

# **MICHIGAN’S MISSION-BASED PERFORMANCE INDICATOR SYSTEM**

## **FY26 PIHP Reporting Codebook**

**Michigan Department of Health and Human Services  
Health Services  
Bureau of Specialty Behavioral Health Services**

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## PERFORMANCE INDICATOR REPORTING DUE DATES

Indicator Title	Period	Due	Period	Due	Period	Due	Period	Due	Data Submitted by
2. 1 <sup>st</sup> request	10/01 to 12/31	3/31	1/01 to 3/31	6/30	4/01 to 6/30	9/30	7/01 to 9/30	12/31	PIHPs

# PERFORMANCE INDICATOR CODEBOOK

## General Rules for Reporting Performance Indicators

### 1. Due dates

All data are due 90 days following the end of the reporting period (Note: reporting periods are 90 days, six months, or 12 months).

Consultation drafts will be issued for editing purposes approximately two weeks after the due date.

Final report will be posted on the MDHHS website approximately 30 days following the due date.

### 2. Children

Children are counted as such who are less than age 18 on the last day of the reporting period.

### 3. Emergency and urgent requests for services used here as defined in the Mental Health Code. 330.1100 (18 & 29).

### 4. Medicaid

Count as Medicaid eligible any person who qualified as a Medicaid beneficiary during at least one month of the reporting period. This includes both traditional Medicaid and Healthy Michigan. Individuals covered under the autism benefit are included. Indicator #2 is to be reported by the PIHPs for all their Medicaid beneficiaries.

### 5. Intellectual Disability and Developmental Disability (I/DD)

As defined in the Mental Health Code 330.1100 (12 & 25).

### 6. Mental Illness/Serious Emotional Disturbance (MI/SED)

The individual has an MI DSM Diagnosis.

### 7. Rules for categorizing individuals who have both mental illness and an intellectual or developmental disability (MI/SED & I/DD)

- a. If a biopsychosocial assessment has been completed for the person:
  - i. Assign person to either MI or I/DD category based on primary diagnosis.
  - ii. If person has both MI and I/DD primary diagnoses:
    - a. Assign a person as either MI or I/DD based on the primary diagnosis related to the greatest level of impairment.
    - b. The services they are being referred to or being treated for.
  - iii. If can't determine whether MI or I/DD category is predominant, categorize the person as I/DD.
- b. If a biopsychosocial assessment has not yet been completed for the person:
  - i. Assign person to either the MI or I/DD category based on the services the person requests.
  - ii. If the person requests both MH and I/DD services, categorize the person as I/DD.

- iii. If it can't be determined what type of services are being requested, categorize the person as MI.

8. Exclusions

The following scenarios should not be counted in the indicators:

- a. Those who are not medically or physically able to receive services.
- b. Individuals who decline to receive services.
- c. Individuals receiving CCBHC only services. Dual enrolled CCBHC/PIHP beneficiaries should be included.

## **ACCESS: TIMELINESS/FIRST REQUEST**

### **Mental Health and Intellectual and Developmental Disabilities**

#### **Indicator #2**

The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service (by four sub-populations: MI-adults, MI-children, I/DD-adults, I/DD-children.)

Standard percentiles were created based on FY22 time period and reported on an annual basis.

Performance is based on the cumulative percentage for the total eligible within each population group.

	50 <sup>TH</sup> PERCENTILE	75 <sup>TH</sup> PERCENTILE
INDICATOR 2	57.0%	62.0%

1. PIHPs that are below the 50th percentile benchmark will be expected to reach or exceed the 50th percentile.
2. PIHPs that are in the 50th -75th percentile benchmark will be expected to reach or exceed the 75th Percentile.
3. PIHPs that are above the 75th percentile benchmark will be expected to maintain the level of performance.
  - a. Quarterly report
  - b. For all Medicaid beneficiaries
  - c. MI adults, MI children, I/DD adults, and I/DD children

#### **Rationale for Use**

Quick, convenient entry into the public behavioral health system is a critical aspect of accessibility of services. Delays may lead to exacerbation of symptoms and distress, disengagement from the system and poorer role functioning. The amount of time between a request for service and the delivery of needed treatments and supports is one measure of access to care. The assessment process is especially important for individuals seeking services for mental illness or intellectual and developmental disability and the completed assessment is critical for person-centered planning. In addition, timely assessment is critical to the engagement process and connecting the consumer to necessary services and supports while the person is motivated towards treatment.

## Receiving a Biopsychosocial Assessment within 14 Calendar Days of First Request

**Table 2a – Indicator #2**

<b>1. Population</b>	<b>2. (A) # of New Persons Who Requested Mental Health or I/DD Services and Supports and are Referred for a Biopsychosocial Assessment</b>	<b>3. (B) # of Persons Completing the Biopsychosocial Assessment within 14 Calendar Days of First Request for Service</b>	<b>4. (B/A X 100) % of Persons Requesting a Service Who Received a Completed Biopsychosocial Assessment within 14 Calendar Days (Calculated)</b>
<b>1. MI-C</b>	<b>B2</b>	<b>C2</b>	<b>L2</b>
<b>2. MI-A</b>	<b>D2</b>	<b>E2</b>	<b>M2</b>
<b>3. IDD-C</b>	<b>F2</b>	<b>G2</b>	<b>N2</b>
<b>4. IDD-A</b>	<b>H2</b>	<b>I2</b>	<b>O2</b>
<b>5. Total Population</b>	<b>J2</b>	<b>K2</b>	<b>P2</b>

### Column 1 – Population

See General Rules for definitions of children, Medicaid, Mental illness (MI/SED) and intellectual and developmental disability (I/DD).

For Indicator #2:

- Medicaid includes people who have both Medicaid and Medicare coverage, except Mild to Moderate beneficiaries covered under MI Health Link who are excluded from this indicator.
- People covered under OBRA are excluded from the indicator.
- Individuals receiving CCBHC only services. Dual enrolled CCBHC/PIHP beneficiaries should be included.

### Column 2- Selection Methodology

- Cases selected for inclusion in Column 2 are those new Medicaid consumers who made a non-emergency request for specialty MH or I/DD services and supports and were referred for a biopsychosocial assessment during the quarter.
- “First request” is the initial telephone or walk-in request for non-emergency services by the individual, parent of minor child, legal guardian, or referral source. In the case of a referral from an outside organization the request date is the date the referring agency makes a request for services on behalf of the person. If the person is referred from an inpatient psychiatric facility, the request date is the date that the person is discharged from the facility.
- Emergent and urgent requests for MH and I/DD services are excluded from this indicator.

4. “New” persons are defined as follows:

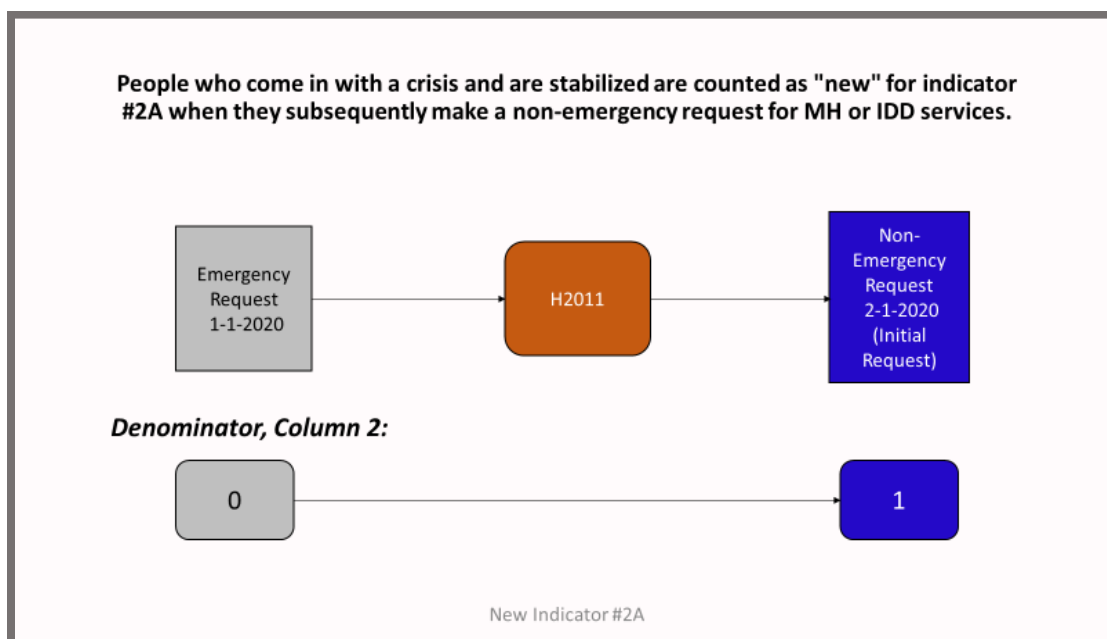
- a. A new person cannot be active in the PIHPs mental health system. “New” is defined as either never seen by the PIHP for mental health services or for services for intellectual and developmental disabilities, or it has been 90 days or more since the individual has received any MH or I/DD service from the PIHP.

➤ **If the person has received SUD services in the last 90 days but no MH or I/DD services, the person is “new” or reportable for Indicator 2.**

- b. Consumers who come in with a crisis and are stabilized are counted as "new" for indicator #2 when they subsequently make a non-emergency request for MH or I/DD services. The indicator will be tracked from the point of the non-emergent request forward. (See Figure 2a.2).



**Figure 2a.2**



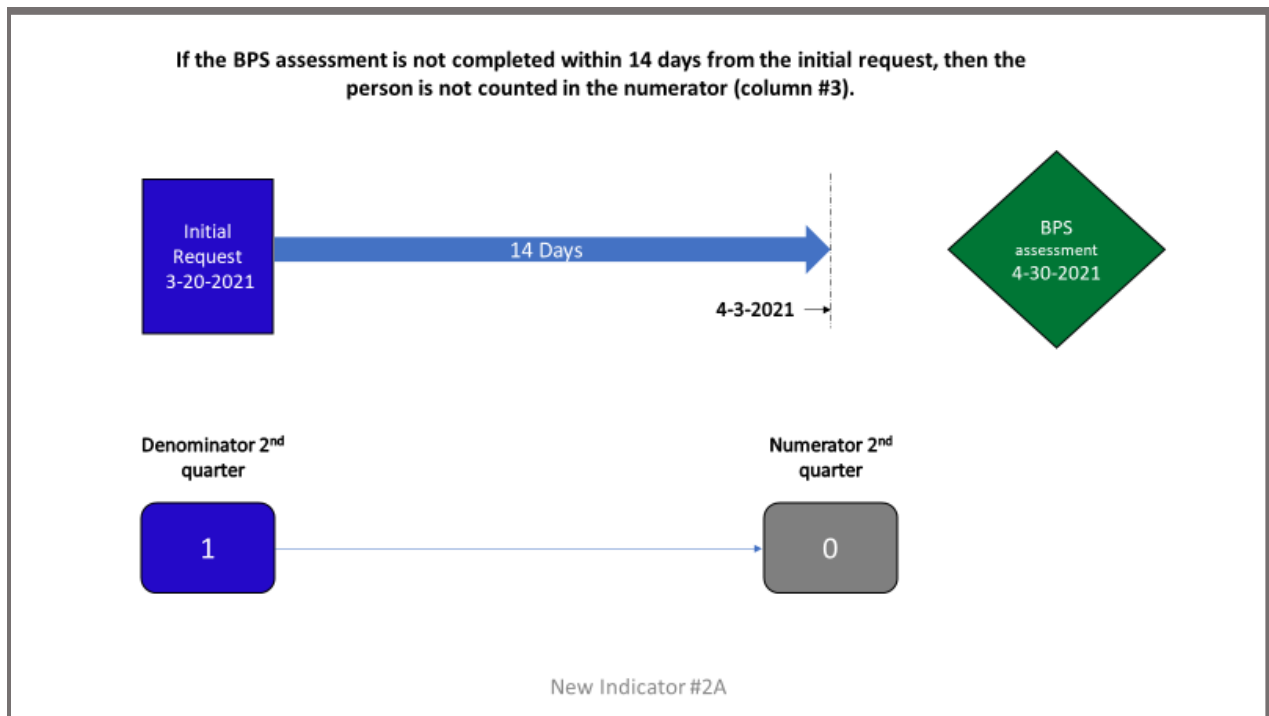
**Important to Note:** A person can be counted no more than twice in the denominator during a quarter.

- **If over the past 90 days the person has only received crisis services, the person is new or reportable for indicator 2.**
- **Crisis services are defined by the following codes:**
  - Crisis intervention, Intensive Crisis Stabilization for Children or for Adults, **H2011**
  - Intensive Crisis Stabilization, **S9484**
  - Screening for Inpatient Program, **T1023**
  - Psychotherapy for Crisis, **90839 & 90840**
  - Crisis Residential, **H0018**
  - **Any service from a psychiatric inpatient stay**
  - Partial Hospitalization if T1023 reported, **0912, 0913**

### **Column 3 – Numerator Methodology**

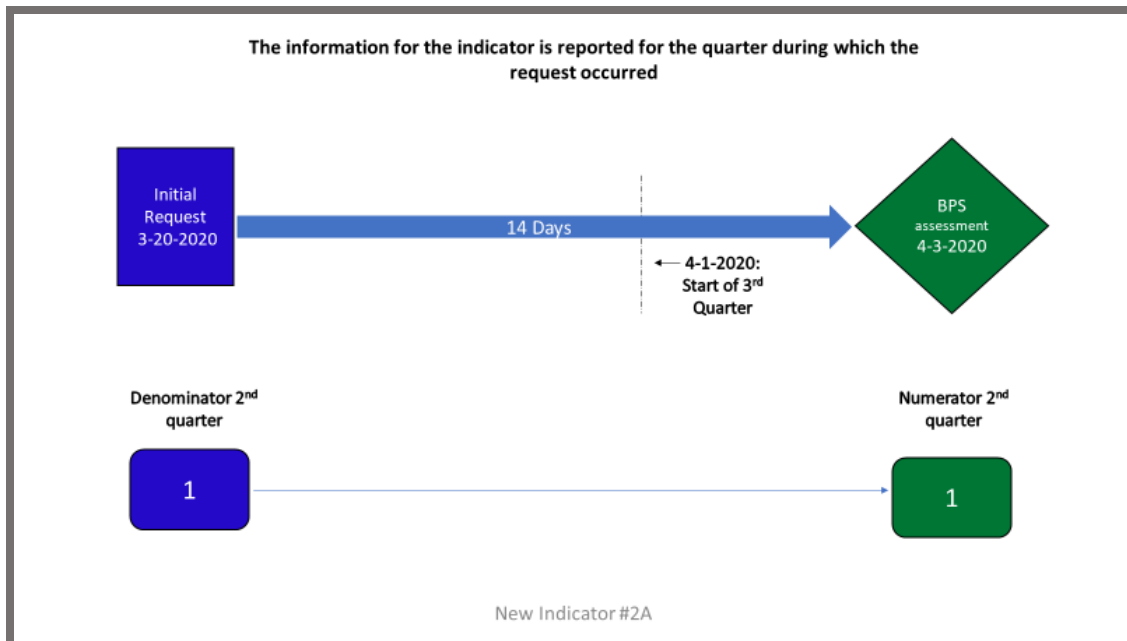
1. Cases selected for inclusion in Column 3 are those in Column 2 for which the biopsychosocial assessment was completed within 14 calendar days following the first request.
2. Count forward from the date of the first request to the completion date of the biopsychosocial assessment for mental health or I/DD treatment or support even if this spans across quarters. (Example: If the initial request is made on 3-20-2021 and the person does not complete a biopsychosocial assessment by the end of the day 4-3-2021 (14 days) then for 2<sup>nd</sup> quarter 2021 the person is counted in column #2 and not counted in column #3). (See Figure 2a.3).

**Figure 2a.3**



3. For this indicator, a biopsychosocial assessment is considered completed once the professional has submitted an encounter for the assessment and a qualified professional has determined a qualifying diagnosis for the individual. If the biopsychosocial assessment and the determination of the diagnosis occur on different dates, use the latter date when calculating the time from the initial request to the completion of the biopsychosocial assessment.
4. The reporting quarter is based on the date of the request for service. (See Figure 2a.4). If date of request and referral date are not on the same day, the reporting quarter is based on the request date. (Example: If the request is 3/31/2021 and the referral is 4/1/2021, the reporting quarter is the 2<sup>nd</sup> quarter 2021 (Jan-March 2021)).

**Figure 2a.4**

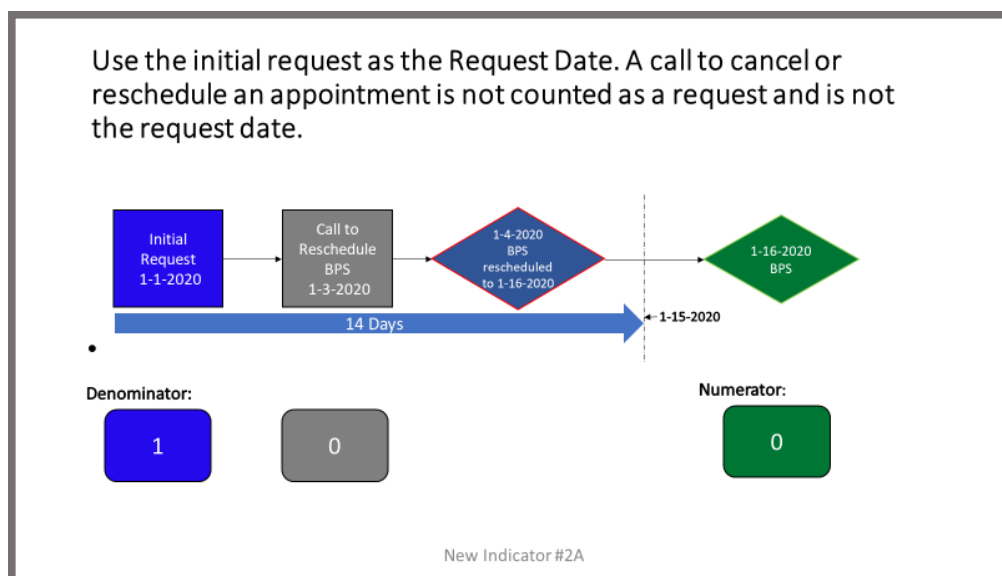


5. The request date is the date the person makes their first request in which they include their name and contact information. The 14-day count starts at this first request, even if multiple attempts are needed to contact the person to set up a referral. (Example: On 1/1/2021 the person calls for the first time and leaves a message, with name and call-back information, requesting services. On 1/1/2021 the access center calls the person back, is unable to reach the person but leaves a message. On 1/15/2021 the person calls back to request services and receives a referral for a biopsychosocial assessment. The request date is 1/1/2021.)

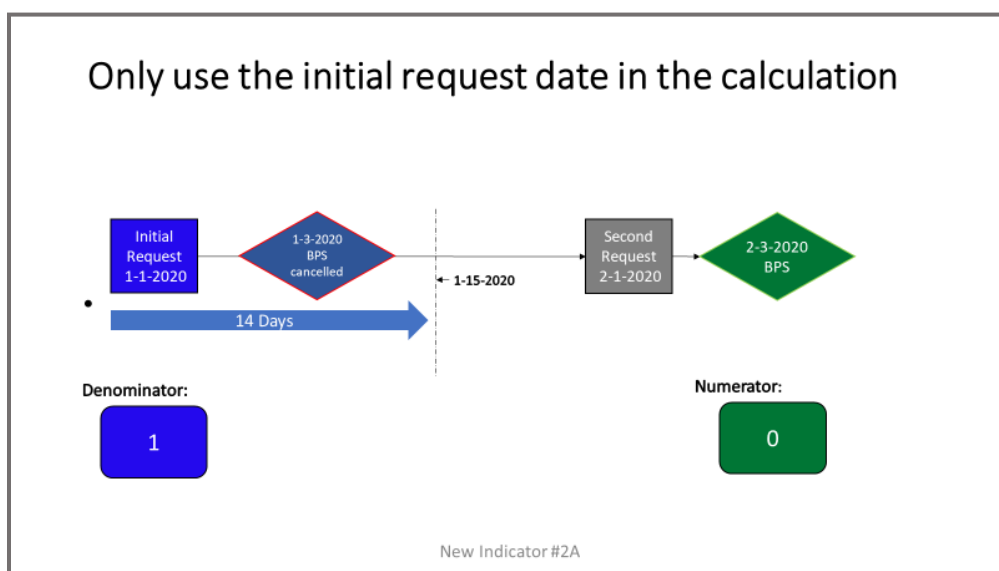
**TIP:** A call to cancel or reschedule an appointment is not counted as a request for this indicator and is not the request date. (See Figure 2a.5).

**TIP:** Only use the initial request date in the calculation (See Figure 2a.6).

**Figure 2a.5**



**Figure 2a.6**



#### Column 4 – Calculation Methodology

Calculate the percentage of persons who made a request for services who received a completed assessment within 14 days of the initial request date. Only use the initial request date in this calculation. For example, if the person does not show for first scheduled appointment and reschedules, calculate the number of days between the initial request and the rescheduled appointment. Do not calculate the number of days between the request for a reschedule and the new appointment date.

#### Documentation

The PIHP must maintain documentation available for state review on the date of the first request as well as the date the biopsychosocial assessment is completed even if this spans two quarters or multiple quarters. The PIHP must also maintain documentation on the dates offered to the individual as well as scheduled dates for which the individual did not show up or reschedule.