

State of Michigan



Department of Community Health

**Mental Health and Substance Abuse Administration  
Prepaid Inpatient Health Plans**

**STATE FISCAL YEAR 2010**

**VALIDATION OF PERFORMANCE MEASURES**

*for*

**CMH Affiliation of Mid-Michigan**

July 2010



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# Validation of Performance Measures

## for CMH Affiliation of Mid-Michigan

### Validation Overview

Validation of performance measures is one of three mandatory external quality review (EQR) activities that the Balanced Budget Act of 1997 (BBA) requires state Medicaid agencies to perform. Health Services Advisory Group, Inc. (HSAG), the external quality review organization (EQRO) for the State of Michigan Department of Community Health (MDCH), Mental Health and Substance Abuse Administration, conducted the validation activities. For state fiscal year (SFY) 2009, MDCH contracted with 18 prepaid inpatient health plans (PIHPs) to provide mental health and substance abuse services to Medicaid-eligible recipients. MDCH identified a set of performance measures (indicators) that were calculated and reported by the PIHPs for validation. HSAG conducted the validation activities as outlined in the Centers for Medicare & Medicaid Services (CMS) publication, *Validating Performance Measures: A Protocol for Use in Conducting External Quality Review Activities*, Final Protocol, Version 1.0, May 1, 2002 (CMS Performance Measure Validation Protocol).

### Prepaid Inpatient Health Plan (PIHP) Information

HSAG validated performance indicators calculated and reported by **CMH Affiliation of Mid-Michigan**. Information about **CMH Affiliation of Mid-Michigan** appears in Table 1.

Table 1—CMH Affiliation of Mid-Michigan Information	
<b>PIHP Name:</b>	CMH Affiliation of Mid-Michigan
<b>PIHP Location:</b>	812 East Jolly Rd., Suite G13, Lansing, MI 48910
<b>PIHP Contact:</b>	Joanne Holland
<b>Contact Telephone Number:</b>	(517) 346-8237
<b>Contact E-mail Address:</b>	holland@ceicmh.org
<b>Site Visit Date:</b>	November 3, 2009

## Performance Measures Validated

HSAG validated a set of performance indicators that were developed by MDCH and selected for validation. The reporting cycle and review period were specified for each indicator by MDCH. The majority of the performance indicators were reported and validated for the first quarter of the Michigan SFY, which began October 1, 2009, and ended December 31, 2009. Table 2 lists the performance indicators that were validated, who performed the calculation of the performance indicator and the validation review period. The indicators are numbered as they appear in the MDCH Codebook.

Table 2—List of Performance Indicators for PIHPs			
	Indicator	Calculation by:	Validation Review Period
1.	Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	PIHP	First Quarter SFY 2010
2.	Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	PIHP	First Quarter SFY 2010
3.	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional.	PIHP	First Quarter SFY 2010
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	PIHP	First Quarter SFY 2010
4b.	Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	PIHP	First Quarter SFY 2010
5.	Percentage of Medicaid recipients having received PIHP-managed services.	MDCH	First Quarter SFY 2010
8.	Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination.	MDCH	First Quarter SFY 2010
10.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of adults with dual diagnoses served by PIHPs who are employed competitively.	MDCH	SFY 2009
11.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of adults with dual diagnoses served by PIHPs who earned minimum wage or more from any employment activities.	MDCH	SFY 2009
12.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	PIHP	First Quarter SFY 2010
13.	The annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by PIHPs.	MDCH	SFY 2009

Table 2—List of Performance Indicators for PIHPs		
Indicator	Calculation by:	Validation Review Period
14. Number of sentinel events during the six-month period per 1,000 Medicaid beneficiaries served by the following populations: adults with mental illness, children with mental illness, and persons with developmental disabilities not on the Habilitation Supports Waiver, persons on the Habilitation Supports Waiver, and persons with substance abuse disorder.	PIHP	Last Half of SFY 2009

## 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 that were selected by MDCH for validation. Indicator definitions and reporting templates were also provided by MDCH 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 consisted of the Information Systems Capabilities Assessment Tool (ISCAT), Appendix Z of the CMS Performance Measure Validation Protocol. Working in collaboration with MDCH and PIHP participants, HSAG customized the ISCAT to collect the necessary data that were 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 approximately one month 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 team was composed of a lead auditor and validation team members. The 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 office; others conducted their work at HSAG offices. **CMH Affiliation of Mid-Michigan’s** validation team was composed of the following members in the designated positions. Each individual’s particular expertise is described in Table 3.

Table 3—Validation Team		
Name	Team Position	Skills and Expertise
Margaret Ketterer, BSN, CHCA	Executive Director Audits/State & Corporate Services	Auditing expertise, clinical expertise, tool development, health plan operations
Patience Hoag, RHIT, CHCA, CCS, CCS-P, CPC	Lead Auditor	Coding expertise, encounter data validation, analysis
Maricris Kueny	Administrative Assistant	Administrative communications and organization
Tammy GianFrancisco	Administrative Assistant	Administrative communications and organization

### Technical Methods of Data Collection and Analysis

The CMS Performance Measure Validation Protocol identified 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 this data:

- ◆ *Information Systems Capabilities Assessment Tools (ISCATs)* were requested and received from each PIHP. Upon receipt by HSAG, the ISCATs underwent a cursory review to ensure all sections were completed and all attachments were present. The ISCATs were then forwarded to the validation team for review. The validation team reviewed all ISCAT documents, noting issues or items that needed further follow-up. Information included in the ISCAT was used by the review team to begin completion of the review tools, as applicable.
- ◆ *Source code (programming language) for performance indicators* was requested. PIHPs that calculated the indicators using automated computer code submitted the requested information. Line-by-line code review and observation of program logic flow was completed by the review team to ensure compliance with State indicator definitions during the site visit. Areas of deviation were identified and shared with the lead auditor to evaluate the impact of the deviation on the indicator and assess the degree of bias (if any).
- ◆ *Performance indicator reports for the first quarter of SFY 2010* were reviewed by the validation team. Previous reports were also reviewed to assess for trending patterns and rate reasonability.
- ◆ *Supporting documentation* included any documentation that provided reviewers with additional information to complete the validation process, including, but not limited to, policies and procedures, file layouts, system flow diagrams, system log files, and data collection process

descriptions. All supporting documentation was reviewed by the validation team, with issues or clarifications flagged for further follow-up.

### **On-site Activities**

HSAG conducted on-site visits to each PIHP. Information was collected 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 meetings**—included introductions of the validation team and key PIHP staff involved in the performance indicator activities. The review purpose, the required documentation, basic meeting logistics, and queries to be performed were discussed.
- ◆ **Evaluation of system compliance**—included a review of the information systems assessment, focusing on the processing of claims and encounter data, patient data, and provider data. Additionally, the review 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).
- ◆ **Review of ISCAT and supporting documentation**—included a review of the processes used for collecting, storing, validating, and reporting performance indicator data. This session was designed to be interactive with key PIHP staff so that the review team could obtain a complete picture of all the steps taken to generate the performance indicators. The goal of the session was to obtain a complete picture of the degree of compliance with written documentation. Interviews were used to confirm findings from the documentation review, expand or clarify outstanding issues, and ascertain that written policies and procedures were used and followed in daily practice.
- ◆ **Overview of data integration and control procedures**—included discussion and observation of source code logic and a review of how all data sources were combined and how the analytic file was produced for the reporting of selected performance indicators. Primary source verification was performed to further validate the output files. Backup documentation on data integration was reviewed. Data control and security procedures were also addressed during this session.
- ◆ **Closing conference**—summarized preliminary findings based on the review of the ISCAT and the on-site visit, and revisited the documentation requirements for any postvisit activities.

HSAG conducted several interviews with key **CMH Affiliation of Mid-Michigan** staff members who were involved with any aspect of performance indicator reporting. Table 4 displays a list of **CMH Affiliation of Mid-Michigan** key interviewees:

Table 4—List of CMH Affiliation of Mid-Michigan Interviewees	
Name	Title
Chuck Dougherty	Information Systems (IS) Director
Joanne Holland	Business Analyst Manager
Paul Duff	Senior Utilization Specialist
Stephanie Zinn	Compliance Officer
Kim Zimmerman	Affiliation Compliance Administrator
Roslin Griffin	Senior Reimbursement Specialist
John Hill	Business Analyst
Katherine VanZwoll	Business Analyst

## Data Integration, Data Control, and Performance Indicator Documentation

There are several aspects involved in the calculation of performance indicators that are crucial to the 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, the data integration processes in place at **CMH Affiliation of Mid-Michigan** were determined by the audit team to be:

- 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 validated the data control processes used by **CMH Affiliation of Mid-Michigan**, which included a review of disaster recovery procedures, data backup protocols, and related policies and procedures. Overall, the data control processes in place at **CMH Affiliation of Mid-Michigan** were determined by the audit team to be:

- Acceptable
- Not acceptable

### Performance Indicator Documentation

Sufficient, complete documentation is necessary to support validation activities. While interviews and system demonstrations can provide supplementary information, the majority of the validation review findings were based 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, the documentation of performance indicator calculations by **CMH Affiliation of Mid-Michigan** was determined by the audit team to be:

- Acceptable
- Not acceptable

## Validation Results

Through the validation process, the review team identified overall strengths and areas for improvement for **CMH Affiliation of Mid-Michigan**. In addition, the team evaluated **CMH Affiliation of Mid-Michigan**'s data systems for processing of each type of data used for reporting the MDCH performance indicators. General findings are indicated below:

### ***PIHP Strengths***

The PIHP continued to demonstrate its commitment to the performance indicator reporting process by following the recommendations from the previous year's audit. The PIHP continued its close oversight of data and maintained the requirement for a corrective action plan (CAP) for findings at the affiliate level during annual on-site audits. The PIHP staff's active participation on various statewide work groups reflected the PIHP's commitment to quality data and the goal of comparable, consistent data across the State.

### ***PIHP Areas for Improvement***

**CMH Affiliation of Mid-Michigan** should continue its close oversight of all data from affiliates and coordinating agencies (CAs). The PIHP may consider integrating a data omission piece into the Medicaid claims verification process, looking for documentation in the record that may not have been submitted as an encounter. Last, the PIHP should continue to explore all areas for improvement in data quality/completeness.

### ***Eligibility Data System Findings***

The reviewers had no concerns related to the PIHP's eligibility data system or enrollment file loads. The process is highly automated, errors are worked manually, and numbers are manageable. Because of some issues related to the State's new CHAMPS system file formats and the loss of some detail related to payment, the PIHP should continue to monitor this and explore a resolution with MDCH.

### ***Claims/Encounter Data System Findings***

The reviewers had no concerns with the PIHP's claims and encounter data system or file submission to MDCH. Each entity within the PIHP submits data after it has passed edits and goes through additional edits before going to MDCH. The PIHP had sufficient processes in place to ensure that data were complete, including reviewing productivity reports, trending, and volumes.

### ***Quality Improvement (QI) Data Production***

Each affiliate/agency within the PIHP has internal processes to review and monitor QI data for completeness and accuracy. The PIHP has an IS work group that reviews and monitors QI data completeness on an ongoing basis, and the PIHP met thresholds for completeness during the previous reporting period.

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

The PIHP conducts annual audits of each affiliate and, as mentioned earlier as a strength, the PIHP requires corrective actions for issues identified in the course of the audit. This audit includes performance indicator, QI, and encounter data, so it incorporates all facets in the data collection and reporting process at the affiliate level.

### ***PIHP Oversight of Coordinating Agencies***

Similar to the oversight of the affiliates, the PIHP conducts annual audits of each CA and, as mentioned earlier as a strength, the PIHP requires corrective actions for issues identified in the course of the audit. This audit includes performance indicator, QI, and encounter data, so it incorporates all facets in the data collection and reporting process at the CA level.

### ***PIHP Corrective Actions***

For the first quarter of SFY 2010, the PIHP's QI data completeness met MDCH's threshold of 95 percent complete for each required data element. No corrective action was required.

### ***PIHP Actions Related to Previous Recommendations***

The PIHP followed through on its requirement for CAP submission for each affiliate/agency where issues were found. **CMH Affiliation of Mid-Michigan** also incorporated a timeliness requirement into its policies/procedures for corrected encounter data to be submitted by its affiliates. Last, the PIHP worked with CareNet/NetSmart to correct programming related to the calculation of timeliness measures.

**Performance Indicator Specific Findings**

Based on all validation activities, the HSAG validation team determined validation results for each performance indicator. Table 5 displays the key review results. For more detailed information, please see Appendix B.

Table 5—Key Review Results for CMH Affiliation of Mid-Michigan Performance Indicators		
	Performance Indicator	Key Review Findings and Recommendations
1.	Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	The data were determined to be accurate and complete. Also, the calculation process was in accordance with MDCH Codebook specifications.
2.	Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	The data were determined to be accurate and complete. Also, the calculation process was in accordance with MDCH Codebook specifications.
3.	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional.	The data were determined to be accurate and complete. Also, the calculation process was in accordance with MDCH Codebook specifications.
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	The data were determined to be accurate and complete. Also, the calculation process was in accordance with MDCH Codebook specifications.
4b.	Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	The data were determined to be accurate and complete. Also, the calculation process was in accordance with MDCH Codebook specifications.
5.	Percentage of Medicaid recipients having received PIHP-managed services.	The indicator was calculated by MDCH and was determined to be fully compliant with MDCH Codebook specifications.
8.	Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination.	The indicator was calculated by MDCH and was determined to be fully compliant with MDCH Codebook specifications.
10.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of adults with dual diagnoses served by PIHPs who are employed competitively.	The indicator was calculated by MDCH and was determined to be fully compliant with MDCH Codebook specifications.
11.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of adults with dual diagnoses served by PIHPs who earn minimum wage or more from any employment activities.	The indicator was calculated by MDCH and was determined to be fully compliant with MDCH Codebook specifications.

Table 5—Key Review Results for CMH Affiliation of Mid-Michigan Performance Indicators	
Performance Indicator	Key Review Findings and Recommendations
12. Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	The data were determined to be accurate and complete. Also, the calculation process was in accordance with MDCH Codebook specifications.
13. The annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by PIHPs.	The indicator was calculated by MDCH and was determined to be fully compliant with MDCH Codebook specifications.
14. Number of sentinel events during the six-month period per 1,000 Medicaid beneficiaries served by the following populations: adults with mental illness, children with mental illness, and persons with developmental disabilities not on the Habilitation Supports Waiver, persons on the Habilitation Supports Waiver, and persons with substance abuse disorder.	The data were determined to be accurate and complete. Also, the calculation process was in accordance with MDCH Codebook specifications.

## Validation Findings

The CMS Performance Measure Validation Protocol identified four separate validation findings for each performance indicator, which are defined in Table 6:

Table 6—Validation Findings Definitions	
<b>Fully Compliant (FC)</b>	Indicates that the performance indicator was fully compliant with MDCH specifications.
<b>Substantially Compliant (SC)</b>	Indicates that the performance indicator was substantially compliant with MDCH specifications and had only minor deviations that did not significantly bias the reported rate.
<b>Not Valid (NV)</b>	Indicates that the performance indicator deviated from MDCH specifications such that the reported rate was significantly biased. This designation is also assigned to indicators for which no rate was reported, although reporting of the rate was required.
<b>Not Applicable (NA)</b>	Indicates that the performance indicator was not reported because the PIHP did not have any Medicaid consumers who qualified for that denominator.

According to the protocol, the validation finding for each measure is determined by the magnitude of the errors detected for the audit elements, not by the number of audit elements determined to be Not Met. Consequently, it is possible that an error for a single audit element may result in a designation of NV 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, resulting in an indicator designation of SC.

Table 7 displays the final validation findings for **CMH Affiliation of Mid-Michigan** for each performance indicator.

<b>Table 7—Validation Findings for CMH Affiliation of Mid-Michigan Performance Indicators</b>		
	<b>Performance Indicator</b>	<b>Validation Finding</b>
1.	Percentage of Medicaid beneficiaries receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	<b>Fully Compliant</b>
2.	Percentage of Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service.	<b>Fully Compliant</b>
3.	Percentage of Medicaid beneficiaries starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional.	<b>Fully Compliant</b>
4a.	Percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	<b>Fully Compliant</b>
4b.	Percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.	<b>Fully Compliant</b>
5.	Percentage of Medicaid recipients having received PIHP-managed services.	<b>Fully Compliant</b>
8.	Percentage of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in the data warehouse who are receiving at least one HSW service per month other than supports coordination.	<b>Fully Compliant</b>
10.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of adults with dual diagnoses served by PIHPs who are employed competitively.	<b>Fully Compliant</b>
11.	Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of adults with dual diagnoses served by PIHPs who earn minimum wage or more from employment activities.	<b>Fully Compliant</b>
12.	Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	<b>Fully Compliant</b>

Table 7—Validation Findings for CMH Affiliation of Mid-Michigan Performance Indicators	
Performance Indicator	Validation Finding
<p><b>13.</b> The annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by PIHPs.</p>	<p><b>Fully Compliant</b></p>
<p><b>14.</b> Number of sentinel events during the six-month period per 1,000 Medicaid beneficiaries served by the following populations: adults with mental illness, children with mental illness, and persons with developmental disabilities not on the Habilitation Supports Waiver, persons on the Habilitation Supports Waiver, and persons with substance abuse disorder.</p>	<p><b>Fully Compliant</b></p>

*Appendix A.* **Data Integration and Control Findings**  
for **CMH Affiliation of Mid-Michigan**

### Documentation Worksheet

<b>PIHP Name:</b>	CMH Affiliation of Mid-Michigan
<b>On-Site Visit Date:</b>	November 3, 2009
<b>Reviewers:</b>	Patience Hoag and Maricris Kueny

Data Integration and Control Element	Met	Not Met	N/A	Comments
<b>Accuracy of data transfers to assigned performance measure data repository</b>				
The PIHP accurately and completely processes transfer data from the transaction files (e.g., membership, provider, encounter/claims) into the performance measure data repository used to keep the data until the calculations of the performance measures have been completed and validated.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Samples of data from performance measure data repository are complete and accurate.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Accuracy of file consolidations, extracts, and derivations</b>				
The PIHP's processes to consolidate diversified files and to extract required information from the performance measure data repository are appropriate.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Actual results of file consolidations or extracts are consistent with those that should have resulted according to documented algorithms or specifications.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Procedures for coordinating the activities of multiple subcontractors ensure the accurate, timely, and complete integration of data into the performance measure database.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Computer program reports or documentation reflect vendor coordination activities, and no data necessary to performance measure reporting are lost or inappropriately modified during transfer.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>If the PIHP uses a performance measure data repository, its structure and format facilitates any required programming necessary to calculate and report required performance measures.</b>				
The performance measure data repository's design, program flow charts, and source codes enable analyses and reports.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Proper linkage mechanisms are employed to join data from all necessary sources (e.g., identifying a member with a given disease/condition).	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Data Integration and Control Element	Met	Not Met	N/A	Comments
<b>Assurance of effective management of report production and of the reporting software.</b>				
Documentation governing the production process, including PIHP production activity logs and the PIHP staff review of report runs, is adequate.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Prescribed data cutoff dates are followed.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
The PIHP retains copies of files or databases used for performance measure reporting in case results need to be reproduced.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
The reporting software program is properly documented with respect to every aspect of the performance measure data repository, including building, maintaining, managing, testing, and report production.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
The PIHP's processes and documentation comply with the PIHP standards associated with reporting program specifications, code review, and testing.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

*Appendix B.* **Denominator and Numerator Validation Findings**  
for **CMH Affiliation of Mid-Michigan**

### Reviewer Worksheets

<b>PIHP Name:</b>	CMH Affiliation of Mid-Michigan
<b>On-Site Visit Date:</b>	November 3, 2009
<b>Reviewers:</b>	Patience Hoag and Maricris Kueny

Denominator Validation Findings for CMH Affiliation of Mid-Michigan				
Audit Element	Met	Not Met	N/A	Comments
For each of the performance measures, all members of the relevant populations identified in the performance measure specifications are included in the population from which the denominator is produced.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Adequate programming logic or source code exists to appropriately identify all relevant members of the specified denominator population for each of the performance measures.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
The PIHP correctly calculates member months and member years if applicable to the performance measure.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Member months calculations were not necessary for performance indicator reporting.
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 measure.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
If any time parameters are required by the specifications of the performance measure, they are followed (e.g., cutoff dates for data collection, counting 30 calendar days after discharge from a hospital, etc.).	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Exclusion criteria included in the performance measure specifications are followed.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Systems or methods used by the PIHP to estimate populations when they cannot be accurately or completely counted (e.g., newborns) are valid.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Population estimates were not necessary for the calculation of the performance indicators.

Numerator Validation Findings for CMH Affiliation of Mid-Michigan				
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.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Qualifying medical events (such as diagnoses, procedures, prescriptions, etc.) are properly identified and confirmed for inclusion in terms of time and services.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
The PIHP avoids or eliminates all double-counted members or numerator events.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
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.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Nonstandard codes were not used or reported by the PIHP.
If any time parameters are required by the specifications of the performance measure, they are followed (i.e., the measured event occurred during the time period specified or defined in the performance measure).	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

## Appendix C. Performance Measure Results for CMH Affiliation of Mid-Michigan

### Indicator 1

The percentage of persons receiving a preadmission screening for psychiatric inpatient care for whom the disposition was completed within three hours (by two subpopulations: children and adults). *(Standard of 95 percent.)*

**Table C-1—Indicator 1: Access—Timeliness/Inpatient Screening  
for CMH Affiliation of Mid-Michigan**

1. Population	2. Number of Emergency Referrals for Inpatient Screening During the Time Period	3. Number of Dispositions of Emergency Referrals Completed Within Three Hours or Less	4. Percent of Emergency Referrals Completed Within the Time Standard
1. # Children	56	56	100.00%
2. # Adults	288	287	99.65%

### Indicator 2

The percentage of persons receiving a face-to-face assessment with a professional within 14 calendar days of a nonemergency request for service (by five subpopulations: mentally ill [MI]-adults, MI-children, developmentally disabled [DD]-adults, DD-children, and persons with Substance Use Disorders [SA]). *(Standard of 95 percent.)*

**Table C-2—Indicator 2: Access—Timeliness/First Request  
for CMH Affiliation of Mid-Michigan**

1. Population	2. # of New Persons Receiving an Initial, Nonemergent, 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
1. MI—Children	205	35	170	169	99.41%
2. MI—Adults	84	6	78	78	100.00%
3. DD—Children	17	1	16	16	100.00%
4. DD—Adults	20	5	15	15	100.00%
Subtotal	326	47	279	278	99.64%
SA total	215	16	199	199	100.00%
TOTAL	541	63	478	477	99.79%

### Indicator 3

Percentage of persons starting any needed, ongoing service within 14 days of a nonemergent assessment with a professional (by five subpopulations: MI-adults, MI-children, DD-adults, DD-children, and persons with SA). (Standard of 95 percent.)

Table C-3—Indicator 3: Access—Timeliness/First Service for CMH Affiliation of Mid-Michigan					
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
1. MI—Children	171	74	97	96	98.97%
2. MI—Adults	52	7	45	44	97.78%
3. DD—Children	13	5	8	8	100.00%
4. DD—Adults	12	6	6	5	83.33%
Subtotal	248	92	156	153	98.08%
SA total	192	45	147	141	95.92%
<b>TOTAL</b>	<b>440</b>	<b>137</b>	<b>303</b>	<b>294</b>	<b>97.03%</b>

### Indicators 4a and 4b

The percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days. (Standard of 95 percent.)

Table C-4—Indicator 4a: Access—Continuity of Care for CMH Affiliation of Mid-Michigan					
1. Population	2. # of Discharges From a Psychiatric Inpatient Unit	3. # of Discharges From Col 2 Who Are Exceptions	4. Net # of Discharges (Col 2 Minus Col 3)	5. # of Discharges From Col 4 Followed Up by PIHP Within 7 Days	6. % of Discharges Seen Within 7 Days
1. # of Children	20	7	13	11	84.62%
2. # of Adults	107	47	60	55	91.67%

The percentage of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.

Table C-5—Indicator 4b: Access—Continuity of Care for CMH Affiliation of Mid-Michigan					
1. Population	2. # of Discharges From a Substance Abuse/Detox Unit	3. # of Discharges From Col 2 Who Are Exceptions	4. Net # of Discharges (Col 2 Minus Col 3)	5. # of Discharges From Col 4 Followed Up by CA/PIHP Within 7 Days	6. % of Discharges Seen Within 7 Days
# of Consumers	14	11	3	3	100.00%
<b>TOTAL</b>	<b>14</b>	<b>11</b>	<b>3</b>	<b>3</b>	<b>100.00%</b>

### Indicator 5

The percentage of Medicaid recipients having received PIHP-managed services.

Table C-6—Indicator 5: Penetration Rate for CMH Affiliation of Mid-Michigan		
# of Area Medicaid Recipients	Consumers Served	Penetration Rate
94,234	5,488	5.82%

### Indicator 8

The percentage of Habilitation Supports Waiver (HSW) enrollees in the quarter who received at least one HSW service each month other than supports coordination.

Table C-7—Indicator 8: Adequacy/Appropriateness—Habilitation Supports Waiver (HSW) for CMH Affiliation of Mid-Michigan			
Population	# of Enrollees	# of Enrollees Receiving at Least One HSW Service Each Month Other Than Supports Coordination	HSW Rate
Habilitation Supports Waiver Enrollees	380	370	97.37%

### Indicator 10

Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of adults with dual diagnoses served by PIHPs who are employed competitively.

Table C-8—Indicator 10: Outcomes—Competitive Employment for CMH Affiliation of Mid-Michigan			
Population	# of Enrollees	# of Enrollees Who Are Employed Competitively	Competitive Employment Rate
MI—Adults	3,105	312	10.05%
DD—Adults	891	119	13.36%
MI & DD – Adults	664	86	12.95%

## Indicator 11

Percentage of adults with mental illness, the percentage of adults with developmental disabilities, and the percentage of adults with dual diagnoses served by PIHPs who earned minimum wage or more from any employment activities.

Table C-9—Indicator 11: Outcomes—Minimum Wage for CMH Affiliation of Mid-Michigan			
Population	# of Enrollees	# of Enrollees Who Earn Minimum Wage or More From Employment Activities	Minimum Wage Rate
MI—Adults	298	246	82.55%
DD—Adults	206	102	49.51%
MI & DD – Adults	127	67	52.76%

## Indicator 12

The percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge. *(Standard of 15 percent or less.)*

Table C-10—Indicator 12: Outcome—Inpatient Recidivism for CMH Affiliation of Mid-Michigan					
1. Population	2. # of Discharges From a Psychiatric Inpatient Unit During the Reporting Period	3. # of Discharges From Col 2 Who 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
1. # of Children	20	3	17	1	5.88%
2. # of Adults	105	40	65	9	13.85%

## Quality Improvement (QI) Data Elements

The QI data elements in Michigan PIHP performance indicator reporting are displayed in Table C-11. The table depicts how complete specific data elements were within the QI data file that the PIHP submitted to MDCH. Shown are the percent complete and the indicators for which the data elements were used. Data in the “Percent Complete” column were provided by MDCH.

Table C-11—QI Data Elements in Performance Measure Reporting for CMH Affiliation of Mid-Michigan			
QI Data Element	Percent Complete SFY 2009	Percent Complete 1st Quarter SFY 2010	Quarterly and Annual Indicators Impacted
Age*	99.99%	100.00%	5
Disability Designation*	100.00%	100.00%	5
Employment Status*	99.76%	99.94%	10, 11
Medicaid ID*	99.09%	98.56%	5, 8
Minimum Wage*	96.80%	99.45%	10, 11

\* Based on the PIHP/MDCH contract, 95 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.