# MICHIGAN'S MISSION-BASED PERFORMANCE INDICATOR SYSTEM

# PIHP & CMHSP Reporting Codebook

**Michigan Department of Health and Human Services**
**Behavioral and Physical Health and Aging Services Administration**

**Revision May 2024**

# Table of Contents

# PERFORMANCE INDICATOR REPORTING DUE DATES

| Indicator Title | Period | Due | Period | Due | Period | Due | Period | Due | Data Submitted by |
|---|---|---|---|---|---|---|---|---|---|
| 1. Pre-admission screening | 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/ CMHSPs |
| 2. 1st 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/ CMHSPs |
| 2.e. 1st request – SUD* | 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/ MDHHS |
| 3. 1st service | 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/ CMHSPs |
| 4. Follow-up | 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/ CMHSPs |
| 5. Medicaid Penetration* | 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 | MDHHS |
| 5. Denials | 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 | CMHSPs |
| 6. HSW Services* | 10/01 to 12/31 | 3/31 | 1/01to 3/31 | 6/30 | 4/01 to 6/30 | 9/30 | 7/01 to 9/30 | 12/31 | MDHHS |
| 6. 2nd Opinions | 10/01 to 12/31 | 3/31 | 1/01to 3/31 | 6/30 | 4/01 to 6/30 | 9/30 | 7/01 to 9/30 | 12/31 | CMHSPs |
| 8. Competitive employment* | 10/01 to 9/30 | N/A | | | | | | | MDHHS |
| 9. Minimum wage* | 10/01 to 9/30 | N/A | | | | | | | MDHHS |
| 10. Readmissions | 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/ CMHSPs |
| 13. Residence (DD)* | 10/01 to 9/30 | N/A | | | | | | | MDHHS |
| 14. Residence (MI)* | 10/01 to 9/30 | N/A | | | | | | | MDHHS |

*Indicators with *: MDHHS collects data from encounters, BH TEDS or cost reports and calculates performance indicators

# 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. Dual Eligible
   Do not include those individuals who are Medicare/Medicaid dual eligible in indicators number 4a & 4b (Follow-up Care) and number 10 (Readmissions).

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

5. 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. Indicators # 1, 2, 2e, 3, 4, and 10 are to be reported by the CMHSPs for all their people served, and by the PIHPs for all their Medicaid beneficiaries. The PIHP reports these indicators for all the Medicaid beneficiaries in their region. The PIHPs who are also a single CMHSP, therefore, will submit two reports: One as a CMHSP for all its consumers, and one as a PIHP for all its Medicaid beneficiaries.

6. Intellectual Disability and Developmental Disability (I/DD)
   As defined in the Mental Health Code 330.1100 (12 & 25).

7. Mental Illness/Serious Emotional Disturbance (MI/SED)
   The individual has an MI DSM Diagnosis.

8. 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.

9. Substance use beneficiaries
   Persons receiving substance use disorder services under the SUD benefit managed by the PIHP (this is not applicable to CMHSP). Managed by the PIHP means substance abuse services that the PIHP may deliver directly or may subcontract directly with a substance use disorder provider.

10. Substance Use Disorder Providers
    Entity licensed by distinct street address (facility location) to operate a substance abuse treatment and/or rehabilitation program in accordance with the provisions of Act 368 of the Public Acts of 1978, as amended, and the Administrative Rules (R 325.14101-R 325.14928) of the Michigan Department of Licensing and Regulatory Affairs.

11. Documentation
    It is expected that CMHSPs and PIHPs will maintain documentation of:
    a. persons counted in the "exception" columns on the applicable indicators – who, why, and source documents; and start and stop times for timeliness indicators.
    b. Documentation will be requested and reviewed during external quality reviews.

# ACCESS: TIMELINESS/INPATIENT SCREENING

## Indicator #1 (CMHSP & PIHP)

The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours (by two sub-populations: Children and Adults). Standard = 95%

The percent of all Medicaid adult and children beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.

a. Standard = 95% in three hours
b. Quarterly report
c. Prepaid Inpatient Health Plan (PIHP) for all Medicaid beneficiaries
d. Community Mental Health Services Program (CMHSP) for all consumers

**Rationale for Use**

People who are experiencing symptoms serious enough to warrant evaluation for inpatient care are potentially at risk of danger to themselves or others. Thus, time is of the essence. This indicator assesses whether CMHSPs and PIHPs are meeting the Department's standard that 95%

of the inpatient screenings have a final disposition within three hours. This indicator is a standard measure of access to care.

**Table 1 – Indicator #1**

| 1. Population | 2. Number (#) of Emergency Referrals for Inpatient Screening During the Time Period | 3. Number (#) of Dispositions about Emergency Referrals Completed Within Three Hours or Less | 4. Percent (%) of Emergency Referrals Completed Within the Time Standard (Calculated) |
|---|---|---|---|
| **1. # Children** | **B2** | **C2** | **F2** |
| **2. # Adults** | **D2** | **E2** | **G2** |

**Definitions and Instructions**

"Disposition" means the decision was made to refer, or not refer, to inpatient psychiatric care.

1. If screening is not possible due to intoxication or sedation, do not start the clock.

2. Start time: When the person is clinically, medically, and physically available to the CMHSP and PIHP.

    a. When emergency room or jail staff informs CMHSP and PIHP that individual needs, and is ready, to be assessed; or
    b. When an individual presents at an access center and then is clinically cleared (as needed).

3. Stop time: Clinician (in access center or emergency room) who has the authority, or utilization management unit that has the authority, makes the decision whether or not to admit.

4. After the decision is made, the clock stops but other activities will continue (screening, transportation, arranging for bed, crisis intervention).

5. Documentation of start/stop times needs to be maintained by the CMHSP and PIHP.

# ACCESS: TIMELINESS/FIRST REQUEST

**Mental Health and Intellectual and Developmental Disabilities**

## Indicator #2 (PIHP & CMHSP)

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.

| | 50TH PERCENTILE | 75TH 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. CMHSP for all consumers
   d. 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**

| 1. Population | 2. (A) # of New Persons Who Requested Mental Health or I/DD Services and Supports and are Referred for a Biopsychosocial Assessment | 3. (B) # of Persons Completing the Biopsychosocial Assessment within 14 Calendar Days of First Request for Service | 4. (B/A X 100) % of Persons Requesting a Service Who Received a Completed Biopsychosocial Assessment within 14 Calendar Days (Calculated) |
|---|---|---|---|
| **1. MI-C** | **H2** | **I2** | **R2** |
| **2. MI-A** | **J2** | **K2** | **S2** |
| **3. IDD-C** | **L2** | **M2** | **T2** |
| **4. IDD-A** | **N2** | **O2** | **U2** |
| **5. Total Population** | **P2** | **Q2** | **V2** |

**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:

a. 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.
b. People covered under OBRA are excluded from the indicator.

**Column 2- Selection Methodology**

1. 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.

2. "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. For the request to be included in this indicator, the individual must consent to treatment.

> ***TIP:*** Reporting inpatient discharges for indicator #2 and #4
> Those people who are discharged from an inpatient psychiatric facility and reported in indicator #4 will also be reported in this indicator #2 if they are new to the PIHP.

3. Emergent and urgent requests for MH and I/DD services are excluded from this indicator.

4. If a new consumer is requesting services for both mental health/intellectual and developmental disability as well as substance use disorder, include the person in this current indicator (#2) as well as the indicator for substance use disorder (indicator #2e).

> ***TIP:*** Persons included in this current indicator (#2) are those requesting services at a CMHSP. Those people who are also approved for services at a licensed and accredited SUD provider are to also be included in the substance use disorder indicator (#2).

5. "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.**
>
> - **If a person is new to a CMHSP but not to the PIHP because they were seen at another CMHSP within that PIHP, the person will be included in**

**indicator #2 for that CMHSP but the PIHP will not report this person as the person is not new to the PIHP.**

b. A new consumer did not receive any subsequent services following an initial request (for example due to cancelled appointments), the consumer is re-counted as "new" for the current quarter if it has been more than 60 days since the initial request, either in-person or non-face-to-face. (See Figure 2a.1).

c. 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.1**

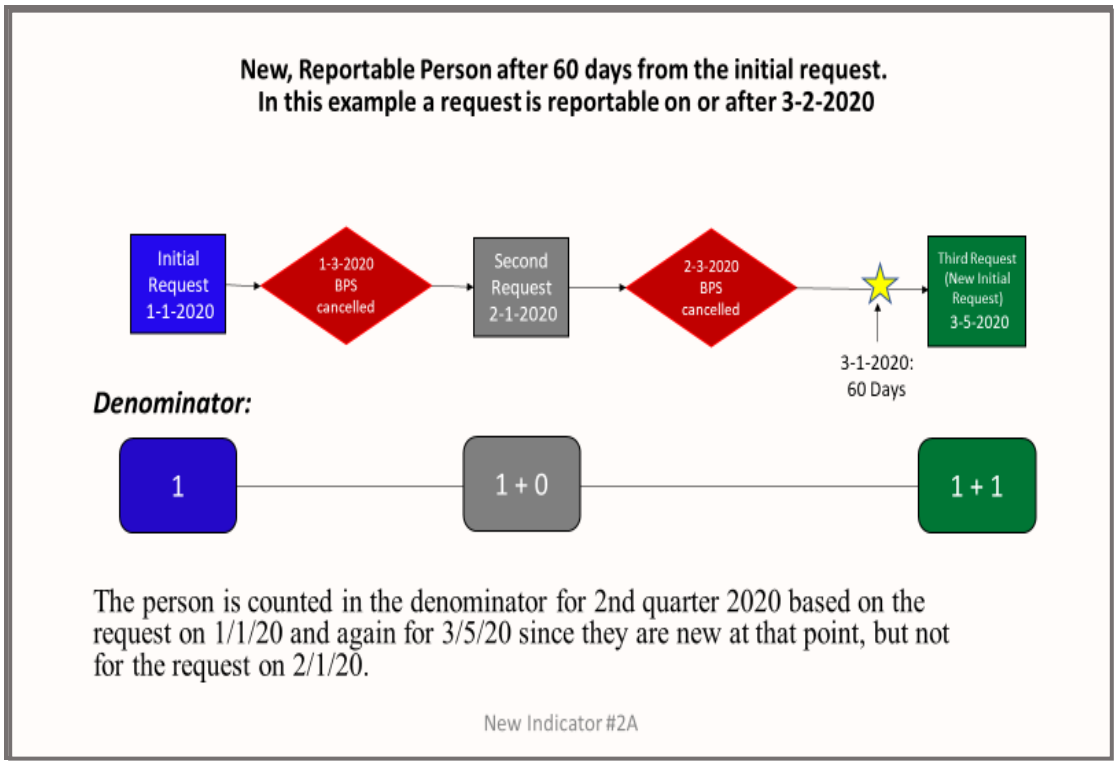
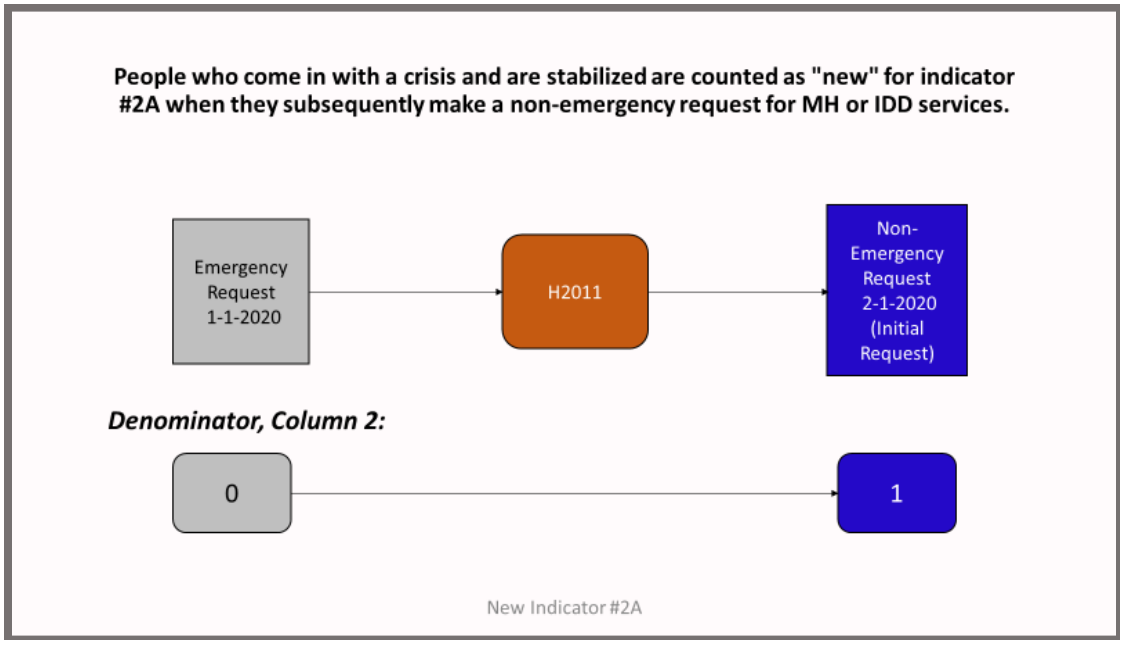


**Figure 2a.2**




**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.**

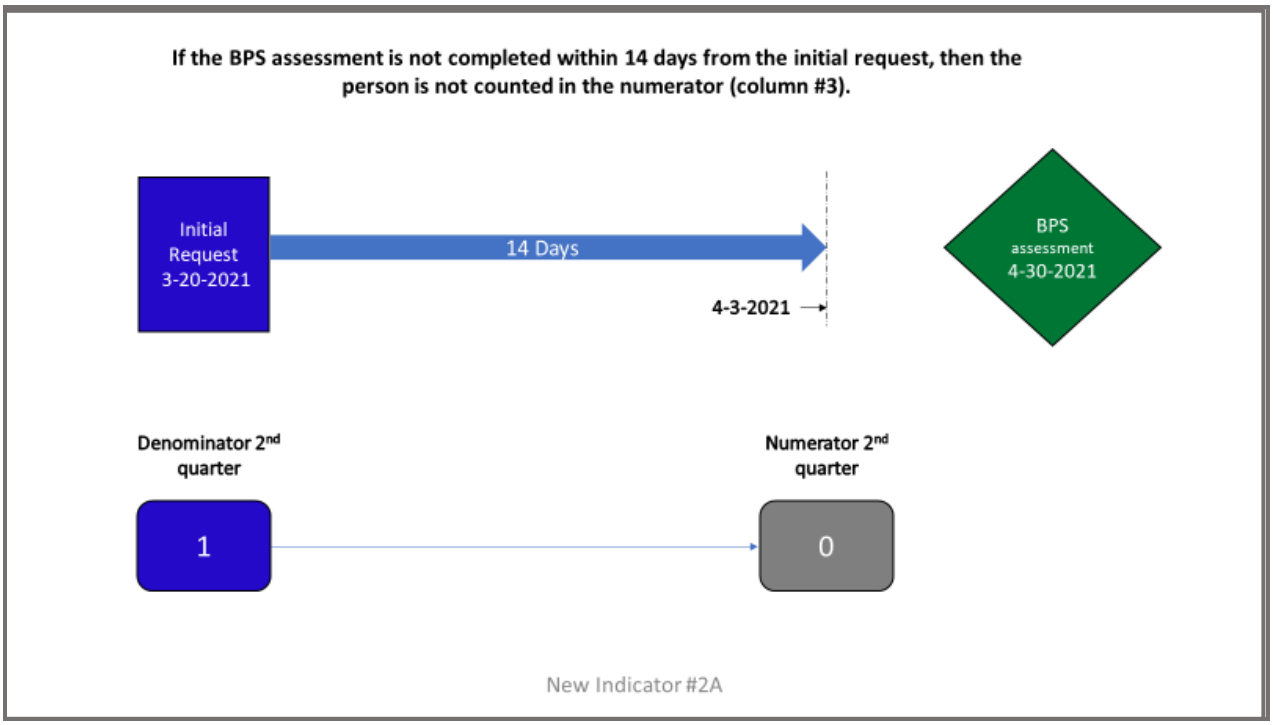
- **Crisis services are defined by the following codes:**
  - Crisis intervention, Intensive Crisis Stabilization for Children or for Adults, **H2011**
  - Intensive Crisis Stabilization, **S9484**
  - Screening for Inpatient Program, **T1023**
  - Psychotherapy for Crisis, **90839 & 90840**
  - Crisis 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 2nd quarter 2021 the person is counted in column #2 and not counted in column #3). (See Figure 2a.3).

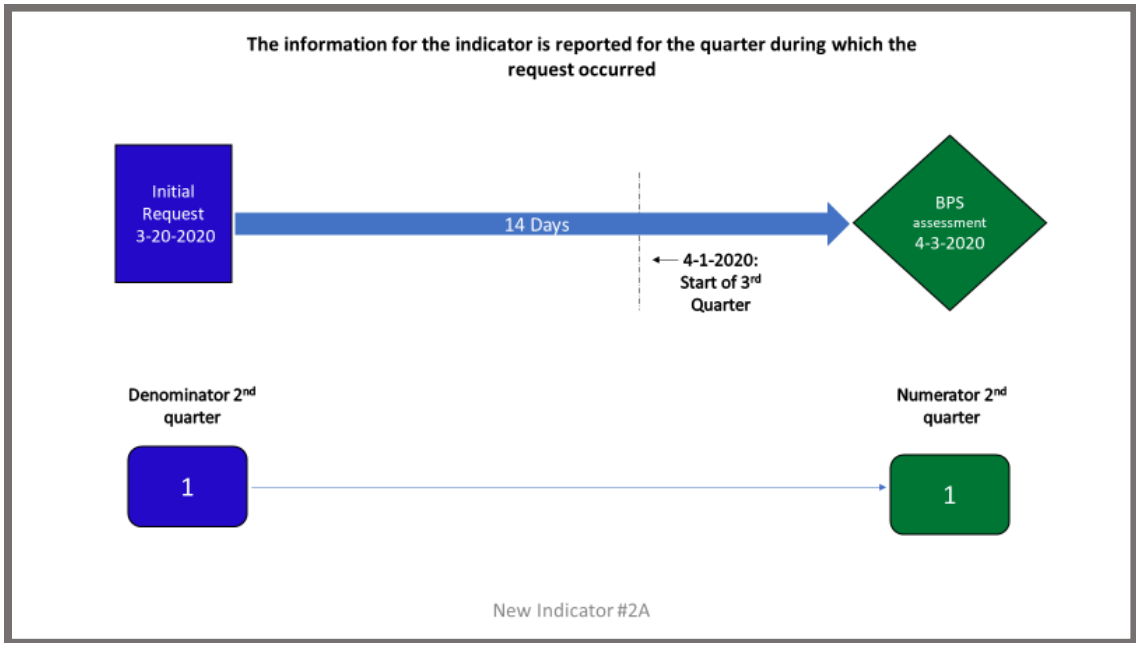
**Figure 2a.3**




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 2nd 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**

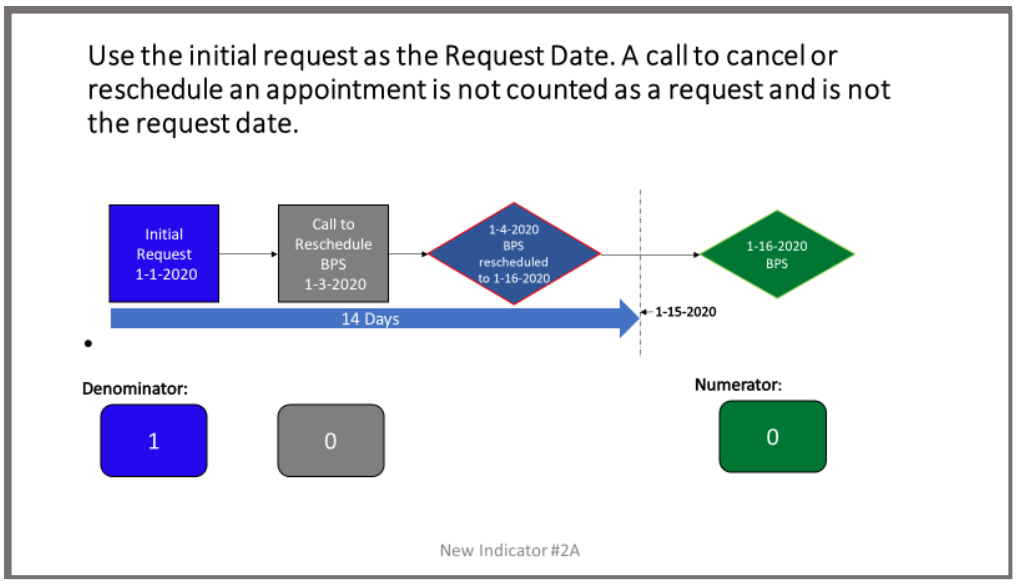
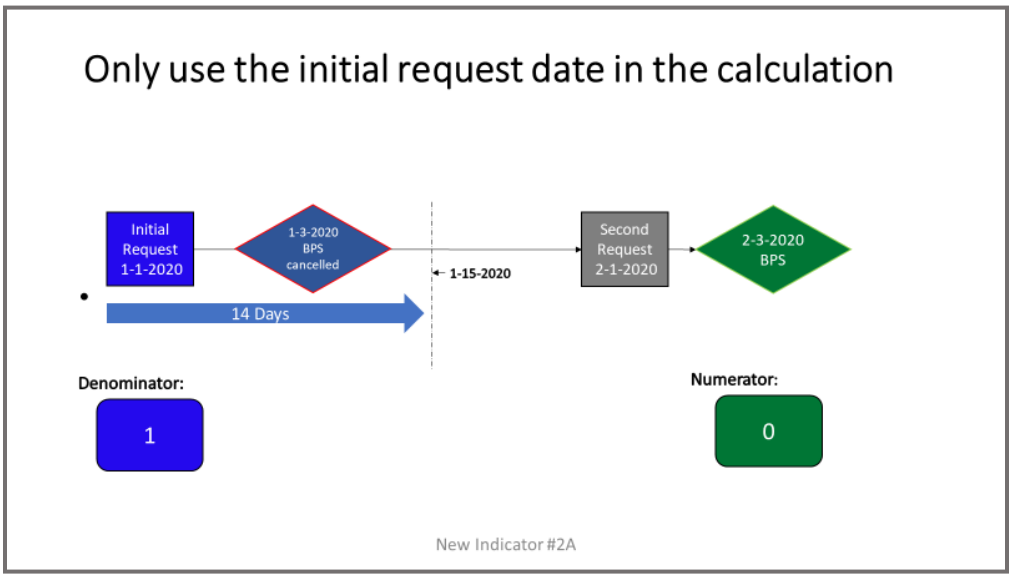



**Figure 2a.6**




**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.

# ACCESS: TIMELINESS/FIRST REQUEST SUBSTANCE USE DISORDER

## Indicator #2e (PIHP)

The percentage of persons admitted to treatment during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of a non-emergency request for service for persons with substance use disorders (SUD).

Standard percentiles was 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.

| | 50TH PERCENTILE | 75TH PERCENTILE |
|---|---|---|
| INDICATOR 2.e | 68.2% | 75.3% |

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. PIHP for all Medicaid and non-Medicaid persons
    c. Persons approved for SUD services.

BPHASA will calculate this indicator based on the PIHP's submission of "Time to Treatment in Days" in qualifying BHTEDS records. BPHASA will combined the BHTEDS reporting with the PIHP's quarterly submission of expired requests.

**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 and poorer role functioning and disengagement of the person from the treatment system. The amount of time between a request for service and the delivery of needed treatments and supports is one measure of access to care. This separate indicator for individuals with SUD is important as specialty behavioral health manages the entire SUD benefit. This indicator reflects the emphasis of transitioning individuals who are approved for SUD services directly to ongoing face-to-face services.

**Receiving a Service for Treatment or Supports within 14 Calendar Days of First Request**

**Table 2b – Indicator #2e**

| 1.<br># of Persons Admitted Who Requested and Were Approved for SUD Treatment or Supports<br><br>X = Xa + Xb | | 2.<br># of Persons from column 1 Receiving a Service for Treatment or Supports Within 14 Calendar Days of First Request<br><br>Y | 3.<br>% of Persons Requesting a Service Who Received Treatment or Supports Within 14 Days.<br><br>Y/X |
|---|---|---|---|
| Xa. The count of BH TEDS SUD Admission Records (Client Transaction Type = A) for the Quarter.* | Xb. *Expired Request:* All SUD Approved Service Requests During the Quarter for Which There is No BHTEDS Admission Record. ** | Based on the BHTEDS *Time to Treatment* Field for Admissions Counted in Xa.* | |
| W2 – Calculated* | X2** | Y2 – Calculated* | Z2 – Calculated* |

***BPHASA Calculations**

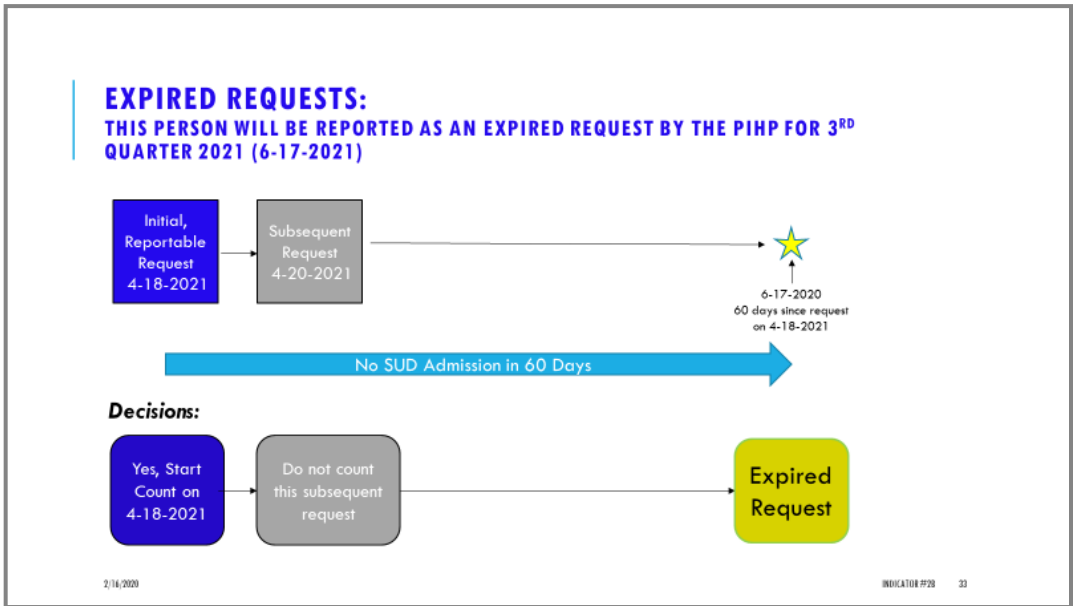
****PIHP Reports *Expired Requests***

The PIHP will report an aggregate count of the number of requests for SUD services that expired during the quarter. This information will be reported to the State in the Performance Indicator PIHP Workbook.

Expired requests are approved requests at an SUD provider that do not result in a BH TEDS Admission within 60 days of the request date. PIHPs will report information on expired requests for the quarter in which the request expired. (See Figure 2b.1)

- Example:
  - The person requests services at Provider A on 3/1/2021. This is the request date.
  - Provider A approves the person for SUD services on 3/3/2021.
  - If the person has not received services from Provider A by or on 5/1/2021, the request is expired.
  - For 3rd quarter reporting, PIHP is to report the aggregate count of expired request for the quarter.

**Figure 2b.1**




**Column 1 – Selection Methodology**

1. Cases selected for inclusion in Column 1 are those persons admitted to treatment, both Medicaid and non- Medicaid, who made a non-emergency request and were authorized for an SUD service during the quarter.

2. Emergent and urgent requests for SUD services are excluded from this indicator. These are defined as requests for services for: a. pregnant women who are injecting drug users or using other substances and b. other urgent situations in which the PIHP deems that the person requesting SUD services requires treatment or supports within 24 to 48 hours. Requests for services needed within 24 to 48 hours will be included in this indicator.

***TIPs** For Counting Expired Requests:*

- **The PIHP is to exclude requests for services from pregnant women in the PIHPs reporting of expired requests.**

- **For 2020 the PIHP will include requests for services needed within 24 to 48 hours in the expired requests submitted to the state. (**In 2021, when information is available in BH TEDS, the PIHPs will exclude requests for services needed with 24 to 48 hours.)

***TIP**: For counting expired requests, the PIHP is to count ONLY those approved requests for services that are subsequent to one of the following conditions or situations:*

- The person has never received SUD services from **this** SUD provider.

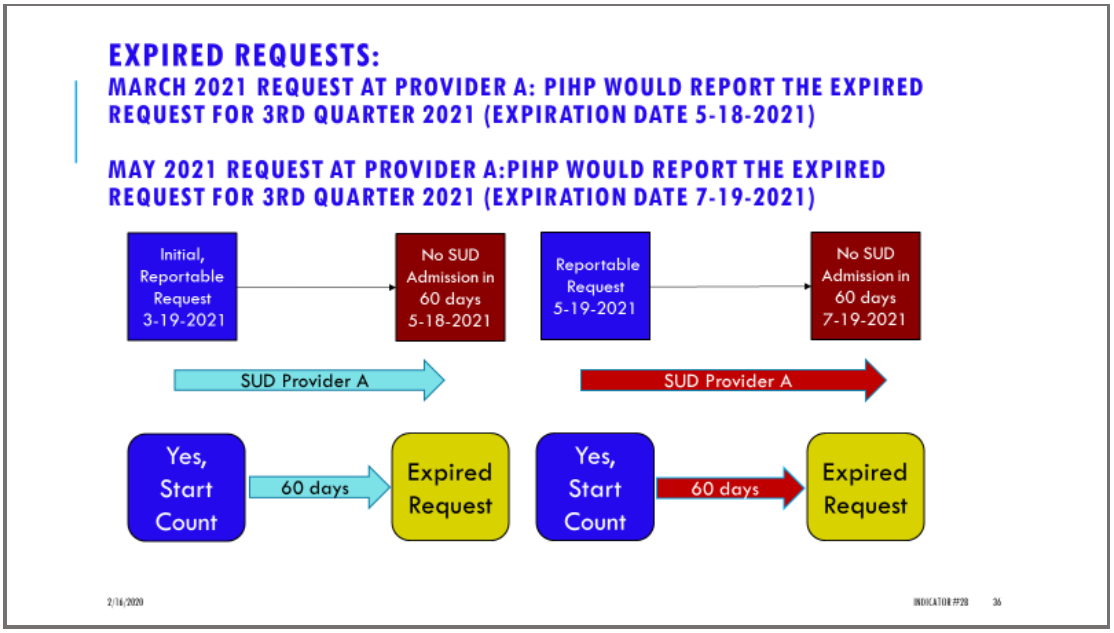
**or**

- The person made an approved request to this SUD provider more than 60 days ago and has not yet received services (expired request). (See Figure 2b.2.)

**or**

- The person was discharged from this SUD provider more than 60 days ago and is not currently receiving services from this SUD provider.

**Figure 2b.2**




3. Consumers who come in with a crisis and are stabilized are counted for indicator #2e when they subsequently make a non-emergency request for SUD services. The indicator will be tracked from the point of the non-emergent request forward. Only requests from pregnant women injecting drugs will be excluded. All other requests will be included.

4. Consumers covered under OBRA should be excluded from the count.

**Column 2 – Numerator Methodology**

1. "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 provider makes a request for service on the person's behalf. For the request to be included in this indicator, the individual must consent to treatment.

***TIP*** *Determining Request Date for reporting Time to Treatment in BH TEDS as well as Expired Requests.*

- The person receives referral from Provider A to Provider B. The request date is the date that the person requests services from Provider B.

  Example:
  - 2/15/2020 The person starts outpatient services at Provider A
  - 2/21/2020 Provider A contacts Provider B to make a request for services on the person's behalf.
  - 2/23/2020 The person agrees to receive treatment from Provider B.
  - 2/24/2020 The person makes a request for services at Provider B and is approved for services.
  - 2/29/2020 The person starts services at Provider B.
  - **The request date at Provider B is 2/21/2020.**

- The person is receiving treatment at a residential facility and receives referral from Provider B to Provider C. The request date is the date that the person is discharged from Provider B.

  Example:
  - 4/07/2020 The person starts residential treatment at Provider B
  - 4/20/2020 Provider B contacts Provider C to ask to get the person into non-intensive outpatient services.
  - 4/20/2020 The person agrees to receive services from Provider C.
  - 4/25/2020 Person is discharged from Provider B residential facility.
  - 4/26/2020 The person starts services at Provider C.
  - **The request date at Provider C is 4/25/2020 – the discharge date.**

2. Cases selected for inclusion in Column 2 are those in Column 1 for which the service for treatment or supports took place within 14 calendar days following the first request. (BPHASA will calculate this using BH TEDS.)

3. BPHASA will count forward from the date of the first request to the first service for SUD treatment or support, even if it spans across quarters. (Example: if the initial request is made on 3-20-2019 and the person does not receive their first SUD service or support by the end of the day 4-3-2019 (14 days) then for 2nd quarter 2019 the person is counted in column #1 and not counted in column #2).

***TIP****: For Reporting Time to Treatment in BH TEDS as well as Expired Requests.*

- If date of request and date for approval for services are not on the same day, the initial request is the request date.

  Example: if the request date is 3/31/2020 and the approval date is 4/1/2020, then the request date is 3/31/2020. (See Figure 2b.3 and Figure 2b.4).

**Figure 2b.3**

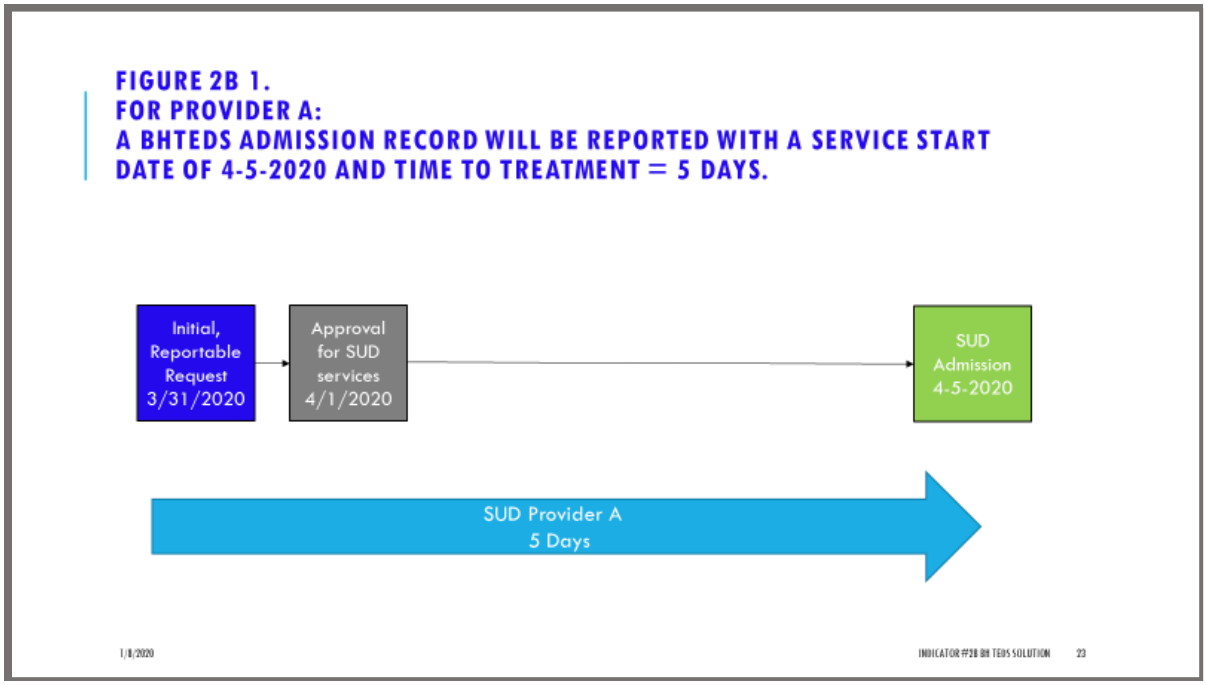
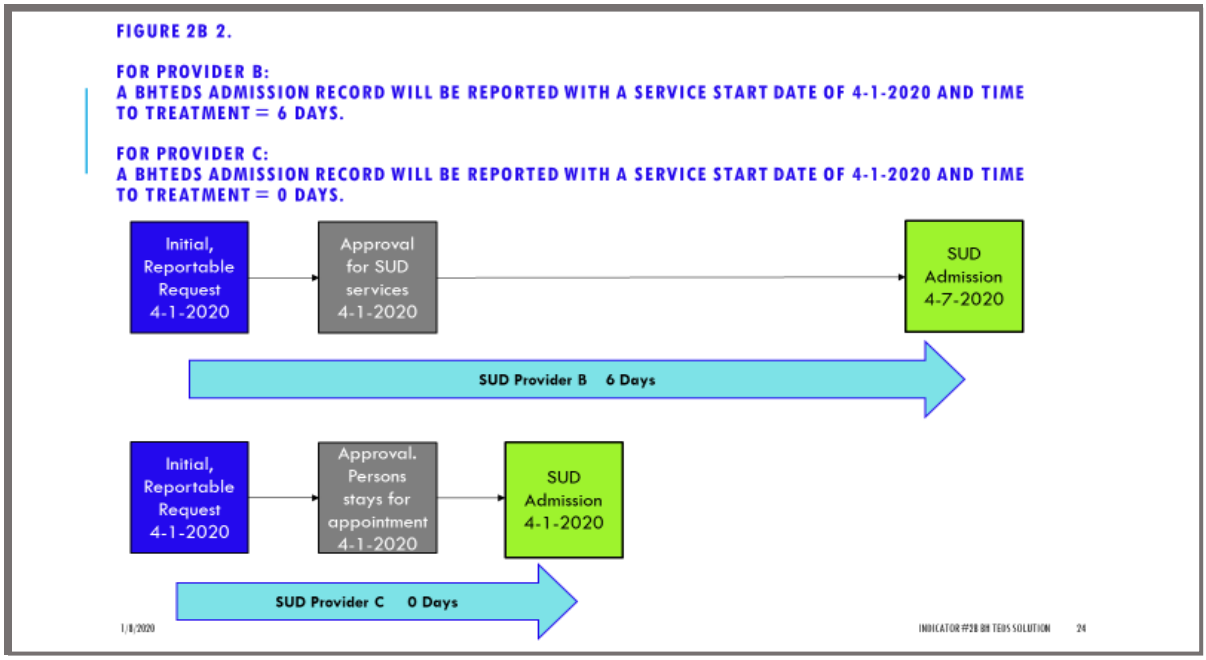



**Figure 2b.4**




4. 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 and approve for services. (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 agency 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 is approved for SUD services. The request date is 1/1/2021.)

5. Initial face-to-face service for treatment or supports – This is the date of the first face-to-face treatment contact and corresponds to the Service Start Date reported in BH TEDS. Person will receive an encounter on this date as well. For this SUD indicator, an assessment can be counted as the first service. A screening is considered an administrative function and cannot be counted as a service.

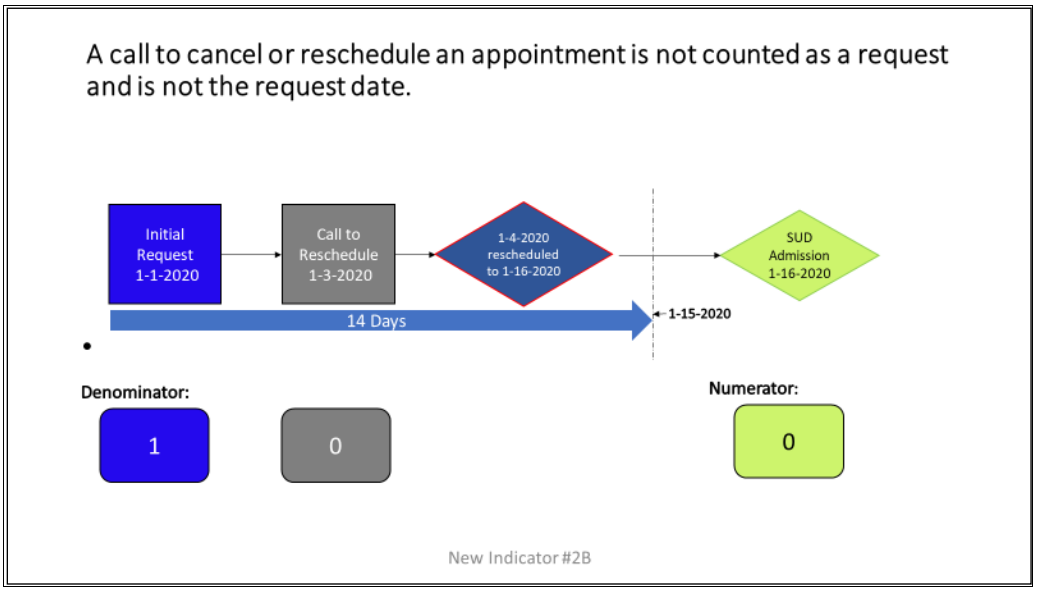
6. PIHPs will report information on the expired requests for the quarter in which the request expired.

> ***TIP*** *For Reporting Expired Requests.*
>
> - **Reporting quarter for expired requests.** The PIHP will determine the reporting quarter based on the expiration date of the request.
>
>  Example:
>  - Date of approved request is 3/31/2021.
>  - The expiration date of the request is 5/31/2021 (60 days since 3/31/2021).
>  - The person does not receive SUD services and a BH TEDS Admission record is not submitted.
>  - This expired request will be included in the information submitted to the state for **3rd quarter 2021** which is due to BPHASA September 30.
>
> - If a person makes **multiple concurrent requests** to get into treatment, count this only as one request. The person's intent is to see one provider not to see multiple providers concurrently.
>  - If the person is seen for services at one of the providers, use the date that provider was contacted as the request date. Do not report the concurrent requests as expired requests.
>  - If the person does not start treatment, count as one expired request once 60 days has lapsed from the date of the person's first request.

**Column 3** – Using the Time to Treatment reported by the PIHP in BH TEDS, BPHASA will calculate the percentage of persons who made a request for SUD services who received their first service within 14 days of the initial request date.

In determining Expired Requests and for reporting Time to Treatment in BH TEDS, PIHPs are to only use the initial request date in the 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. (See Figure 2b.5)

**Figure 2b.5**




A BH TEDS record will be submitted with a Service Start Date of 1-16-2020 and a Time to Treatment of 15 days.

**Documentation**

The PIHP must maintain documentation available for state review on the date of the first request as well as the date of the initial face-to-face service for treatment or supports 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 that the individual declined or for which the individual did not show up.

# ACCESS: TIMELINESS/FIRST SERVICE

## Indicator #3 (PIHP & CMHSP)

Percentage of new persons during the quarter starting any medically necessary on-going covered service within 14 days of completing a non-emergent biopsychosocial assessment (by four sub-populations: MI-adults, MI-children, I/DD-adults, and 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.

| | 50TH PERCENTILE | 75TH PERCENTILE |
|---|---|---|
| INDICATOR 3 | 72.9% | 83.8% |

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. PIHP for all Medicaid beneficiaries
    c. CMHSP for all consumers
    d. Scope: MI adults, MI children, I/DD adults, and I/DD children

**Rationale for Use**

The amount of time between the professional assessment and the delivery of medically necessary treatments and supports addresses a different aspect of access to care than Indicator #2. Delay in the delivery of necessary services and supports may lead to exacerbation of symptoms and distress and poorer role functioning and disengagement from the system. The timely start of on-going services is critical to the engagement process, connecting the consumer to services and supports while the person is motivated towards treatment.

***Table 3 – Indicator #3***

| 1. Population | 2. # of New Persons Who Completed a Biopsychosocial Assessment Within the Quarter and are Determined Eligible for Ongoing Services. | 3. # of Persons from Col 2 Who Started a Face-to-Face Service Within 14 Calendar Days of the Completion of the Biopsychosocial Assessment | 4. % of Persons Who Started Service Within 14 Days of Biopsychosocial Assessment (Calculated) |
|---|---|---|---|
| **1. MI-C** | **(PIHP) AA2**<br>**(CMHSP) W2** | **(PIHP) AB2**<br>**(CMHSP) X2** | **(PIHP) AK2**<br>**(CMHSP) AG2** |
| **2. MI-A** | **(PIHP) AC2**<br>**(CMHSP) Y2** | **(PIHP) AD2**<br>**(CMHSP) Z2** | **(PIHP) AL2**<br>**(CMHSP) AH2** |
| **3. I/DD -C** | **(PIHP) AE2**<br>**(CMHSP) AA2** | **(PIHP) AF2**<br>**(CMHSP) AB2** | **(PIHP) AM2**<br>**(CMHSP)AI2** |
| **4. I/DD-A** | **(PIHP) AG2**<br>**(CMHSP) AC2** | **(PIHP) AH2**<br>**(CMHSP) AD2** | **(PIHP) AN2**<br>**(CMHSP) AJ2** |
| **5. Total Population** | **(PIHP) AI2**<br>**(CMHSP) AE2** | **(PIHP) AJ2**<br>**(CMHSP) AF2** | **(PIHP) AO2**<br>**(CMHSP) AK2** |

**Column 2 – Selection Methodology**

1. Cases selected are those Medicaid persons who have been reported in Column 2 of indicator #2 either during the current quarter or during previous quarters and for whom a biopsychosocial assessment was completed during the current quarter. The person was determined eligible for mental health or intellectual and developmental disability services.

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

***TIP:*** *Selection Methodology*

- Those few people who are referred for a biopsychosocial assessment and found not eligible for specialty services will be reported in Indicator #2 but not in Indicator #3.

***Medicaid persons***

- If at the time the PIHP submits the indicators it is determined that the person was retroactively eligible for Medicaid during the reporting quarter, then the person should be included in the Medicaid version of the indicator.

***Important note***

- A person can be non-Medicaid for indicator #2 but become Medicaid for indicator #3, or the reverse.

2. 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 completion of the biopsychosocial assessment to the start of ongoing services.

3. If a person has an emergent need at some point following the biopsychosocial assessment and as a result is not able to receive a non-emergent face-to-face service within the 14-day window, this person **should** be counted in column #2 and not counted in column #3.

**Column 3 – Numerator Methodology**

1. Cases selected for inclusion in Column 3 are those in Column 2 for which a planned service was received within 14 calendar days of the completion of the biopsychosocial assessment.

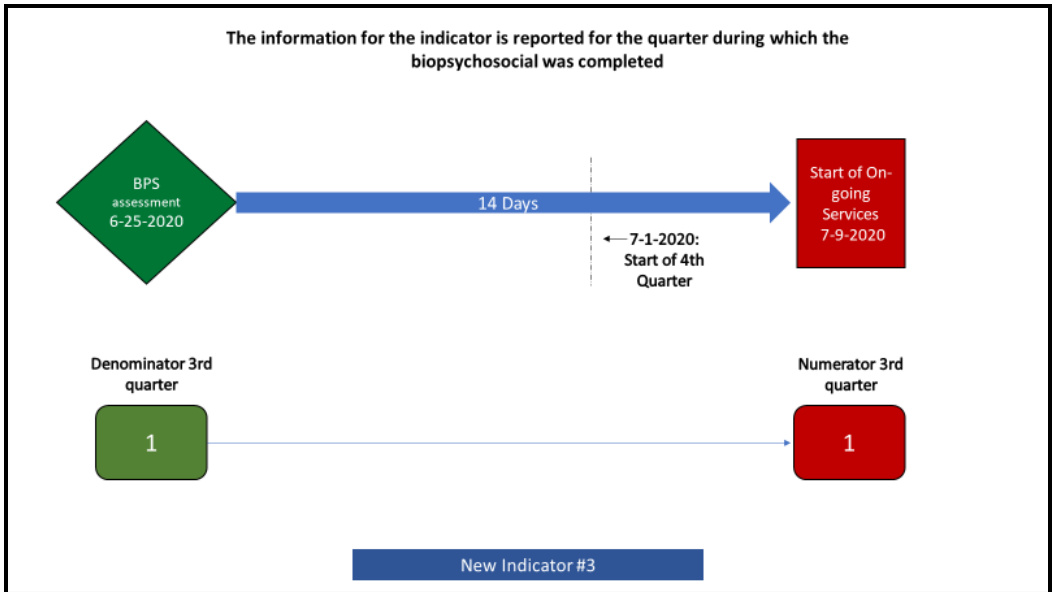
2. "Service" means any non-emergent face-to-face CMHSP service that is included in the person's plan of service or moves a person toward development of their plan of service. Do not count pre-admission screening for, and receipt of, psychiatric in-patient care or crisis contacts.

***TIP:*** *Definition of Ongoing Services*

For this indicator, as long as the service is face-to-face and is not a crisis contact, pre-admission inpatient screening or inpatient care, any encounterable service for specialty mental health (MH) or intellectual and developmental disability (I/DD) services and supports can be used to satisfy the requirement that the service is in the person's Individual Plan of Service (IPOS) or moves them toward development of their IPOS. For list of crisis services see TIP in Indicator #2.

3. Count forward from the date of the completed biopsychosocial assessment to the date of the first service for ongoing treatment and supports, even if it crosses quarters, in order to calculate the number of calendar days from the completion of the biopsychosocial assessment to the start of ongoing services. (See Figure 3.1)

**Figure 3.1**




4. Consumers covered under OBRA should be excluded from the count.

**Documentation**

The PIHP must maintain documentation available for state review on the date the biopsychosocial assessment is completed as well as the date of the first face-to-face service 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 that the individual rescheduled or for which the individual did not show up.

# ACCESS: CONTINUITY OF CARE

## Indicator #4a (CMHSP & PIHP)

The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within seven (7) days.

a. Standard = 95%
b. Quarterly report
c. PIHP for all Medicaid beneficiaries
d. CMHSP for all consumers
e. Scope: All children and all adults (MI, DD) – Do not include dual eligibles (Medicare/Medicaid) in these counts.

**Rationale for Use**

When responsibility for the care of an individual shifts from one organization to another, it is important that services remain relatively uninterrupted and continuous. Otherwise, the quality of

care and consumer outcomes may suffer. This is an indicator required by the federal Substance Abuse and Mental Health Services Administration.

**Table 4a – Indicator #4a**

| 1. Population | 2. # of Discharges from a Psychiatric Inpatient Unit | 3. # of Discharges from Col 2 that are Exceptions | 4. # Net Discharges (Col 2 Minus Col 3) (Calculated) | 5. # of Discharges from Col 4 Followed up by CMHSP/PIHP within 7days | 6. % of Persons Discharged Seen Within 7 days (Calculated) |
|---|---|---|---|---|---|
| **1. # of Children** | **(PIHP) AP2 (CMHSP) AL2** | **(PIHP) AQ2 (CMHSP) AM2** | **(PIHP) AR2 (CMHSP) AN2** | **(PIHP) AS2 (CMHSP) AO2** | **(PIHP) AX2 (CMHSP) AT2** |
| **2. # of Adults** | **(PIHP) AT2 (CMHSP) AP2** | **(PIHP) AU2 (CMHSP) AQ2** | **(PIHP) AV2 (CMHSP) AR2** | **(PIHP) AW2 (CMHSP) AS2** | **(PIHP) AY2 (CMHSP) AU2** |

**Column 2 – Selection Methodology**

1. "Discharges" are the events involving people who are discharged from a Psychiatric Inpatient Unit (community, IMD, or state hospital) who meet the criteria for specialty mental health services and are the responsibility of the CMHSP/PIHP for follow-up services. In the event of multiple discharges of one person during the reporting period, count the number of discharges. (If a person is discharged from Psychiatric Inpatient but goes directly to the hospital, they are not considered to meet criteria for specialty mental health services and would not be included.)

2. Pre-admission screening for psychiatric in-patient care. The psychiatric in-patient care should not be counted here.

3. Do not include dual eligibles (Medicare/Medicaid) in these counts.

4. Do not include those being discharged from jail.

**Column 3 – Exception Methodology**

1. Consumers who request an appointment outside the seven-day period or refuse an appointment offered that would have occurred within the seven-calendar day period, or do not show for an appointment or reschedule it.

2. Consumers who choose not to use CMHSP/PIHP services.

CMHSP/PIHP must maintain documentation available for state review of the reasons for all exclusions. In the case of refused appointments, the dates offered to the individual must be documented.

**Column 4- Calculation of denominator**

1. Subtract the number of discharges in column 3 from the number of discharges in column 2 and enter the number.

**Column 5- Numerator Methodology**

1. Enter the number of discharges from column 4 (net) who were seen for follow-up care by the CMHSP/PIHP within seven days.

2. "Seen for follow-up care," means a face-to-face service (not screening for inpatient service, or the inpatient service) with a professional (not exclusively psychiatrists).

3. "Days" mean calendar days.

## Indicator #4.b (PIHP)

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

a. Standard = 95%
b. Quarterly report
c. Scope: PIHP for all Medicaid beneficiaries - Do not include dual eligibles (Medicare/Medicaid) in these counts.

**Table 4b – Indicator #4b**

| 1. Population | 2. # of Discharges from a Substance Abuse Detox Unit | 3. # of Discharges from Col 2 that are Exceptions | 4. # Net Discharges (Col 2 Minus Col 3) (Calculated) | 5. # of Discharges from Col 4 Followed Up by CMHSP/PIHP Within 7days | 6. % of Persons Discharged Seen Within 7 days (Calculated) |
|---|---|---|---|---|---|
| # of Consumers | AZ2 | BA2 | BB2 | BC2 | BD2 |

**Column 2 – Selection Methodology**

1. "Discharges" are the events involving consumers with substance use disorders who were discharged from a sub-acute detoxification unit, who meet the criteria for specialty mental health services and are the responsibility of the CMHSP/PIHP for follow-up services. In the event of multiple discharges of one person during the reporting period, count the number of discharges.

2. Do not include dual eligibles (Medicare/Medicaid) in these counts.

**Column 3 – Exception Methodology**

1. Consumers who request an appointment outside the seven-day period or refuse an appointment offered that would have occurred within the seven-calendar day period, or do not show for an appointment or reschedule it.

2. Consumers who choose not to use CMHSP/PIHP services.

   CMHSP/PIHP must maintain documentation available for state review of the reasons for all exclusions. In the case of refused appointments, the dates offered to the individual must be documented.

**Column 4 – Calculation of denominator**

Subtract the number of discharges in column 3 from the number of discharges in column 2 and enter the number.

**Column 5 – Numerator Methodology**

1. Enter the number of discharges from column 4 (net) who were seen for follow-up care by the CMHSP/PIHP within seven days.

2. Seen for follow-up care," means a face-to-face service with a substance abuse professional.

3. "Days" mean calendar days.

# ACCESS: MEDICAID PENETRATION RATE

## Indicator #5 (PIHP)

The percent of Medicaid recipients having received PIHP managed services.

**Rationale for Use:**
This indicator measures the penetration rate of Medicaid recipients who receive mental health services from the public mental health system. This indicator is required by Centers for Medicare and Medicaid Services.

**Method of Calculation**
MDHHS will calculate this indicator quarterly using encounter data.

Numerator: the number of Medicaid eligibles receiving at least one PIHP managed Medicaid service during the quarter.

Denominator: the number of Medicaid eligibles for which the PIHP was paid during the quarter.

# ACCESS: DENIAL/APPEAL

## Indicator #5 (CMHSP)

The percent of face-to-face assessments with professionals that result in decisions to deny CMHSP services.

a. Quarterly report
b. CMHSP
c. Scope: all MI/DD consumers

**Rationale for Use**

As managed care organizations, CMHSPs are responsible for exercising appropriate control of entry into the public mental health system. The professional assessment represents one of the first opportunities for a CMHSP to control access to its non-emergent services and supports.

**Table 5 – Indicator #5**

| 1. Total # of New Persons Receiving an Initial Non-Emergent Face-to-Face Professional Assessment | 2. Total # of Persons Assessed but Denied CMHSP Service | 3. Total # of Persons Requesting Second Opinion | 4. Total # of Persons Receiving Mental Health Service Following a Second Opinion |
|---|---|---|---|
| BA2 | BB2 | BC2 | BD2 |

**Note:** Do not include in any column in Table 5 individuals who only received telephone screens or access center screens performed by non-professionals. Table 5 excludes those cases in which the individual refused CMHSP services that were authorized.

**Definitions**

Section 330.1705 of Public Act 1974 as revised, was intended to capture requests for initial entry into the CMHSP. Requests for changes in the levels of care received are governed by other sections of the Code.
"Professional Assessment" is that face-to-face meeting with a professional that results in an admission to ongoing CMHSP service or a denial of CMHSP service.

**Methodology**

Column 1: Enter the number of those people who received an initial face-to-face professional assessment during the time period (from Indicator #2, Column #2).
Column 2: Enter the number of people who were denied CMHSP services.
Column 3: Enter the number of people who were denied who requested a second opinion.
Column 4: Enter the number of people who received a mental health service as a result of the second opinion.

## Indicator #6 (CMHSP)

Percentage of Section 705 second opinions that result in services.

a. Quarterly report

b. CMHSP
c. Scope: all MI/DD consumers

**Rationale for Use**
As managed care organizations, CMHSPs are responsible for exercising appropriate control of entry into the public mental health system. The professional assessment represents one of the first opportunities for a CMHSP to control access to its non-emergent services and supports.

**Table 5 – Indicator #6**

| 1. Total # of New Persons Receiving an Initial Non-Emergent Face-to-Face Professional Assessment | 2. Total # of Persons Assessed but Denied CMHSP Service | 3. Total # of Persons Requesting Second Opinion | 4. Total # of Persons Receiving Mental Health Service Following a Second Opinion |
|---|---|---|---|
| BA2 | BB2 | BC2 | BD2 |

**Note:** Do not include in any column in Table 5 individuals who only received telephone screens or access center screens performed by non-professionals. Table 5 excludes those cases in which the individual refused CMHSP services that were authorized.

**Definitions**
Section 330.1705 of Public Act 1974 as revised, was intended to capture requests for initial entry into the CMHSP. Requests for changes in the levels of care received are governed by other sections of the Code.
"Professional Assessment" is that face-to-face meeting with a professional that results in an admission to ongoing CMHSP service or a denial of CMHSP service.

**Methodology**
Column 1: Enter the number of those people who received an initial face-to-face professional assessment during the time period (from Indicator #2, Column #2).
Column 2: Enter the number of people who were denied CMHSP services.
Column 3: Enter the number of people who were denied who requested a second opinion.
Column 4: Enter the number of people who received a mental health service as a result of the second opinion.

# ADEQUACY/APPROPRIATENESS

## Indicator #6 (PIHP)

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.

a. Quarterly report (MDHHS calculates from encounter data)

b. PIHP
c. Scope: HSW enrollees only

**Rationale for Use**
People enrolled in the Habilitation Supports Waiver are among the most severely disabled people served by the public mental health system. If it were not for the waiver services supporting these people in the community, they would require services in an ICF/MR. Therefore, it is expected that the services provided to them in the community are adequate to meet their needs.

**Method of Calculation**
MDHHS will calculate this indicator quarterly using encounter data.

Numerator: the number of Habilitation Supports Waiver enrollees receiving at least one Habilitation Supports Waiver service each month other than supports coordination each month.

Denominator: the number of Habilitation Supports Waiver enrollees.

This indicator should not be interpreted to mean that each Habilitation Supports Waiver enrollee must receive a Supports Coordination contact each month.

# OUTCOMES: EMPLOYMENT

## Indicator #8 (PIHP/CMHSP)

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

**Rationale for Use**
A positive outcome of improved functioning and recovery is the ability to work in a job obtained through competition with candidates who may not have disabilities. While there are variables, like unemployment rates, that the CMHSPs and PIHPs cannot control, it is expected that through treatment and/or support they will enable and empower individuals who want jobs to secure them.

**Method of Calculation**
MDHHS will calculate this indicator after the end of the fiscal year using employment data from the individual's most recent QI record.

Numerator: the total number of (a) adult Medicaid beneficiaries with mental illness, the total number of (b) adult Medicaid beneficiaries with developmental disabilities, and the total number of (c) adult Medicaid beneficiaries dually diagnosed with mental illness/developmental disability who are employed competitively.

Denominator: the total number of (a) adult Medicaid beneficiaries with mental illness, the total number of (b) adult Medicaid beneficiaries with developmental disabilities, and the total number of (c) adult Medicaid beneficiaries dually diagnosed with mental illness/developmental disability served by the PIHP.

## Indicator #9 (PIHP/CMHSP)

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

**Rationale for Use**

A positive outcome of improved functioning and recovery is the ability to earn an income that enables individuals the independence to purchase goods and services and pay for housing.

**Method of Calculation**

MDHHS will calculate this indicator after the end of the fiscal year using employment data from the individual's most recent QI record. A new minimum wage data element will be added to the FY 2006 reporting requirements.

Numerator: the total number of (a) adult Medicaid beneficiaries with mental illness, the total number of (b) adult Medicaid beneficiaries with developmental disabilities, and the total number of (c) adult Medicaid beneficiaries dually diagnosed with mental illness/developmental disability, who received Michigan's minimum wage or more from employment activities (competitive, supported or self-employment, or sheltered workshop).

Denominator: the total number of (a) adult Medicaid beneficiaries with mental illness, the total number of (b) adult Medicaid beneficiaries with developmental disabilities, and the total number of (c) adult Medicaid beneficiaries dually diagnosed with mental illness/developmental disability served by the PIHP.

# OUTCOMES: INPATIENT RECIDIVISM

## Indicator #10 (PIHP/CMHSP)

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

**Rationale for Use**

For some people with mental illness, the occasional use of psychiatric inpatient care is essential. However, rapid readmission following discharge may suggest that people were prematurely discharged or that the post discharge follow-up was not timely or sufficient. This indicator assessed whether CMHSPs are meeting the Department's standard of no more than 15 percent of people discharged from inpatient units are being readmitted within 30 days.

**Table 6 – Indicator #10**

| 1. Population | 2. # of Discharges from Psychiatric Inpatient | 3. # of Discharges in Col 2 that are Exceptions | 4. # Net Discharges (Col 2 Minus Col 3) (Calculated) | 5. # of Discharges (from Net Col. 4) Readmitted | 6. % of Discharges Readmitted to Inpatient Care Within |
|---|---|---|---|---|---|

| | Care During the Reporting Period | | | to Inpatient Care Within 30 Days of Discharge | 30 days of Discharge (Calculated) |
|---|---|---|---|---|---|
| **1. # of Children** | **BE2** | **BF2** | **BG** | **BH2** | **BM2** |
| **2. # of Adults** | **BI2** | **BJ2** | **BK2** | **BL2** | **BN2** |

**NOTE:** This information is intended to capture Admissions and Readmissions, not transfers to another psychiatric unit, or transfers to a medical inpatient unit. Do not include transfers or dual-eligibles (Medicare/Medicaid) in the counts in any column on this table.

**Column 2 – Selection Methodology**

1. Discharges" are the events involving all people (for the CMHSPs) and Medicaid eligibles only (for the PIHPs) who are discharged from a Psychiatric Inpatient Unit (community, IMD or state hospital), who meet the criteria for specialty mental health services and are the responsibility of the CMHSP for follow-up services. In the event of multiple discharges of one person during the reporting period, count the total number of discharges.

2. Do not include dual eligibles (Medicare/Medicaid) in these counts.

**Column 3 – Exception Methodology**

1. Enter the discharges who chose not to use CMHSP/PIHP services.

2. CMHSP/PIHP must maintain documentation available for state review of the reasons for exceptions in column 3.

**Column 4 – Calculation of Denominator**

1. Subtract the number of discharges in column 3 from the number of discharges in column 2 and enter the number.

**Column 5 – Numerator Methodology**

1. Enter the number of persons from column 4 who were readmitted to a psychiatric inpatient unit within 30 days of discharge from a psychiatric inpatient unit.

2. In order to obtain correct counts for column 5, you must look 30 days into the **next quarter** for possible readmissions of persons discharged toward the end of the current reporting period.

3. "Days" mean calendar days

# PRIVATE RESIDECE

## Indicator #13 (PIHP/CMHSP)

The Percent of Adults with Dual Diagnosis (MI & DD) Served, Who Live in a Private Residence Alone, With Spouse, or Non-Relatives.

a. Medicaid only
b. # of Adults Served includes those who had an unreported residential living status.

## Indicator #14 (PIHP/CMHSP)

The Percent of Adults with Mental Illness Served, Who Live in a Private Residence Alone, With Spouse, or Non-Relatives.

a. Medicaid only
b. # of Adults Served includes those who had an unreported residential living status.