequently, submitting encounter data using **Mid-State Health Network**'s REMI system. The CMHSPs were required to submit EDI 837 professional and institutional encounters to **Mid-State Health Network** 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. Additionally, **Mid-State Health Network** contracted with CEI to conduct an annual site review that included a detailed record review of EMR data in comparison to BH-TEDS data submitted. This oversight included the reconciliation of data between the MDHHS data warehouse and REMI encounter data files.

Data files received from the CMHSPs were loaded into REMI via an automated process. REMI contained validation edits and processes that allowed **Mid-State Health Network**, and its CMHSPs, to assess the accuracy of data at major transmission points—i.e., to **Mid-State Health Network**, 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. The State generated a 999 response file, confirming receipt of each submission. In addition, one week or more following the PIHP's file submission, the PIHP received a 4950 detailed response file, which included an explanation for each file and record rejection that occurred. Each CMHSP had the capability to download and review its response file from **Mid-State Health Network**'s REMI system.

Performance indicator data were captured and submitted by each CMHSP quarterly. **Mid-State Health Network** and the CMHSPs maintained comprehensive technical specifications that translated MDHHS Codebook requirements into CMHSP-specific system requirements. **Mid-State Health Network** ensured consistency in the application and interpretation of performance indicators across its partners through the Quality Improvement Council (QIC), which met regularly to review reporting requirements; address PIHP/CMHSP performance; and implement corrective actions, where appropriate. Additionally, **Mid-State Health Network** 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 **Mid-State Health Network**. All data files were placed into a staging table, where several validations were applied to ensure data completeness and accuracy.

For performance metric production, **Mid-State Health Network** used source code in the PCE system for aggregating the CMHSPs' data. Each CMHSP was responsible for identifying cases for inclusion in each data element (e.g., denominator, numerator, exceptions) based on the measure specifications

provided in the MDHHS Codebook. Member-level detail files, along with summary rate files, were submitted to the PIHP. The files were reviewed by the PIHP, and any notable issues were reviewed with the CMHSPs. 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 the CMHSP level as well as the PIHP level, and due to the CMHSPs using the same PCE system, there were rarely issues with the data submitted to the State for reporting.

During PSV of members' records, several cases were identified for follow-up and clarification from some of the CMHSPs reviewed. Nearly all the clarification requested was provided and satisfactorily resolved. However, it was identified that programming code used by Lifeways for Indicator #3 included two no-show appointments as follow-up service dates, programming code used by CEI for Indicator #2 allowed four dates prior to the service requests to be identified as completed assessment dates, and misinterpretation by CEI staff led to reporting of two cases as exceptions for Indicators #4b and #10 that did not meet exception criteria.

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

Mid-State Health Network 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 and 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 had the ability to log into 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.

After reviewing the final BH-TEDS data submitted by MDHHS, HSAG noted 12 member records with discrepant employment and minimum wage BH-TEDS data. To ensure the risk for potential data discrepancies is mitigated, a recommendation is outlined in the Performance Indicator Specific Findings and Recommendations section of this report.

PIHP Oversight of Affiliate Community Mental Health Centers

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

Mid-State Health Network continued to demonstrate appropriate oversight processes for all CMHSPs. The PIHP continued to use a standard template document to ensure that the CMHSPs have the same understanding of how to report performance indicators and lessen the error threshold. Consistent communication and monthly QIC committee meetings facilitated the resolution of any issues and provided opportunities to collaborate on solutions. In addition, the PIHP performed a full evaluation for each CMHSP, which included on-site desk audits and chart reviews for compliance with data capture and reporting requirements. A corrective action plan (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 SFY 2021, HSAG recommended that CEI consider adding a validation step to its programming code to look for billed services associated with the service date in the service activity log (SAL), due to the fact that no-show appointments were being identified as numerator-compliant records for Indicator #3. Additionally, HSAG recommended that **Mid-State Health Network** consider performing additional validation of the quarterly submissions against its own encounter data prior to MDHHS submission to ensure that no-show appointments were not being confused for follow-up services. During the SFY 2022 virtual review, CEI reported that changes were made to programming code following the prior year's review to ensure that no-show appointments were not being identified as compliant follow-up services and that testing of the code changes was successful.

During SFY 2021, HSAG recommended that Newaygo review two cases of non-Medicaid consumers that were reported for Indicators #1 and #3 to identify factors that led to programming code not excluding the records from the final submission (e.g., retroactive eligibility changes or coding limitations) and use the information to update the programming code. Additionally, HSAG recommended for **Mid-State Health Network** to consider performing a final validation step of the quarterly submissions against its own eligibility data to ensure that all non-Medicaid consumers are excluded from the measures. During the SFY 2022 virtual review, **Mid-State Health Network** reported that it added an extra step of validation of CMHSP data prior to MDHHS submission to check eligibility using the 834 enrollment file data as well as 270/271 data for all consumers being reported. The PIHP reported that the testing was successful and continue to use the additional validation step each quarter.

Mid-State Health Network also continued several quality improvement initiatives to address challenges and to improve indicator rates through its QIC. **Mid-State Health Network**'s QIC reviewed indicator rates at least quarterly and addressed deficiencies while also identifying solutions for improving rates. **Mid-State Health Network** reported using CAPs more during the past year and working more closely with the CMHSPs on performance issues, and as a result finding that many issues were more systemic and could be addressed through process improvement efforts across all CMHSPs. The PIHP also reported working with the CMHSPs to implement many strategies to improve access to

services, such as same-day access clinics, appointment reminders, new psychiatric urgent care facilities, and analyzing the causes of non-compliance.

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 **Mid-State Health Network**.

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

Performance Indicator		Key Review Findings	Indicator Designation
#1	The percentage of 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
#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 percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.	The PIHP/CMHSPs calculated this indicator in compliance with 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

Performance Indicator		Key Review Findings	Indicator Designation
#8	The percent of (a) adults with mental illness, and the percent of (b) adults with intellectual or developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/ intellectual or 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 intellectual or developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/ intellectual or 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 MI and I/DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.	The PIHP/CMHSPs calculated this indicator in compliance with the MDHHS Codebook specifications.	R
#13	The percent of adults with intellectual or developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	MDHHS calculated this indicator in compliance with the MDHHS Codebook specifications.	R
#14	The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	MDHHS calculated this indicator in compliance with the MDHHS Codebook specifications.	R

Strengths, Opportunities for Improvement, and Recommendations

By assessing **Mid-State Health Network**'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: Mid-State Health Network is working closely with the regional CMHSPs to implement multiple interventions to improve access to services (e.g., same-day access, appointment reminders, psychiatric urgent care centers, utilizing paraprofessionals such as family support assistants, and developing a support program for inpatient high utilizers). [**Quality**, **Timeliness**, and **Access**]

Strength #2: Mid-State Health Network has been increasingly leveraging CAPs with delegated CMHSPs and reports that through the process of working closely with the CMHSPs and monitoring performance improvement efforts, it is collectively finding many systemic issues that are being addressed through process improvements. [**Quality**]

Weaknesses and Recommendations

Weakness #1: For Indicator #2, four cases reported to HSAG in the member-level detail file indicated numerator compliance, but the assessment date in the file was prior to the service request date (e.g., 1, 351, 356, or 2,325 days prior to the request). [**Quality**]

Why the weakness exists: Programming code used by the CMHSP for the indicator was allowing dates prior to the service request to be identified as a completed assessment date.

Recommendation: The MDHHS Codebook specifications state that the date of assessment must fall within 14 days following the service request. HSAG recommends that **Mid-State Health Network** ensure that programming code used for data extraction from source systems is not using service dates prior to the qualifying event to identify numerator compliance.

Weakness #2: Two discrepancies were identified in the PSV samples for Indicator #3, as clinical documentation could not be located to validate the service dates reported in the member-level detail file provided to HSAG. [**Quality**]

Why the weakness exists: Lifeways' programming code was including no-show appointments as compliant follow-up service dates.

Recommendation: HSAG recommends that **Mid-State Health Network** ensure that programming code for all delegated CMHSPs is not identifying no-show appointments as a compliant record for the performance indicator. Additionally, HSAG recommends that the PIHP continue using the Encounters-to-BH-TEDS report as an additional check of any records that show as compliant in the BH-TEDS record but do not have a corresponding encounter for the same date.

Weakness #3: Two cases reported by CEI for Indicators #4a and #10 were reported as exceptions; but upon further review during primary source verification, it was determined that the records did not quality as exceptions. [**Quality**]

Why the weakness exists: CEI reported during the virtual review that staff members appeared to mark the cases as exceptions in the BH-TEDS record screen even though they did not quality as exceptions in the MDHHS Codebook.

Recommendation: HSAG recommends that **Mid-State Health Network** ensure that all delegated CMHSPs are identifying case exceptions using the methodology outlined in the MDHHS Codebook for each performance indicator. HSAG also recommends that the PIHP include unusual case scenarios during QIC meetings with the CMHSPs in the region to ensure that all delegates are interpreting the scenarios consistently and in accordance with the specifications.

Weakness #4: After reviewing the final BH-TEDS data submitted by MDHHS, HSAG noted 12 **Mid-State Health Network** member records with discrepant employment and minimum wage BH-TEDS data. **[Quality]**

Why the weakness exists: While errors in 12 member records are not impactful to the reported rates, individual staff member manual data entry may result in discrepancies in BH-TEDS data.

Recommendation: HSAG recommends that **Mid-State Health Network** and the CMHSPs employ additional enhancements to their BH-TEDS validation process to ensure that there are no discrepant data entered.

Appendix A. Data Integration and Control Findings

Documentation Worksheet

PIHP Name:	Mid-State Health Network
PMV Date:	June 17, 2022
Reviewers:	Emily Higgins

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.	☒	☐	☐	
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:	June 17, 2022
Reviewers:	Emily Higgins

Denominator Validation Findings for Mid-State Health Network				
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 Mid-State Health Network				
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.	☐	☐	☒	The PIHP does 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 indicators #1, #2, #2e, #3, #4a, #4b, #5, #6, and #10 is 1st Quarter SFY 2022 (October 1, 2021–December 31, 2021). The measurement period for indicators #8, #9, #13, and #14 is SFY 2021 (October 1, 2020–September 30, 2021).

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 Mid-State Health Network

1. Population	2. # of Emergency Referrals for Inpatient Screening During the Time Period	3. # of Dispositions About Emergency Referrals Completed Within Three Hours or Less	4. % of Emergency Referrals Completed Within the Time Standard
Children—Indicator #1a	**794**	**768**	**96.73%**
Adults—Indicator #1b	**2,358**	**2,339**	**99.19%**

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. *No standard currently established.*

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

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	**1,490**	**980**	**65.77%**
MI–Adults—Indicator #2b	**2,438**	**1,526**	**62.59%**
I/DD–Children—Indicator #2c	**217**	**135**	**62.21%**
I/DD–Adults—Indicator #2d	**79**	**51**	**64.56%**
Total—Indicator #2	**4,224**	**2,692**	**63.73%**

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. *No standard currently established.*

Table C-3—Indicator #2e: Access—Timeliness/First Request SUD for Mid-State Health Network 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	**387**	**2,548**	**2,935**	**13.19%**	**2,199**	**74.92%**
Northern Michigan Regional Entity	249	934	1,183	21.05%	762	64.41%
Lakeshore Regional Entity	215	1,200	1,415	15.19%	969	68.48%
Southwest Michigan Behavioral Health	401	1,247	1,648	24.33%	1,059	64.26%
NorthCare Network	111	463	574	19.34%	428	74.56%
Community Mental Health Partnership of Southeast Michigan	208	773	981	21.20%	608	61.98%
Detroit Wayne Integrated Health Network	851	2,497	3,348	25.42%	2,108	62.96%
Oakland Community Health Network	30	1,036	1,066	2.81%	983	92.21%
Macomb County Community Mental Health	53	1,169	1,222	4.34%	1,070	87.56%
Region 10 PIHP	492	1,512	2,004	24.55%	1,333	66.52%

*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 upon 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. *No standard currently established.*

Table C-4—Indicator #3: Access—Timeliness/First Service for Mid-State Health Network

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	1,191	686	57.60%
MI–Adults—Indicator #3b	1,790	1,129	63.07%
I/DD–Children—Indicator #3c	225	153	68.00%
I/DD–Adults—Indicator #3d	76	43	56.58%
Total—Indicator #3	3,282	2,011	61.27%

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 Mid-State Health Network

1. Population	2. # of Discharges From a Psychiatric Inpatient Unit	3. # of Discharges From Col 2 That Are Exceptions	4. # of Net Discharges (Col 2 Minus Col 3)	5. # of Discharges From Col 4 Followed Up by PIHP Within 7 Days	6. % of Persons Discharged Seen Within 7 Days
Children	140	46	94	91	96.81%
Adults	743	309	434	412	94.93%

Indicator #4b

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

Table C-6—Indicator #4b: Access—Continuity of Care for Mid-State Health Network

1. Population	2. # of Discharges From a Substance Abuse Detox Unit	3. # of Discharges From Col 2 That Are Exceptions	4. # of Net Discharges (Col 2 Minus Col 3)	5. # of Discharges From Col 4 Followed Up by CMHSP/PIHP Within 7 Days	6. % of Persons Discharged Seen Within 7 Days
Consumers	305	150	155	148	95.48%

Indicator #5

The percent of Medicaid recipients having received PIHP managed services.

Table C-7—Indicator #5: Access—Penetration Rate for Mid-State Health Network

1. Total Medicaid Beneficiaries Served	2. # of Area Medicaid Recipients	3. Penetration Rate
34,604	463,090	7.47%

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 Mid-State Health Network

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	1,555	1,352	86.95%

Indicator #8

The percent of (a) adults with mental illness, the percent of (b) adults with intellectual or developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/intellectual or developmental disabilities served by the CMHSPs and PIHPs who are employed competitively.[2]

Table C-9—Indicator #8: Outcomes—Competitive Employment for Mid-State Health Network

1. Population	2. Total # of Enrollees	3. # of Enrollees Who Are Competitively Employed	4. Competitive Employment Rate
MI–Adults—Indicator #8a	20,517	3,992	19.46%
I/DD–Adults—Indicator #8b	3,510	264	7.52%
MI and I/DD–Adults—Indicator #8c	2,665	250	9.38%

Indicator #9

The percent of (a) adults with mental illness, the percent of (b) adults with intellectual or developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/ intellectual or developmental disability served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.[3]

Table C-10—Indicator #9: Outcomes—Minimum Wage for Mid-State Health Network

1. Population	2. Total # of Enrollees	3. # of Enrollees Who Earn Minimum Wage or More	4. Minimum Wage Rate
MI–Adults—Indicator #9a	3,994	3,983	99.72%
I/DD–Adults—Indicator #9b	324	289	89.20%
MI and I/DD–Adults—Indicator #9c	290	269	92.76%

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

[3] 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 MI and I/DD 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 Mid-State Health Network

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
MI and I/DD–Children—Indicator #10a	**175**	**19**	**156**	**6**	**3.85%**
MI and I/DD–Adults—Indicator #10b	**933**	**76**	**857**	**98**	**11.44%**

Indicator #13

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

Table C-12—Indicator #13: Outcomes—Private Residence for Mid-State Health Network

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
I/DD–Adults	**3,510**	**651**	**18.55%**
MI and I/DD–Adults	**2,665**	**710**	**26.64%**

Indicator #14

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

Table C-13—Indicator #14: Outcomes—Private Residence-MI for Mid-State Health Network

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	20,517	10,213	49.78%

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 Mid-State Health Network

BH-TEDS Data Element	Percent Complete SFY 2021	Percent Complete 1st Quarter SFY 2022	Quarterly and Annual Indicators Impacted
Age*	100.00%	100.00%	1, 4, 8, 9, 10, 13, 14
Disability Designation*	93.34%	96.64%	8, 9, 10, 13, 14
Employment Status*	96.11%	99.70%	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.