EXCERPTS

Michigan Department of Health and Human Services

State Fiscal Year 2016 Validation of Performance Measures for Region 7—Detroit Wayne Mental Health Authority

Behavioral Health and Developmental Disabilities Administration
Prepaid Inpatient Health Plans

September 2016

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Validation Overview

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

In 2013, MDHHS issued an *Application for Participation for Specialty Prepaid Inpatient Health Plans* and selected 10 regional entities to manage the Medicaid specialty benefit for the entire region defined by MDHHS. HSAG conducted the state fiscal year (SFY) 2016 validation activities for the 10 regional entities as outlined in the Centers for Medicare & Medicaid Services (CMS) publication, *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 1, 2012.[1]

Prepaid Inpatient Health Plan (PIHP) Information

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

Table 1—Detroit Wayne Mental Health Authority Information

PIHP Name:	Detroit Wayne Mental Health Authority
PIHP Site Visit Location:	707 W. Milwaukee Detroit, Michigan 48202
PIHP Contact:	Corine S. Mann, Quality Director
Contact Telephone Number:	313.334.9099
Contact Email Address:	Cmann1@dwmha.com
Site Visit Date:	July 29, 2016

[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html. Accessed on: Feb 19, 2013.

Performance Measures Validated

HSAG validated a set of performance indicators that were developed and selected by MDHHS for validation. The reporting cycle and measurement period were specified for each indicator by MDHHS. Table 2 lists the audited performance indicators calculated by the PIHPs for different populations for the first quarter of Michigan SFY 2016, which began October 1, 2015, and ended December 31, 2015. Table 3 lists the audited performance indicators calculated by MDHHS, each with its specific measurement period. The indicators are numbered as they appear in the MDHHS codebook.

Table 2—List of Audited Performance Indicators Calculated by PIHPs

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

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

Table 3—List of Audited Performance Indicators Calculated by MDHHS

	Indicator	Sub-Populations	Measurement Period
#5	The percent of Medicaid recipients having received PIHP managed services.	• Medicaid Recipients	First Quarter SFY 2016
#6	The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	• HSW Enrollees	First Quarter SFY 2016
#8	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs* and PIHPs who are employed competitively.	• MI-Adults • DD-Adults • MI and DD Adults	SFY 2015
#9	The percent of (a) adults with mental illness, the percent of (b) adults with developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/developmental disabilities served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.	• MI-Adults • DD-Adults • MI and DD Adults	SFY 2015
#13	The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	• DD-Adults	SFY 2015
#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 2015

*CMHSP = Community Mental Health Services Program

Description of Validation Activities

Preaudit Strategy

HSAG conducted the validation activities as outlined in the CMS Performance Measure Validation Protocol. HSAG obtained a list of the indicators selected by MDHHS for validation. Indicator definitions and reporting templates were also provided by MDHHS for review by the HSAG validation team. Based on the indicator definitions and reporting guidelines, HSAG developed indicator-specific worksheets derived from Attachment I of the CMS Performance Measure Validation Protocol.

HSAG prepared a documentation request, which included the Information Systems Capabilities Assessment Tool (ISCAT), Appendix V of the CMS Performance Measure Validation Protocol. In

collaboration with MDHHS and PIHP participants, HSAG customized the ISCAT to collect the necessary data consistent with Michigan's mental health service delivery model. The ISCAT was forwarded to each PIHP with a timetable for completion and instructions for submission. HSAG fielded ISCAT-related questions directly from the PIHPs during the pre-on-site phase.

HSAG prepared an agenda describing all on-site visit activities and indicating the type of staff needed for each session. The agendas were forwarded to the respective PIHPs prior to the on-site visit. When requested, HSAG conducted pre-on-site conference calls with the PIHPs to discuss any outstanding ISCAT questions and on-site visit activities.

Validation Team

The HSAG performance measure validation (PMV) team was assembled based on the full complement of skills required for the validation and requirements of the particular PIHP. Some team members, including the lead auditor, participated in the on-site meetings at the PIHP location; others conducted their work at HSAG offices. Table 4 describes each team member's role and expertise.

Table 4—Validation Team

Name and Role	Skills and Expertise
Mariyah Badani, JD, MBA, CHCA *Director, Audits/State & Corporate Services*	Management of audit department, multiple years of auditing experience, certified HEDIS compliance auditor, data integration, systems review, and analysis.
Timea Jonas, CHCA *Lead Auditor*	Multiple years of auditing experience, certified HEDIS compliance auditor, claims processing, data review and analysis, and healthcare fraud analysis experience.
Tanishia Bailey, BA *Secondary Auditor*	Multiple years of auditing experience, quality improvement, data review and analysis, and healthcare industry experience.
Judy Yip-Reyes, PhD, CHCA *Source Code Review Manager & Associate Director, Audits/State & Corporate Services*	Multiple years of auditing experience, certified HEDIS compliance auditor, extensive performance measure knowledge, and source code review management.
Tammy GianFrancisco *Project Leader*	Project coordination and communication.

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Technical Methods of Data Collection and Analysis

The CMS Performance Measure Validation 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 these data:

- **Information Systems Capabilities Assessment Tool (ISCAT)**—The PIHPs were required to submit a completed ISCAT that provided information on its information systems, processes used for collecting 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. Where applicable, HSAG used the information provided in the ISCAT(s) to begin completion of the review tools.
- **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 steps the PIHP took for indicator calculation.
- **Performance indicator reports**—HSAG also reviewed the PIHP performance indicator reports provided by MDHHS for the first quarter of SFY 2016. Previous reports were used along with the current reports to assess trending patterns and rate reasonability.
- **Supporting documentation**—The PIHPs 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.

On-site Activities

HSAG conducted on-site visits 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 on-site visit 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.

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- **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 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.
- **Closing conference**—The closing conference summarized preliminary findings based on the review of the ISCAT and the on-site visit, and reviewed the documentation requirements for any post-on-site activities.

HSAG conducted several interviews with key **Detroit Wayne Mental Health Authority** staff members who were involved with any aspect of performance indicator reporting. Table 5 displays a list of **Detroit Wayne Mental Health Authority** key interviewees:

Table 5—List of Detroit Wayne Mental Health Authority Interviewees

Name	Title
Tony Crook	MCO Deputy Director
Carla Spight Mackey	Clinical Specialist Quality Improvement
Corine Smith Mann	Quality Director
Michele A. Vasconcellos	Director, Customer Services
Crystal Palmer	Director, Children's Initiatives
Darlene D. Owens	Director, Substance Use Disorder (SUD)
Stacie Durant	Chief Finance Officer
Nakia Young	Manager, Integrated Healthcare
Julia Kyle	Director, Integrated Care
Nasr Doss	Senior Project Manager
Brian G. Wagner	Senior Program Manager
Chad June	Chief Information Officer
Gary Herman	Information Technology

Name	Title
Allison Smith	Quality Improvement
Carmen McIntyre	Chief Operational Officer
Aline Hedwood	Quality Management Support
Tracy Lee	Supervisor, Billing and Claims
Virgil Williams	Manager, Clinical Practice Improvement

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 Mental Health Authority** 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 Mental Health Authority**, 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 Mental Health Authority** 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 the majority 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, work flow diagrams, narrative descriptions of performance indicator calculations, and other related documentation. Overall, HSAG determined that the documentation of performance indicator calculations by **Detroit Wayne Mental Health Authority** was:

☒ Acceptable

☐ Not acceptable

Validation Results

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

PIHP Strengths

Detroit Wayne Mental Health Authority experienced several staff changes during the last reporting period. All newly hired staff had extensive background working with behavioral health data as well as familiarity with performance indicator policies and procedures.

The PIHP was in the process of implementing several quality improvement (QI) processes, including the calculation of Performance Indicator 1, which was previously performed by the MCOs. This more centralized process will further ensure accuracy of the data being used for reporting.

The PIHP developed the Mycare Connect program, which created an integrated care model to ensure that various entities all have access to the consumer's information

In addition, the PIHP implemented the use of a standard monitoring tool to ensure that all participating Managers of Comprehensive Provider Networks (MCPNs) are held to the same standard developed by the PIHP.

PIHP Areas for Improvement

For the current reporting period, **Detroit Wayne Mental Health Authority** performed below standard for the adult population of Performance Indicator 1 and for both populations of Performance Indicator 10. HSAG recommended that the PIHP investigate the reasons behind this decline and explore options for rate improvement. Additional crisis residential facilities could help to reduce the hospital recidivism rate for the next reporting period.

HSAG noted that a new process was implemented to collect and report demographic information. **Detroit Wayne Mental Health Authority**'s Behavioral Health-Treatment Episode (BH-TEDS) rates showed a need for substantial rate increases; therefore, the PIHP should explore opportunities to improve rates for the next reporting period.

During the rate validation process, the auditor noted that the number of cases in the rate reporting summary did not match the number of cases present in the consumer detail file reviewed at the time of the on-site audit. The PIHP indicated being unable to recreate the same number of cases due to several records having been adjusted from the time the data were extracted for rate reporting. HSAG recommended that for the following reporting period the PIHP should create a consumer-level detail file

for each quarter, with the snapshot of data used for rate calculation. This step will ensure that accurate records are validated for each performance indicator.

Although **Detroit Wayne Mental Health Authority** performed primary source verification on selected cases, this process took place after each rate was calculated and submitted to the State. HSAG recommended that in the future the PIHP perform this validation prior to State submission, to ensure that only accurate and valid data are used for rate calculation.

During the on-site primary source verification, HSAG found that for exclusion cases reported in Performance Indicator 2, adequate documentation of the "first offered appointment" was not present in the transactional system. HSAG recommended that the PIHP consider providing additional training to its providers to ensure that the appointment data offered are clearly documented in the data system.

HSAG was unable to perform primary source verification for Performance Indicator 4b, due to incomplete data in MH-WIN, the PIHP's transactional system. **Detroit Wayne Mental Health Authority** indicated that data were migrated from the former CA's system last year. It appears that no proper validation process was in place to ensure that the data from the former CA's system accurately and fully transferred to the PIHP's system. The PIHP now collects all data related to this indicator in MH-WIN; therefore, this will not be a concern for future reporting. However, for the current reporting period, HSAG was unable to validate the data and assigned an indicator designation of "Not Reportable" for Performance Indicator 4b.

In addition, during off-site primary source verification for Performance Indicator 1, HSAG found that several selected cases were incorrectly included in the denominator and numerator. More specifically, some dates of service indicated in the data file did not match dates of service present on the supporting document submitted by the PIHP. Due to this finding, HSAG was unable to validate the data and assigned an indicator designation of "Not Reportable" for Performance Indicator 1. The PIHP was encouraged to perform root cause analysis and develop a validation process ensuring future data accuracy.

Eligibility Data System Findings

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

For the current reporting period, the PIHP continued to use the same process for receiving and processing eligibility information. As in prior years, the PIHP continued to contract Peter Chang Enterprises, Inc. (PCE) to obtain and process eligibility information. Monthly eligibility full files and daily change files were received in an 834 file format via the State Web portal. Each file was subject to a validation process to ensure that only accurate data were loaded into MH-WIN, the PIHP's transactional system. In addition, the PIHP continued to send nightly 270 eligibility inquiry file to the State's Community Health Automated Medicaid Processing System (CHAMPS). The 271 response file was used to update eligibility information. Adequate validation processes continued in place to ensure data accuracy. Weekly, PCE provided enrollment data to all contracted MCPNs with a list of consumers

assigned to them. In addition, providers, MCPNs, and PIHP staff members were able to perform a real-time eligibility lookup by logging into CHAMPS via a link located in the MH-WIN data warehouse or by using their own individual systems. During the on-site visit, **Detroit Wayne Mental Health Authority** demonstrated the MH-WIN system, from which the auditor was able identify that the capture of eligibility effective dates, termination dates, and historical eligibility spans as well as identification of dual (Medicare/Medicaid) consumers were appropriate. Adequate reconciliation and validation processes were in place at each point of data transfer to ensure data completeness and data accuracy.

Claims/Encounter Data System Findings

HSAG identified no concerns with how **Detroit Wayne Mental Health Authority** received and processed claims/encounters; however, did identify some areas for improvement for a more accurate performance indicator reporting.

For the current reporting period, the PIHP received encounters and Fee-For-Service (FFS) claims. Behavioral health and SUD claims/encounters were received and processed the same way.

The MCPN providers submitted encounters by uploading them to MH-WIN. Each file was subjected to a built-in validation process to ensure data completeness and data accuracy. In the event an error was detected, the file was sent back to its original source for correction, ensuring data accuracy prior to State submission. The majority of FFS claims were received electronically via a secure FTP site. Providers were able to enter claims information directly or upload 837 files to MH-WIN. All claims (100 percent) were auto-adjudicated. Only out-of-network providers were allowed to submit paper claims to the PIHP. These claims were received by the mail room, date stamped, and manually entered into MH-WIN. Manually entered claims were validated using system built-in edits.

Validated 837 files were submitted to the State. The State generated a 999 response file, confirming the receipt of each submission. In addition, within one day of submission, the PIHP received a 4950 detailed response file which included an explanation for each file/record rejection that occurred. Each MCPN had the capability to download and review its response file. The PIHP closely monitored the quality of data submitted to the State.

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

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

Quality Improvement (QI)/Behavioral Health-Treatment Episode Data Set (BH-TEDS) Data Production

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

As of October 2015, only BH-TEDS data files were being submitted to the State as required, replacing the previous QI data files. The process of collecting QI/BH-TEDS data remained the same as in prior years. As in prior years, the PIHP continued to contract with PCE to prepare and submit QI/BH-TEDS data files to the State. At the time of the consumer's initial screening, providers collected QI/BH-TEDS-related data and either first entered them in their respective transactional systems and then submitted data files to the PIHP via a secure FTP site or logged into MH-WIN and entered information into BH-TEDS entry area. BH-TEDS information was updated annually or if any major change occurred in the consumer information. Adequate validation processes were in place to ensure data accuracy and data completeness. The PIHP submitted QI/BH-TEDS data files to the State weekly, via the FTP site. After submission, the PIHP received a 4956 QI detailed response file, which included explanations for any file rejection that occurred. Errors received from the State were handled at the PIHP level. Due to the tight validation process, file rejection was minimal for the current reporting period; however, HSAG recommends that **Detroit Wayne Mental Health Authority** work with the State to resolve identified issues with QI reporting for SFY 2015. In addition, **Detroit Wayne Mental Health Authority**'s rates showed a need for substantial increases regarding BH-TEDS data. To meet this need, the PIHP should explore opportunities to improve rates for the next reporting period.

PIHP Oversight of Affiliate Community Mental Health Centers

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

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

PIHP Actions Related to Previous Recommendations

Based on recommendations made last year during the performance validation audit, the PIHP implemented a crisis care plan in an effort to improve hospital recidivism rates. This process was implemented in March 2016; therefore, rate improvement will not be expected until the following reporting period.

Performance Indicator Specific Findings and Recommendations

Based on all validation activities, HSAG determined results for each performance indicator. The CMS Performance Measure Validation Protocol identifies three possible validation finding designations for performance indicators, which are defined in Table 6. For more detailed information, please see Appendix B.

Table 6—Designation Categories for Performance Indicators

Report (R)	Indicator was compliant with the State's specifications and the rate can be reported.
Not Reported (NR)	This designation is assigned to measures for which: (1) the PIHP rate was materially biased or (2) the PIHP was not required to report.
No Benefit (NB)	Indicator was not reported because the PIHP did not offer the benefit required by the indicator.

According to the protocol, the validation designation for each indicator is determined by the magnitude of the errors detected for the audit elements, not by the number of audit elements determined to be not compliant based on the review findings. Consequently, an error for a single audit element may result in a designation of NR because the impact of the error biased the reported performance indicator by more than 5 percentage points. Conversely, it is also possible that several audit element errors may have little impact on the reported rate, and the indicator could be given a designation of R. Audit elements and their scoring designations (i.e., *Met*, *Not Met*, and *Not Applicable [N/A]*) can be found in Appendix A—Data Integration and Control Findings and Appendix B—Denominator and Numerator Elements.

Table 7 displays the indicator-specific review findings and designations for **Detroit Wayne Mental Health Authority**.

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

Performance Indicator		Key Review Findings	Indicator Designation
#1	The percentage of Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	The calculation process was in accordance with MDHHS Codebook specifications; however, during the primary source verification it was found that some dates of service indicated in the data file did not match with the dates of service present in the supporting document submitted by the PIHP.	NR
#2	The percentage of new Medicaid beneficiaries during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service.	The calculation process was in accordance with MDHHS Codebook specifications.	R
#3	The percentage of new Medicaid beneficiaries during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional.	The calculation process was in accordance with 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 calculation process was in accordance with 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 calculation process was in accordance with MDHHS Codebook specifications; however, lack of a proper validation process during data migration from the former CA's system caused a data completeness issue and resulted in a *Not Reportable* status for this performance indicator.	NR
#5	The percent of Medicaid recipients having received PIHP managed services.	MDHHS calculated this indicator in compliance with MDHHS Codebook specifications.	R

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

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Appendix A. Data Integration and Control Findings

Documentation Worksheet

PIHP Name:	Detroit Wayne Mental Health Authority
On-Site Visit Date:	July 29, 2016
Reviewers:	Timea Jonas, Tanishia Bailey

Data Integration and Control Element	Met	Not Met	N/A	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.	☐	☒	☐	Lack of a proper validation process during data migration from the former CA's system caused a data completeness issue and resulted in a *Not Reportable* status for Performance Indicator 4b.
Samples of data from performance indicator data repository are complete and accurate.	☐	☒	☐	Lack of a proper validation process during data migration from the former CA's system caused a data completeness issue and resulted in a *Not Reportable* status for Performance Indicator 4b.
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.	☒	☐	☐	

Data Integration and Control Element	Met	Not Met	N/A	Comments
Procedures for coordinating the activities of multiple subcontractors ensure the accurate, timely, and complete integration of data into the performance indicator database.	☐	☒	☐	Lack of a proper validation process during data migration from the former CA's system caused a data completeness issue and resulted in a *Not Reportable* status for Performance Indicator 4b.
Computer program reports or documentation reflect vendor coordination activities, and no data necessary for performance indicator reporting are lost or inappropriately modified during transfer.	☐	☒	☐	Lack of a proper validation process during data migration from the former CA's system caused a data completeness issue and a *Not Reportable* status for Performance Indicator 4b.
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).	☒	☐	☐	
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 PIHP indicated being unable to recreate the same number of cases due to several records having been adjusted from the time the data were extracted

Data Integration and Control Element	Met	Not Met	N/A	Comments
				for rate reporting. HSAG recommended that for the following reporting period the PIHP create a consumer-level detail file for each quarter, with the snapshot of data used for rate calculation. This step will ensure that accurate records are validated for each performance indicator.
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 Mental Health Authority
On-Site Visit Date:	July 29, 2016
Reviewers:	Timea Jonas, Tanishia Bailey

Denominator Validation Findings for Detroit Wayne Mental Health Authority				
Audit Element	Met	Not Met	N/A	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.	☐	☒	☐	For Performance Indicator 2, adequate documentation of the “first offered appointment” was not present in the transactional system for some records reported as exclusions.

Denominator Validation Findings for Detroit Wayne Mental Health Authority				
Audit Element	**Met**	**Not Met**	**N/A**	**Comments**
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 Mental Health Authority				
Audit Element	**Met**	**Not Met**	**N/A**	**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.	☐	☐	☒	Only standard codes were used or reported by the PIHP.
If any time parameters are required by the specifications for the performance indicator, they are followed (i.e., the indicator event occurred during the time period specified or defined in the specifications).	☒	☐	☐	

Indicator #1

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

Table C-1—Indicator #1: Access—Timeliness/Inpatient Screening for Detroit Wayne Mental Health Authority

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	**506**	**501**	**99.01%**
Adults	**1,842**	**1,745**	**94.73%**

Indicator #2

The percentage of new Medicaid beneficiaries during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service. *Standard=95%*

Table C-2—Indicator #2: Access—Timeliness/First Request for Detroit Wayne Mental Health Authority

1. Population	2. # of New Persons Receiving an Initial Non-emergent Professional Assessment Following a First Request	3. # of New Persons From Col 2 Who Are Exceptions	4. Net # of New Persons Receiving an Initial Assessment (Col 2 Minus Col 3)	5. # of Persons From Col 4 Receiving an Initial Assessment Within 14 Calendar Days of First Request	6. % of Persons Receiving an Initial Assessment Within 14 Calendar Days of First Request
MI—Children	**756**	**158**	**598**	**589**	**98.49%**
MI—Adults	**774**	**205**	**569**	**553**	**97.19%**
DD—Children	**119**	**13**	**106**	**105**	**99.06%**
DD—Adults	**74**	**8**	**66**	**66**	**100.00%**
Medicaid SA	**1,469**	**42**	**1,427**	**1,403**	**98.32%**
TOTAL	**3,192**	**426**	**2,766**	**2,716**	**98.19%**

Indicator #3

The percentage of new Medicaid beneficiaries during the quarter starting any needed ongoing service within 14 days of a non-emergent face-to-face assessment with a professional. *Standard=95% within 14 days*

Table C-3—Indicator #3: Access—Timeliness/First Service for Detroit Wayne Mental Health Authority

1. Population	2. # of New Persons Who Started Face-to-Face Service During the Period	3. # of New Persons From Col 2 Who Are Exceptions	4. Net # of Persons Who Started Service (Col 2 Minus Col 3)	5. # of Persons From Col 4 Who Started a Face-to-Face Service Within 14 Days of a Face-to-Face Assessment With a Professional	6. % of Persons Who Started Service Within 14 days of Assessment
MI—Children	638	34	604	592	98.01%
MI—Adults	701	16	685	659	96.20%
DD—Children	116	8	108	105	97.22%
DD—Adults	71	8	63	60	95.24%
SA—Adults	1,376	2	1,374	1,355	98.62%
TOTAL	2,902	68	2,834	2,771	97.78%

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-4—Indicator #4a: Access—Continuity of Care for Detroit Wayne Mental Health Authority

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	280	24	256	256	100.00
Adults	1,114	352	762	734	96.33%

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-5—Indicator #4b: Access—Continuity of Care for Detroit Wayne Mental Health Authority

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	**1,189**	**434**	**755**	**744**	**98.54%**

Indicator #5

The percent of Medicaid recipients having received PIHP managed services.

Table C-6—Indicator #5: Access—Penetration Rate for Detroit Wayne Mental Health Authority

Total Medicaid Beneficiaries Served	# of Area Medicaid Recipients	Penetration Rate
35,053	**473,219**	**7.41%**

Indicator #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.

Table C-7—Indicator #6: Adequacy/Appropriateness—Habilitation Supports Waiver for Detroit Wayne Mental Health Authority

Population	Total # of HSW Enrollees	# of HSW Enrollees Receiving at Least One HSW Service Other Than Supports Coordination	HSW Rate
HSW Enrollees	**1,157**	**1,145**	**98.96%**

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 disabilities served by the CMHSPs and PIHPs who are employed competitively.

Table C-8—Indicator #8: Outcomes—Competitive Employment for Detroit Wayne Mental Health Authority

Population	Total # of Enrollees	# of Enrollees Who Are Competitively Employed	Competitive Employment Rate
MI—Adults	**2,603**	**3**	**0.12%**
DD—Adults	**181**	**1**	**0.55%**
MI and DD—Adults	**20**	**0**	**0.00%**

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 disabilities served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.

Table C-9—Indicator #9: Outcomes—Minimum Wage for Detroit Wayne Mental Health Authority

Population	Total # of Enrollees	# of Enrollees Who Earn Minimum Wage or More	Minimum Wage Rate
MI—Adults	**3**	**3**	**100.00%**
DD—Adults	**13**	**5**	**38.46%**
MI and DD—Adults	**0**	**0**	**0.00%**

Indicator #10

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

Table C-10—Indicator #10: Outcomes—Inpatient Recidivism for Detroit Wayne Mental Health Authority

1. Population	2. # of Discharges From a 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 DD—Children	280	7	273	42	15.38%
MI and DD—Adults	1,118	45	1,073	183	17.05%

Indicator #13

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

Table C-11—Indicator #13: Outcomes—Private Residence for Detroit Wayne Mental Health Authority

Population	Total # of Enrollees	# of Enrollees Who Live in a Private Residence Alone, With Spouse, or Non-Relative(s)	Private Residence Rate
DD—Adults	6,827	5	0.07%

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-12—Indicator #14: Outcomes—Private Residence-MI for Detroit Wayne Mental Health Authority

Population	Total # of Enrollees	# of Enrollees Who Live in a Private Residence Alone, With Spouse, or Non-Relative(s)	Private Residence Rate
MI—Adults	37,190	15	0.04%

Quality Improvement (QI) Data Elements

The QI data elements in Michigan PIHP performance indicator reporting are displayed in Table C-13. The table depicts how complete specific data elements were within the QI 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-13—QI Data Elements in Performance Indictor Reporting for Detroit Wayne Mental Health Authority

QI Data Element	Percent Complete SFY 2015	Percent Complete 1st Quarter SFY 2016	Quarterly and Annual Indicators Impacted
Age*	**100.00%**	**85.17%**	**1, 2, 3, 4, 8, 9, 10, 13, 14**
Disability Designation*	**99.05%**	**84.00%**	**2, 3, 8, 9, 10, 13, 14**
Employment Status*	**27.75%**	**84.88%**	**8, 9**
Minimum Wage*	**100.00%**	**99.57%**	**9**

* Based on the PIHP/MDHHS contract, 95 percent of records must contain a value in this field, and the value must be within acceptable ranges. Due to implementation of a new process to collect demographic data, the PIHPs will not be held to the 95 percent completeness requirement for the first quarter SFY 2016.