Michigan Department of Health and Human Services

State Fiscal Year 2017 Validation of Performance Measures for Region 7—Detroit Wayne Mental Health Authority

Behavioral Health and Developmental Disabilities Administration
Prepaid Inpatient Health Plans

September 2017

HSAG HEALTH SERVICES ADVISORY GROUP

Validation Overview

Validation of performance measures is one of three mandatory external quality review (EQR) activities required by the Balanced Budget Act of 1997 (BBA). State Medicaid agencies must ensure that performance measures reported by their managed care organizations (MCOs) are validated. The state, its agent that is not an MCO or an external quality review organization (EQRO) can perform this validation. Health Services Advisory Group, Inc. (HSAG), the EQRO for the Michigan Department of Health and Human Services (MDHHS), Behavioral Health and Developmental Disabilities Administration, conducted the validation activities for the prepaid inpatient health plans (PIHPs) that provided mental health and substance abuse services to Medicaid-eligible recipients.

In 2013, MDHHS issued an *Application for Participation for Specialty Prepaid Inpatient Health Plans* and selected 10 regional entities to manage the Medicaid specialty benefit for the entire region defined by MDHHS. HSAG conducted the state fiscal year (SFY) 2017 validation activities for the 10 regional entities as outlined in the Centers for Medicare & Medicaid Services (CMS) publication, *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 1, 2012.[1]

Prepaid Inpatient Health Plan (PIHP) Information

Information about **Detroit Wayne Mental Health Authority** appears in Table 1.

Table 1—Detroit Wayne Mental Health Authority Information

PIHP Name:	Detroit Wayne Mental Health Authority
PIHP Site Visit Location:	707 W. Milwaukee Street Detroit, MI 48202
PIHP Contact:	Mary Allix
Contact Telephone Number:	313.344.9099, ext. 3101
Contact Email Address:	mallix@dwmha.com
Site Visit Date:	July 21, 2017

[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Aug 25, 2017.

Performance Measures 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 audited performance indicators calculated by the PIHPs for different populations for the first quarter of Michigan SFY 2017, which began October 1, 2016, and ended December 31, 2016. Table 3 lists the audited 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 Audited Performance Indicators Calculated by PIHPs

Indicator		Sub-Populations
#1	The percent of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	• Children • Adults
#2	The percent of new Medicaid beneficiaries during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service.	• MI-Adults • MI-Children • DD-Adults • DD-Children • Medicaid SA
#3	The percent of new Medicaid beneficiaries during the quarter starting any needed ongoing service within 14 days of a non-emergent face-to-face assessment with a professional.	• MI-Adults • MI-Children • DD-Adults • DD-Children • SA-Adult
#4a	The percent of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.	• Children • Adults
#4b	The percent of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.	• Consumers
#10	The percent of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.	• MI and DD-Adults • MI and DD-Children

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

Table 3—List of Audited Performance Indicators Calculated by MDHHS

Indicator		Sub-Populations	Measurement Period
#5	The percent of Medicaid recipients having received PIHP managed services.	• Medicaid Recipients	First Quarter SFY 2017
#6	The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	• HSW Enrollees	First Quarter SFY 2017
#8	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs* and PIHPs who are employed competitively.	• MI-Adults • DD-Adults • MI and DD Adults	SFY 2016
#9	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.	• MI-Adults • DD-Adults • MI and DD Adults	SFY 2016
#13	The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	• DD-Adults	SFY 2016
#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 2016

*CMHSP = Community Mental Health Services Program

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 also provided by MDHHS for review by the HSAG validation team. Based on the indicator definitions and reporting guidelines, HSAG developed indicator-specific worksheets derived from Attachment I of the CMS Performance Measure Validation Protocol.

Validation Results

HSAG identified overall strengths and areas for improvement for **Detroit Wayne Mental Health Authority**. In addition, HSAG evaluated **Detroit Wayne Mental Health Authority**'s data systems for the processing of each type of data used for reporting the MDHHS performance indicators. General findings are indicated below:

PIHP Strengths

The PIHP has implemented a centralized process for conducting inpatient screenings and scheduling initial appointments for non-emergent requests, which allows the PIHP to ensure it is meeting all required timelines.

The PIHP contracted with Peter Chang Enterprises, Inc. (PCE) to calculate Performance Indicator 1. The PCE system allowed the data to be locked at the time of reporting, so the PIHP had a consumer-level detail file reflective of the data used for reporting to the State.

The PIHP maintained an on-demand data dashboard that Managers of Comprehensive Provider Networks (MCPNs) can access to monitor and to ensure overall data completeness and accuracy.

PIHP Areas for Improvement

The PIHP experienced some issues with data completeness for the Behavioral Health Treatment Episode Data Set (BH-TEDS). However, the PIHP reported that it had already identified the issue. At the time of the audit, the providers submitted BH-TEDS records in batch, so the records were often received non-sequentially, resulting in file rejection. The PIHP reported that it is planning to implement a new system that will allow the PIHP to create the BH-TEDS records centrally for submission to the State. HSAG encouraged the PIHP to continue to work toward improving BH-TEDS completion rates as the PIHP did not meet the 85 percent reporting requirements for the State.

As in previous years, the PIHP struggled to provide the consumer-level detail information used for reporting to the State. HSAG recommended that the PIHP continue to explore options for creating a locked patient-level detail file, whether that is accomplished via updates to the PIHP's Mental Health Wellness Information Network (MH-WIN) or by saving copies of the files where they can be easily accessed for reference.

For Performance Indicator 1, the PIHP received data from providers for the Children population in a Microsoft Excel template developed specifically for reporting the measure. The PIHP reported that it reviewed the data for irregularities, and followed up with providers as needed, but there was no formalized validation process for these data. HSAG recommends that the PIHP develop a formal data validation process to ensure the numerator and denominator are correct.

As part of HSAG's primary source verification process, the auditor selected two cases that were reported as numerator positive for Performance Indicator 4. The auditor found that although these cases were reported as numerator positive, evidence within the PIHP's transactional system to support this decision was insufficient. Therefore, for the current reporting period, the auditor assigned a Not Reported (NR) audit designation for Performance Indicator 4a. HSAG recommended that the PIHP implement a stringent validation process to ensure that only cases with sufficient evidence for services are included in the measure calculation.

The PIHP did not meet the 95 percent standard for the DD Children and DD Adults populations in Performance Indicator 3, for the DD Children population in Performance Indicator 4a, and for both populations in Performance Indicator 10. HSAG recommended that the PIHP complete a root cause analysis to identify potential causes and explore options to increase rates for these indicators.

Eligibility Data System Findings

HSAG had no concerns with the way **Detroit Wayne Mental Health Authority** received and processed eligibility data.

For the current reporting period, the PIHP continued to use the same process for receiving and processing eligibility information. As in prior years, the PIHP continued to contract PCE to obtain and process eligibility information. Monthly eligibility full files and daily change files were received in an 834 file format via the State Web portal. Each file was subject to a validation process to ensure that only accurate data were loaded into MH-WIN, the PIHP's transactional system. In addition, the PIHP continued to send a nightly 270 eligibility inquiry file to the State's Community Health Automated Medicaid Processing System (CHAMPS) for new consumers, consumers on spend down, consumers whose eligibility is missing, and a portion of active consumers. The 271 response file was used to update eligibility information. All consumer eligibility was validated through the 270/271 process at least once per month. Adequate validation processes were in place and continued to ensure data accuracy.

Weekly, PCE provided enrollment data to all contracted MCPNs with a list of consumers assigned to them. In addition, providers, MCPNs, and PIHP staff members were able to perform a real-time eligibility lookup by logging into CHAMPS via a link located in the MH-WIN data warehouse or by using their own systems.

During the on-site visit, **Detroit Wayne Mental Health Authority** demonstrated the MH-WIN system, from which the auditor was able to identify that the capture of eligibility effective dates, termination dates, and historical eligibility spans as well as identification of dual (Medicare/Medicaid) consumers were appropriate. Adequate reconciliation and validation processes were in place at each point of data transfer to ensure data completeness and accuracy.

Claims/Encounter Data System Findings

HSAG identified no concerns with how **Detroit Wayne Mental Health Authority** received and processed claims/encounters.

For the current reporting period, MCPN providers submitted claims by uploading them to MH-WIN. Providers were able to enter claims information directly or upload 837 files to MH-WIN. Each file was subjected to a built-in pre-adjudication validation process to ensure data completeness and accuracy. If an error was detected, the file was sent back to its original source for correction, ensuring data accuracy prior to State submission. Providers were able to enter claims information directly or upload 837 files to MH-WIN. All claims (100 percent) were auto-adjudicated. Only out-of-network providers were allowed to submit paper claims to the PIHP. These claims were received by the mailroom, date stamped, and manually entered into MH-WIN. Manually entered claims were validated using built-in system edits. All system edits aligned with or were stricter that State edits.

Validated 837 files were submitted to the State weekly. The State generated a 999 response file, confirming the receipt of each submission. In addition, within one day of submission, the PIHP received a 4950 detailed response file which included an explanation for each file/record rejection that occurred. The PIHP corrected those errors it was able to correct and forwarded all others to the provider for correction. Each MCPN had the capability to download and review its response file.

The PIHP conducted a review of a 10 percent random sample of claims data for each MCPN to ensure accuracy. PIHP staff also conducted an on-site review of provider files to ensure accuracy and completeness of the claims data. The PIHP also required each MCPN to conduct a similar random sample review of its claims and send the results to the PIHP for review.

The PIHP continued to contract PCE to calculate performance indicators 2, 3, and 4b. Performance indicators 1, 4a, and 10 were calculated by the contracted MCPNs. All cases were identified based on the description provided in the MDHHS Codebook. MCPNs provided both detailed and summary files to the PIHP by using a secure FTP site or by directly uploading them to MH-WIN. The PIHP aggregated data received from the MCPNs and entered the result into a template provided by the State. Several validations were applied to the data files to ensure data completeness and accuracy prior to the final rate calculations for measure reporting.

As mentioned previously, the PIHP should implement a more stringent validation process to ensure data accuracy prior to rate submission to the State.

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

HSAG identified no concerns with **Detroit Wayne Mental Health Authority**'s quality improvement data production process.

The PIHP continued to contract with PCE to prepare and submit BH-TEDS data files to the State. At the time of the consumer's initial screening, providers collected BH-TEDS-related data. Providers entered

the BH-TEDS data into their respective transactional systems and then uploaded data files in batch to the PIHP via MH-WIN. Substance use disorder (SUD) providers entered BH-TEDS directly into MH-WIN. BH-TEDS were completed at an initial assessment and annually thereafter, or if any major change occurred in the consumer information. Adequate validation processes were in place to ensure data accuracy and completeness. The PIHP submitted BH-TEDS data files to the State weekly, via the FTP site. After submission, the PIHP received a 4956 QI detailed response file, which included explanations for any file rejection that occurred. Errors received from the State were resolved at the PIHP level. The PIHP maintained a dashboard where it could monitor the providers' BH-TEDS completion rates. Providers were also able to view their own BH-TEDS completion rates via the dashboard. If the PIHP had any concerns about a particular provider not completing BH-TEDS data, the PIHP would follow up with the provider to resolve the issue.

Detroit Wayne Mental Health Authority's rates showed a need for improvement in completion of its BH-TEDS data. BH-TEDS records were often received non-sequentially because they were submitted by providers in batch. This resulted in change records being received for consumers prior to the initial assessment record, which caused rejection of the records at the State level. The PIHP advised that it was exploring options to resolve this issue. HSAG recommended that the PIHP explore opportunities to improve rates for the next reporting period.

PIHP Oversight of Affiliate Community Mental Health Centers

HSAG found that **Detroit Wayne Mental Health Authority** had sufficient oversight of its four contracted MCPNs.

The PIHP continued to audit its MCPNs both annually and quarterly. Several audit tools continued to assist in performing chart reviews and evaluating claims information for compliance with data capture and reporting requirements. In addition, similar to last year, the PIHP continued to use a dashboard to monitor all encounters received from its MCPNs. This dashboard helped to track each MCPN's progress in encounter submissions and areas for possible improvement. A corrective action plan was implemented for any MCPN not in compliance with requirements set by the PIHP. In addition, monthly quality meetings were also in place to further execute root cause analysis on data quality, discuss performance results, and examine areas for improvement and consistency.

SUD providers were also audited annually using a process similar to the MCPN audit. SUD provider data were not included in the PIHP's dashboard. However, the PIHP reviewed and monitored SUD data submissions, tracked errors, and coordinated with SUD providers to resolve all errors.

The PIHP ended its contract with Gateway Community Health in June 2016 due to performance issues. The system used by Gateway was a standalone system. Data were not integrated into ODIN. However, the PIHP ensured that it had access to Gateway's system after the contract ended to ensure data completeness for rate reporting.

PIHP Actions Related to Previous Recommendations

The PIHP performed below the standards for Performance Indicators 1 and 10 during the previous reporting period. The PIHP implemented several performance improvements which resulted in the PIHP meetings standards for performance indicators 1 and 10 for the Children populations. The PIHP still did not meet standards for the Adult population in Performance Indicator 10.

The PIHP continued to struggle with completion rates for BH-TEDS data.

Regarding issues encountered during data validation caused by not having a locked consumer-level detail file, the PIHP contracted with PCE for calculation of Performance Indicator 1. The PCE system was developed to create a locked consumer-level detail file for reporting purposes. The PIHP developed an internal process for saving a copy of the consumer-level detail file created in MH-WIN for reporting rates to the State.

During the previous audit, the PIHP reported that it performed performance measure data validation, but this often occurred after the data were submitted to the State. The PIHP has enhanced its validation processes to include a review of a 10 percent random sample of claims data for each MCPN each month.

In regard to Performance Indicator 1, for which the PIHP received an NR designation in the previous audit, the PIHP contracted with PCE to calculate this performance measure, and all cases were found to be compliant during primary source verification.

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

Report (R)	Indicator was compliant with the State's specifications and the rate can be reported.
Not Reported (NR)	This designation is assigned to measures for which: (1) the PIHP rate was materially biased or (2) the PIHP was not required to report.
No Benefit (NB)	Indicator was not reported because the PIHP did not offer the benefit required by the 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 NR because the impact of the error biased the reported performance indicator by more than 5 percentage points. Conversely, it is also possible that several audit element errors may have little

impact on the reported rate, and the indicator could be given a designation of R. Audit elements and their scoring designations (i.e., *Met*, *Not Met*, and *Not Applicable [N/A]*) can be found in Appendix A—Data Integration and Control Findings and Appendix B—Denominator and Numerator Elements. Table 7 displays the indicator-specific review findings and designations for **Detroit Wayne Mental Health Authority**.

Table 7—Indicator-Specific Review Findings and Designations for Detroit Wayne Mental Health Authority

Performance Indicator		Key Review Findings	Indicator Designation
#1	The percent of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	The PIHP calculated this indicator in compliance with MDHHS Codebook specifications.	R
#2	The percent of new Medicaid beneficiaries during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service.	The PIHP calculated this indicator in compliance with MDHHS Codebook specifications.	R
#3	The percent of new Medicaid beneficiaries during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional.	The PIHP calculated this indicator in compliance with MDHHS Codebook specifications.	R
#4a	The percent of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.	Although the PIHP calculated this indicator in accordance with MDHHS Codebook specifications, during the primary source verification process, the auditor noted that at least two cases were reported as numerator positive. Evidence within the transactional system to support the decision to report these cases as numerator positive was insufficient.	NR
#4b	The percent of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.	The PIHP calculated this indicator in compliance with MDHHS Codebook specifications.	R
#5	The percent of Medicaid recipients having received PIHP managed services.	MDHHS calculated this indicator in compliance with MDHHS Codebook specifications.	R

Performance Indicator		Key Review Findings	Indicator Designation
#6	The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	MDHHS calculated this indicator in compliance with MDHHS Codebook specifications.	R
#8	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who are employed competitively.	MDHHS calculated this indicator in compliance with MDHHS Codebook specifications.	R
#9	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.	MDHHS calculated this indicator in compliance with MDHHS Codebook specifications.	R
#10	The percent of readmissions of MI and DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.	The PIHP calculated this indicator in compliance with MDHHS Codebook specifications.	R
#13	The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	MDHHS calculated this indicator in compliance with MDHHS Codebook specifications.	R
#14	The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	MDHHS calculated this indicator in compliance with MDHHS Codebook specifications.	R