Michigan Department of Health and Human Services

# State Fiscal Year 2024 Validation of Performance Measures for Region 7—Detroit Wayne Integrated Health Network

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

*October 2024*

HSAG HEALTH SERVICES ADVISORY GROUP

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## Validation Overview

The Michigan Department of Health and Human Services (MDHHS) oversees and administers the Medicaid program in the State of Michigan. In 2013, MDHHS selected 10 behavioral health managed care organizations (MCOs) to serve as prepaid inpatient health plans (PIHPs). The PIHPs are responsible for managing Medicaid beneficiaries' behavioral healthcare, including authorization of services, and monitoring of health outcomes and standards of care. The PIHPs serve members directly or through contracts with providers and community mental health services programs (CMHSPs).

The Centers for Medicare & Medicaid Services (CMS) requires that states, through their contracts with PIHPs, measure and report on performance to assess the quality and appropriateness of care and services provided to members. Validation of performance measures is one of the mandatory external quality review (EQR) activities that Title 42 of the Code of Federal Regulations (CFR) §438.350(a) requires states that contract with MCOs to perform.

The purpose of performance measure validation (PMV) is to assess the accuracy of performance indicators reported by PIHPs and to determine the extent to which performance indicators reported by the PIHPs follow state specifications and reporting requirements. According to CMS' *External Quality Review (EQR) Protocols, February 2023*,[1] the mandatory PMV activity may be performed by the state Medicaid agency, an agent that is not a PIHP, or an external quality review organization (EQRO).

To meet the PMV requirements, MDHHS contracted with Health Services Advisory Group, Inc. (HSAG), the EQRO for MDHHS, to conduct the PMV for each PIHP. HSAG validated the PIHPs' data collection and reporting processes used to calculate performance indicator rates. MDHHS developed a set of performance indicators that the PIHPs were required to calculate and report.

[1] Department of Health and Human Services. Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols, February 2023*. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: September 6, 2024.

# Prepaid Inpatient Health Plan (PIHP) Information

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

**Table 1—DWIHN Information**

| | |
|---|---|
| **PIHP Name:** | Detroit Wayne Integrated Health Network |
| **PIHP Location:** | 8726 Woodward Ave, Detroit, MI 48202 |
| **PIHP Contact:** | April Siebert |
| **Contact Telephone Number:** | 313.949.3551 |
| **Contact Email Address:** | asiebert@dwihn.org |
| **PMV Virtual Review Date:** | August 1, 2024 |

## Performance Indicators Validated

HSAG validated a set of performance indicators that were developed and selected by MDHHS for validation. The reporting cycle and measurement period were specified for each indicator by MDHHS. Table 2 lists the performance indicators calculated by the PIHPs for specific populations for the first quarter (Q1) of state fiscal year (SFY) 2024, which began October 1, 2023, and ended December 31, 2023. Table 3 lists the performance indicators calculated by MDHHS, each with its specific measurement period. The indicators are numbered as they appear in the MDHHS Codebook.

**Table 2—List of Performance Indicators Calculated by PIHPs**

| Indicator | | Sub-Populations | Measurement Period |
|---|---|---|---|
| #1 | The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. | • Children<br>• Adults | Q1<br>SFY 2024 |
| #2 | The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service. | • MI–Adults<br>• MI–Children<br>• I/DD–Adults<br>• I/DD–Children | Q1<br>SFY 2024 |
| #3 | The percentage of new persons during the quarter starting any medically necessary ongoing covered service within 14 days of completing a non-emergent biopsychosocial assessment. | • MI–Adults<br>• MI–Children<br>• I/DD–Adults<br>• I/DD–Children | Q1<br>SFY 2024 |
| #4a | The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days. | • Children<br>• Adults | Q1<br>SFY 2024 |
| #4b | The percent of discharges from a substance abuse detox unit who are seen for follow-up care within 7 days. | • Consumers | Q1<br>SFY 2024 |
| #10 | The percentage of readmissions of children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge. | • Children<br>• Adults | Q1<br>SFY 2024 |

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

**Table 3—List of Performance Indicators Calculated by MDHHS**

| Indicator | | Sub-Populations | Measurement Period |
|---|---|---|---|
| #2e | The percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of a non-emergency request for service for persons with substance use disorders (SUDs). | • Consumers | Q1 SFY 2024 |
| #5 | The percent of Medicaid recipients having received PIHP managed services. | • Medicaid Recipients | Q1 SFY 2024 |
| #6 | The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination. | • HSW Enrollees | Q1 SFY 2024 |
| #8 | The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disability served by the CMHSPs and PIHPs who are employed competitively. | • MI–Adults<br>• DD–Adults<br>• MI and DD–Adults | SFY 2023 |
| #9 | The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disability served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities. | • MI–Adults<br>• DD–Adults<br>• MI and DD–Adults | SFY 2023 |
| #13 | The percent of adults with dual diagnosis (MI and DD) served, who live in a private residence alone, with spouse, or non-relatives. | • DD–Adults<br>• MI and DD–Adults | SFY 2023 |
| #14 | The percent of adults with mental illness served, who live in a private residence alone, with spouse, or non-relatives. | • MI–Adults | SFY 2023 |

# Description of Validation Activities

## *Pre-Audit Strategy*

HSAG conducted the validation activities as outlined in the CMS Performance Measure Validation Protocol. HSAG obtained a list of the indicators selected by MDHHS for validation. Indicator definitions and reporting templates were provided by MDHHS to HSAG.

In collaboration with MDHHS, HSAG prepared a documentation request letter that was submitted to the PIHPs. This documentation request letter outlined the steps in the PMV process. The documentation request letter included a request for the source code for each performance indicator calculated by the PIHP, a completed Information Systems Capabilities Assessment Tool (ISCAT), any additional supporting documentation necessary to complete the audit, a timeline for completion, and instructions for submission. HSAG also requested that each PIHP submit member-level detail files for review.

Following the PIHPs' receipt of the documentation request letter and accompanying documents, HSAG convened a technical assistance webinar with the PIHPs. During this meeting, HSAG discussed the PMV purpose and objectives, reviewed the performance measures in the scope of the current year's PMV activities, and reviewed the documents provided to the PIHPs with the documentation request letter and PMV activities. Throughout the pre-virtual review phase, HSAG also responded to any audit-related questions received directly from the PIHPs.

Upon submission of the requested source code, completed ISCAT, additional supporting documentation, and member-level detail files, HSAG began a desk review of the submitted documents to determine any follow-up questions, potential concerns related to information systems capabilities or measure calculations, and recommendations for improvement based on the PIHPs' and CMHSPs' current processes. HSAG also selected a sample of cases from the member-level detail files and provided the selections to the PIHPs. The PIHPs and/or CMHSPs were required to provide HSAG screen shots from the source system to confirm data accuracy. HSAG communicated any follow-up questions or required clarification to the PIHP during this process.

HSAG prepared an agenda describing all PMV activities and indicating the type of staff (by job function and title) required for each session. This included special requests for system reviews for PIHPs and related CMHSPs, especially when multiple systems were used to collect and track measure-related data. The agendas were sent to the respective PIHPs prior to the PMV conducted virtually.

## Validation Team

HSAG's validation team was composed of a lead auditor and several validation team members. HSAG assembled the team based on the skills required for the validation of the PIHPs' performance indicators. Table 4 describes each team member's role and expertise.

**Table 4—Validation Team**

| Name and Role | Skills and Expertise |
|---|---|
| Emily Redman, MA, LPCC-S, CHCA<br>*Associate Director, Data Science & Advanced Analytics (DSAA);*<br>*Lead Auditor* | Multiple years of experience in conducting audits related to performance measurement, including Healthcare Effectiveness Data and Information Set (HEDIS®)[2] Compliance Audits™,[3]; quality improvement; data review and analysis; data integration and validation; care management; and the healthcare industry. |
| Jacilyn Gatete, MAS, CHCA<br>*Analytics Manager II*, *DSAA*;<br>*PIHP PMV Project Manager* | Multiple years of experience conducting audits, including HEDIS Compliance Audits™ related to performance measurement, electronic health records, medical billing, data integration and validation, and care management. |
| Naomi Abraha, MPH<br>*Analytics Coordinator III, DSAA;*<br>*Source Code Liaison* | Audit support team member; assists with PMV, including implementation, project coordination, analysis, and reporting. |
| Ron Holcomb<br>*Source Code Reviewer* | Multiple years of experience in statistics, analysis, and source code/programming language knowledge. |

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

## Technical Methods of Data Collection and Analysis

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

- **Information Systems Capabilities Assessment Tool (ISCAT)**—The PIHPs were required to submit a completed ISCAT that provided information on the PIHPs' and CMHSPs' information systems; processes used for collecting, storing, and processing data; and processes used for performance measure calculation. Upon receipt by HSAG, the ISCAT(s) underwent a cursory review to ensure each section was complete and all applicable attachments were present. HSAG then thoroughly reviewed all documentation, noting any potential issues, concerns, and items that needed additional clarification.
- **Source code (programming language) for performance indicators**—PIHPs that calculated the performance indicators using computer programming language were required to submit source code for each performance indicator being validated. HSAG completed line-by-line review on the supplied source code to ensure compliance with the State-defined performance indicator specifications. HSAG identified areas of deviation from the specifications, evaluating the impact to the indicator and assessing the degree of bias (if any). PIHPs that did not use computer programming language to calculate the performance indicators were required to submit documentation describing the actions taken to calculate each indicator.
- **Performance indicator reports**—HSAG also reviewed the PIHPs' SFY 2023 performance indicator reports. The previous year's reports were used along with the current reports to assess trending patterns and rate reasonability.
- **Supporting documentation**—The PIHPs and CMHSPs submitted documentation to HSAG that provided additional information to complete the validation process, including policies and procedures, file layouts, system flow diagrams, system log files, and data collection process descriptions. HSAG reviewed all supporting documentation, with issues or clarifications flagged for follow-up. This additional documentation also included measure-level detail files provided for each indicator for data verification.

## PMV Activities

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

- **Opening session**—The opening session included introductions of the validation team and key PIHP staff members involved in the PMV activities. Discussion during the session covered the review purpose, the required documentation, basic meeting logistics, and queries to be performed.

- **Evaluation of system compliance**—The evaluation included a review of the information systems, focusing on the processing of enrollment and disenrollment data. Additionally, HSAG evaluated the processes used to collect and calculate the performance indicators, including accurate numerator and denominator identification, and algorithmic compliance (which evaluated whether rate calculations were performed correctly, all data were combined appropriately, and numerator events were counted accurately). Based on the desk review of the ISCAT(s), HSAG conducted interviews with key PIHP and CMHSP staff members familiar with the processing, monitoring, and calculation of the performance indicators. HSAG used interviews to confirm findings from the documentation review, expand or clarify outstanding issues, and verify that written policies and procedures were used and followed in daily practice.
- **Overview of data integration and control procedures**—The overview included discussion and observation of source code logic, a review of how all data sources were combined, and how the analytic file used for reporting the performance indicators was generated. HSAG performed PSV to further validate the output files. HSAG also reviewed any supporting documentation provided for data integration. This session addressed data control and security procedures as well.
- **PSV**—HSAG performed additional validation using PSV to further validate the output files. PSV is a review technique used to confirm that the information from the primary source matches the output information used for reporting. Each PIHP provided HSAG with measure-level detail files which included the data the PIHPs had reported to MDHHS. HSAG selected a random sample from the submitted data, then requested that the PIHPs provide proof-of-service documents or system screen shots that allowed for validation against the source data in the system. During the pre-PMV and virtual review, these data were also reviewed for verification, both live and using screen shots in the PIHPs' systems, which provided the PIHPs an opportunity to explain processes regarding any exception processing or any unique, case-specific nuances that may not impact final indicator reporting. Instances could exist in which a sample case is acceptable based on clarification during the virtual review and follow-up documentation provided by the PIHPs. Using this technique, HSAG assessed the PIHPs' processes used to input, transmit, and track the data; confirm entry; and detect errors. HSAG selected cases across indicators to verify that the PIHPs have system documentation which supports that the indicators appropriately include records for measure reporting. This technique does not rely on a specific number of cases for review to determine compliance; rather, it is used to detect errors from a small number of cases. If errors were detected, the outcome was determined based on the type of error. For example, the review of one case may have been sufficient in detecting a programming language error and, as a result, no additional cases related to that issue may have been reviewed. In other scenarios, one case error detected may have resulted in the selection of additional cases to better examine the extent of the issue and its impact on reporting.
- **Closing conference**—The closing conference summarized preliminary findings based on the review of the ISCAT and the virtual meeting and reviewed the documentation requirements for any post-virtual review activities.

HSAG conducted several interviews with key **DWIHN** staff members who were involved with any aspect of performance indicator reporting. Table 5 displays a list of **DWIHN** virtual review participants:

**Table 5—List of DWIHN Virtual Review Participants**

| Name | Title |
|---|---|
| Shama Faheem, MD | Chief Medical Officer, DWIHN |
| April Siebert | Quality Improvement Administrator, DWIHN |
| Tania Greason | Quality Improvement Administrator, DWIHN |
| Justin Zeller | Quality Improvement Clinical Specialist, DWIHN |
| Keith Frambro | Vice President (VP) of Information Technology Services, DWIHN |
| Gary Herman | Application Support Manager, DWIHN |
| Deabra Hardrick-Crump | Director of Claims, DWIHN |
| Quinnetta Robinson | Claims Manager, DWIHN |
| Judy Davis | Director of SUD, DWIHN |
| Samy Ganesan | Applications Programmer, DWIHN |
| David DesNoyer | Senior Systems Analyst/Project Manager, Peter Chang Enterprises, Inc. (PCE) |
| Jacqueline Davis | Clinical Officer, DWIHN |
| Daniel West | Director of Crisis Services, DWIHN |
| Yvonne Bostic | Director of Access Call Center, DWIHN |
| Anthony Edwards | Access Call Center Administrator, DWIHN |
| Jeff White | Associate VP of Operations, DWIHN |
| Natasha Conner | Business Analyst, IT Services, DWIHN |
| Davon Jones | Complex Case Manager/Narcan Coordinator, DWIHN |
| Rai Williams | Director of Contract Management, DWIHN |
| Sameh Samaan | Senior Data Analyst, Business Intelligence and Analytics, DWIHN |
| Sharon Matthews | Senior Provider Network Manager, DWIHN |
| Alison Gabridge | Adult Initiatives Administrator, DWIHN |

# 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 **DWIHN** 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 **DWIHN**, 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 **DWIHN** 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 **DWIHN** was:

☒ Acceptable

☐ Not acceptable

# Validation Results

HSAG evaluated **DWIHN**'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 **DWIHN** are indicated below.

## *Eligibility and Enrollment Data System Findings*

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

The PIHP continued to contract with PCE to obtain and process eligibility information directly into **DWIHN**'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 all consumers verified each weekday. 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 **DWIHN**'s direct providers and contract providers. In instances where there were duplicate member records for a consumer in MH-WIN, there was a system process to combine the two member records under one ID number and retain all historical claims and associated records.

Adequate reconciliation and validation processes were in place at each point of data transfer to ensure data completeness and accuracy. **DWIHN** demonstrated that eligibility effective dates, termination dates, historical eligibility spans, and members were identified appropriately.

## *Medical Services Data System (Claims and Encounters) Findings*

HSAG had no concerns with how **DWIHN** received and processed claims/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 in a submitted claim, the provider was required to correct the errors and resubmit the file for payment with 30 days.

**DWIHN** 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, **DWIHN**'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, 91 percent of all claims were processed electronically. A small percentage of paper claims, approximately 9 percent, were submitted via fax at the request of **DWIHN**. These claims were manually entered in MH-WIN and hard copies were stored in an indexing system. Manually entered claims were validated using the system edits and validation edits described above, and the claims supervisor verified that all paper claims were entered into MH-WIN daily using a claims inventory. All claims, regardless of format, were processed electronically through **DWIHN**'s staged claim process. Since all claims were validated upon entry, by providers or PIHP staff members, 99 percent of claims were auto-adjudicated.

Following claims adjudication, service data were batched, translated into EDI 837 transaction files, and submitted to the State weekly. **DWIHN** retrieved 999 and 4950 response files to determine whether files or records were rejected and the reason. **DWIHN** staff members were able to identify and correct some errors based on a report run by the Information Technology team. Any errors that could not be addressed by staff members were forwarded to the appropriate provider to address. Due to MH-WIN 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 in MH-WIN. **DWIHN** continues to use a performance indicator module to support both the collection and reporting of performance measures. The performance indictor module allowed both **DWIHN** 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, **DWIHN** 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. **DWIHN**'s source code was received, reviewed, and approved by HSAG.

During the virtual site visit, **DWIHN** demonstrated MH-WIN 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. 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 **DWIHN**.

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 **DWIHN** via MH-WIN. Providers also had the option to enter BH TEDS data directly into forms in MH-WIN.

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. **DWIHN** submitted BH-TEDS data files to the State monthly via the FTP site. BH-TEDS files were submitted multiple times within a month if additional records 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. **DWIHN** 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, **DWIHN** staff members could follow up with the provider to resolve the issue.

## *PIHP Oversight of Affiliate Community Mental Health Centers*

**DWIHN** is a stand-alone PIHP; therefore, this section is not applicable.

## *PIHP Actions Related to Previous Recommendations and Areas of Improvement*

During the SFY 2023 audit, HSAG identified the following:

- **DWIHN**'s rates for indicator #2a and #2c decreased from SFY 2022 to SFY 2023. HSAG recommended that **DWIHN** 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. During the SFY 2024 audit, **DWIHN** indicated that it had tried to boost hiring efforts by organizing career fairs, offering sign-on bonuses, and providing exam prep classes to help new clinicians pass the licensure exam. Additionally, some providers started contracting with staffing companies to attract and hire master's-level clinicians. Lastly, **DWIHN**'s finance department continued to offer financial incentives for high performance on the indicators.

## 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 **DWIHN**.

**Table 7—Indicator-Specific Review Findings and Designations for DWIHN**

| 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 |

| Performance Indicator | | Key Review Findings | Indicator Designation |
|---|---|---|---|
| #3 | The percentage of new persons during the quarter starting any medically necessary ongoing covered service within 14 days of completing a non-emergent biopsychosocial assessment. | The PIHP 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 percent of discharges from a substance abuse detox unit who are 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 |
| #8 | The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disability served by the CMHSPs and PIHPs who are employed competitively. | MDHHS calculated this indicator in compliance with the MDHHS Codebook specifications. | R |
| #9 | The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disability served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities. | MDHHS calculated this indicator in compliance with the MDHHS Codebook specifications. | R |
| #10 | The percentage of readmissions of children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge. | The PIHP calculated this indicator in compliance with the MDHHS Codebook specifications. | R |

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

## Strengths, Opportunities for Improvement, and Recommendations

By assessing **DWIHN**'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: DWIHN** meets with its clinically responsible service providers every 45 days to review provider-specific rates on the performance indicators and discuss potential interventions to support meeting the required standards. **DWIHN** also created a full time BH-TEDS coordinator within its Clinical Operations team who oversees data collection and supports providers in data entry and correction. [**Quality**]

### Weaknesses and Recommendations

**Weakness #1:** The member-level detail file **DWIHN** submitted to HSAG as part of the audit activity did not list exception reasons for 39 cases reported for indicator #4a. [**Quality**]

**Why the weakness exists: DWIHN** discharge coordinators or call center staff were not fully completing documentation in MH-WIN when consumers refused appointments within seven days of discharge, did not show for scheduled appointments, or cancelled scheduled appointments.

**Recommendation:** HSAG recommends that **DWIHN** try to use the 39 identified cases that are missing exception reasons to isolate process-related issues or staff training needs. HSAG also recommends that **DWIHN** audit a larger sample of exceptions prior to quarterly rate submissions to MDHHS to ensure they are appropriate and there is documentation in MH-WIN to verify the exception. In addition, **DWIHN** should perform a visual validation of the member-level detail file prior to HSAG submission for the annual audit to ensure that all exceptions have documented reasons in the file.

**Weakness #2: DWIHN**'s indicator #2 total rate fell below the 50th percentile benchmark. [**Quality** and **Timeliness**]

**Why the weakness exists: DWIHN**'s indicator #2 total rate fell below the 50th percentile benchmark, suggesting that some new persons may not have been able to get a timely biopsychosocial assessment completed following a non-emergency request for service.

**Recommendation:** HSAG recommends that **DWIHN** continue with its improvement efforts related to indicator #2 so that it meets or exceeds the 50th percentile benchmark and further ensures 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:** | August 1, 2024 |
| **Reviewers:** | Emily Redman |

| Data Integration and Control Element | Met | Not Met | NA | Comments |
|---|---|---|---|---|
| **Accuracy of data transfers to assigned performance indicator data repository** | | | | |
| The PIHP accurately and completely processes transfer data from the transaction files (e.g., membership, provider, encounter/claims) into the performance indicator data repository used to keep the data until the calculations of the performance indicators have been completed and validated. | ☒ | ☐ | ☐ | |
| Samples of data from performance indicator data repository are complete and accurate. | ☒ | ☐ | ☐ | |
| **Accuracy of file consolidations, extracts, and derivations** | | | | |
| The PIHP's processes to consolidate diversified files and to extract required information from the performance indicator data repository are appropriate. | ☒ | ☐ | ☐ | |
| Actual results of file consolidations or extracts are consistent with those that should have resulted according to documented algorithms or specifications. | ☒ | ☐ | ☐ | |
| Procedures for coordinating the activities of multiple subcontractors ensure the accurate, timely, and complete integration of data into the performance indicator database. | ☒ | ☐ | ☐ | |
| Computer program reports or documentation reflect vendor coordination activities, and no data necessary for performance indicator reporting are lost or inappropriately modified during transfer. | ☒ | ☐ | ☐ | |
| **If the PIHP uses a performance indicator data repository, its structure and format facilitates any required programming necessary to calculate and report required performance indicators.** | | | | |
| The performance indicator data repository's design, program flow charts, and source code enables analyses and reports. | ☒ | ☐ | ☐ | |

| Data Integration and Control Element | Met | Not Met | NA | Comments |
|---|---|---|---|---|
| Proper linkage mechanisms are employed to join data from all necessary sources (e.g., identifying a member with a given disease/condition). | ☒ | ☐ | ☐ | |
| **Assurance of effective management of report production and of the reporting software.** | | | | |
| Documentation governing the production process, including PIHP production activity logs and the PIHP staff review of report runs, is adequate. | ☒ | ☐ | ☐ | |
| Prescribed data cutoff dates are followed. | ☒ | ☐ | ☐ | |
| The PIHP retains copies of files or databases used for performance indicator reporting in case results need to be reproduced. | ☒ | ☐ | ☐ | |
| The reporting software program is properly documented with respect to every aspect of the performance indicator data repository, including building, maintaining, managing, testing, and report production. | ☒ | ☐ | ☐ | |
| The PIHP's processes and documentation comply with the PIHP standards associated with reporting program specifications, code review, and testing. | ☒ | ☐ | ☐ | |

# Appendix B. Denominator and Numerator Validation Findings

## Reviewer Worksheet

| | |
|---|---|
| **PIHP Name:** | Detroit Wayne Integrated Health Network |
| **PMV Date:** | August 1, 2024 |
| **Reviewers:** | Emily Redman |

| Denominator Validation Findings for DWIHN | | | | |
|---|---|---|---|---|
| **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 DWIHN | | | | |
|---|---|---|---|---|
| **Audit Element** | **Met** | **Not Met** | **NA** | **Comments** |
| The PIHP uses the appropriate data, including linked data from separate data sets, to identify the entire at-risk population. | ☒ | ☐ | ☐ | |
| Qualifying medical events (such as diagnoses, procedures, prescriptions, etc.) are properly identified and confirmed for inclusion in terms of time and services. | ☒ | ☐ | ☐ | |
| The PIHP avoids or eliminates all double-counted members or numerator events. | ☒ | ☐ | ☐ | |
| Any nonstandard codes used in determining the numerator are mapped to a standard coding scheme in a manner that is consistent, complete, and reproducible, as evidenced by a review of the programming logic or a demonstration of the program. | ☒ | ☐ | ☐ | |
| If any time parameters are required by the specifications for the performance indicator, they are followed (i.e., the indicator event occurred during the period specified or defined in the specifications). | ☒ | ☐ | ☐ | |

# Appendix C. Performance Measure Results

The measurement period for indicators #1, #2, #2e, #3, #4a, #4b, #5, #6, and #10 is Q1 SFY 2024 (October 1, 2023–December 31, 2023). The measurement period for indicators #8, #9, #13, and #14 is SFY 2023 (October 1, 2022–September 30, 2023).

## Indicator #1

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

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

| 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 | 712 | 708 | 99.44% |
| Adults—Indicator #1b | 2,726 | 2,632 | 96.55% |

## Indicator #2

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

**Table C-2—Indicator #2: Access—Timeliness/First Request for DWIHN**

| 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 | 629 | 190 | 30.21% |
| MI–Adults—Indicator #2b | 2,078 | 1,192 | 57.36% |
| I/DD–Children—Indicator #2c | 404 | 88 | 21.78% |
| I/DD–Adults—Indicator #2d | 113 | 66 | 58.41% |
| Total—Indicator #2 | 3,224 | 1,536 | 47.64% |

## Indicator #2e

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

**Table C-3—Indicator #2e: Access—Timeliness/First Request SUD for DWIHN 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** | **995** | **2,901** | **3,896** | **25.54%** | **2,522** | **64.73%** |
| Northern Michigan Regional Entity | 430 | 1,083 | 1,513 | 28.42% | 910 | 60.15% |
| Lakeshore Regional Entity | 247 | 1,234 | 1,481 | 16.68% | 1,005 | 67.86% |
| Southwest Michigan Behavioral Health | 410 | 959 | 1,369 | 29.95% | 809 | 59.09% |
| Mid-State Health Network | 503 | 2,479 | 2,982 | 16.87% | 2,159 | 72.40% |
| Community Mental Health Partnership of Southeast Michigan | 224 | 806 | 1,030 | 21.75% | 610 | 59.22% |
| NorthCare Network | 118 | 415 | 533 | 22.14% | 290 | 54.41% |
| Oakland Community Health Network | 144 | 814 | 958 | 15.03% | 766 | 79.96% |
| Macomb County Community Mental Health | 301 | 1,387 | 1,688 | 17.83% | 1,274 | 75.47% |
| Region 10 PIHP | 330 | 1,620 | 1,950 | 16.92% | 1,446 | 74.15% |

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

## Indicator #3

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

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

| 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 | 468 | 373 | 79.70% |
| MI–Adults—Indicator #3b | 1,682 | 1,522 | 90.49% |
| I/DD–Children—Indicator #3c | 315 | 209 | 66.35% |
| I/DD–Adults—Indicator #3d | 99 | 81 | 81.82% |
| Total—Indicator #3 | 2,564 | 2,185 | 85.22% |

## 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 DWIHN**

| 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 | 99 | 54 | 45 | 44 | 97.78% |
| Adults | 1,644 | 1,044 | 600 | 592 | 98.67% |

## Indicator #4b

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

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

| 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 | 712 | 202 | 510 | 496 | 97.25% |

## Indicator #5

The percent of Medicaid recipients having received PIHP managed services.

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

| 1. Total Medicaid Beneficiaries Served | 2. # of Area Medicaid Recipients | 3. Penetration Rate |
|---|---|---|
| 47,300 | 811,952 | 5.83% |

## 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 DWIHN**

| 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 | 993 | 951 | 95.77% |

## Indicator #8

The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disability served by the CMHSPs and PIHPs who are employed competitively.[4]

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

| 1. Population | 2. Total # of Enrollees | 3. # of Enrollees Who Are Competitively Employed | 4. Competitive Employment Rate |
|---|---|---|---|
| MI–Adults—Indicator #8a | 34,661 | 6,479 | 18.69% |
| DD–Adults—Indicator #8b | 5,856 | 501 | 8.56% |
| MI and DD–Adults—Indicator #8c | 2,309 | 186 | 8.06% |

## Indicator #9

The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disability served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.[5]

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

| 1. Population | 2. Total # of Enrollees | 3. # of Enrollees Who Earn Minimum Wage or More | 4. Minimum Wage Rate |
|---|---|---|---|
| MI–Adults—Indicator #9a | 6,485 | 6,473 | 99.81% |
| DD–Adults—Indicator #9b | 790 | 525 | 66.46% |
| MI and DD–Adults—Indicator #9c | 235 | 188 | 80.00% |

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

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

## Indicator #10

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

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

| 1. Population | 2. # of Discharges From Psychiatric Inpatient Care During the Reporting Period | 3. # of Discharges From Col 2 That Are Exceptions | 4. Net # of Discharges (Col 2 Minus Col 3) | 5. # of Discharges (From Col 4) Readmitted to Inpatient Care Within 30 Days of Discharge | 6. % of Discharges Readmitted to Inpatient Care Within 30 Days of Discharge |
|---|---|---|---|---|---|
| **Children—Indicator #10a** | **174** | **0** | **174** | **15** | **8.62%** |
| **Adults—Indicator #10b** | **1,786** | **0** | **1,786** | **314** | **17.58%** |

## Indicator #13

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

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

| 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** | **5,856** | **1,178** | **20.12%** |
| **MI and I/DD–Adults** | **2,312** | **532** | **23.01%** |

## Indicator #14

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

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

| 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 | 34,874 | 13,816 | 39.62% |

## 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 DWIHN**

| BH-TEDS Data Element | Percent Complete SFY 2023 | Percent Complete Q1 SFY 2024 | Quarterly and Annual Indicators Impacted |
|---|---|---|---|
| Age* | 100.00% | 100.00% | 1, 4, 8, 9, 10, 13, 14 |
| Disability Designation* | 96.03% | 97.88% | 8, 9, 10, 13, 14 |
| Employment Status* | 98.26% | 99.59% | 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.