Michigan Department of Health and Human Services

State Fiscal Year 2023 Validation of Performance Measures for Region 7—Detroit Wayne Integrated Health Network

Behavioral Health and Developmental Disabilities Administration
Prepaid Inpatient Health Plans

September 2023

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: July 28, 2023.

Prepaid Inpatient Health Plan (PIHP) Information

Information about **Detroit Wayne Integrated Health Network** (**Detroit Wayne**) appears in Table 1.

Table 1—Detroit Wayne Information

PIHP Name:	**Detroit Wayne Integrated Health Network**
PIHP Location:	707 W Milwaukee Street, Detroit, MI 48202
PIHP Contact:	April Siebert
Contact Telephone Number:	313.949.3551
Contact Email Address:	asiebert@dwihn.org
PMV Virtual Review Date:	July 10, 2023

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) 2023, which began October 1, 2022, and ended December 31, 2022. 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 2023
#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 2023
#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 2023
#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 2023
#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 2023
#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 2023

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 2023
#5	The percent of Medicaid recipients having received PIHP managed services.	• Medicaid Recipients	1st Quarter SFY 2023
#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 2023
#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 2022
#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 2022
#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 2022
#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 2022

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 Daniel, 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, medical billing, data integration and validation, and care management.
Tiffany Gardiner, BS *Auditor I, DSAA*; *Secondary Auditor*	Audit support team member; assists with EQR PMV and HEDIS audit-related projects, including implementation, project management, analysis, and reporting.
Matt Kelly, MBA *Manager II, DSAA*; *Source Code Liaison*	Multiple years of systems analysis, quality improvement, data review and analysis, and healthcare industry experience.
Ron Holcomb *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 2022 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 **Detroit Wayne** staff members who were involved with any aspect of performance indicator reporting. Table 5 displays a list of **Detroit Wayne** virtual review participants:

Table 5—List of Detroit Wayne Virtual Review Participants

Name	Title
Shama Faheem	Chief Medical Officer, Detroit Wayne
April Siebert	Director of Quality Improvement, Detroit Wayne
Tania Greason	Provider Network—Quality Improvement Administrator, Detroit Wayne
Justin Zeller	Quality Improvement Clinical Specialist, Detroit Wayne
Manny Singla	Executive Vice President (VP) of Operations, Detroit Wayne
Keith Frambro	VP of Information Technology Services, Detroit Wayne
Gary Herman	Application Support Manager, Detroit Wayne
Deabra Hardrick-Crump	Director of Claims, Detroit Wayne
Quinnetta Allen	Claims Manager, Detroit Wayne
Judy Davis	SUD Director, Detroit Wayne
Samy Ganesan	Applications Programmer, Detroit Wayne
David DesNoyer	Senior Systems Analyst/Project Manager, Peter Chang Enterprises, Inc. (PCE)
Brandon Henry	Software Developer, PCE Systems
Jacqueline Davis	Clinical Officer, Detroit Wayne
Daniel West	Director of Crisis Access, Detroit Wayne
Yvonne Bostic	Director of Access, Detroit Wayne
Anthony Edwards	Administrator Access, Detroit Wayne

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 **Detroit Wayne** 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 **Detroit Wayne**, 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 **Detroit Wayne** 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 **Detroit Wayne** was:

☒ Acceptable

☐ Not acceptable

Validation Results

HSAG evaluated **Detroit Wayne**'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 **Detroit Wayne** are indicated below.

Eligibility and Enrollment Data System Findings

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

The PIHP continued to contract with PCE to obtain and process eligibility information directly into **Detroit Wayne**'s Mental Health Wellness Information Network (MH-WIN) electronic medical record. Full Medicaid Electronic Data Interchange (EDI) 834 reconciliation files were processed monthly while daily EDI 834 change files were obtained from the State's secure file transfer protocol (FTP) site and processed nightly into MH-WIN's insurance tables. Each processed file was subject to pre- and post-validation processes to ensure the accuracy of data in the MH-WIN system.

Additionally, the PIHP continued to send 270 eligibility inquiry files to the State's Community Health Automated Medicaid Processing System (CHAMPS) for new members, Medicaid spend-down members, members whose eligibility was missing, and a portion of active members. The 271 response file was used to update eligibility information. All member eligibility was validated through this 270/271 process at least once per month with approximately 5 percent of the monthly EDI 834 files processed daily. The PIHP demonstrated sufficient validation processes were in place to ensure the timeliness and accuracy of incoming eligibility and enrollment data.

Each member was assigned a unique identification (ID) number, which was retained across all service episodes and utilized by **Detroit Wayne**'s direct providers and contract providers. In instances where there were duplicate members within MH-WIN, which happened infrequently, there was a system process to combine the two member records under one ID number.

During the virtual review, **Detroit Wayne** demonstrated the MH-WIN system. HSAG confirmed that the capture of eligibility effective dates, termination dates, and historical eligibility spans, as well as identification of members was appropriate. Adequate reconciliation and validation processes were in place at each point of data transfer to ensure data completeness and accuracy.

Medical Services Data System (Claims and Encounters) Findings

HSAG had no concerns with how **Detroit Wayne** received and processed claim/encounter data for submission to MDHHS.

For the measurement period, contracted providers submitted claims by uploading them directly to MH-WIN, via EDI 837 professional or institutional transaction files, or by fax. Each file was subjected to a built-in pre-adjudication validation process to ensure data completeness and accuracy. Providers were

required to review error reports to ensure the accuracy of claims prior to submission. If an error was detected, the provider was required to correct the errors and resubmit the file for payment with 30 days.

Detroit Wayne implemented a multi-step process to batch and process claims as they were received. In addition to the pre-adjudication checks in place for submitting providers, **Detroit Wayne**'s claims processing incorporated defined steps with pre-defined stages for validating claims to ensure the accuracy of data entered and the proper processing of claims. Overall, 92 to 100 percent of all claims were processed electronically. A small percentage of paper claims, approximately 1 percent, were submitted via fax at the request of **Detroit Wayne**. These claims were manually entered in MH-WIN and hard copies were stored in an indexing system. Manually entered claims were validated using system edits and validation edits described above. All claims, regardless of format, were processed electronically through **Detroit Wayne**'s staged claim process. Since all claims were validated upon entry, by providers or PIHP staff members, 99 percent of claims were auto-adjudicated. SUD providers entered service data directly into MH-WIN prior to being batched and submitted as encounters to the State.

Following claims adjudication, service data were batched, translated into EDI 837 transaction files, and submitted to the State weekly. **Detroit Wayne** retrieved 999 and 4950 response files to determine whether files or records were rejected and the reason. **Detroit Wayne** staff members were able to identify and correct errors based on a report received from information technology. Any errors that could not be addressed by staff members were forwarded to the appropriate provider to address. Due to the MH-WIN system capturing the same edits as the State, most errors were caught prior to submission to the State. Approximately 99 percent of encounters were accepted by the State.

All data required to produce quarterly performance measures were collected and maintained within **Detroit Wayne**'s MH-WIN system. **Detroit Wayne** continues to use a performance indicator module to support both the collection and reporting of performance measures. The performance indictor module allowed both **Detroit Wayne** staff members and providers to review the data in MH-WIN and subsequent compliance with performance indictors in real time. In coordination with its vendor, PCE, performance indictor programming logic was reviewed when MDHHS implemented program changes to ensure compliance with State requirements. Combined with the use and collection of service data in defined forms, **Detroit Wayne** was able to ensure data collection and reporting aligned with the technical specifications provided in the MDHHS Codebook. Regular monitoring of performance indicator data and results enabled the PIHP to not only validate data but confirm the appropriate application of programming logic. **Detroit Wayne**'s source code was received, reviewed, and approved by HSAG.

During the virtual site visit, **Detroit Wayne** demonstrated the MH-WIN system and confirmed that critical data elements for performance measure calculation (e.g., member demographics, dates of service, service outcomes, exclusions) were consistently collected through standard mechanisms. Substantial reconciliation and validation processes were in place within the organization and its systems to ensure data completeness and accuracy.

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

HSAG had no concerns with the BH-TEDS data entry and production processes used by **Detroit Wayne**.

At the time of the member's initial screening, providers collected and entered the BH-TEDS data into their respective transactional systems, then uploaded data files in batch to **Detroit Wayne** via MH-WIN. BH-TEDS data for SUD-related services were entered directly into MH-WIN by the **Detroit Wayne** providers.

BH-TEDS records were completed during the initial assessment, annual update, and at discharge. Updates were also sent more frequently than yearly if any major change occurred in member information. Adequate validation processes were in place to ensure data accuracy and completeness. **Detroit Wayne** submitted BH-TEDS data files to the State monthly via the FTP site. BH-TEDS files could be submitted multiple times within a month if the files were available. After submission, the PIHP received a 4956 QI detailed response file, which included explanation for any file rejection that occurred. Errors received from the State were resolved at the provider level and reviewed by the PIHP prior to the submission to MDHHS. **Detroit Wayne** maintained a dashboard where it could monitor the providers' BH-TEDS completion rates. Providers could also view their own BH-TEDS completion rates via the dashboard. If the PIHP had any concerns about a specific provider not completing BH-TEDS data, **Detroit Wayne** staff members could follow up with the provider to resolve the issue.

PIHP Oversight of Affiliate Community Mental Health Centers

Detroit Wayne is a stand-alone PIHP; therefore, this section is not applicable.

PIHP Actions Related to Previous Recommendations and Areas of Improvement

During the SFY 2022 validation activities, HSAG identified the following:

- **Detroit Wayne**'s member-level detail file captured a different pre-admission screening and disposition date and time for one case. Another case was identified as having a different disposition screening date and time. **Detroit Wayne** noted that the provider(s) in error updated the existing screening for both cases instead of creating a new screening for the consumer. These errors led to two cases being identified as out of compliance when documentation supported these cases as being compliant. While no other cases reviewed during PSV contained this anomaly, in order to improve rates related to Indicator #1 and ensure providers were correctly capturing screening data and meeting MDHHS Codebook requirements, HSAG recommended that **Detroit Wayne** provide training to its providers to ensure they understand the process and procedures of correctly capturing data related to the pre-admission screening. In addition, HSAG recommend that **Detroit Wayne** monitor and review cases that might appear to be anomalies as a quality check. For the two cases that were mentioned above, both cases were out of compliance by nearly a week and should have initiated an inquiry internally by the PIHP due to being so far out of compliance. During the

SFY 2023 audit, **Detroit Wayne** indicated that it had worked with providers on the data and processes surrounding Indicator #1. A pre-admission review amendment is now being used, which allows providers to make updates without changing the original disposition date and time.

- During the PSV session of the virtual review for Indicator #2, **Detroit Wayne** was unable to locate additional documentation within its MH-WIN for two cases after the consumers no showed for their appointments within 14 days of request of service. **Detroit Wayne** was not capturing additional documentation from the providers to show follow-up within 14 days of the request even after the consumers no showed. HSAG recommended that **Detroit Wayne** capture additional follow-up by the providers to ensure providers are still trying to follow-up with a consumer within the 14-day window in order show due diligence of trying to meet MDHHS specifications for the indicator. During the SFY 2023 audit, **Detroit Wayne** discussed that it had implemented an audit tool for Indicators #2, #3, and #4 to ensure that providers are conducting outreach. **Detroit Wayne** also updated its policy for provider outreach to reflect that five outreach attempts using different methods of outreach should be conducted for all members. Previously the policy reflected a requirement of three outreach attempts. Provider outreach was also discussed during monthly meetings.

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 **Detroit Wayne**.

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

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 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 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 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 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 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 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 **Detroit Wayne**'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: Detroit Wayne demonstrated improvement efforts as related to the performance indicators. **Detroit Wayne** continued to meet with its clinically responsible service providers (CRSPs) every 30 to 45 days to review topics such as rates for Indicators #2, #3 and #4a. Previous and current quarter individual rates were shared and discussed at every meeting. Data, barriers, interventions, and opportunities were also discussed at each meeting. Beginning May 2023, CRSPs were able to review their individual rates in **Detroit Wayne**'s risk matrix module, which allowed the CRSPs to view real-time data. In addition, financial incentives from **Detroit Wayne**'s finance department have been offered for high performance for the performance indicators. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: Although improvement efforts were discussed related to Indicator #2, the rates for MI and I/DD children (i.e., Indicators #2a and #2c) decreased from SFY 2022 to SFY 2023. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: The rates for Indicators #2a and #2c decreased from SFY 2022 to SFY 2023, suggesting that some children may not have been able to get a timely biopsychosocial assessment completed following a non-emergency request for service.

Recommendation: HSAG recommends that **Detroit Wayne** continue with its improvement efforts, including provider outreach, monitoring, and financial incentives, related to Indicator #2 to further ensure timely and accessible treatments and supports for individuals. Timely assessments are critical for engagement and person-centered planning.

Appendix A. Data Integration and Control Findings

Documentation Worksheet

PIHP Name:	Detroit Wayne Integrated Health Network
PMV Date:	July 10, 2023
Reviewers:	Jacilyn Daniel and Tiffany Gardiner

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:	Detroit Wayne Integrated Health Network
PMV Date:	July 10, 2023
Reviewers:	Jacilyn Daniel and Tiffany Gardiner

Denominator Validation Findings for Detroit Wayne				
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 Detroit Wayne				
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 1st Quarter SFY 2023 (October 1, 2022–December 31, 2022). The measurement period for indicators #8, #9, #13, and #14 is SFY 2022 (October 1, 2021–September 30, 2022).

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 Detroit Wayne

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	**791**	**785**	**99.24%**
Adults—Indicator #1b	**2,656**	**2,606**	**98.12%**

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 Detroit Wayne

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	**670**	**193**	**28.81%**
MI–Adults—Indicator #2b	**1,964**	**1,067**	**54.33%**
I/DD–Children—Indicator #2c	**425**	**122**	**28.71%**
I/DD–Adults—Indicator #2d	**62**	**27**	**43.55%**
Total—Indicator #2	**3,121**	**1,409**	**45.15%**

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 Detroit Wayne 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
Detroit Wayne Integrated Health Network	**1,031**	**2,844**	**3,875**	**26.61%**	**2,381**	**61.45%**
Northern Michigan Regional Entity	161	1,054	1,215	13.25%	795	65.43%
Lakeshore Regional Entity	258	1,124	1,382	18.67%	929	67.22%
Southwest Michigan Behavioral Health	386	1,207	1,593	24.23%	993	62.34%
Mid-State Health Network	482	2,684	3,166	15.22%	2,301	72.68%
Community Mental Health Partnership of Southeast Michigan	237	824	1,061	22.34%	640	60.32%
NorthCare Network	107	461	568	18.84%	367	64.61%
Oakland Community Health Network	140	833	973	14.39%	795	81.71%
Macomb County Community Mental Health	386	1,207	1,593	24.23%	993	62.34%
Region 10 PIHP	387	1,689	2,076	18.64%	1,499	72.21%

*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 Detroit Wayne

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	478	408	85.36%
MI–Adults—Indicator #3b	1,482	1,316	88.80%
I/DD–Children—Indicator #3c	322	273	84.78%
I/DD–Adults—Indicator #3d	61	47	77.05%
Total—Indicator #3	2,343	2,044	87.24%

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 Detroit Wayne

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	105	55	50	50	100.00%
Adults	1,393	908	485	476	98.14%

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 Detroit Wayne

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	726	219	507	507	100.00%

Indicator #5

The percent of Medicaid recipients having received PIHP managed services.

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

1. Total Medicaid Beneficiaries Served	2. # of Area Medicaid Recipients	3. Penetration Rate
825,835	48,413	5.86%

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 Detroit Wayne

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	990	926	93.54%

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.[4]

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

1. Population	2. Total # of Enrollees	3. # of Enrollees Who Are Competitively Employed	4. Competitive Employment Rate
MI–Adults—Indicator #8a	33,209	5,793	17.44%
I/DD–Adults—Indicator #8b	5,822	512	8.79%
MI and I/DD–Adults—Indicator #8c	2,007	151	7.52%

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.[5]

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

1. Population	2. Total # of Enrollees	3. # of Enrollees Who Earn Minimum Wage or More	4. Minimum Wage Rate
MI–Adults—Indicator #9a	5,794	5,785	99.84%
I/DD–Adults—Indicator #9b	566	534	94.35%
MI and I/DD–Adults—Indicator #9c	154	152	98.70%

[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 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 Detroit Wayne

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	**173**	**0**	**173**	**13**	**7.51%**
MI and I/DD–Adults—Indicator #10b	**1,702**	**0**	**1,702**	**250**	**14.69%**

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 Detroit Wayne

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	**5,822**	**1,227**	**21.08%**
MI and I/DD–Adults	**2,013**	**586**	**29.11%**

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 Detroit Wayne

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	33,433	13,186	39.44%

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 Detroit Wayne

BH-TEDS Data Element	Percent Complete SFY 2022	Percent Complete 1st Quarter SFY 2023	Quarterly and Annual Indicators Impacted
Age*	100.00%	100.00%	1, 4, 8, 9, 10, 13, 14
Disability Designation*	95.94%	97.62%	8, 9, 10, 13, 14
Employment Status*	98.37%	100.00%	8, 9
Minimum Wage*	99.98%	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.