Managed Care Program Annual Report (MCPAR) for Michigan: Michigan, Bureau of Specialty Behavioral Health Services

Due date	Last edited	Edited by	Status
03/29/2023	03/29/2023	Audra Parsons	Submitted

Indicator	Response
Exclusion of CHIP from MCPAR Enrollees in separate CHIP programs funded under Title XXI should not be reported in the MCPAR. Please check this box if the state is unable to remove information about Separate CHIP enrollees from its reporting on this program.	Not Selected

Section A: Program Information

Point of Contact

Find in the Excel Workbook
A_Program_Info

Number	Indicator	Response
A.1	**State name** Auto-populated from your account profile.	Michigan
A.2a	**Contact name**	Audra Parsons

Number	Indicator	Response
	First and last name of the contact person. States that do not wish to list a specific individual on the report are encouraged to use a department or program-wide email address that will allow anyone with questions to quickly reach someone who can provide answers.	
A.2b	**Contact email address** Enter email address. Department or program-wide email addresses ok.	parsonsa@michigan.gov
A.3a	**Submitter name** CMS receives this data upon submission of this MCPAR report.	Audra Parsons
A.3b	**Submitter email address** CMS receives this data upon submission of this MCPAR report.	parsonsa@michigan.gov
A.4	**Date of report submission** CMS receives this date upon submission of this MCPAR report.	03/29/2023

Reporting Period

Find in the Excel Workbook
A_Program_Info

Number	Indicator	Response
A.5a	**Reporting period start date** Auto-populated from report dashboard.	10/01/2001
A.5b	**Reporting period end date** Auto-populated from report dashboard.	09/30/2022

Number	Indicator	Response
A.6	**Program name** Auto-populated from report dashboard.	Michigan, Bureau of Specialty Behavioral Health Services

Add plans (A.7)

Enter the name of each plan that participates in the program for which the state is reporting data.

Find in the Excel Workbook
A_Program_Info

Indicator	Response
Plan name	Reg 1 NorthCare
	Reg 2 Northern MI Regional Entity
	Reg 3 Lakeshore Regional Entity
	Reg 4 South West Michigan Behavioral Health
	Reg 5 Mid-State Health Network
	Reg 6 CMH Partnership of Southeast MI
	Reg 7 Detroit Wayne Integrated Health Network
	Reg 8 Oakland Community Health Network
	Reg 9 Macomb County CMH Services
	Region 10 PIHP

Add BSS entities (A.8)

Enter the names of Beneficiary Support System (BSS) entities that support enrollees in the program for which the state is reporting data. Learn more about BSS entities at 42 CFR 438.71. See Glossary in Excel Workbook for the definition of BSS entities.

Examples of BSS entity types include a: State or Local Government Entity, Ombudsman Program, State Health Insurance Program (SHIP), Aging and Disability Resource Network (ADRN), Center for Indepedent Living (CIL), Legal Assistance

Organization, Community-based Organization, Subcontractor, Enrollment Broker, Consultant, or Academic/Research Organization.

Find in the Excel Workbook
A_Program_Info

Indicator	Response
BSS entity name	Reg 1 NorthCare
	Reg 2 Northern MI Regional Entity
	Reg 3 Lakeshore Regional Entity
	Reg 4 South West Michigan Behavioral Health
	Reg 5 Mid-State Health Network
	Reg 6 CMH Partnership of Southeast MI
	Reg 7 Detroit Wayne Integrated Health Network
	Reg 8 Oakland Community Health Network
	Reg 9 Macomb County CMH Services
	Region 10 PIHP

Section B: State-Level Indicators

Topic I. Program Characteristics and Enrollment

Find in the Excel Workbook
B_State

Number	Indicator	Response
B.I.1	**Statewide Medicaid enrollment** Enter the total number of individuals enrolled in Medicaid as of the first day of the last month of the reporting year. Include all FFS and managed care enrollees, and count each person only once, regardless of	3,117,240

Number	Indicator	Response
	the delivery system(s) in which they are enrolled.	
B.I.2	**Statewide Medicaid managed care enrollment** Enter the total, unduplicated number of individuals enrolled in any type of Medicaid managed care as of the first day of the last month of the reporting year. Include enrollees in all programs, and count each person only once, even if they are enrolled in more than one managed care program or more than one managed care plan.	3,007,277

Topic III. Encounter Data Report

Find in the Excel Workbook
B_State

Number	Indicator	Response
B.III.1	**Data validation entity** Select the state agency/division or contractor tasked with evaluating the validity of encounter data submitted by MCPs. Encounter data validation includes verifying the accuracy, completeness, timeliness, and/or consistency of encounter data records submitted to the state by Medicaid managed care plans. Validation steps may include pre-acceptance edits and post-acceptance analyses. See Glossary in Excel Workbook for more information.	State Medicaid agency staff

Topic X: Program Integrity

Find in the Excel Workbook
B_State

Number	Indicator	Response
B.X.1	**Payment risks between the state and plans** Describe service-specific or other focused PI activities that the state conducted during the past year in this managed care program. Examples include analyses focused on use of long-term services and supports (LTSS) or prescription drugs or activities that focused on specific payment issues to identify, address, and prevent fraud, waste or abuse. Consider data analytics, reviews of under/overutilization, and other activities.	The State did not conduct service-specific or other focused PI activities during the past year. There are ongoing discussions to incorporate this into future contract language.
B.X.2	**Contract standard for overpayments** Does the state allow plans to retain overpayments, require the return of overpayments, or has established a hybrid system? Select one.	Allow plans to retain overpayments
B.X.3	**Location of contract provision stating overpayment standard** Describe where the overpayment standard in the previous indicator is located in plan contracts, as required by 42 CFR 438.608(d)(1)(i).	PIHP: 1.R - General Requirements - Program Integrity
B.X.4	**Description of overpayment contract standard** Briefly describe the overpayment standard (for example, details on whether the state allows plans to retain overpayments, requires the plans to return overpayments, or administers a hybrid system) selected in indicator B.X.2.	The plan is currently able to retain overpayments identified and recovered as OIG does not currently have language in the PIHP contract to initiate investigations in place of the PIHPs.
B.X.5	**State overpayment reporting monitoring** Describe how the state monitors plan performance in reporting overpayments to the state, e.g. does the state track compliance with this	MDHHS mandate quarterly submissions of overpayment activities, including providing feedback of OIG's assessment.

Number	Indicator	Response
	requirement and/or timeliness of reporting? The regulations at 438.604(a)(7), 608(a)(2) and 608(a)(3) require plan reporting to the state on various overpayment pieces (whether annually or promptly). This indicator is asking the state how it monitors that reporting.	
B.X.6	**Changes in beneficiary circumstances** Describe how the state ensures timely and accurate reconciliation of enrollment files between the state and plans to ensure appropriate payments for enrollees experiencing a change in status (e.g., incarcerated, deceased, switching plans).	The system performs an auto look back on a 24 month rolling basis for all changes in enrollment and eligibility sent in our 834 file. When the system see's a change it recoups and repays based on the change sent in the file. For most of our programs we have a daily file but for the Waiver programs we only have the monthly file because we have to receive them from Optum before ingesting into CHAMPS.
B.X.7a	**Changes in provider circumstances: Monitoring plans** Does the state monitor whether plans report provider "for cause" terminations in a timely manner under 42 CFR 438.608(a)(4)? Select one.	Yes
B.X.7b	**Changes in provider circumstances: Metrics** Does the state use a metric or indicator to assess plan reporting performance? Select one.	Yes
B.X.7c	**Changes in provider circumstances: Describe metric** Describe the metric or indicator that the state uses.	OIG mandates quarterly submissions of overpayment activities, including providing feedback of OIG's assessment. These quarterly submissions include provider disenrollments. OIG also requires submission of for-cause terminations to be provided within a specific form, which includes termination dates that are routinely assessed.
B.X.8a	**Federal database checks: Excluded person or entities** During the state's federal database checks, did the state find any person or entity	No

Number	Indicator	Response
	excluded? Select one. Consistent with the requirements at 42 CFR 455.436 and 438.602, the State must confirm the identity and determine the exclusion status of the MCO, PIHP, PAHP, PCCM or PCCM entity, any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the MCO, PIHP, PAHP, PCCM or PCCM entity through routine checks of Federal databases.	
B.X.9a	**Website posting of 5 percent or more ownership control** Does the state post on its website the names of individuals and entities with 5% or more ownership or control interest in MCOs, PIHPs, PAHPs, PCCMs and PCCM entities and subcontractors? Refer to §455.104 and required by 42 CFR 438.602(g)(3).	No
B.X.10	**Periodic audits** If the state conducted any audits during the contract year to determine the accuracy, truthfulness, and completeness of the encounter and financial data submitted by the plans, what is the link(s) to the audit results? Refer to 42 CFR 438.602(e).	The State did not conduct an audit during the FY22 contract period, but the MDHHS Actuarial encounter data team monitors the submission of encounter files and works with the plans when they have issues getting encounters accepted in CHAMPS. This team also runs reports and monitors encounter submissions, in addition to reviewing encounters at an aggregate level via our Encounter Quality Initiative (EQI) process which points out variances between the plan reported data and the encounters in accepted in the data warehouse. The team works with the plans to reduce data variances. MDHHS OIG performs periodic audits of DHPs and MHPs to ensure that a plan's internal policies and procedures outlined in the yearly program integrity submission are enacted within the organization. MDHHS will contract with HSAG for FY23 moving forward.

Section C: Program-Level Indicators

Topic I: Program Characteristics

Find in the Excel Workbook
C1_Program_Set

Number	Indicator	Response
C1.I.1	**Program contract** Enter the title and date of the contract between the state and plans participating in the managed care program.	Notice of Contract October 1, 2020 - September 30, 2023
N/A	N/A	10/01/2020
C1.I.2	**Contract URL** Provide the hyperlink to the model contract or landing page for executed contracts for the program reported in this program.	https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Doing-Business-wi MDHHS/Contract-and-Subrecipient-Resources/PIHP_Master_Contract_Template.pdf?rev=5225234b83044c27a6ca4ae48f7e426c&hash=AA3C9305928F2CC838FDF734BCA33
C1.I.3	**Program type** What is the type of MCPs that contract with the state to provide the services covered under the program? Select one.	Prepaid Inpatient Health Plan (PIHP)
C1.I.4a	**Special program benefits** Are any of the four special	Behavioral health Long-term services and supports (LTSS) Transportation

Number	Indicator	Response
	benefit types covered by the managed care program: (1) behavioral health, (2) long-term services and supports, (3) dental, and (4) transportation, or (5) none of the above? Select one or more. Only list the benefit type if it is a covered service as specified in a contract between the state and managed care plans participating in the program. Benefits available to eligible program enrollees via fee-for-service should not be listed here.	
C1.I.4b	**Variation in special benefits** What are any variations in the availability of special benefits within the program (e.g. by service area or population)? Enter "N/A" if not applicable.	N/A
C1.I.5	**Program enrollment** Enter the total number of individuals enrolled in the managed care program as of the first day of	3,021,426

Number	Indicator	Response
	the last month of the reporting year.	
C1.I.6	**Changes to enrollment or benefits** Briefly explain any major changes to the population enrolled in or benefits provided by the managed care program during the reporting year.	FY22 was the DY1 for the Certified Community Behaviroal Health Clinic in Michigan. Michigan was still operating under the Public Heatlh Emergency guidance which paused Medicaid redeterminations.

Topic III: Encounter Data Report

Find in the Excel Workbook
C1_Program_Set

Number	Indicator	Response
C1.III.1	**Uses of encounter data** For what purposes does the state use encounter data collected from managed care plans (MCPs)? Select one or more. Federal regulations require that states, through their contracts with MCPs, collect and maintain sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees (42 CFR 438.242(c)(1)).	Rate setting Quality/performance measurement Monitoring and reporting Contract oversight Program integrity Policy making and decision support
C1.III.2	**Criteria/measures to evaluate MCP performance** What types of measures are used by the state to evaluate managed care plan performance in encounter data submission and correction? Select one or more. Federal regulations also require that states validate that submitted enrollee encounter data they receive is a complete	Timeliness of initial data submissions Timeliness of data corrections Use of correct file formats Overall data accuracy (as determined through data validation)

Number	Indicator	Response
	and accurate representation of the services provided to enrollees under the contract between the state and the MCO, PIHP, or PAHP. 42 CFR 438.242(d).	
C1.III.3	**Encounter data performance criteria contract language** Provide reference(s) to the contract section(s) that describe the criteria by which managed care plan performance on encounter data submission and correction will be measured. Use contract section references, not page numbers.	Encounter Timeliness Calculation
C1.III.4	**Financial penalties contract language** Provide reference(s) to the contract section(s) that describes any financial penalties the state may impose on plans for the types of failures to meet encounter data submission and quality standards. Use contract section references, not page numbers.	8. Payment Terms, D. Contractor Performance Bonus, 1.A.iv
C1.III.5	**Incentives for encounter data quality** Describe the types of incentives that may be awarded to managed care plans for encounter data quality. Reply with "N/A" if the plan does not use incentives to award encounter data quality.	Penalty if financial reports not timely.
C1.III.6	**Barriers to collecting/validating encounter data** Describe any barriers to collecting and/or validating managed care plan encounter data that the state has experienced during the reporting period.	N/A

Topic IV. Appeals, State Fair Hearings & Grievances

Find in the Excel Workbook
C1_Program_Set

Number	Indicator	Response
C1.IV.1	**State's definition of "critical incident," as used for reporting purposes in its MLTSS program** If this report is being completed for a managed care program that covers LTSS, what is the definition that the state uses for "critical incidents" within the managed care program? Respond with "N/A" if the managed care program does not cover LTSS.	Critical Incidents are defined as the following events: Suicide; Non-suicide death, Arrest of consumer, Emergency Medical Treatment due to injury or Medication Error: Type of injury will include a subcategory for reporting injuries that resulted form the use of physical management; Hospitalization due to Injury or Medication Error; Hospitalization due to injury related to the use of physical management.
C1.IV.2	**State definition of "timely" resolution for standard appeals** Provide the state's definition of timely resolution for standard appeals in the managed care program. Per 42 CFR §438.408(b)(2), states must establish a timeframe for timely resolution of standard appeals that is no longer than 30 calendar days from the day the MCO, PIHP or PAHP receives the appeal.	MDHHS/PIHP Contract, Schedule A, Statement of Work; 1. General Requirements; L. Grievance and Appeals Process for Beneficiaries; 1.e.iv. Contractor must make a determination on non-expedited Appeals not later than 30 days after an appeal is submitted in writing by the beneficiary. MDHHS Appeal and Grievance Resolution Processes Technical Requirement, VI. PIHP Appeal Process, Letter C. Appeal Resolution Timing and Notice Requirements, Item 1: Standard Appeal Resolution (timing): The PIHP must resolve the Appeal and provide notice of resolution to the affected parties as expeditiously as the Enrollee's health condition requirement, but not to exceed 30 calendar days from the day the PIHP receives the Appeal.
C1.IV.3	**State definition of "timely" resolution for expedited appeals** Provide the state's definition of timely resolution for expedited appeals in the managed care program. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal.	MDHHS/PIHP Contract, Schedule A, Statement of Work; 1. General Requirements; L. Grievance and Appeals Process for Beneficiaries; 8.b.iii: Contractor must make a decision on the Expedited Appeal within 72 hours of receipt of the Expedited Appeal. MDHHS Appeal and Grievance Resolution Processes Technical Requirement, VI. PIHP Appeal Process, Letter C. Appeal Resolution Timing and Notice Requirements, Item 2.d: Expedited Appeal Resolution (timing): If a request for expedited resolution is granted, the PIHP must resolve the Appeal and provide notice of resolution to the affected parties no longer than 72 hours after

Number	Indicator	Response
		the PIHP receives the request for expedited resolution of the Appeal. 42 CFR 438.408.
C1.IV.4	**State definition of "timely" resolution for grievances** Provide the state's definition of timely resolution for grievances in the managed care program. Per 42 CFR §438.408(b)(1), states must establish a timeframe for timely resolution of grievances that is no longer than 90 calendar days from the day the MCO, PIHP or PAHP receives the grievance.	MDHHS/PIHP Contract, Schedule A, Statement of Work; 1. General Requirements; L. Grievance and Appeals Process for Beneficiaries; 1.e.v. Contractor must make a determination on Grievances within 90 days of the submission of a Grievance. MDHHS Appeal and Grievance Resolution Processes Technical Requirement, VII. Grievance Process, D. Grievance Resolution Timing and Notice Requirements, Item 1: Timing of Grievance Resolution: Provide the Enrollee a written notice of resolution not to exceed 90 calendar days from the day the PIHP received the Grievance.

Topic V. Availability, Accessibility and Network Adequacy

Network Adequacy

Find in the Excel Workbook
C1_Program_Set

Number	Indicator	Response
C1.V.1	**Gaps/challenges in network adequacy** What are the state's biggest challenges? Describe any challenges MCPs have maintaining adequate networks and meeting standards.	Staff capacity issues and rate of pay are the main challenges MDHHS is experiencing and seeing throughout the State with Providers. Many experienced staff members with a wealth of knowledge and experience have left the employ of Providers, taking historical perspective with them. As Providers bring on new staff, there is a lack of experience which can't be taught. Additionally, because of the lack of experienced and knowledgable staff, the training of new staff is problematic, resulting in new staff who aren't familiar with the Medicaid Provider Manual, CMS Rules, Waiver Rules, the Mental Health Code, etc. This has resulted in compliance issues being identified. Additionally, the rate of pay for workers is very low, even with hourly wage increases the past three (3) fiscal years, especially for direct care workers. This low wage range has dissuaded new staff from joining this field of work, and has discouraged experienced staff enough that

Number	Indicator	Response
		many have left to pursue other opportunities in schools, private practice, or a different career field entirely.
C1.V.2	**State response to gaps in network adequacy** How does the state work with MCPs to address gaps in network adequacy?	The Public Health Emergency has allowed for flexibilities to address Network Adequacy issues and to preserve current provider capacity. Some of those flexibilities are as follows: • Allowing for verbal consents and signatures • Easing the requirements as it relates training and training timeframe requirements for staff. • Allowing the use of telehealth and audio only for services. A telehealth policy has been created to allow many of these services to continue to be provided via telehealth. • Premium pay provided to behavioral health direct care workers during the pandemic continuing in FY22. This increased pay by $2.00 per hour. • Extending Level of Care requirements for an additional 365 days. MDHHS has created an internal workgroup to address workforce capacity issues which severely impacts network adequacy. MDHHS has provided 1915 (c) Waiver trainings to PIHPs and CMHSP staff regarding the SEDW and CWP requirements, eligibility and waiver services to address the increased volume of newly hired staff who are recent graduates and the loss of legacy staff. Frequent and ongoing technical assistance is provided by MDHHS staff to lead PIHP and CMHSP staff. Conferences and Webinars moved to a hybrid platform (virtual/in-person) to ensure education and training is continued to a broad audience.

Topic V. Availability, Accessibility and Network Adequacy

Access Measures

Describe the measures the state uses to monitor availability, accessibility, and network adequacy. Report at the program level.

Revisions to the Medicaid managed care regulations in 2016 and 2020 built on existing requirements that managed care plans maintain provider networks sufficient to ensure adequate access to covered services by: (1) requiring states to develop quantitative network adequacy standards for at least eight specified provider types if

covered under the contract, and to make these standards available online; (2) strengthening network adequacy monitoring requirements; and (3) addressing the needs of people with long-term care service needs (42 CFR 438.66; 42 CFR 438.68).

42 CFR 438.66(e) specifies that the MCPAR must provide information on and an assessment of the availability and accessibility of covered services within the MCO, PHIP, or PAHP contracts, including network adequacy standards for each managed care program.

Find in the Excel Workbook
C2_Program_State

Access measure total count: 22

Complete

C2.V.1 General category: General quantitative availability and accessibility standard 1 / 22

C2.V.2 Measure standard

As part of ongoing commitment to exceptional beneficiary care, strong payer-provider relationships, and fiscal responsibility, the MDHHS Behavioral and Physical Health and Aging Services Administration (BPHASA) regularly reviews the performance of our managed care partners. In 2022, a reorganization of the Administration resulted in a broad-based review of contract monitoring activities. BPHASA identified several areas where additional information was requested. This included Provider Network Adequacy.

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	Urban	Adult

C2.V.7 Monitoring Methods

EVV data analysis

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard 2 / 22

C2.V.2 Measure standard

ASAM 0.5 (Early Intervention)

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	Regional PIHP as defined by the State of MI	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

3 / 22

C2.V.2 Measure standard

ASAM 1-WM (Ambulatory Withdrawal Management without Extended On-Site Monitoring)

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	Covers all 10 PIHP Regions	Adult and pediatric

C2.V.7 Monitoring Methods

Review of grievances related to access

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

4 / 22

C2.V.2 Measure standard

ASAM 2.1 (Intensive Outpatient Services)

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	All 10 PIHP Regions	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

5 / 22

C2.V.2 Measure standard

ASAM 2.5 (Partial Hospitalization Services)

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	All 10 PIHP Regions	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

6 / 22

C2.V.2 Measure standard

ASAM 2-WM (Ambulatory Withdrawal Management with Extended On-Site Monitoring)

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	All 10 PIHP Regions	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

7 / 22

C2.V.2 Measure standard

ASAM 3.1 (Clinically Managed Low Intensity Residential Services)

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	All 10 PIHP Regions	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

8 / 22

C2.V.2 Measure standard

ASAM 3.2-WM (Clinically Managed Residential Withdrawal Management)

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	All 10 PIHP Regions	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard 9 / 22

C2.V.2 Measure standard

ASAM 3.3 (Clinically Managed Population Specific High Intensity Residential Services)

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	All 10 PIHP Regions	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard 10 / 22

C2.V.2 Measure standard

ASAM 3.5 (Clinically Managed High Intensity Residential Services)

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	All 10 PIHP Regions	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard 11 / 22

C2.V.2 Measure standard

ASAM 3.7 (Medically Monitored Intensive Inpatient Services)

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	All 10 PIHP Regions	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

12 / 22

C2.V.2 Measure standard

ASAM 3.7-WM (Medically Monitored Inpatient Withdrawal Management)

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	All 10 PIHP Regions	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

13 / 22

C2.V.2 Measure standard

OTP Level 1 (Opioid Treatment Program)

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population

Behavioral health	All 10 PIHP Regions	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

14 / 22

C2.V.2 Measure standard

Assertive Community Treatment

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	All 10 PIHP Regions	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

15 / 22

C2.V.2 Measure standard

Crisis Residential

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	All 10 PIHP Regions	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard 16 / 22

C2.V.2 Measure standard

Crisis Residential (Pediatric)

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	All 10 PIHP Regions	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard 17 / 22

C2.V.2 Measure standard

Home Based (Pediatric)

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	All 10 PIHP Regions	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard 18 / 22

C2.V.2 Measure standard

Inpatient Psychiatric (Adult)

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	All 10 PIHP Regions	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard 19 / 22

C2.V.2 Measure standard

Inpatient Psychiatric (Pediatric)

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	All 10 PIHP Regions	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard 20 / 22

C2.V.2 Measure standard

Opioid Treatment Programs

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	All 10 PIHP Regions	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

21 / 22

C2.V.2 Measure standard

Psychosocial Rehabilitation (Clubhouses)

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	All 10 PIHP Regions	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

22 / 22

C2.V.2 Measure standard

Wraparound (Pediatric)

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	All 10 PIHP Regions	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Topic IX: Beneficiary Support System (BSS)

Find in the Excel Workbook
C1_Program_Set

Number	Indicator	Response
C1.IX.1	**BSS website** List the website(s) and/or email address that beneficiaries use to seek assistance from the BSS through electronic means. Separate entries with commas.	https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/customer-services beneficiarysupport@michigan.gov
C1.IX.2	**BSS auxiliary aids and services** How do BSS entities offer services in a manner that is accessible to all beneficiaries who need their services, including beneficiaries with disabilities, as required by 42 CFR 438.71(b)(2))? CFR 438.71 requires that the beneficiary support system be accessible in multiple ways including phone, Internet, in-person, and via auxiliary aids and services when requested.	MDHHS contract with the PIHPs require: All written materials for potential beneficiaries must include taglines in the prevalent non-English languages in the Contractor's region, as well as large print, explaining the availability of written translations or oral interpretation to understand the information provided and the toll-free telephone number of the entity providing choice counseling services as required by §438.71(a) and as defined in 42 CFR Parts 438.10 (d)(3) and 431.10(d)(4). In accordance with 42 CFR Parts 438.10(d)(3) 438.10(d)(6) and 438.10(d)(6)(iv), Large print means printed in a font size no smaller than 18 point. The Health Plans are required to take into consideration the special needs of beneficiaries with disabilities or LEP, the Contractor must ensure that beneficiaries are notified that oral interpretation is available for any language, written information is available in prevalent languages, and auxiliary aids, such as and Teletypewriter/Text Telephone (TTY/TDY) and American Sign Language (ASL), and services are available upon request at no cost, and how to access those services as referenced in 42 CFR Parts 438.10(d)(3) and 438.10(d)(4). The Contractor must also ensure that beneficiaries are notified how to access alternative formats as defined in 42 CFR 438.10(d)(6)(iv). In mental

Number	Indicator	Response
		health settings, Video Remote Interpreting (VRI) is to be used only in emergency situations, extenuating circumstances, or during a state or national emergency as a temporary solution until they can secure a qualified interpreter and in accordance with R 393.5055 VRI standards, usage, limitations, educational, legal, medical, mental health standards.
C1.IX.3	**BSS LTSS program data** How do BSS entities assist the state with identifying, remediating, and resolving systemic issues based on a review of LTSS program data such as grievances and appeals or critical incident data? Refer to 42 CFR 438.71(d)(4).	The State of Michigan requires the PIHPs to report critical incident data in the Critical Incident Reporting system (CIRS). The CIRS was implemented in FY2011 and improved the ability of the State of Michigan (MDHHS) and the PIHPs to identify issues at the individual level for remediation, analysis, and trending. This data informs the PIHPs and MDHHS systemic issues that require remediations. Effectiveness of systemic remediations can also be analyzed through ongoing and regular data report pulls. MDHHS uses this information to measure how well the PIHPs and its provider network monitor the care of vulnerable service recipients, including 1915(c) Waiver participants. Effective for FY23, MDHHS moved to a new Critical Incident Reporting system platform through Customer Relationship Management (CRM) system. The new CIR platform will provide real time access and monitoring by to review and address Critical Incident reports. This will result in more immediate remediations at both an individual and systemic level. The State of Michigan delegates responsibility for utilization management (UM) functions to the PIHPs and are well-trained in Medicaid Fair Hearing process and requirements. MDHHS reviews the numbers and types of Medicaid Fair Hearing requests filed as an indicator when UM decisions may not be consistent with policy. Outcomes of hearing requests is monitored and reviewed by MDHHS to analyze issues and trends related to systemic issues. Any individual remediation required to address deficiencies in the UM decisions would be made by the Administrative Law Judge in the form of a Decision & Order.
C1.IX.4	**State evaluation of BSS entity performance**	The State of Michigan requires that each Prepaid Inpatient Health Plan (PIHP) have a

Number	Indicator	Response
	What are steps taken by the state to evaluate the quality, effectiveness, and efficiency of the BSS entities' performance?	Quality Assessment and Performance Improvement Program (QAPIP) which meets the standards based upon the Guidelines for Internal Quality Assurance Programs as distributed by the Health Care Financing Administration's (HCFA) Medicaid Bureau in its guide to states in July of 1993; the Balanced Budget Act (BBA) of 1997, Public Law 105-33; and 42 Code of Federal Regulations (CFR) 438.358 of 2002. The QAPIP specifies 1.) an adequate organizational structure which allows for clear and appropriate administration and evaluation of the QAPIP; 2.) the components and activities of the QAPIP including those as required below; 3.) the role for recipients of service in the QAPIP; and 4.) the mechanisms or procedures to be used for adopting and communicating process and outcome improvement. The updated QAPIP description and associated work plan must be submitted to MDHHS annually by February 28.

Topic X: Program Integrity

Find in the Excel Workbook
C1_Program_Set

Number	Indicator	Response
C1.X.3	**Prohibited affiliation disclosure** Did any plans disclose prohibited affiliations? If the state took action, enter those actions under D: Plan-level Indicators, Section VIII - Sanctions (Corresponds with Tab D3 in the Excel Workbook). Refer to 42 CFR 438.610(d).	No

Section D: Plan-Level Indicators

Topic I. Program Characteristics & Enrollment

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1.I.1	**Plan enrollment** What is the total number of individuals enrolled in each plan as of the first day of the last month of the reporting year?	**Reg 1 NorthCare** 81,696 **Reg 2 Northern MI Regional Entity** 153,001 **Reg 3 Lakeshore Regional Entity** 261,132 **Reg 4 South West Michigan Behavioral Health** 261,132 **Reg 5 Mid-State Health Network** 483,746 **Reg 6 CMH Partnership of Southeast MI** 154,868 **Reg 7 Detroit Wayne Integrated Health Network** 811,125 **Reg 8 Oakland Community Health Network** 234,322 **Reg 9 Macomb County CMH Services** 255,349 **Region 10 PIHP** 244,999
D1.I.2	**Plan share of Medicaid** What is the plan enrollment (within the specific program) as a percentage of the state's total Medicaid enrollment? • Numerator: Plan enrollment (D1.I.1) • Denominator: Statewide Medicaid enrollment (B.I.1)	**Reg 1 NorthCare** 3% **Reg 2 Northern MI Regional Entity** 5% **Reg 3 Lakeshore Regional Entity** 11% **Reg 4 South West Michigan Behavioral Health**

Number	Indicator	Response
		8% **Reg 5 Mid-State Health Network** 16% **Reg 6 CMH Partnership of Southeast MI** 5% **Reg 7 Detroit Wayne Integrated Health Network** 26% **Reg 8 Oakland Community Health Network** 8% **Reg 9 Macomb County CMH Services** 8% **Region 10 PIHP** 8%
D1.I.3	**Plan share of any Medicaid managed care** What is the plan enrollment (regardless of program) as a percentage of total Medicaid enrollment in any type of managed care? • Numerator: Plan enrollment (D1.I.1) • Denominator: Statewide Medicaid managed care enrollment (B.I.2)	**Reg 1 NorthCare** 3% **Reg 2 Northern MI Regional Entity** 5% **Reg 3 Lakeshore Regional Entity** 11% **Reg 4 South West Michigan Behavioral Health** 9% **Reg 5 Mid-State Health Network** 16% **Reg 6 CMH Partnership of Southeast MI** 5% **Reg 7 Detroit Wayne Integrated Health Network** 27% **Reg 8 Oakland Community Health Network**

Number	Indicator	Response
		8% **Reg 9 Macomb County CMH Services** 8% **Region 10 PIHP** 8%

Topic II. Financial Performance

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1.II.1a	**Medical Loss Ratio (MLR)** What is the MLR percentage? Per 42 CFR 438.66(e)(2)(i), the Managed Care Program Annual Report must provide information on the Financial performance of each MCO, PIHP, and PAHP, including MLR experience. If MLR data are not available for this reporting period due to data lags, enter the MLR calculated for the most recently available reporting period and indicate the reporting period in item D1.II.3 below. See Glossary in Excel Workbook for the regulatory definition of MLR.	**Reg 1 NorthCare** 98.41% **Reg 2 Northern MI Regional Entity** 88.66% **Reg 3 Lakeshore Regional Entity** 77.36% **Reg 4 South West Michigan Behavioral Health** 85.66% **Reg 5 Mid-State Health Network** 94.01% **Reg 6 CMH Partnership of Southeast MI** 94.02% **Reg 7 Detroit Wayne Integrated Health Network** 95.42% **Reg 8 Oakland Community Health Network** 95.78% **Reg 9 Macomb County CMH Services** 77.29%

Number	Indicator	Response
		Region 10 PIHP 76.48%
D1.II.1b	**Level of aggregation** What is the aggregation level that best describes the MLR being reported in the previous indicator? Select one. As permitted under 42 CFR 438.8(i), states are allowed to aggregate data for reporting purposes across programs and populations.	**Reg 1 NorthCare** Program-specific statewide **Reg 2 Northern MI Regional Entity** Program-specific statewide **Reg 3 Lakeshore Regional Entity** Program-specific statewide **Reg 4 South West Michigan Behavioral Health** Program-specific statewide **Reg 5 Mid-State Health Network** Program-specific statewide **Reg 6 CMH Partnership of Southeast MI** Program-specific statewide **Reg 7 Detroit Wayne Integrated Health Network** Program-specific statewide **Reg 8 Oakland Community Health Network** Program-specific statewide **Reg 9 Macomb County CMH Services** Program-specific statewide **Region 10 PIHP** Program-specific statewide
D1.II.2	**Population specific MLR description** Does the state require plans to submit separate MLR calculations for specific populations served within this program, for example, MLTSS or Group VIII expansion enrollees? If so, describe the populations here. Enter "N/A" if not applicable. See glossary for the regulatory definition of MLR.	**Reg 1 NorthCare** We request separate calculations for Traditional Medicaid and the Healthy Michigan Plan. **Reg 2 Northern MI Regional Entity** We request separate calculations for Traditional Medicaid and the Healthy Michigan Plan. **Reg 3 Lakeshore Regional Entity**

Number	Indicator	Response
		We request separate calculations for Traditional Medicaid and the Healthy Michigan Plan. **Reg 4 South West Michigan Behavioral Health** We request separate calculations for Traditional Medicaid and the Healthy Michigan Plan. **Reg 5 Mid-State Health Network** We request separate calculations for Traditional Medicaid and the Healthy Michigan Plan. **Reg 6 CMH Partnership of Southeast MI** We request separate calculations for Traditional Medicaid and the Healthy Michigan Plan. **Reg 7 Detroit Wayne Integrated Health Network** We request separate calculations for Traditional Medicaid and the Healthy Michigan Plan. **Reg 8 Oakland Community Health Network** We request separate calculations for Traditional Medicaid and the Healthy Michigan Plan. **Reg 9 Macomb County CMH Services** We request separate calculations for Traditional Medicaid and the Healthy Michigan Plan. **Region 10 PIHP** We request separate calculations for Traditional Medicaid and the Healthy Michigan Plan.
D1.II.3	**MLR reporting period discrepancies** Does the data reported in item D1.II.1a cover a different time period than the MCPAR report?	**Reg 1 NorthCare** No **Reg 2 Northern MI Regional Entity** No **Reg 3 Lakeshore Regional Entity**

Number	Indicator	Response
		No **Reg 4 South West Michigan Behavioral Health** No **Reg 5 Mid-State Health Network** No **Reg 6 CMH Partnership of Southeast MI** No **Reg 7 Detroit Wayne Integrated Health Network** No **Reg 8 Oakland Community Health Network** No **Reg 9 Macomb County CMH Services** No **Region 10 PIHP** No

Topic III. Encounter Data

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1.III.1	**Definition of timely encounter data submissions** Describe the state's standard for timely encounter data submissions used in this program. If reporting frequencies and standards differ by type of encounter within this program, please explain.	**Reg 1 NorthCare** Requirements 1. The PIHP must have at least one claim accepted by CHAMPS for the report month. This count will be based on the date of service. The adjudication date will not be considered in this calculation. As an example, for the timeliness metrics analyzed in December 2014, the PIHP must have submitted at least one claim with an October 2014 date of service. 2. Based on the logic below, the PIHP must have at least 70% of encounters reported timely. (Percentage based on 75% of the PIHP average for February 2014 using the new

Number	Indicator	Response
		methodology. See highlighted section below). Logic Encounter timeliness is determined by calculating the percent of encounter lines that are accepted by CHAMPS by the end of the month following the month of adjudication. This calculation is done each month. As an example, on December 15th the query is run to determine what percent of the encounters adjudicated during October were accepted by CHAMPS by November 30th. The analyses are only run once for each adjudication month. The adjudication date is taken from the DTP segment of the 2430 loop or the DTP segment of the 2330B loop. (The data warehouse uses the date from the line if it is available otherwise it populates with the claim date.) For claims that are not adjudicated, Medicaid Health Plans populate the DTP field with the date they created the encounter for submission. The Medicaid Health Plans are required to report this field and the encounter is rejected if neither DTP field is populated (error 2650). Currently, for mental health encounters this error is informational only. However, PIHPs will also be required to populate this field with either the adjudication date or the date the encounter was created for submission. These queries only include consumers who are Medicaid eligible at the time of services, with Scope = 1 or 2 and coverage = D, F, K, P, or T. The queries include all PIHP submitted encounters, both mental health and substance abuse. Concerns have been raised that the timeliness measure will penalize PIHPs for correcting encounter errors. To address this, the query will include all active encounters (original and replacement) except those replacement encounters that are not timely. In this way, PIHPs will not be discouraged from reporting replacements that require additional time to research or resolve. The Department plans on continuing these test analyses through November 2019. The first production analyses will be run in December 2019. **Reg 2 Northern MI Regional Entity** Requirements 1. The PIHP must have at least one claim accepted by CHAMPS for the report month. This count will be based on the date of service. The adjudication date will not be

Number	Indicator	Response
		considered in this calculation. As an example, for the timeliness metrics analyzed in December 2014, the PIHP must have submitted at least one claim with an October 2014 date of service. 2. Based on the logic below, the PIHP must have at least 70% of encounters reported timely. (Percentage based on 75% of the PIHP average for February 2014 using the new methodology. See highlighted section below). Logic Encounter timeliness is determined by calculating the percent of encounter lines that are accepted by CHAMPS by the end of the month following the month of adjudication. This calculation is done each month. As an example, on December 15th the query is run to determine what percent of the encounters adjudicated during October were accepted by CHAMPS by November 30th. The analyses are only run once for each adjudication month. The adjudication date is taken from the DTP segment of the 2430 loop or the DTP segment of the 2330B loop. (The data warehouse uses the date from the line if it is available otherwise it populates with the claim date.) For claims that are not adjudicated, Medicaid Health Plans populate the DTP field with the date they created the encounter for submission. The Medicaid Health Plans are required to report this field and the encounter is rejected if neither DTP field is populated (error 2650). Currently, for mental health encounters this error is informational only. However, PIHPs will also be required to populate this field with either the adjudication date or the date the encounter was created for submission. These queries only include consumers who are Medicaid eligible at the time of services, with Scope = 1 or 2 and coverage = D, F, K, P, or T. The queries include all PIHP submitted encounters, both mental health and substance abuse. Concerns have been raised that the timeliness measure will penalize PIHPs for correcting encounter errors. To address this, the query will include all active encounters (original and replacement) except those replacement encounters that are not timely. In this way, PIHPs will not be discouraged from reporting replacements that require additional time to research or resolve. The Department plans on continuing these test analyses

Number	Indicator	Response
		through November 2019. The first production analyses will be run in December 2019. **Reg 3 Lakeshore Regional Entity** Requirements 1. The PIHP must have at least one claim accepted by CHAMPS for the report month. This count will be based on the date of service. The adjudication date will not be considered in this calculation. As an example, for the timeliness metrics analyzed in December 2014, the PIHP must have submitted at least one claim with an October 2014 date of service. 2. Based on the logic below, the PIHP must have at least 70% of encounters reported timely. (Percentage based on 75% of the PIHP average for February 2014 using the new methodology. See highlighted section below). Logic Encounter timeliness is determined by calculating the percent of encounter lines that are accepted by CHAMPS by the end of the month following the month of adjudication. This calculation is done each month. As an example, on December 15th the query is run to determine what percent of the encounters adjudicated during October were accepted by CHAMPS by November 30th. The analyses are only run once for each adjudication month. The adjudication date is taken from the DTP segment of the 2430 loop or the DTP segment of the 2330B loop. (The data warehouse uses the date from the line if it is available otherwise it populates with the claim date.) For claims that are not adjudicated, Medicaid Health Plans populate the DTP field with the date they created the encounter for submission. The Medicaid Health Plans are required to report this field and the encounter is rejected if neither DTP field is populated (error 2650). Currently, for mental health encounters this error is informational only. However, PIHPs will also be required to populate this field with either the adjudication date or the date the encounter was created for submission. These queries only include consumers who are Medicaid eligible at the time of services, with Scope = 1 or 2 and coverage = D, F, K, P, or T. The queries include all PIHP submitted encounters, both mental health and substance abuse. Concerns have been raised that the timeliness measure will penalize PIHPs for

Number	Indicator	Response
		correcting encounter errors. To address this, the query will include all active encounters (original and replacement) except those replacement encounters that are not timely. In this way, PIHPs will not be discouraged from reporting replacements that require additional time to research or resolve. The Department plans on continuing these test analyses through November 2019. The first production analyses will be run in December 2019. **Reg 4 South West Michigan Behavioral Health** Requirements 1. The PIHP must have at least one claim accepted by CHAMPS for the report month. This count will be based on the date of service. The adjudication date will not be considered in this calculation. As an example, for the timeliness metrics analyzed in December 2014, the PIHP must have submitted at least one claim with an October 2014 date of service. 2. Based on the logic below, the PIHP must have at least 70% of encounters reported timely. (Percentage based on 75% of the PIHP average for February 2014 using the new methodology. See highlighted section below). Logic Encounter timeliness is determined by calculating the percent of encounter lines that are accepted by CHAMPS by the end of the month following the month of adjudication. This calculation is done each month. As an example, on December 15th the query is run to determine what percent of the encounters adjudicated during October were accepted by CHAMPS by November 30th. The analyses are only run once for each adjudication month. The adjudication date is taken from the DTP segment of the 2430 loop or the DTP segment of the 2330B loop. (The data warehouse uses the date from the line if it is available otherwise it populates with the claim date.) For claims that are not adjudicated, Medicaid Health Plans populate the DTP field with the date they created the encounter for submission. The Medicaid Health Plans are required to report this field and the encounter is rejected if neither DTP field is populated (error 2650). Currently, for mental health encounters this error is informational only. However, PIHPs will also be required to populate this field with either the adjudication date or the date the

Number	Indicator	Response
		encounter was created for submission. These queries only include consumers who are Medicaid eligible at the time of services, with Scope = 1 or 2 and coverage = D, F, K, P, or T. The queries include all PIHP submitted encounters, both mental health and substance abuse. Concerns have been raised that the timeliness measure will penalize PIHPs for correcting encounter errors. To address this, the query will include all active encounters (original and replacement) except those replacement encounters that are not timely. In this way, PIHPs will not be discouraged from reporting replacements that require additional time to research or resolve. The Department plans on continuing these test analyses through November 2019. The first production analyses will be run in December 2019. **Reg 5 Mid-State Health Network** Requirements 1. The PIHP must have at least one claim accepted by CHAMPS for the report month. This count will be based on the date of service. The adjudication date will not be considered in this calculation. As an example, for the timeliness metrics analyzed in December 2014, the PIHP must have submitted at least one claim with an October 2014 date of service. 2. Based on the logic below, the PIHP must have at least 70% of encounters reported timely. (Percentage based on 75% of the PIHP average for February 2014 using the new methodology. See highlighted section below). Logic Encounter timeliness is determined by calculating the percent of encounter lines that are accepted by CHAMPS by the end of the month following the month of adjudication. This calculation is done each month. As an example, on December 15th the query is run to determine what percent of the encounters adjudicated during October were accepted by CHAMPS by November 30th. The analyses are only run once for each adjudication month. The adjudication date is taken from the DTP segment of the 2430 loop or the DTP segment of the 2330B loop. (The data warehouse uses the date from the line if it is available otherwise it populates with the claim date.) For claims that are not adjudicated, Medicaid Health Plans populate the DTP field with the date they

Number	Indicator	Response
		created the encounter for submission. The Medicaid Health Plans are required to report this field and the encounter is rejected if neither DTP field is populated (error 2650). Currently, for mental health encounters this error is informational only. However, PIHPs will also be required to populate this field with either the adjudication date or the date the encounter was created for submission. These queries only include consumers who are Medicaid eligible at the time of services, with Scope = 1 or 2 and coverage = D, F, K, P, or T. The queries include all PIHP submitted encounters, both mental health and substance abuse. Concerns have been raised that the timeliness measure will penalize PIHPs for correcting encounter errors. To address this, the query will include all active encounters (original and replacement) except those replacement encounters that are not timely. In this way, PIHPs will not be discouraged from reporting replacements that require additional time to research or resolve. The Department plans on continuing these test analyses through November 2019. The first production analyses will be run in December 2019. **Reg 6 CMH Partnership of Southeast MI** Requirements 1. The PIHP must have at least one claim accepted by CHAMPS for the report month. This count will be based on the date of service. The adjudication date will not be considered in this calculation. As an example, for the timeliness metrics analyzed in December 2014, the PIHP must have submitted at least one claim with an October 2014 date of service. 2. Based on the logic below, the PIHP must have at least 70% of encounters reported timely. (Percentage based on 75% of the PIHP average for February 2014 using the new methodology. See highlighted section below). Logic Encounter timeliness is determined by calculating the percent of encounter lines that are accepted by CHAMPS by the end of the month following the month of adjudication. This calculation is done each month. As an example, on December 15th the query is run to determine what percent of the encounters adjudicated during October were accepted by CHAMPS by November 30th. The analyses are

Number	Indicator	Response
		only run once for each adjudication month. The adjudication date is taken from the DTP segment of the 2430 loop or the DTP segment of the 2330B loop. (The data warehouse uses the date from the line if it is available otherwise it populates with the claim date.) For claims that are not adjudicated, Medicaid Health Plans populate the DTP field with the date they created the encounter for submission. The Medicaid Health Plans are required to report this field and the encounter is rejected if neither DTP field is populated (error 2650). Currently, for mental health encounters this error is informational only. However, PIHPs will also be required to populate this field with either the adjudication date or the date the encounter was created for submission. These queries only include consumers who are Medicaid eligible at the time of services, with Scope = 1 or 2 and coverage = D, F, K, P, or T. The queries include all PIHP submitted encounters, both mental health and substance abuse. Concerns have been raised that the timeliness measure will penalize PIHPs for correcting encounter errors. To address this, the query will include all active encounters (original and replacement) except those replacement encounters that are not timely. In this way, PIHPs will not be discouraged from reporting replacements that require additional time to research or resolve. The Department plans on continuing these test analyses through November 2019. The first production analyses will be run in December 2019.
		Reg 7 Detroit Wayne Integrated Health Network Requirements 1. The PIHP must have at least one claim accepted by CHAMPS for the report month. This count will be based on the date of service. The adjudication date will not be considered in this calculation. As an example, for the timeliness metrics analyzed in December 2014, the PIHP must have submitted at least one claim with an October 2014 date of service. 2. Based on the logic below, the PIHP must have at least 70% of encounters reported timely. (Percentage based on 75% of the PIHP average for February 2014 using the new methodology. See highlighted section below). Logic Encounter timeliness is determined by

Number	Indicator	Response
		calculating the percent of encounter lines that are accepted by CHAMPS by the end of the month following the month of adjudication. This calculation is done each month. As an example, on December 15th the query is run to determine what percent of the encounters adjudicated during October were accepted by CHAMPS by November 30th. The analyses are only run once for each adjudication month. The adjudication date is taken from the DTP segment of the 2430 loop or the DTP segment of the 2330B loop. (The data warehouse uses the date from the line if it is available otherwise it populates with the claim date.) For claims that are not adjudicated, Medicaid Health Plans populate the DTP field with the date they created the encounter for submission. The Medicaid Health Plans are required to report this field and the encounter is rejected if neither DTP field is populated (error 2650). Currently, for mental health encounters this error is informational only. However, PIHPs will also be required to populate this field with either the adjudication date or the date the encounter was created for submission. These queries only include consumers who are Medicaid eligible at the time of services, with Scope = 1 or 2 and coverage = D, F, K, P, or T. The queries include all PIHP submitted encounters, both mental health and substance abuse. Concerns have been raised that the timeliness measure will penalize PIHPs for correcting encounter errors. To address this, the query will include all active encounters (original and replacement) except those replacement encounters that are not timely. In this way, PIHPs will not be discouraged from reporting replacements that require additional time to research or resolve. The Department plans on continuing these test analyses through November 2019. The first production analyses will be run in December 2019. **Reg 8 Oakland Community Health Network** Requirements 1. The PIHP must have at least one claim accepted by CHAMPS for the report month. This count will be based on the date of service. The adjudication date will not be considered in this calculation. As an example, for the timeliness metrics analyzed in

Number	Indicator	Response
		December 2014, the PIHP must have submitted at least one claim with an October 2014 date of service. 2. Based on the logic below, the PIHP must have at least 70% of encounters reported timely. (Percentage based on 75% of the PIHP average for February 2014 using the new methodology. See highlighted section below). Logic Encounter timeliness is determined by calculating the percent of encounter lines that are accepted by CHAMPS by the end of the month following the month of adjudication. This calculation is done each month. As an example, on December 15th the query is run to determine what percent of the encounters adjudicated during October were accepted by CHAMPS by November 30th. The analyses are only run once for each adjudication month. The adjudication date is taken from the DTP segment of the 2430 loop or the DTP segment of the 2330B loop. (The data warehouse uses the date from the line if it is available otherwise it populates with the claim date.) For claims that are not adjudicated, Medicaid Health Plans populate the DTP field with the date they created the encounter for submission. The Medicaid Health Plans are required to report this field and the encounter is rejected if neither DTP field is populated (error 2650). Currently, for mental health encounters this error is informational only. However, PIHPs will also be required to populate this field with either the adjudication date or the date the encounter was created for submission. These queries only include consumers who are Medicaid eligible at the time of services, with Scope = 1 or 2 and coverage = D, F, K, P, or T. The queries include all PIHP submitted encounters, both mental health and substance abuse. Concerns have been raised that the timeliness measure will penalize PIHPs for correcting encounter errors. To address this, the query will include all active encounters (original and replacement) except those replacement encounters that are not timely. In this way, PIHPs will not be discouraged from reporting replacements that require additional time to research or resolve. The Department plans on continuing these test analyses through November 2019. The first production analyses will be run in December 2019.

Number	Indicator	Response
		Reg 9 Macomb County CMH Services Requirements 1. The PIHP must have at least one claim accepted by CHAMPS for the report month. This count will be based on the date of service. The adjudication date will not be considered in this calculation. As an example, for the timeliness metrics analyzed in December 2014, the PIHP must have submitted at least one claim with an October 2014 date of service. 2. Based on the logic below, the PIHP must have at least 70% of encounters reported timely. (Percentage based on 75% of the PIHP average for February 2014 using the new methodology. See highlighted section below). Logic Encounter timeliness is determined by calculating the percent of encounter lines that are accepted by CHAMPS by the end of the month following the month of adjudication. This calculation is done each month. As an example, on December 15th the query is run to determine what percent of the encounters adjudicated during October were accepted by CHAMPS by November 30th. The analyses are only run once for each adjudication month. The adjudication date is taken from the DTP segment of the 2430 loop or the DTP segment of the 2330B loop. (The data warehouse uses the date from the line if it is available otherwise it populates with the claim date.) For claims that are not adjudicated, Medicaid Health Plans populate the DTP field with the date they created the encounter for submission. The Medicaid Health Plans are required to report this field and the encounter is rejected if neither DTP field is populated (error 2650). Currently, for mental health encounters this error is informational only. However, PIHPs will also be required to populate this field with either the adjudication date or the date the encounter was created for submission. These queries only include consumers who are Medicaid eligible at the time of services, with Scope = 1 or 2 and coverage = D, F, K, P, or T. The queries include all PIHP submitted encounters, both mental health and substance abuse. Concerns have been raised that the timeliness measure will penalize PIHPs for correcting encounter errors. To address this, the query will include all active encounters (original and replacement) except those replacement encounters that are not timely. In

Number	Indicator	Response
		this way, PIHPs will not be discouraged from reporting replacements that require additional time to research or resolve. The Department plans on continuing these test analyses through November 2019. The first production analyses will be run in December 2019. **Region 10 PIHP** Requirements 1. The PIHP must have at least one claim accepted by CHAMPS for the report month. This count will be based on the date of service. The adjudication date will not be considered in this calculation. As an example, for the timeliness metrics analyzed in December 2014, the PIHP must have submitted at least one claim with an October 2014 date of service. 2. Based on the logic below, the PIHP must have at least 70% of encounters reported timely. (Percentage based on 75% of the PIHP average for February 2014 using the new methodology. See highlighted section below). Logic Encounter timeliness is determined by calculating the percent of encounter lines that are accepted by CHAMPS by the end of the month following the month of adjudication. This calculation is done each month. As an example, on December 15th the query is run to determine what percent of the encounters adjudicated during October were accepted by CHAMPS by November 30th. The analyses are only run once for each adjudication month. The adjudication date is taken from the DTP segment of the 2430 loop or the DTP segment of the 2330B loop. (The data warehouse uses the date from the line if it is available otherwise it populates with the claim date.) For claims that are not adjudicated, Medicaid Health Plans populate the DTP field with the date they created the encounter for submission. The Medicaid Health Plans are required to report this field and the encounter is rejected if neither DTP field is populated (error 2650). Currently, for mental health encounters this error is informational only. However, PIHPs will also be required to populate this field with either the adjudication date or the date the encounter was created for submission. These queries only include consumers who are Medicaid eligible at the time of services, with Scope = 1 or 2 and coverage = D, F, K, P, or T.

Number	Indicator	Response
		The queries include all PIHP submitted encounters, both mental health and substance abuse. Concerns have been raised that the timeliness measure will penalize PIHPs for correcting encounter errors. To address this, the query will include all active encounters (original and replacement) except those replacement encounters that are not timely. In this way, PIHPs will not be discouraged from reporting replacements that require additional time to research or resolve. The Department plans on continuing these test analyses through November 2019. The first production analyses will be run in December 2019.
D1.III.2	**Share of encounter data submissions that met state's timely submission requirements** What percent of the plan's encounter data file submissions (submitted during the reporting period) met state requirements for timely submission? If the state has not yet received any encounter data file submissions for the entire contract period when it submits this report, the state should enter here the percentage of encounter data submissions that were compliant out of the file submissions it has received from the managed care plan for the reporting period.	**Reg 1 NorthCare** 99% **Reg 2 Northern MI Regional Entity** 100% **Reg 3 Lakeshore Regional Entity** 92% **Reg 4 South West Michigan Behavioral Health** 99% **Reg 5 Mid-State Health Network** 99% **Reg 6 CMH Partnership of Southeast MI** 99% **Reg 7 Detroit Wayne Integrated Health Network** 95% **Reg 8 Oakland Community Health Network** 98% **Reg 9 Macomb County CMH Services** 100% **Region 10 PIHP** 97%

Number	Indicator	Response
D1.III.3	**Share of encounter data submissions that were HIPAA compliant** What percent of the plan's encounter data submissions (submitted during the reporting period) met state requirements for HIPAA compliance? If the state has not yet received encounter data submissions for the entire contract period when it submits this report, enter here percentage of encounter data submissions that were compliant out of the proportion received from the managed care plan for the reporting period.	**Reg 1 NorthCare** 97% **Reg 2 Northern MI Regional Entity** 98% **Reg 3 Lakeshore Regional Entity** 100% **Reg 4 South West Michigan Behavioral Health** 98% **Reg 5 Mid-State Health Network** 98% **Reg 6 CMH Partnership of Southeast MI** 88% **Reg 7 Detroit Wayne Integrated Health Network** 100% **Reg 8 Oakland Community Health Network** 100% **Reg 9 Macomb County CMH Services** 99% **Region 10 PIHP** 100%

Topic IV. Appeals, State Fair Hearings & Grievances

Appeals Overview

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1.IV.1	**Appeals resolved (at the plan level)**	**Reg 1 NorthCare** 24

Number	Indicator	Response
	Enter the total number of appeals resolved as of the first day of the last month of the reporting year. An appeal is "resolved" at the plan level when the plan has issued a decision, regardless of whether the decision was wholly or partially favorable or adverse to the beneficiary, and regardless of whether the beneficiary (or the beneficiary's representative) chooses to file a request for a State Fair Hearing or External Medical Review.	**Reg 2 Northern MI Regional Entity** 58 **Reg 3 Lakeshore Regional Entity** 118 **Reg 4 South West Michigan Behavioral Health** 81 **Reg 5 Mid-State Health Network** 246 **Reg 6 CMH Partnership of Southeast MI** 30 **Reg 7 Detroit Wayne Integrated Health Network** 42 **Reg 8 Oakland Community Health Network** 32 **Reg 9 Macomb County CMH Services** 58 **Region 10 PIHP** 28
D1.IV.2	**Active appeals** Enter the total number of appeals still pending or in process (not yet resolved) as of the first day of the last month of the reporting year.	**Reg 1 NorthCare** 0 **Reg 2 Northern MI Regional Entity** 1 **Reg 3 Lakeshore Regional Entity** 14 **Reg 4 South West Michigan Behavioral Health** 4 **Reg 5 Mid-State Health Network** 2 **Reg 6 CMH Partnership of Southeast MI**

Number	Indicator	Response
		0 **Reg 7 Detroit Wayne Integrated Health Network** 8 **Reg 8 Oakland Community Health Network** 0 **Reg 9 Macomb County CMH Services** 2 **Region 10 PIHP** 2
D1.IV.3	**Appeals filed on behalf of LTSS users** Enter the total number of appeals filed during the reporting year by or on behalf of LTSS users. Enter "N/A" if not applicable. An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the appeal was filed).	**Reg 1 NorthCare** 19 **Reg 2 Northern MI Regional Entity** 5 **Reg 3 Lakeshore Regional Entity** 9 **Reg 4 South West Michigan Behavioral Health** 10 **Reg 5 Mid-State Health Network** 153 **Reg 6 CMH Partnership of Southeast MI** 27 **Reg 7 Detroit Wayne Integrated Health Network** 0 **Reg 8 Oakland Community Health Network** 18 **Reg 9 Macomb County CMH Services** 14 **Region 10 PIHP**

Number	Indicator	Response
		0
D1.IV.4	**Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed an appeal** For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting period by (or on behalf of) LTSS users who previously filed appeals in the reporting year. If the managed care plan does not cover LTSS, enter "N/A". Also, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, enter "N/A". The appeal and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the appeal need to have been filed in relation to delivery of LTSS — they may have been filed for any reason, related to any service received (or desired) by an LTSS user. To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed an appeal during the reporting year, and whether the filing of the appeal preceded the filing of the critical incident.	**Reg 1 NorthCare** N/A **Reg 2 Northern MI Regional Entity** N/A **Reg 3 Lakeshore Regional Entity** N/A **Reg 4 South West Michigan Behavioral Health** N/A **Reg 5 Mid-State Health Network** N/A **Reg 6 CMH Partnership of Southeast MI** N/A **Reg 7 Detroit Wayne Integrated Health Network** N/A **Reg 8 Oakland Community Health Network** N/A **Reg 9 Macomb County CMH Services** N/A **Region 10 PIHP** N/A
D1.IV.5a	**Standard appeals for which timely resolution was provided**	**Reg 1 NorthCare** 18

Number	Indicator	Response
	Enter the total number of standard appeals for which timely resolution was provided by plan during the reporting period. See 42 CFR §438.408(b)(2) for requirements related to timely resolution of standard appeals.	**Reg 2 Northern MI Regional Entity** 68 **Reg 3 Lakeshore Regional Entity** 64 **Reg 4 South West Michigan Behavioral Health** 75 **Reg 5 Mid-State Health Network** 75 **Reg 6 CMH Partnership of Southeast MI** 28 **Reg 7 Detroit Wayne Integrated Health Network** 37 **Reg 8 Oakland Community Health Network** 32 **Reg 9 Macomb County CMH Services** 53 **Region 10 PIHP** 28
D1.IV.5b	**Expedited appeals for which timely resolution was provided** Enter the total number of expedited appeals for which timely resolution was provided by plan during the reporting period. See 42 CFR §438.408(b)(3) for requirements related to timely resolution of standard appeals.	**Reg 1 NorthCare** 2 **Reg 2 Northern MI Regional Entity** 3 **Reg 3 Lakeshore Regional Entity** 16 **Reg 4 South West Michigan Behavioral Health** 1 **Reg 5 Mid-State Health Network** 1 **Reg 6 CMH Partnership of Southeast MI**

Number	Indicator	Response
		1 **Reg 7 Detroit Wayne Integrated Health Network** 5 **Reg 8 Oakland Community Health Network** 1 **Reg 9 Macomb County CMH Services** 1 **Region 10 PIHP** 0
D1.IV.6a	**Resolved appeals related to denial of authorization or limited authorization of a service** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of authorization for a service not yet rendered or limited authorization of a service. (Appeals related to denial of payment for a service already rendered should be counted in indicator D1.IV.6c).	**Reg 1 NorthCare** 9 **Reg 2 Northern MI Regional Entity** 35 **Reg 3 Lakeshore Regional Entity** 2 **Reg 4 South West Michigan Behavioral Health** 46 **Reg 5 Mid-State Health Network** 46 **Reg 6 CMH Partnership of Southeast MI** 11 **Reg 7 Detroit Wayne Integrated Health Network** 18 **Reg 8 Oakland Community Health Network** 23 **Reg 9 Macomb County CMH Services** 19 **Region 10 PIHP**

Number	Indicator	Response
		18
D1.IV.6b	**Resolved appeals related to reduction, suspension, or termination of a previously authorized service** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's reduction, suspension, or termination of a previously authorized service.	**Reg 1 NorthCare** 15 **Reg 2 Northern MI Regional Entity** 20 **Reg 3 Lakeshore Regional Entity** 49 **Reg 4 South West Michigan Behavioral Health** 9 **Reg 5 Mid-State Health Network** 9 **Reg 6 CMH Partnership of Southeast MI** 16 **Reg 7 Detroit Wayne Integrated Health Network** 28 **Reg 8 Oakland Community Health Network** 5 **Reg 9 Macomb County CMH Services** 39 **Region 10 PIHP** 10
D1.IV.6c	**Resolved appeals related to payment denial** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial, in whole or in part, of payment for a service that was already rendered.	**Reg 1 NorthCare** 0 **Reg 2 Northern MI Regional Entity** 0 **Reg 3 Lakeshore Regional Entity** 0 **Reg 4 South West Michigan Behavioral Health**

Number	Indicator	Response
		2 **Reg 5 Mid-State Health Network** 2 **Reg 6 CMH Partnership of Southeast MI** 0 **Reg 7 Detroit Wayne Integrated Health Network** 0 **Reg 8 Oakland Community Health Network** 1 **Reg 9 Macomb County CMH Services** 0 **Region 10 PIHP** 0
D1.IV.6d	**Resolved appeals related to service timeliness** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to provide services in a timely manner (as defined by the state).	**Reg 1 NorthCare** 0 **Reg 2 Northern MI Regional Entity** 0 **Reg 3 Lakeshore Regional Entity** 2 **Reg 4 South West Michigan Behavioral Health** 0 **Reg 5 Mid-State Health Network** 0 **Reg 6 CMH Partnership of Southeast MI** 4 **Reg 7 Detroit Wayne Integrated Health Network** 0 **Reg 8 Oakland Community Health Network** 0

Number	Indicator	Response
		Reg 9 Macomb County CMH Services 0 **Region 10 PIHP** 0
D1.IV.6e	**Resolved appeals related to lack of timely plan response to an appeal or grievance** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to act within the timeframes provided at 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.	**Reg 1 NorthCare** 0 **Reg 2 Northern MI Regional Entity** 0 **Reg 3 Lakeshore Regional Entity** 2 **Reg 4 South West Michigan Behavioral Health** 0 **Reg 5 Mid-State Health Network** 0 **Reg 6 CMH Partnership of Southeast MI** 0 **Reg 7 Detroit Wayne Integrated Health Network** 0 **Reg 8 Oakland Community Health Network** 0 **Reg 9 Macomb County CMH Services** 0 **Region 10 PIHP** 0
D1.IV.6f	**Resolved appeals related to plan denial of an enrollee's right to request out-of-network care** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's	**Reg 1 NorthCare** 0 **Reg 2 Northern MI Regional Entity** 0 **Reg 3 Lakeshore Regional Entity**

Number	Indicator	Response
	denial of an enrollee's request to exercise their right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the network (only applicable to residents of rural areas with only one MCO).	0 **Reg 4 South West Michigan Behavioral Health** 0 **Reg 5 Mid-State Health Network** 0 **Reg 6 CMH Partnership of Southeast MI** 0 **Reg 7 Detroit Wayne Integrated Health Network** 0 **Reg 8 Oakland Community Health Network** 0 **Reg 9 Macomb County CMH Services** 0 **Region 10 PIHP** 0
D1.IV.6g	**Resolved appeals related to denial of an enrollee's request to dispute financial liability** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to dispute a financial liability.	**Reg 1 NorthCare** 0 **Reg 2 Northern MI Regional Entity** 0 **Reg 3 Lakeshore Regional Entity** 0 **Reg 4 South West Michigan Behavioral Health** 0 **Reg 5 Mid-State Health Network** 0 **Reg 6 CMH Partnership of Southeast MI** 0 **Reg 7 Detroit Wayne Integrated Health Network**

Number	Indicator	Response
		0 **Reg 8 Oakland Community Health Network** 0 **Reg 9 Macomb County CMH Services** 0 **Region 10 PIHP** 0

Topic IV. Appeals, State Fair Hearings & Grievances

Appeals by Service

Number of appeals resolved during the reporting period related to various services. Note: A single appeal may be related to multiple service types and may therefore be counted in multiple categories.

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1.IV.7a	**Resolved appeals related to general inpatient services** Enter the total number of appeals resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include appeals related to inpatient behavioral health services – those should be included in indicator D1.IV.7c. If the managed care plan does not cover general inpatient services, enter "N/A".	**Reg 1 NorthCare** N/A **Reg 2 Northern MI Regional Entity** N/A **Reg 3 Lakeshore Regional Entity** N/A **Reg 4 South West Michigan Behavioral Health** N/A **Reg 5 Mid-State Health Network** N/A **Reg 6 CMH Partnership of Southeast MI** N/A

Number	Indicator	Response
		Reg 7 Detroit Wayne Integrated Health Network N/A **Reg 8 Oakland Community Health Network** N/A **Reg 9 Macomb County CMH Services** N/A **Region 10 PIHP** N/A
D1.IV.7b	**Resolved appeals related to general outpatient services** Enter the total number of appeals resolved by the plan during the reporting year that were related to general outpatient care, including diagnostic and laboratory services. Please do not include appeals related to outpatient behavioral health services – those should be included in indicator D1.IV.7d. If the managed care plan does not cover general outpatient services, enter "N/A".	**Reg 1 NorthCare** N/A **Reg 2 Northern MI Regional Entity** N/A **Reg 3 Lakeshore Regional Entity** N/A **Reg 4 South West Michigan Behavioral Health** N/A **Reg 5 Mid-State Health Network** N/A **Reg 6 CMH Partnership of Southeast MI** N/A **Reg 7 Detroit Wayne Integrated Health Network** N/A **Reg 8 Oakland Community Health Network** N/A **Reg 9 Macomb County CMH Services** N/A **Region 10 PIHP** N/A

Number	Indicator	Response
D1.IV.7c	**Resolved appeals related to inpatient behavioral health services** Enter the total number of appeals resolved by the plan during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover inpatient behavioral health services, enter "N/A".	**Reg 1 NorthCare** 0 **Reg 2 Northern MI Regional Entity** 10 **Reg 3 Lakeshore Regional Entity** 11 **Reg 4 South West Michigan Behavioral Health** 37 **Reg 5 Mid-State Health Network** 1 **Reg 6 CMH Partnership of Southeast MI** 0 **Reg 7 Detroit Wayne Integrated Health Network** 11 **Reg 8 Oakland Community Health Network** 8 **Reg 9 Macomb County CMH Services** 11 **Region 10 PIHP** 1
D1.IV.7d	**Resolved appeals related to outpatient behavioral health services** Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient mental health and/or substance use services. If the managed care plan does not cover outpatient behavioral health services, enter "N/A".	**Reg 1 NorthCare** 20 **Reg 2 Northern MI Regional Entity** 39 **Reg 3 Lakeshore Regional Entity** 49 **Reg 4 South West Michigan Behavioral Health** 41 **Reg 5 Mid-State Health Network**

Number	Indicator	Response
		8 **Reg 6 CMH Partnership of Southeast MI** 30 **Reg 7 Detroit Wayne Integrated Health Network** 38 **Reg 8 Oakland Community Health Network** 24 **Reg 9 Macomb County CMH Services** 43 **Region 10 PIHP** 25
D1.IV.7e	**Resolved appeals related to covered outpatient prescription drugs** Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover outpatient prescription drugs, enter "N/A".	**Reg 1 NorthCare** N/A **Reg 2 Northern MI Regional Entity** N/A **Reg 3 Lakeshore Regional Entity** N/A **Reg 4 South West Michigan Behavioral Health** N/A **Reg 5 Mid-State Health Network** N/A **Reg 6 CMH Partnership of Southeast MI** N/A **Reg 7 Detroit Wayne Integrated Health Network** N/A **Reg 8 Oakland Community Health Network** N/A **Reg 9 Macomb County CMH Services** N/A

Number	Indicator	Response
		Region 10 PIHP N/A
D1.IV.7f	**Resolved appeals related to skilled nursing facility (SNF) services** Enter the total number of appeals resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover skilled nursing services, enter "N/A".	**Reg 1 NorthCare** N/A **Reg 2 Northern MI Regional Entity** N/A **Reg 3 Lakeshore Regional Entity** N/A **Reg 4 South West Michigan Behavioral Health** N/A **Reg 5 Mid-State Health Network** N/A **Reg 6 CMH Partnership of Southeast MI** N/A **Reg 7 Detroit Wayne Integrated Health Network** N/A **Reg 8 Oakland Community Health Network** N/A **Reg 9 Macomb County CMH Services** N/A **Region 10 PIHP** N/A
D1.IV.7g	**Resolved appeals related to long-term services and supports (LTSS)** Enter the total number of appeals resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including	**Reg 1 NorthCare** 4 **Reg 2 Northern MI Regional Entity** 3 **Reg 3 Lakeshore Regional Entity** 9 **Reg 4 South West Michigan Behavioral Health**

Number	Indicator	Response
	personal care and self-directed services. If the managed care plan does not cover LTSS services, enter "N/A".	6 **Reg 5 Mid-State Health Network** 0 **Reg 6 CMH Partnership of Southeast MI** 16 **Reg 7 Detroit Wayne Integrated Health Network** 0 **Reg 8 Oakland Community Health Network** 3 **Reg 9 Macomb County CMH Services** 14 **Region 10 PIHP** 0
D1.IV.7h	**Resolved appeals related to dental services** Enter the total number of appeals resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover dental services, enter "N/A".	**Reg 1 NorthCare** N/A **Reg 2 Northern MI Regional Entity** N/A **Reg 3 Lakeshore Regional Entity** N/A **Reg 4 South West Michigan Behavioral Health** N/A **Reg 5 Mid-State Health Network** N/A **Reg 6 CMH Partnership of Southeast MI** N/A **Reg 7 Detroit Wayne Integrated Health Network** N/A **Reg 8 Oakland Community Health Network**

Number	Indicator	Response
		N/A **Reg 9 Macomb County CMH Services** N/A **Region 10 PIHP** N/A
D1.IV.7i	**Resolved appeals related to non-emergency medical transportation (NEMT)** Enter the total number of appeals resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover NEMT, enter "N/A".	**Reg 1 NorthCare** 0 **Reg 2 Northern MI Regional Entity** 0 **Reg 3 Lakeshore Regional Entity** 0 **Reg 4 South West Michigan Behavioral Health** 0 **Reg 5 Mid-State Health Network** 0 **Reg 6 CMH Partnership of Southeast MI** 0 **Reg 7 Detroit Wayne Integrated Health Network** 0 **Reg 8 Oakland Community Health Network** 0 **Reg 9 Macomb County CMH Services** 0 **Region 10 PIHP** 0
D1.IV.7j	**Resolved appeals related to other service types** Enter the total number of appeals resolved by the plan during the reporting year that were related to services that do	**Reg 1 NorthCare** 0 **Reg 2 Northern MI Regional Entity**

Number	Indicator	Response
	not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.7a-i, enter "N/A".	0 **Reg 3 Lakeshore Regional Entity** 0 **Reg 4 South West Michigan Behavioral Health** 4 **Reg 5 Mid-State Health Network** 0 **Reg 6 CMH Partnership of Southeast MI** 0 **Reg 7 Detroit Wayne Integrated Health Network** 0 **Reg 8 Oakland Community Health Network** 0 **Reg 9 Macomb County CMH Services** 0 **Region 10 PIHP** 0

Topic IV. Appeals, State Fair Hearings & Grievances

State Fair Hearings

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1.IV.8a	**State Fair Hearing requests** Enter the total number of requests for a State Fair Hearing filed during the reporting year by plan that issued the adverse benefit determination.	**Reg 1 NorthCare** 4 **Reg 2 Northern MI Regional Entity** 10 **Reg 3 Lakeshore Regional Entity**

Number	Indicator	Response
		11 **Reg 4 South West Michigan Behavioral Health** 1 **Reg 5 Mid-State Health Network** 6 **Reg 6 CMH Partnership of Southeast MI** 7 **Reg 7 Detroit Wayne Integrated Health Network** 3 **Reg 8 Oakland Community Health Network** 1 **Reg 9 Macomb County CMH Services** 0 **Region 10 PIHP** 3
D1.IV.8b	**State Fair Hearings resulting in a favorable decision for the enrollee** Enter the total number of State Fair Hearing decisions rendered during the reporting year that were partially or fully favorable to the enrollee.	**Reg 1 NorthCare** 1 **Reg 2 Northern MI Regional Entity** 6 **Reg 3 Lakeshore Regional Entity** 0 **Reg 4 South West Michigan Behavioral Health** 1 **Reg 5 Mid-State Health Network** 1 **Reg 6 CMH Partnership of Southeast MI** 3 **Reg 7 Detroit Wayne Integrated Health Network**

Number	Indicator	Response
		1 **Reg 8 Oakland Community Health Network** 0 **Reg 9 Macomb County CMH Services** 0 **Region 10 PIHP** 1
D1.IV.8c	**State Fair Hearings resulting in an adverse decision for the enrollee** Enter the total number of State Fair Hearing decisions rendered during the reporting year that were adverse for the enrollee.	**Reg 1 NorthCare** 3 **Reg 2 Northern MI Regional Entity** 2 **Reg 3 Lakeshore Regional Entity** 13 **Reg 4 South West Michigan Behavioral Health** 3 **Reg 5 Mid-State Health Network** 4 **Reg 6 CMH Partnership of Southeast MI** 3 **Reg 7 Detroit Wayne Integrated Health Network** 2 **Reg 8 Oakland Community Health Network** 1 **Reg 9 Macomb County CMH Services** 1 **Region 10 PIHP** 2
D1.IV.8d	**State Fair Hearings retracted prior to**	**Reg 1 NorthCare**

Number	Indicator	Response
	reaching a decision Enter the total number of State Fair Hearing decisions retracted (by the enrollee or the representative who filed a State Fair Hearing request on behalf of the enrollee) prior to reaching a decision.	1 **Reg 2 Northern MI Regional Entity** 2 **Reg 3 Lakeshore Regional Entity** 0 **Reg 4 South West Michigan Behavioral Health** 0 **Reg 5 Mid-State Health Network** 0 **Reg 6 CMH Partnership of Southeast MI** 1 **Reg 7 Detroit Wayne Integrated Health Network** 0 **Reg 8 Oakland Community Health Network** 1 **Reg 9 Macomb County CMH Services** 0 **Region 10 PIHP** 0
D1.IV.9a	**External Medical Reviews resulting in a favorable decision for the enrollee** If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were partially or fully favorable to the enrollee. If your state does not offer an external medical review process, enter "N/A". External medical review is defined and described at 42 CFR §438.402(c)(i)(B).	**Reg 1 NorthCare** N/A **Reg 2 Northern MI Regional Entity** N/A **Reg 3 Lakeshore Regional Entity** N/A **Reg 4 South West Michigan Behavioral Health** N/A **Reg 5 Mid-State Health Network** N/A

Number	Indicator	Response
		Reg 6 CMH Partnership of Southeast MI N/A **Reg 7 Detroit Wayne Integrated Health Network** N/A **Reg 8 Oakland Community Health Network** N/A **Reg 9 Macomb County CMH Services** N/A **Region 10 PIHP** N/A
D1.IV.9b	**External Medical Reviews resulting in an adverse decision for the enrollee** If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were adverse to the enrollee. If your state does not offer an external medical review process, enter "N/A". External medical review is defined and described at 42 CFR §438.402(c)(i)(B).	**Reg 1 NorthCare** N/A **Reg 2 Northern MI Regional Entity** N/A **Reg 3 Lakeshore Regional Entity** N/A **Reg 4 South West Michigan Behavioral Health** N/A **Reg 5 Mid-State Health Network** N/A **Reg 6 CMH Partnership of Southeast MI** N/A **Reg 7 Detroit Wayne Integrated Health Network** N/A **Reg 8 Oakland Community Health Network** N/A **Reg 9 Macomb County CMH Services** N/A **Region 10 PIHP**

Number	Indicator	Response
		N/A

Topic IV. Appeals, State Fair Hearings & Grievances

Grievances Overview

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1.IV.10	**Grievances resolved** Enter the total number of grievances resolved by the plan during the reporting year. A grievance is "resolved" when it has reached completion and been closed by the plan.	**Reg 1 NorthCare** 34 **Reg 2 Northern MI Regional Entity** 241 **Reg 3 Lakeshore Regional Entity** 87 **Reg 4 South West Michigan Behavioral Health** 188 **Reg 5 Mid-State Health Network** 142 **Reg 6 CMH Partnership of Southeast MI** 196 **Reg 7 Detroit Wayne Integrated Health Network** 79 **Reg 8 Oakland Community Health Network** 112 **Reg 9 Macomb County CMH Services** 73 **Region 10 PIHP** 117

Number	Indicator	Response
D1.IV.11	**Active grievances** Enter the total number of grievances still pending or in process (not yet resolved) as of the first day of the last month of the reporting year.	**Reg 1 NorthCare** 0 **Reg 2 Northern MI Regional Entity** 3 **Reg 3 Lakeshore Regional Entity** 8 **Reg 4 South West Michigan Behavioral Health** 3 **Reg 5 Mid-State Health Network** 3 **Reg 6 CMH Partnership of Southeast MI** 0 **Reg 7 Detroit Wayne Integrated Health Network** 4 **Reg 8 Oakland Community Health Network** 7 **Reg 9 Macomb County CMH Services** 3 **Region 10 PIHP** 13
D1.IV.12	**Grievances filed on behalf of LTSS users** Enter the total number of grievances filed during the reporting year by or on behalf of LTSS users. An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the grievance was	**Reg 1 NorthCare** 32 **Reg 2 Northern MI Regional Entity** 18 **Reg 3 Lakeshore Regional Entity** 35 **Reg 4 South West Michigan Behavioral Health** 17 **Reg 5 Mid-State Health Network**

Number	Indicator	Response
	filed). If this does not apply, enter N/A.	96 **Reg 6 CMH Partnership of Southeast MI** 186 **Reg 7 Detroit Wayne Integrated Health Network** 0 **Reg 8 Oakland Community Health Network** 94 **Reg 9 Macomb County CMH Services** 21 **Region 10 PIHP** 110
D1.IV.13	**Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed a grievance** For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting period by (or on behalf of) LTSS users who previously filed grievances in the reporting year. The grievance and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the grievance need to have been filed in relation to delivery of LTSS - they may have been filed for any reason, related to any service received (or desired) by an LTSS user. If the managed care plan does not cover LTSS, the state should enter "N/A" in this field. Additionally, if the state already	**Reg 1 NorthCare** N/A **Reg 2 Northern MI Regional Entity** N/A **Reg 3 Lakeshore Regional Entity** N/A **Reg 4 South West Michigan Behavioral Health** N/A **Reg 5 Mid-State Health Network** N/A **Reg 6 CMH Partnership of Southeast MI** N/A **Reg 7 Detroit Wayne Integrated Health Network** N/A **Reg 8 Oakland Community Health Network** N/A **Reg 9 Macomb County CMH Services** N/A

Number	Indicator	Response
	submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, the state can enter "N/A" in this field. To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed a grievance during the reporting year, and whether the filing of the grievance preceded the filing of the critical incident.	**Region 10 PIHP** N/A
D1.IV.14	**Number of grievances for which timely resolution was provided** Enter the number of grievances for which timely resolution was provided by plan during the reporting period. See 42 CFR §438.408(b)(1) for requirements related to the timely resolution of grievances.	**Reg 1 NorthCare** 35 **Reg 2 Northern MI Regional Entity** 241 **Reg 3 Lakeshore Regional Entity** 87 **Reg 4 South West Michigan Behavioral Health** 147 **Reg 5 Mid-State Health Network** 150 **Reg 6 CMH Partnership of Southeast MI** 196 **Reg 7 Detroit Wayne Integrated Health Network** 84 **Reg 8 Oakland Community Health Network**

Number	Indicator	Response
		112 **Reg 9 Macomb County CMH Services** 73 **Region 10 PIHP** 117

Topic IV. Appeals, State Fair Hearings & Grievances

Grievances by Service

Report the number of grievances resolved by plan during the reporting period by service.

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1.IV.15a	**Resolved grievances related to general inpatient services** Enter the total number of grievances resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include grievances related to inpatient behavioral health services — those should be included in indicator D1.IV.15c. If the managed care plan does not cover this type of service, enter "N/A".	**Reg 1 NorthCare** N/A **Reg 2 Northern MI Regional Entity** N/A **Reg 3 Lakeshore Regional Entity** N/A **Reg 4 South West Michigan Behavioral Health** N/A **Reg 5 Mid-State Health Network** N/A **Reg 6 CMH Partnership of Southeast MI** N/A **Reg 7 Detroit Wayne Integrated Health Network** N/A **Reg 8 Oakland Community Health Network**

Number	Indicator	Response
		N/A **Reg 9 Macomb County CMH Services** N/A **Region 10 PIHP** N/A
D1.IV.15b	**Resolved grievances related to general outpatient services** Enter the total number of grievances resolved by the plan during the reporting year that were related to general outpatient care, including diagnostic and laboratory services. Do not include grievances related to outpatient behavioral health services — those should be included in indicator D1.IV.15d. If the managed care plan does not cover this type of service, enter "N/A".	**Reg 1 NorthCare** N/A **Reg 2 Northern MI Regional Entity** N/A **Reg 3 Lakeshore Regional Entity** N/A **Reg 4 South West Michigan Behavioral Health** N/A **Reg 5 Mid-State Health Network** N/A **Reg 6 CMH Partnership of Southeast MI** N/A **Reg 7 Detroit Wayne Integrated Health Network** N/A **Reg 8 Oakland Community Health Network** N/A **Reg 9 Macomb County CMH Services** N/A **Region 10 PIHP** N/A
D1.IV.15c	**Resolved grievances related to inpatient behavioral health services** Enter the total number of grievances resolved by the plan	**Reg 1 NorthCare** 0 **Reg 2 Northern MI Regional Entity**

Number	Indicator	Response
	during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter "N/A".	6 **Reg 3 Lakeshore Regional Entity** 2 **Reg 4 South West Michigan Behavioral Health** 5 **Reg 5 Mid-State Health Network** 1 **Reg 6 CMH Partnership of Southeast MI** 0 **Reg 7 Detroit Wayne Integrated Health Network** 0 **Reg 8 Oakland Community Health Network** 2 **Reg 9 Macomb County CMH Services** 0 **Region 10 PIHP** 1
D1.IV.15d	**Resolved grievances related to outpatient behavioral health services** Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter "N/A".	**Reg 1 NorthCare** 0 **Reg 2 Northern MI Regional Entity** 163 **Reg 3 Lakeshore Regional Entity** 59 **Reg 4 South West Michigan Behavioral Health** 153 **Reg 5 Mid-State Health Network** 16 **Reg 6 CMH Partnership of Southeast MI** 196

Number	Indicator	Response
		Reg 7 Detroit Wayne Integrated Health Network 84 **Reg 8 Oakland Community Health Network** 92 **Reg 9 Macomb County CMH Services** 12 **Region 10 PIHP** 111
D1.IV.15e	**Resolved grievances related to coverage of outpatient prescription drugs** Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover this type of service, enter "N/A".	**Reg 1 NorthCare** N/A **Reg 2 Northern MI Regional Entity** N/A **Reg 3 Lakeshore Regional Entity** N/A **Reg 4 South West Michigan Behavioral Health** N/A **Reg 5 Mid-State Health Network** N/A **Reg 6 CMH Partnership of Southeast MI** N/A **Reg 7 Detroit Wayne Integrated Health Network** N/A **Reg 8 Oakland Community Health Network** N/A **Reg 9 Macomb County CMH Services** N/A **Region 10 PIHP** N/A

Number	Indicator	Response
D1.IV.15f	**Resolved grievances related to skilled nursing facility (SNF) services** Enter the total number of grievances resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover this type of service, enter "N/A".	**Reg 1 NorthCare** N/A **Reg 2 Northern MI Regional Entity** N/A **Reg 3 Lakeshore Regional Entity** N/A **Reg 4 South West Michigan Behavioral Health** N/A **Reg 5 Mid-State Health Network** N/A **Reg 6 CMH Partnership of Southeast MI** N/A **Reg 7 Detroit Wayne Integrated Health Network** N/A **Reg 8 Oakland Community Health Network** N/A **Reg 9 Macomb County CMH Services** N/A **Region 10 PIHP** N/A
D1.IV.15g	**Resolved grievances related to long-term services and supports (LTSS)** Enter the total number of grievances resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover this type of service, enter "N/A".	**Reg 1 NorthCare** 0 **Reg 2 Northern MI Regional Entity** 9 **Reg 3 Lakeshore Regional Entity** 35 **Reg 4 South West Michigan Behavioral Health** 1 **Reg 5 Mid-State Health Network**

Number	Indicator	Response
		0 **Reg 6 CMH Partnership of Southeast MI** 186 **Reg 7 Detroit Wayne Integrated Health Network** 0 **Reg 8 Oakland Community Health Network** 18 **Reg 9 Macomb County CMH Services** 0 **Region 10 PIHP** 110
D1.IV.15h	**Resolved grievances related to dental services** Enter the total number of grievances resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover this type of service, enter "N/A".	**Reg 1 NorthCare** N/A **Reg 2 Northern MI Regional Entity** N/A **Reg 3 Lakeshore Regional Entity** N/A **Reg 4 South West Michigan Behavioral Health** N/A **Reg 5 Mid-State Health Network** N/A **Reg 6 CMH Partnership of Southeast MI** N/A **Reg 7 Detroit Wayne Integrated Health Network** N/A **Reg 8 Oakland Community Health Network** N/A **Reg 9 Macomb County CMH Services** N/A

Number	Indicator	Response
		Region 10 PIHP N/A
D1.IV.15i	**Resolved grievances related to non-emergency medical transportation (NEMT)** Enter the total number of grievances resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover this type of service, enter "N/A".	**Reg 1 NorthCare** 0 **Reg 2 Northern MI Regional Entity** 0 **Reg 3 Lakeshore Regional Entity** 0 **Reg 4 South West Michigan Behavioral Health** 0 **Reg 5 Mid-State Health Network** 0 **Reg 6 CMH Partnership of Southeast MI** 0 **Reg 7 Detroit Wayne Integrated Health Network** 0 **Reg 8 Oakland Community Health Network** 0 **Reg 9 Macomb County CMH Services** 0 **Region 10 PIHP** 0
D1.IV.15j	**Resolved grievances related to other service types** Enter the total number of grievances resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those	**Reg 1 NorthCare** 3 **Reg 2 Northern MI Regional Entity** 42 **Reg 3 Lakeshore Regional Entity** 4 **Reg 4 South West Michigan Behavioral Health**

Number	Indicator	Response
	in items D1.IV.15a-i, enter "N/A".	2 **Reg 5 Mid-State Health Network** 8 **Reg 6 CMH Partnership of Southeast MI** 7 **Reg 7 Detroit Wayne Integrated Health Network** 0 **Reg 8 Oakland Community Health Network** 0 **Reg 9 Macomb County CMH Services** 0 **Region 10 PIHP** 6

Topic IV. Appeals, State Fair Hearings & Grievances

Grievances by Reason

Report the number of grievances resolved by plan during the reporting period by reason.

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1.IV.16a	**Resolved grievances related to plan or provider customer service** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider customer service. Customer service grievances include complaints about	**Reg 1 NorthCare** 0 **Reg 2 Northern MI Regional Entity** 77 **Reg 3 Lakeshore Regional Entity** 6 **Reg 4 South West Michigan Behavioral Health**

Number	Indicator	Response
	interactions with the plan's Member Services department, provider offices or facilities, plan marketing agents, or any other plan or provider representatives.	35 **Reg 5 Mid-State Health Network** 0 **Reg 6 CMH Partnership of Southeast MI** 0 **Reg 7 Detroit Wayne Integrated Health Network** 44 **Reg 8 Oakland Community Health Network** 20 **Reg 9 Macomb County CMH Services** 9 **Region 10 PIHP** 76
D1.IV.16b	**Resolved grievances related to plan or provider care management/case management** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider care management/case management. Care management/case management grievances include complaints about the timeliness of an assessment or complaints about the plan or provider care or case management process.	**Reg 1 NorthCare** 0 **Reg 2 Northern MI Regional Entity** 62 **Reg 3 Lakeshore Regional Entity** 0 **Reg 4 South West Michigan Behavioral Health** 29 **Reg 5 Mid-State Health Network** 8 **Reg 6 CMH Partnership of Southeast MI** 42 **Reg 7 Detroit Wayne Integrated Health Network** 5 **Reg 8 Oakland Community Health Network**

Number	Indicator	Response
		5 **Reg 9 Macomb County CMH Services** 4 **Region 10 PIHP** 31
D1.IV.16c	**Resolved grievances related to access to care/services from plan or provider** Enter the total number of grievances resolved by the plan during the reporting year that were related to access to care. Access to care grievances include complaints about difficulties finding qualified in-network providers, excessive travel or wait times, or other access issues.	**Reg 1 NorthCare** 9 **Reg 2 Northern MI Regional Entity** 8 **Reg 3 Lakeshore Regional Entity** 24 **Reg 4 South West Michigan Behavioral Health** 21 **Reg 5 Mid-State Health Network** 30 **Reg 6 CMH Partnership of Southeast MI** 44 **Reg 7 Detroit Wayne Integrated Health Network** 26 **Reg 8 Oakland Community Health Network** 31 **Reg 9 Macomb County CMH Services** 56 **Region 10 PIHP** 21
D1.IV.16d	**Resolved grievances related to quality of care** Enter the total number of grievances resolved by the plan during the reporting year that were related to quality of care.	**Reg 1 NorthCare** 22 **Reg 2 Northern MI Regional Entity**

Number	Indicator	Response
	Quality of care grievances include complaints about the effectiveness, efficiency, equity, patient-centeredness, safety, and/or acceptability of care provided by a provider or the plan.	80 **Reg 3 Lakeshore Regional Entity** 24 **Reg 4 South West Michigan Behavioral Health** 31 **Reg 5 Mid-State Health Network** 64 **Reg 6 CMH Partnership of Southeast MI** 118 **Reg 7 Detroit Wayne Integrated Health Network** 50 **Reg 8 Oakland Community Health Network** 20 **Reg 9 Macomb County CMH Services** 5 **Region 10 PIHP** 48.
D1.IV.16e	**Resolved grievances related to plan communications** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan communications. Plan communication grievances include grievances related to the clarity or accuracy of enrollee materials or other plan communications or to an enrollee's access to or the accessibility of enrollee materials or plan communications.	**Reg 1 NorthCare** 0 **Reg 2 Northern MI Regional Entity** 2 **Reg 3 Lakeshore Regional Entity** 0 **Reg 4 South West Michigan Behavioral Health** 1 **Reg 5 Mid-State Health Network** 13 **Reg 6 CMH Partnership of Southeast MI** 0

Number	Indicator	Response
		Reg 7 Detroit Wayne Integrated Health Network 0 **Reg 8 Oakland Community Health Network** 2 **Reg 9 Macomb County CMH Services** 0 **Region 10 PIHP** 107
D1.IV.16f	**Resolved grievances related to payment or billing issues** Enter the total number of grievances resolved during the reporting period that were filed for a reason related to payment or billing issues.	**Reg 1 NorthCare** 1 **Reg 2 Northern MI Regional Entity** 1 **Reg 3 Lakeshore Regional Entity** 2 **Reg 4 South West Michigan Behavioral Health** 1 **Reg 5 Mid-State Health Network** 2 **Reg 6 CMH Partnership of Southeast MI** 1 **Reg 7 Detroit Wayne Integrated Health Network** 4 **Reg 8 Oakland Community Health Network** 7 **Reg 9 Macomb County CMH Services** 2 **Region 10 PIHP** 0

Number	Indicator	Response
D1.IV.16g	**Resolved grievances related to suspected fraud** Enter the total number of grievances resolved during the reporting year that were related to suspected fraud. Suspected fraud grievances include suspected cases of financial/payment fraud perpetuated by a provider, payer, or other entity. Note: grievances reported in this row should only include grievances submitted to the managed care plan, not grievances submitted to another entity, such as a state Ombudsman or Office of the Inspector General.	**Reg 1 NorthCare** 0 **Reg 2 Northern MI Regional Entity** 0 **Reg 3 Lakeshore Regional Entity** 0 **Reg 4 South West Michigan Behavioral Health** 1 **Reg 5 Mid-State Health Network** 0 **Reg 6 CMH Partnership of Southeast MI** 0 **Reg 7 Detroit Wayne Integrated Health Network** 0 **Reg 8 Oakland Community Health Network** 0 **Reg 9 Macomb County CMH Services** 0 **Region 10 PIHP** 0
D1.IV.16h	**Resolved grievances related to abuse, neglect or exploitation** Enter the total number of grievances resolved during the reporting year that were related to abuse, neglect or exploitation. Abuse/neglect/exploitation grievances include cases involving potential or actual patient harm.	**Reg 1 NorthCare** 4 **Reg 2 Northern MI Regional Entity** 139 **Reg 3 Lakeshore Regional Entity** 57 **Reg 4 South West Michigan Behavioral Health** 35 **Reg 5 Mid-State Health Network**

Number	Indicator	Response
		128 **Reg 6 CMH Partnership of Southeast MI** 97 **Reg 7 Detroit Wayne Integrated Health Network** 193 **Reg 8 Oakland Community Health Network** 36 **Reg 9 Macomb County CMH Services** 66 **Region 10 PIHP** 61
D1.IV.16i	**Resolved grievances related to lack of timely plan response to a service authorization or appeal (including requests to expedite or extend appeals)** Enter the total number of grievances resolved during the reporting year that were filed due to a lack of timely plan response to a service authorization or appeal request (including requests to expedite or extend appeals).	**Reg 1 NorthCare** 0 **Reg 2 Northern MI Regional Entity** 4 **Reg 3 Lakeshore Regional Entity** 0 **Reg 4 South West Michigan Behavioral Health** 0 **Reg 5 Mid-State Health Network** 0 **Reg 6 CMH Partnership of Southeast MI** 0 **Reg 7 Detroit Wayne Integrated Health Network** 4 **Reg 8 Oakland Community Health Network** 0 **Reg 9 Macomb County CMH Services** 0

Number	Indicator	Response
		Region 10 PIHP 1
D1.IV.16j	**Resolved grievances related to plan denial of expedited appeal** Enter the total number of grievances resolved during the reporting year that were related to the plan's denial of an enrollee's request for an expedited appeal. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal. If a plan denies a request for an expedited appeal, the enrollee or their representative have the right to file a grievance.	**Reg 1 NorthCare** 0 **Reg 2 Northern MI Regional Entity** 0 **Reg 3 Lakeshore Regional Entity** 0 **Reg 4 South West Michigan Behavioral Health** 0 **Reg 5 Mid-State Health Network** 0 **Reg 6 CMH Partnership of Southeast MI** 0 **Reg 7 Detroit Wayne Integrated Health Network** 0 **Reg 8 Oakland Community Health Network** 0 **Reg 9 Macomb County CMH Services** 0 **Region 10 PIHP** 0
D1.IV.16k	**Resolved grievances filed for other reasons** Enter the total number of grievances resolved during the reporting period that were filed for a reason other than the reasons listed above.	**Reg 1 NorthCare** 2 **Reg 2 Northern MI Regional Entity** 21 **Reg 3 Lakeshore Regional Entity** 12 **Reg 4 South West Michigan Behavioral Health**

Number	Indicator	Response
		34 **Reg 5 Mid-State Health Network** 6 **Reg 6 CMH Partnership of Southeast MI** 6 **Reg 7 Detroit Wayne Integrated Health Network** 7 **Reg 8 Oakland Community Health Network** 23 **Reg 9 Macomb County CMH Services** 0 **Region 10 PIHP** 4

Topic VII: Quality & Performance Measures

Report on individual measures in each of the following eight domains: (1) Primary care access and preventive care, (2) Maternal and perinatal health, (3) Care of acute and chronic conditions, (4) Behavioral health care, (5) Dental and oral health services, (6) Health plan enrollee experience of care, (7) Long-term services and supports, and (8) Other. For composite measures, be sure to include each individual sub-measure component.

Find in the Excel Workbook
D2_Plan_Measures

Quality & performance measure total count: 12

Complete

D2.VII.1 Measure Name: 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. 1 / 12

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

n/a

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

State-specific

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Numerator - Number (#) of Dispositions about Emergency Referrals Completed within Three Hours or Less Denominator - Number (#) of Emergency Referrals for Inpatient Screening During the Time Period Calculation = Percent (%) of Emergency Referrals Completed within the Time Standard

Measure results

Reg 1 NorthCare

Children 100% Adults 98.99%

Reg 2 Northern MI Regional Entity

"Children- 98.78% Adults 98.86%"

Reg 3 Lakeshore Regional Entity

"Children 99.71% Adults 98.82%"

Reg 4 South West Michigan Behavioral Health

"Children 99.36% Adults 99.32%"

Reg 5 Mid-State Health Network

"Children 96.73% Adults 99.19%"

Reg 6 CMH Partnership of Southeast MI

"Children 98.80% Adults 99.30%"

Reg 7 Detroit Wayne Integrated Health Network

"Children 97.78% Adults 97.14%"

Reg 8 Oakland Community Health Network

"Children 97.92% Adults 93.04%"

Reg 9 Macomb County CMH Services

"Children 100% Adults 99.41%"

Region 10 PIHP

"Children - 100% Adults 100%"

Complete

D2.VII.1 Measure Name: The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service.

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

n/a

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

State-specific

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Numerator - # of Persons Completing the Biopsychosocial Assessment within 14 Calendar Days of First Request for Service Denominator - # of New Persons Who Requested Mental Health or I/DD Services and Supports and are Referred for a Biopsychosocial Assessment Calculation = % of Persons Requesting a Service Who Received a Completed BPS Assessment within 14 Calendar Days

Measure results

Reg 1 NorthCare

"MI Children - 71.88% MI Adults -64.63% IDD Children - 55.56% IDD Adults - 63.64 Total Population - 66.79%"

Reg 2 Northern MI Regional Entity

"MI Children -53.15% MI Adults - 50.63% IDD Children -55.74% IDD Adults - 46.88% Total Population - 61.61%"

Reg 3 Lakeshore Regional Entity

"MI Children -71.73% MI Adults -78.94% IDD Children -73.33% IDD Adults - 47.22% Total Population - 73.41%"

Reg 4 South West Michigan Behavioral Health

"MI Children -71.97% MI Adults -70.75% IDD Children -83.50% IDD Adults - 82.35% Total Population - 72.12%"

Reg 5 Mid-State Health Network

"MI Children - 65.77% MI Adults -62.59% IDD Children -62.21% IDD Adults - 64.56% Total Population - 63.73%"

Reg 6 CMH Partnership of Southeast MI

"MI Children -68.15% MI Adults -63.95% IDD Children -72.06% IDD Adults - 59.38% Total Population - 66.17%"

Reg 7 Detroit Wayne Integrated Health Network

"MI Children - 44.40% MI Adults - 57.14% IDD Children -47.90% IDD Adults - 53.45% Total Population - 52.85%"

Reg 8 Oakland Community Health Network

"MI Children -45.54% MI Adults - 50.43% IDD Children - 53.33% IDD Adults - 42.86% Total Population - 48.61%"

Reg 9 Macomb County CMH Services

"MI Children - 32.73% MI Adults - 45.09% IDD Children - 57.78% IDD Adults - 45.16% Total Population - 42.22%"

Region 10 PIHP

"MI Children - 66.80% MI Adults - 51.83% IDD Children -67.68% IDD Adults - 57.41% Total Population - 58.64%"

Complete

D2.VII.1 Measure Name: The percentage of new persons during the quarter starting any medically necessary ongoing covered service within 14 days of completing a non-emergent biopsychosocial assessment.

3 / 12

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

n/a

D2.VII.6 Measure Set

State-specific

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Numerator - # of Persons Who Started a Face-to-Face Service Within 14 Calendar Days of the Completion of the Biopsychosocial Assessment Denominator - # of New Persons Who Completed a Biopsychosocial Assessment within the Quarter and Are Determined Eligible for Ongoing Services Calculation = % of Persons Who Started Service within 14 days of Biopsychosocial Assessment

Measure results

Reg 1 NorthCare

"MI Children - 72.73% MI Adults - 67.38% IDD Children -78.57% IDD Adults - 55.00% Total Population - 69.21%"

Reg 2 Northern MI Regional Entity

"MI Children -63.22% MI Adults -68.30% IDD Children -86.44% IDD Adults - 81.82% Total Population - 68.13%"

Reg 3 Lakeshore Regional Entity

"MI Children - 75.59% MI Adults -70.29% IDD Children -80.00% IDD Adults - 79.73% Total Population - 74.35%"

Reg 4 South West Michigan Behavioral Health

"MI Children -64.99% MI Adults -67.04% IDD Children -52.94% IDD Adults - 80.00% Total Population - 65.64%"

Reg 5 Mid-State Health Network

"MI Children -57.60% MI Adults - 63.07% IDD Children - 68.00% IDD Adults - 56.58% Total Population - 61.27%"

Reg 6 CMH Partnership of Southeast MI

"MI Children - 73.08% MI Adults -81.28% IDD Children - 85.29% IDD Adults - 57.14% Total Population - 77.25%"

Reg 7 Detroit Wayne Integrated Health Network

"MI Children -80.61% MI Adults - 81.15% IDD Children -90.54% IDD Adults - 88.00% Total Population - 82.36%"

Reg 8 Oakland Community Health Network

"MI Children - 99.63% MI Adults - 99.77% IDD Children - 100% IDD Adults - 100% Total Population - 99.74%"

Reg 9 Macomb County CMH Services

N/A

Region 10 PIHP

"MI Children - 95.19% MI Adults - 88.60% IDD Children -92.73% IDD Adults - 84.31% Total Population - 91.25%"

Complete

D2.VII.1 Measure Name: The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.

4 / 12

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

n/a

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

State-specific

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Numerator - 1. Enter the number of discharges from # Net Discharges denominator - Subtract the number of discharges from # of Discharges from a Psychiatric Inpatient Unit that are exceptions Calculation = % of Persons discharged seen within 7 days

Measure results

Reg 1 NorthCare

"Children - 95.65% Adults - 97.30%"

Reg 2 Northern MI Regional Entity

"Children- 100% Adults 100%"

Reg 3 Lakeshore Regional Entity

"Children 96.51% Adults 97.28%"

Reg 4 South West Michigan Behavioral Health

"Children 98.11% Adults 96.21%"

Reg 5 Mid-State Health Network

"Children 96.81% Adults 94.93%"

Reg 6 CMH Partnership of Southeast MI

"Children 89.74% Adults 95.95%"

Reg 7 Detroit Wayne Integrated Health Network

"Children 98.15% Adults 94.80%"

Reg 8 Oakland Community Health Network

"Children 100% Adults 95.56%"

Reg 9 Macomb County CMH Services

"Children 52.63% Adults 55.44%"

Region 10 PIHP

"Children 95.77% Adults 92.65%"

Complete

D2.VII.1 Measure Name: The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.

5 / 12

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

D2.VII.4 Measure Reporting and D2.VII.5 Programs

n/a

Program-specific rate

D2.VII.6 Measure Set

State-specific

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

"Numerator - Enter the number of discharges from net discharges who were seen for follow-up care by the CA/PIHP or CMHSP/PIHP within seven days denominator - subtract # of Discharges from a Substance Abuse Detox Unit from those that are Exceptions Calculation = % of Persons discharged seen within 7 days"

Measure results

Reg 1 NorthCare

Consumers - 100%

Reg 2 Northern MI Regional Entity

Consumers 95.65%

Reg 3 Lakeshore Regional Entity

Consumers 97.66%

Reg 4 South West Michigan Behavioral Health

Consumers 97.93%

Reg 5 Mid-State Health Network

Consumers 95.48%

Reg 6 CMH Partnership of Southeast MI

Consumers 98.77%

Reg 7 Detroit Wayne Integrated Health Network

Consumers 100%

Reg 8 Oakland Community Health Network

Consumers - 100%

Reg 9 Macomb County CMH Services

Consumers 100%

Region 10 PIHP

Consumers 91.49%

Complete

D2.VII.1 Measure Name: The percent of Medicaid recipients having received PIHP managed services.

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

n/a

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

State-specific

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

"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. Calculation = Penetration Rate"

Measure results

Reg 1 NorthCare

6.84%

Reg 2 Northern MI Regional Entity

7.66%

Reg 3 Lakeshore Regional Entity

5.33%

Reg 4 South West Michigan Behavioral Health

5.90%

Reg 5 Mid-State Health Network

7.47%

Reg 6 CMH Partnership of Southeast MI

6.11%

Reg 7 Detroit Wayne Integrated Health Network

5.90%

Reg 8 Oakland Community Health Network

7.00%

Reg 9 Macomb County CMH Services

4.48%

Region 10 PIHP

6.66%

Complete

D2.VII.1 Measure Name: The percent of HSW enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.

7 / 12

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

n/a

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

State-specific

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

"Numerator - the number of HSW enrollees receiving at least one HSW service each month other than supports coordination each month. denominator - the number of HSW enrollees. Calculation = HSW Rate"

Measure results

Reg 1 NorthCare

92.97%

Reg 2 Northern MI Regional Entity

88.57%

Reg 3 Lakeshore Regional Entity

77.22%

Reg 4 South West Michigan Behavioral Health

88.13%

Reg 5 Mid-State Health Network

86.95%

Reg 6 CMH Partnership of Southeast MI

85.33%

Reg 7 Detroit Wayne Integrated Health Network

91.02%

Reg 8 Oakland Community Health Network

91.40%

Reg 9 Macomb County CMH Services

92.81%

Region 10 PIHP

90.56%

Complete

D2.VII.1 Measure Name: The percent of (a) adults with mental illness, the percent of (b) adults with intellectual or developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/intellectual or developmental disabilities served by the CMHSPs and PIHPs who are employed competitively.

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

n/a

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

State-specific

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

"Numerator - the total number of (a) adults with mental illness, the total number of (b) adults with developmental disabilities, and the total number of (c) adults dually diagnosed with mental illness/developmental disability who are employed competitively. denominator - the total number of (a) adults with mental illness, the total number of (b) adults with developmental disabilities, and the total number of (c) adults dually diagnosed with mental illness/developmental disability served by the CMHSP. Calculation = Competitive Employment Rate"

Measure results

Reg 1 NorthCare

"MI - Adults-17.39% I/DD Adults - 7.90% Total population - 8.14%"

Reg 2 Northern MI Regional Entity

"MI - Adults - 21.76% I/DD Adults - 11.08% Total population - 15.55%"

Reg 3 Lakeshore Regional Entity

"MI - Adults - 17.70% I/DD Adults - 8.79% Total population -8.92%"

Reg 4 South West Michigan Behavioral Health

"MI - Adults - 19.14% I/DD Adults - 8.46% Total population - 8.45%"

Reg 5 Mid-State Health Network

"MI - Adults -19.46% I/DD Adults - 7.52% Total population - 9.38%"

Reg 6 CMH Partnership of Southeast MI

"MI - Adults - 16.40% I/DD Adults - 9.63% Total population -8.97%"

Reg 7 Detroit Wayne Integrated Health Network

"MI - Adults - 14.00% I/DD Adults - 8.23% Total population -6.02%"

Reg 8 Oakland Community Health Network

"MI - Adults - 19.14% I/DD Adults - 12.57% Total population -8.62%"

Reg 9 Macomb County CMH Services

"MI - Adults - 17.21% I/DD Adults - 5.03% Total population - 6.42%"

Region 10 PIHP

"MI - Adults - 13.78% I/DD Adults - 6.33% Total population -7.58%"

Complete

9 / 12

D2.VII.1 Measure Name: The percent of (a) adults with mental illness, the percent of (b) adults with intellectual or developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/ intellectual or developmental disability served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

n/a

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

State-specific

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

CMHSP Numerator - the total number of (a) adults with mental illness denominator - the total number of adults with developmental disabilities Calculation = adults dually diagnosed with mental illness/developmental disability, who received Michigan's minimum wage or more from employment activities PIHP Numerator - the total number of adult Medicaid beneficiaries with mental illness denominator - the total number of adult Medicaid beneficiaries with developmental disabilities Calculation = the total number of adult Medicaid beneficiaries dually diagnosed with mental illness/developmental disability served by the PIHP.

Measure results

Reg 1 NorthCare

"MI - Adults - 100% I/DD Adults - 92.75% Total population - 95.24%"

Reg 2 Northern MI Regional Entity

"MI - Adults -99.85% I/DD Adults - 69.58% Total population -94.59%"

Reg 3 Lakeshore Regional Entity

"MI - Adults -99.78% I/DD Adults - 92.57% Total population -91.06%"

Reg 4 South West Michigan Behavioral Health

"MI - Adults -99.74% I/DD Adults - 92.70% Total population - 88.75%"

Reg 5 Mid-State Health Network

"MI - Adults - 99.72% I/DD Adults - 89.20% Total population -92.76%"

Reg 6 CMH Partnership of Southeast MI

"MI - Adults - 99.52% I/DD Adults - 88.95% Total population - 91.43%"

Reg 7 Detroit Wayne Integrated Health Network

"MI - Adults - 99.77% I/DD Adults - 93.69% Total population -96.69%"

Reg 8 Oakland Community Health Network

"MI - Adults - 99.60% I/DD Adults - 77.84% Total population - 62.42%"

Reg 9 Macomb County CMH Services

"MI - Adults - 100% I/DD Adults - 94.17% Total population - 93.94%"

Region 10 PIHP

"MI - Adults - 99.84% I/DD Adults - 93.57% Total population - 92.59%"

Complete

D2.VII.1 Measure Name: The percentage of readmissions of MI and I/DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

n/a

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

State-specific

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

The percentage of readmissions of MI and I/DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.

Measure results

Reg 1 NorthCare

"Children - 20.83% Adults - 10.23%"

Reg 2 Northern MI Regional Entity

"Children - 5.00% Adults -11.95%"

Reg 3 Lakeshore Regional Entity

"Children - 6.03% Adults -9.81%"

Reg 4 South West Michigan Behavioral Health

"Children - 7.69% Adults -12.27%"

Reg 5 Mid-State Health Network

"Children - 3.85% Adults - 11.44%"

Reg 6 CMH Partnership of Southeast MI

"Children - 5.13% Adults - 12.39%"

Reg 7 Detroit Wayne Integrated Health Network

"Children - 5.06% Adults -14.93%"

Reg 8 Oakland Community Health Network

"Children - 0.00% Adults -5.96%"

Reg 9 Macomb County CMH Services

"Children - 10.00% Adults - 14.83%"

Region 10 PIHP

"Children - 10.53% Adults - 9.86%"

Complete

D2.VII.1 Measure Name: The percent of adults with intellectual or developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).

11 / 12

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

n/a

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

State-specific

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

"Numerator - Total # of Enrollees denominator - # of Enrollees Who Live in a Private Residence Alone, With Spouse, or Non-Relative(s) Calculation = Private Residence Rate"

Measure results

Reg 1 NorthCare

"I/DD-Adults - 16.93% MI and I/DD Adults - 20.56%"

Reg 2 Northern MI Regional Entity

"I/DD-Adults - 20.85% MI and I/DD Adults - 32.93%"

Reg 3 Lakeshore Regional Entity

"I/DD-Adults - 15.31% MI and I/DD Adults - 23.60%"

Reg 4 South West Michigan Behavioral Health

"I/DD-Adults - 20.06% MI and I/DD Adults - 21.99%"

Reg 5 Mid-State Health Network

"I/DD-Adults - 18.55% MI and I/DD Adults - 26.64%"

Reg 6 CMH Partnership of Southeast MI

"I/DD-Adults - 25.61% MI and I/DD Adults - 34.35%"

Reg 7 Detroit Wayne Integrated Health Network

"I/DD-Adults - 21.69% MI and I/DD Adults - 27.84%"

Reg 8 Oakland Community Health Network

"I/DD-Adults - 18.99% MI and I/DD Adults - 27.18%"

Reg 9 Macomb County CMH Services

"I/DD-Adults - 16.74% MI and I/DD Adults - 22.14%"

Region 10 PIHP

"I/DD-Adults - 16.89% MI and I/DD Adults - 24.40%"

Complete

D2.VII.1 Measure Name: The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).

12 / 12

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

n/a

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

State-specific

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

"Numerator - Total # of Enrollees denominator - # of Enrollees Who Live in a Private Residence Alone, With Spouse, or Non-Relative(s) Calculation = Private Residence Rate"

Measure results

Reg 1 NorthCare

MI-Adults 53.73%

Reg 2 Northern MI Regional Entity

MI-Adults 50.58%

Reg 3 Lakeshore Regional Entity

MI-Adults 46.66%

Reg 4 South West Michigan Behavioral Health

MI-Adults 51.68%

Reg 5 Mid-State Health Network

MI-Adults 49.78%

Reg 6 CMH Partnership of Southeast MI

MI-Adults 36.31%

Reg 7 Detroit Wayne Integrated Health Network

MI-Adults 38.15%

Reg 8 Oakland Community Health Network

MI-Adults 33.13%

Reg 9 Macomb County CMH Services

MI-Adults 46.20%

Region 10 PIHP

MI-Adults 47.38%

Topic VIII. Sanctions

Describe sanctions that the state has issued for each plan. Report all known actions across the following domains: sanctions, administrative penalties, corrective action

plans, other. Include any pending or unresolved actions.

42 CFR 438.66(e)(2)(viii) specifies that the MCPAR include the results of any sanctions or corrective action plans imposed by the State or other formal or informal intervention with a contracted MCO, PIHP, PAHP, or PCCM entity to improve performance.

Find in the Excel Workbook
D3_Plan_Sanctions

Sanction total count: 103

Complete

D3.VIII.1 Intervention type: Corrective action plan 1 / 103

D3.VIII.2 Intervention topic
EQR Compliance Review

D3.VIII.3 Plan name
Reg 1 NorthCare

D3.VIII.4 Reason for intervention

All Not Met elements within each standard of the Compliance Review requires a CAP for the SFY22 review, the PIHP was required to submit CAPs for Standards VII Provider Selection, IX Grievance & Appeal, X Subcontractual Relationships & Delegation, XI Practice Guidelines, XII - Health Information Systems, XIII QAPIP. MDHHS monitors implementation of the CAP through regular progress reports and remediation of the deficiencies are evaluated for completion during the 3rd year of the EQR Compliance Review cycle (SFY23).

Sanction details

D3.VIII.5 Instances of non-compliance
19

D3.VIII.6 Sanction amount
$ 0

D3.VIII.7 Date assessed
11/04/2022

D3.VIII.8 Remediation date non-compliance was corrected
Not answered

D3.VIII.9 Corrective action plan
Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan 2 / 103

D3.VIII.2 Intervention topic

D3.VIII.3 Plan name

EQR Compliance Review Reg 2 Northern MI Regional Entity

D3.VIII.4 Reason for intervention

All Not Met elements within each standard of the Compliance Review requires a CAP for the SFY22 review, the PIHP was required to submit CAPs for Standards VII Provider Selection, VIII Confidentiality, IX Grievance & Appeal, X Subcontractual Relationships & Delegation, XI Practice Guidelines, XII - Health Information Systems, XIII QAPIP. MDHHS monitors implementation of the CAP through regular progress reports and remediation of the deficiencies are evaluated for completion during the 3rd year of the EQR Compliance Review cycle (SFY23).

Sanction details

D3.VIII.5 Instances of non-compliance

26

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

11/02/2022

D3.VIII.8 Remediation date non-compliance was corrected

Not answered

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

3 / 103

D3.VIII.2 Intervention topic **D3.VIII.3 Plan name**

EQR Compliance Review Reg 3 Lakeshore Regional Entity

D3.VIII.4 Reason for intervention

All Not Met elements within each standard of the Compliance Review requires a CAP for the SFY22 review, the PIHP was required to submit CAPs for Standards VII Provider Selection, VIII Confidentiality, IX Grievance & Appeal, X Subcontractual Relationships & Delegation, XI Practice Guidelines, XII - Health Information Systems, XIII QAPIP. MDHHS monitors implementation of the CAP through regular progress reports and remediation of the deficiencies are evaluated for completion during the 3rd year of the EQR Compliance Review cycle (SFY23). For this MCPAR, only using FY22 'not-met' scores as this is the first year and report year is FY22.

Sanction details

D3.VIII.5 Instances of non-compliance

19

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

11/02/2022

D3.VIII.8 Remediation date non-compliance was corrected

Not answered

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

4 / 103

D3.VIII.2 Intervention topic

EQR Compliance Review

D3.VIII.3 Plan name

Reg 4 South West Michigan Behavioral Health

D3.VIII.4 Reason for intervention

All Not Met elements within each standard of the Compliance Review requires a CAP for the SFY22 review, the PIHP was required to submit CAPs for Standards VII Provider Selection, VIII Confidentiality, IX Grievance & Appeal, XI Practice Guidelines, XII - Health Information Systems, XIII QAPIP. MDHHS monitors implementation of the CAP through regular progress reports and remediation of the deficiencies are evaluated for completion during the 3rd year of the EQR Compliance Review cycle (SFY23). For this MCPAR, only using FY22 'not-met' scores as this is the first year and report year is FY22.

Sanction details

D3.VIII.5 Instances of non-compliance

24

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

11/02/2022

D3.VIII.8 Remediation date non-compliance was corrected

Not answered

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

5 / 103

D3.VIII.2 Intervention topic

EQR Compliance Review

D3.VIII.3 Plan name

Reg 5 Mid-State Health Network

D3.VIII.4 Reason for intervention

All Not Met elements within each standard of the Compliance Review requires a CAP for the SFY22 review, the PIHP was required to submit CAPs for Standards VII Provider Selection, VIII Confidentiality, IX Grievance & Appeal, XII - Health Information Systems, XIII QAPIP. MDHHS monitors implementation of the CAP through regular progress reports and remediation of the deficiencies are evaluated for completion during the 3rd year of the EQR Compliance Review cycle (SFY23). For this MCPAR, only using FY22 'not-met' scores as this is the first year and report year is FY22.

Sanction details

D3.VIII.5 Instances of non-compliance

14

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

11/02/2022

D3.VIII.8 Remediation date non-compliance was corrected

Not answered

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

6 / 103

D3.VIII.2 Intervention topic

EQR Compliance Review

D3.VIII.3 Plan name

Reg 6 CMH Partnership of Southeast MI

D3.VIII.4 Reason for intervention

All Not Met elements within each standard of the Compliance Review requires a CAP for the SFY22 review, the PIHP was required to submit CAPs for Standards VII Provider Selection, VIII Confidentiality, IX Grievance & Appeal, X Subcontractual Relationships & Delegation, XI Practice Guidelines, XII - Health Information Systems, XIII QAPIP. MDHHS monitors implementation of the CAP through regular progress reports and remediation of the deficiencies are evaluated for completion during the 3rd year of the EQR Compliance Review cycle (SFY23). For this MCPAR, only using FY22 'not-met' scores as this is the first year and report year is FY22.

Sanction details

D3.VIII.5 Instances of non-compliance

26

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

11/02/2022

D3.VIII.8 Remediation date non-compliance was corrected

Not answered

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

7 / 103

D3.VIII.2 Intervention topic

EQR Compliance Review

D3.VIII.3 Plan name

Reg 7 Detroit Wayne Integrated Health Network

D3.VIII.4 Reason for intervention

All Not Met elements within each standard of the Compliance Review requires a CAP for the SFY22 review, the PIHP was required to submit CAPs for Standards VII Provider Selection, VIII Confidentiality, IX Grievance & Appeal, X Subcontractual Relationships & Delegation, XI Practice Guidelines, XII - Health Information Systems, XIII QAPIP. MDHHS monitors implementation of the CAP through regular progress reports and remediation of the deficiencies are evaluated for completion during the 3rd year of the EQR Compliance Review cycle (SFY23). For this MCPAR, only using FY22 'not-met' scores as this is the first year and report year is FY22.

Sanction details

D3.VIII.5 Instances of non-compliance

20

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

11/02/2022

D3.VIII.8 Remediation date non-compliance was corrected

Not answered

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

8 / 103

D3.VIII.2 Intervention topic

EQR Compliance Review

D3.VIII.3 Plan name

Reg 8 Oakland Community Health Network

D3.VIII.4 Reason for intervention

All Not Met elements within each standard of the Compliance Review requires a CAP for the SFY22 review, the PIHP was required to submit CAPs for Standards VII Provider Selection, VIII Confidentiality, IX Grievance & Appeal, X Subcontractual Relationships & Delegation, XII - Health

Information Systems, XIII QAPIP. MDHHS monitors implementation of the CAP through regular progress reports and remediation of the deficiencies are evaluated for completion during the 3rd year of the EQR Compliance Review cycle (SFY23). For this MCPAR, only using FY22 'not-met' scores as this is the first year and report year is FY22.

Sanction details

D3.VIII.5 Instances of non-compliance
18

D3.VIII.6 Sanction amount
$ 0

D3.VIII.7 Date assessed
11/02/2022

D3.VIII.8 Remediation date non-compliance was corrected
Not answered

D3.VIII.9 Corrective action plan
No

Complete

D3.VIII.1 Intervention type: Corrective action plan

9 / 103

D3.VIII.2 Intervention topic
EQR Compliance Review

D3.VIII.3 Plan name
Reg 9 Macomb County CMH Services

D3.VIII.4 Reason for intervention

All Not Met elements within each standard of the Compliance Review requires a CAP for the SFY22 review, the PIHP was required to submit CAPs for Standards VII Provider Selection, VIII Confidentiality, IX Grievance & Appeal, X Subcontractual Relationships & Delegation, XI Practice Guidelines, XII - Health Information Systems, XIII QAPIP. MDHHS monitors implementation of the CAP through regular progress reports and remediation of the deficiencies are evaluated for completion during the 3rd year of the EQR Compliance Review cycle (SFY23). For this MCPAR, only using FY22 'not-met' scores as this is the first year and report year is FY22.

Sanction details

D3.VIII.5 Instances of non-compliance
30

D3.VIII.6 Sanction amount
$ 0

D3.VIII.7 Date assessed
11/02/2022

D3.VIII.8 Remediation date non-compliance was corrected
Not answered

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan 10 / 103

D3.VIII.2 Intervention topic
EQR Compliance Review

D3.VIII.3 Plan name
Region 10 PIHP

D3.VIII.4 Reason for intervention

All Not Met elements within each standard of the Compliance Review requires a CAP for the SFY22 review, the PIHP was required to submit CAPs for Standards VII Provider Selection, VIII Confidentiality, IX Grievance & Appeal, XII - Health Information Systems, XIII QAPIP. MDHHS monitors implementation of the CAP through regular progress reports and remediation of the deficiencies are evaluated for completion during the 3rd year of the EQR Compliance Review cycle (SFY23). For this MCPAR, only using FY22 'not-met' scores as this is the first year and report year is FY22.

Sanction details

D3.VIII.5 Instances of non-compliance
15

D3.VIII.6 Sanction amount
$ 0

D3.VIII.7 Date assessed
11/02/2022

D3.VIII.8 Remediation date non-compliance was corrected
Not answered

D3.VIII.9 Corrective action plan
No

Complete

D3.VIII.1 Intervention type: Corrective action plan 11 / 103

D3.VIII.2 Intervention topic
Performance Improvement

D3.VIII.3 Plan name
Reg 6 CMH Partnership of Southeast MI

D3.VIII.4 Reason for intervention

Follow up site review from May-August 2022 to review implementation status and effectiveness of CAPs for the HSW submitted to MDHHS as a result of initial site visit in Fall 2021. Lack of remediation/sufficient remediation was noted in CWP (P.1.2) and HSW (B.2 and Q.2.4). Being referred to contracts for further review and follow-up.

Sanction details

D3.VIII.5 Instances of non-compliance

3

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

08/31/2022

D3.VIII.8 Remediation date non-compliance was corrected

Not answered

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

12 / 103

D3.VIII.2 Intervention topic

Timely access

D3.VIII.3 Plan name

Reg 1 NorthCare

D3.VIII.4 Reason for intervention

Systemic Issue with Copper Country CMH and a lack of home-based providers for children, youth, and families.

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

05/23/2022

D3.VIII.8 Remediation date non-compliance was corrected

Not answered

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

13 / 103

D3.VIII.2 Intervention topic

Performance Improvement

D3.VIII.3 Plan name

Reg 2 Northern MI Regional Entity

D3.VIII.4 Reason for intervention

Northern Lakes CMH, Lack of compliance with Children's Waiver Program (CWP) requirements.

Sanction details

D3.VIII.5 Instances of non-compliance
3

D3.VIII.6 Sanction amount
$ 0

D3.VIII.7 Date assessed
08/28/2022

D3.VIII.8 Remediation date non-compliance was corrected
02/28/2023

D3.VIII.9 Corrective action plan
Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

14 / 103

D3.VIII.2 Intervention topic
Timely access

D3.VIII.3 Plan name
Reg 2 Northern MI Regional Entity

D3.VIII.4 Reason for intervention

Northern Lakes CMH, Inappropriate MIChoice Waiver referrals.

Sanction details

D3.VIII.5 Instances of non-compliance
4

D3.VIII.6 Sanction amount
$ 0

D3.VIII.7 Date assessed
07/25/2022

D3.VIII.8 Remediation date non-compliance was corrected
Not answered

D3.VIII.9 Corrective action plan
Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

15 / 103

D3.VIII.2 Intervention topic
Reporting

D3.VIII.3 Plan name
Reg 3 Lakeshore Regional Entity

D3.VIII.4 Reason for intervention

Systemic non-compliance of timely financial reporting, EQI & FSR reports.

Sanction details

D3.VIII.5 Instances of non-compliance
3

D3.VIII.6 Sanction amount
$ 0

D3.VIII.7 Date assessed
08/25/2022

D3.VIII.8 Remediation date non-compliance was corrected
Not answered

D3.VIII.9 Corrective action plan
Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

16 / 103

D3.VIII.2 Intervention topic
Reporting

D3.VIII.3 Plan name
Reg 3 Lakeshore Regional Entity

D3.VIII.4 Reason for intervention

Failure to submit single audit & compliance exam by June 30, 2022.

Sanction details

D3.VIII.5 Instances of non-compliance
1

D3.VIII.6 Sanction amount
$ 0

D3.VIII.7 Date assessed
07/01/2022

D3.VIII.8 Remediation date non-compliance was corrected
Not answered

D3.VIII.9 Corrective action plan
No

Complete

D3.VIII.1 Intervention type: Corrective action plan

17 / 103

D3.VIII.2 Intervention topic
Performance management

D3.VIII.3 Plan name
Reg 3 Lakeshore Regional Entity

D3.VIII.4 Reason for intervention

Waiting List for ABA Services at Network180

Sanction details

D3.VIII.5 Instances of non-compliance
50

D3.VIII.6 Sanction amount
$ 0

D3.VIII.7 Date assessed
02/16/2022

D3.VIII.8 Remediation date non-compliance was corrected
04/30/2023

D3.VIII.9 Corrective action plan
Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

18 / 103

D3.VIII.2 Intervention topic
Performance management

D3.VIII.3 Plan name
Reg 6 CMH Partnership of Southeast MI

D3.VIII.4 Reason for intervention

Credentialing Standards met prior to enrollment of the provider

Sanction details

D3.VIII.5 Instances of non-compliance
15

D3.VIII.6 Sanction amount
$ 0

D3.VIII.7 Date assessed
10/18/2001

D3.VIII.8 Remediation date non-compliance was corrected
Not answered

D3.VIII.9 Corrective action plan
Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

19 / 103

D3.VIII.2 Intervention topic
Performance management

D3.VIII.3 Plan name
Reg 5 Mid-State Health Network

D3.VIII.4 Reason for intervention

The IPOS is developed through a person-centered planning process consistent with Family Driven, Youth Guided Practice, etc.

Sanction details

D3.VIII.5 Instances of non-compliance

13

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

06/13/2022

D3.VIII.8 Remediation date non-compliance was corrected

Not answered

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

20 / 103

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

Reg 5 Mid-State Health Network

D3.VIII.4 Reason for intervention

Claims are coded in accordance with MDCH policies and procedures - Respite reflected in Plan as H0045, CLS being provided/invoiced in facility-based location (not allowed under CWP).

Sanction details

D3.VIII.5 Instances of non-compliance

4

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

06/13/2022

D3.VIII.8 Remediation date non-compliance was corrected

Not answered

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

21 / 103

D3.VIII.2 Intervention topic

D3.VIII.3 Plan name

Performance management	Reg 5 Mid-State Health Network

D3.VIII.4 Reason for intervention

IPOS is modified in response to changes in the individual's needs.

Sanction details

D3.VIII.5 Instances of non-compliance

15

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

06/13/2022

D3.VIII.8 Remediation date non-compliance was corrected

Not answered

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

22 / 103

D3.VIII.2 Intervention topic	D3.VIII.3 Plan name
Performance management	Reg 5 Mid-State Health Network

D3.VIII.4 Reason for intervention

IPOS has been developed in accordance with policies and procedures established by MDHHS.

Sanction details

D3.VIII.5 Instances of non-compliance

38

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

06/13/2022

D3.VIII.8 Remediation date non-compliance was corrected

Not answered

D3.VIII.9 Corrective action plan

Yes

D3.VIII.1 Intervention type: Corrective action plan

23 / 103

Complete

D3.VIII.2 Intervention topic
Performance management

D3.VIII.3 Plan name
Reg 5 Mid-State Health Network

D3.VIII.4 Reason for intervention

Service and supports identified in IPOS address individual's needs - CLS/Respite assessed as needed, not reflected in Plan.

Sanction details

D3.VIII.5 Instances of non-compliance
36

D3.VIII.6 Sanction amount
$ 0

D3.VIII.7 Date assessed
06/13/2022

D3.VIII.8 Remediation date non-compliance was corrected
Not answered

D3.VIII.9 Corrective action plan
Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

24 / 103

D3.VIII.2 Intervention topic
Performance management

D3.VIII.3 Plan name
Reg 5 Mid-State Health Network

D3.VIII.4 Reason for intervention

Lack of Coordination of Care letter with primary care physician. Lack of Coordination of Care letter with primary care physician (will need to include psychotropic meds prescribed by BABH) and lack of medication consent.

Sanction details

D3.VIII.5 Instances of non-compliance
4

D3.VIII.6 Sanction amount
$ 0

D3.VIII.7 Date assessed
06/13/2022

D3.VIII.8 Remediation date non-compliance was corrected
Not answered

D3.VIII.9 Corrective action plan
Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

25 / 103

D3.VIII.2 Intervention topic

Performance management

D3.VIII.3 Plan name

Reg 5 Mid-State Health Network

D3.VIII.4 Reason for intervention

Services and treatment identified in the IPOS are provided as specified in the plan.

Sanction details

D3.VIII.5 Instances of non-compliance

44

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

06/13/2022

D3.VIII.8 Remediation date non-compliance was corrected

Not answered

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

26 / 103

D3.VIII.2 Intervention topic

Performance management

D3.VIII.3 Plan name

Reg 5 Mid-State Health Network

D3.VIII.4 Reason for intervention

The strategies identified in the IPOS are adequate to address assessed health and safety needs.

Sanction details

D3.VIII.5 Instances of non-compliance

25

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

06/13/2022

D3.VIII.8 Remediation date non-compliance was corrected

Not answered

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan 27 / 103

D3.VIII.2 Intervention topic
Performance management

D3.VIII.3 Plan name
Reg 5 Mid-State Health Network

D3.VIII.4 Reason for intervention

Providers meet staff training requirements.

Sanction details

D3.VIII.5 Instances of non-compliance
75

D3.VIII.6 Sanction amount
$ 0

D3.VIII.7 Date assessed
06/13/2022

D3.VIII.8 Remediation date non-compliance was corrected
Not answered

D3.VIII.9 Corrective action plan
Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan 28 / 103

D3.VIII.2 Intervention topic
Performance management

D3.VIII.3 Plan name
Reg 5 Mid-State Health Network

D3.VIII.4 Reason for intervention

Credentialing Standards met prior to enrollment of the provider.

Sanction details

D3.VIII.5 Instances of non-compliance
16

D3.VIII.6 Sanction amount
$ 0

D3.VIII.7 Date assessed
06/13/2022

D3.VIII.8 Remediation date non-compliance was corrected
Not answered

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

29 / 103

D3.VIII.2 Intervention topic

Performance management

D3.VIII.3 Plan name

Reg 6 CMH Partnership of Southeast MI

D3.VIII.4 Reason for intervention

No habilitative goal/service reflected in the Plan.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

06/05/2022

D3.VIII.8 Remediation date non-compliance was corrected

Not answered

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

30 / 103

D3.VIII.2 Intervention topic

Performance management

D3.VIII.3 Plan name

Reg 6 CMH Partnership of Southeast MI

D3.VIII.4 Reason for intervention

PRN meds prescribed for behavioral control/mgt, with no BTPRC oversight/ involvement found in record.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

D3.VIII.8 Remediation date non-compliance was corrected

05/25/2022

Not answered

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

31 / 103

D3.VIII.2 Intervention topic

Performance management

D3.VIII.3 Plan name

Reg 6 CMH Partnership of Southeast MI

D3.VIII.4 Reason for intervention

Providers meet staff training requirements

Sanction details

D3.VIII.5 Instances of non-compliance

7

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

10/18/2001

D3.VIII.8 Remediation date non-compliance was corrected

Not answered

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

32 / 103

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

Reg 3 Lakeshore Regional Entity

D3.VIII.4 Reason for intervention

Due to changes in reporting processes, several control issues were identified that impacted quality and timely submissions. Some of the control issues were related to individual CMHSP system changes and others were related to process changes designed to ensure compliance with all financial reporting requirements.

Sanction details

D3.VIII.5 Instances of non-compliance

D3.VIII.6 Sanction amount

1

$ 0

D3.VIII.7 Date assessed

02/28/2022

D3.VIII.8 Remediation date non-compliance was corrected

04/15/2022

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

33 / 103

D3.VIII.2 Intervention topic

Contract Compliance

D3.VIII.3 Plan name

Reg 3 Lakeshore Regional Entity

D3.VIII.4 Reason for intervention

Non-compliance of timely financial reporting, EQI & FSR reports.

Sanction details

D3.VIII.5 Instances of non-compliance

5

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

08/04/2022

D3.VIII.8 Remediation date non-compliance was corrected

Not answered

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

34 / 103

D3.VIII.2 Intervention topic

Performance management

D3.VIII.3 Plan name

Reg 5 Mid-State Health Network

D3.VIII.4 Reason for intervention

Non Licensed providers meet provider qualifications identified in the Medicaid Provider Manual.

Sanction details

D3.VIII.5 Instances of non-compliance

64

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

06/13/2022

D3.VIII.8 Remediation date non-compliance was corrected

Not answered

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

35 / 103

D3.VIII.2 Intervention topic

Performance management

D3.VIII.3 Plan name

Reg 5 Mid-State Health Network

D3.VIII.4 Reason for intervention

Credentialing Standards continue to be met after formal enrollment of the provider.

Sanction details

D3.VIII.5 Instances of non-compliance

18

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

06/13/2022

D3.VIII.8 Remediation date non-compliance was corrected

Not answered

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

36 / 103

D3.VIII.2 Intervention topic

Performance management

D3.VIII.3 Plan name

Reg 5 Mid-State Health Network

D3.VIII.4 Reason for intervention

The IPOS for individuals enrolled in waiver updated within 365 days of their last IPOS.

Sanction details

D3.VIII.5 Instances of non-compliance
2

D3.VIII.6 Sanction amount
$ 0

D3.VIII.7 Date assessed
06/13/2022

D3.VIII.8 Remediation date non-compliance was corrected
Not answered

D3.VIII.9 Corrective action plan
Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

37 / 103

D3.VIII.2 Intervention topic
Performance management

D3.VIII.3 Plan name
Reg 5 Mid-State Health Network

D3.VIII.4 Reason for intervention

Individual provided information/education on how to report abuse/neglect/exploitation and other critical incidents.

Sanction details

D3.VIII.5 Instances of non-compliance
2

D3.VIII.6 Sanction amount
$ 0

D3.VIII.7 Date assessed
06/13/2022

D3.VIII.8 Remediation date non-compliance was corrected
Not answered

D3.VIII.9 Corrective action plan
No

Complete

D3.VIII.1 Intervention type: Corrective action plan

38 / 103

D3.VIII.2 Intervention topic

D3.VIII.3 Plan name
Reg 5 Mid-State Health Network

Performance management

D3.VIII.4 Reason for intervention

Individual served received health care appraisal.

Sanction details

D3.VIII.5 Instances of non-compliance

3

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

06/13/2022

D3.VIII.8 Remediation date non-compliance was corrected

Not answered

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

39 / 103

D3.VIII.2 Intervention topic

Performance management

D3.VIII.3 Plan name

Reg 5 Mid-State Health Network

D3.VIII.4 Reason for intervention

BTP are developed in accordance with the Technical Requirement for BTPRC.

Sanction details

D3.VIII.5 Instances of non-compliance

3

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

06/13/2022

D3.VIII.8 Remediation date non-compliance was corrected

Not answered

D3.VIII.9 Corrective action plan

No

D3.VIII.1 Intervention type: Corrective action plan

40 / 103

Complete

D3.VIII.2 Intervention topic
Performance management

D3.VIII.3 Plan name
Reg 5 Mid-State Health Network

D3.VIII.4 Reason for intervention

Person-centered planning addressed individual's goals, interests and desires.

Sanction details

D3.VIII.5 Instances of non-compliance
6

D3.VIII.6 Sanction amount
$ 0

D3.VIII.7 Date assessed
06/13/2022

D3.VIII.8 Remediation date non-compliance was corrected
Not answered

D3.VIII.9 Corrective action plan
No

Complete

D3.VIII.1 Intervention type: Corrective action plan

41 / 103

D3.VIII.2 Intervention topic
Performance management

D3.VIII.3 Plan name
Reg 8 Oakland Community Health Network

D3.VIII.4 Reason for intervention

Credentialing Standards met prior to enrollment of the provider.

Sanction details

D3.VIII.5 Instances of non-compliance
1

D3.VIII.6 Sanction amount
$ 0

D3.VIII.7 Date assessed
01/18/2022

D3.VIII.8 Remediation date non-compliance was corrected
08/24/2022

D3.VIII.9 Corrective action plan
Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

42 / 103

D3.VIII.2 Intervention topic

Performance management

D3.VIII.3 Plan name

Reg 8 Oakland Community Health Network

D3.VIII.4 Reason for intervention

Credentialing Standards continue to be met after formal enrollment of the provider.

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

01/18/2022

D3.VIII.8 Remediation date non-compliance was corrected

08/24/2022

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

43 / 103

D3.VIII.2 Intervention topic

Performance management

D3.VIII.3 Plan name

Reg 8 Oakland Community Health Network

D3.VIII.4 Reason for intervention

Non Licensed providers meet provider qualifications identified in the Medicaid Provider Manual.

Sanction details

D3.VIII.5 Instances of non-compliance

15

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

01/18/2022

D3.VIII.8 Remediation date non-compliance was corrected

08/24/2022

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

44 / 103

D3.VIII.2 Intervention topic

Performance management

D3.VIII.3 Plan name

Reg 8 Oakland Community Health Network

D3.VIII.4 Reason for intervention

Providers meet staff training requirements.

Sanction details

D3.VIII.5 Instances of non-compliance

10

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

01/18/2022

D3.VIII.8 Remediation date non-compliance was corrected

08/24/2022

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

45 / 103

D3.VIII.2 Intervention topic

Performance management

D3.VIII.3 Plan name

Reg 8 Oakland Community Health Network

D3.VIII.4 Reason for intervention

Service and supports identified in IPOS address individual's needs.

Sanction details

D3.VIII.5 Instances of non-compliance

23

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

01/18/2022

D3.VIII.8 Remediation date non-compliance was corrected

08/24/2022

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

46 / 103

D3.VIII.2 Intervention topic

Performance management

D3.VIII.3 Plan name

Reg 8 Oakland Community Health Network

D3.VIII.4 Reason for intervention

Person-centered planning addressed health and safety.

Sanction details

D3.VIII.5 Instances of non-compliance

11

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

01/18/2022

D3.VIII.8 Remediation date non-compliance was corrected

08/24/2022

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

47 / 103

D3.VIII.2 Intervention topic

Performance management

D3.VIII.3 Plan name

Reg 8 Oakland Community Health Network

D3.VIII.4 Reason for intervention

Person-centered planning addressed individual's goals, interests and desires.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

D3.VIII.8 Remediation date non-compliance was corrected

01/18/2022 08/24/2022

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

48 / 103

D3.VIII.2 Intervention topic

Performance management

D3.VIII.3 Plan name

Reg 8 Oakland Community Health Network

D3.VIII.4 Reason for intervention

IPOS has been developed in accordance with policies and procedures established by MDHHS.

Sanction details

D3.VIII.5 Instances of non-compliance

33

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

01/18/2022

D3.VIII.8 Remediation date non-compliance was corrected

08/24/2022

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

49 / 103

D3.VIII.2 Intervention topic

Performance management

D3.VIII.3 Plan name

Reg 8 Oakland Community Health Network

D3.VIII.4 Reason for intervention

IPOS is modified in response to changes in the individual's needs

Sanction details

D3.VIII.5 Instances of non-compliance

3

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

01/18/2022

D3.VIII.8 Remediation date non-compliance was corrected

08/24/2022

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

50 / 103

D3.VIII.2 Intervention topic

Performance management

D3.VIII.3 Plan name

Reg 8 Oakland Community Health Network

D3.VIII.4 Reason for intervention

Services and treatment identified in the IPOS are provided as specified in the plan

Sanction details

D3.VIII.5 Instances of non-compliance

26

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

01/18/2022

D3.VIII.8 Remediation date non-compliance was corrected

08/24/2022

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

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D3.VIII.2 Intervention topic

Performance management

D3.VIII.3 Plan name

Reg 8 Oakland Community Health Network

D3.VIII.4 Reason for intervention

BTP are developed in accordance with the Technical Requirement for BTPRC

Sanction details

D3.VIII.5 Instances of non-compliance

5

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

01/18/2022

D3.VIII.8 Remediation date non-compliance was corrected

08/24/2022

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

52 / 103

D3.VIII.2 Intervention topic

Performance management

D3.VIII.3 Plan name

Reg 8 Oakland Community Health Network

D3.VIII.4 Reason for intervention

LOC evaluations that are completed accurately

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

01/18/2022

D3.VIII.8 Remediation date non-compliance was corrected

08/24/2022

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

53 / 103

D3.VIII.2 Intervention topic

Performance management

D3.VIII.3 Plan name

Reg 8 Oakland Community Health Network

D3.VIII.4 Reason for intervention

The IPOS is developed through a person-centered planning process consistent with Family Driven, Youth Guided Practice, etc

Sanction details

D3.VIII.5 Instances of non-compliance
4

D3.VIII.6 Sanction amount
$ 0

D3.VIII.7 Date assessed
01/18/2022

D3.VIII.8 Remediation date non-compliance was corrected
08/24/2022

D3.VIII.9 Corrective action plan
No

Complete

D3.VIII.1 Intervention type: Corrective action plan

54 / 103

D3.VIII.2 Intervention topic
Performance management

D3.VIII.3 Plan name
Reg 7 Detroit Wayne Integrated Health Network

D3.VIII.4 Reason for intervention

LOC evaluations that are completed accurately

Sanction details

D3.VIII.5 Instances of non-compliance
2

D3.VIII.6 Sanction amount
$ 0

D3.VIII.7 Date assessed
03/14/2022

D3.VIII.8 Remediation date non-compliance was corrected
11/04/2022

D3.VIII.9 Corrective action plan
Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

55 / 103

D3.VIII.2 Intervention topic
Performance management

D3.VIII.3 Plan name
Reg 7 Detroit Wayne Integrated Health Network

D3.VIII.4 Reason for intervention

Claims are coded in accordance with MDCH policies and procedures

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

03/14/2022

D3.VIII.8 Remediation date non-compliance was corrected

11/04/2022

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

56 / 103

D3.VIII.2 Intervention topic

Performance management

D3.VIII.3 Plan name

Reg 7 Detroit Wayne Integrated Health Network

D3.VIII.4 Reason for intervention

Credentialing Standards met prior to enrollment of the provider

Sanction details

D3.VIII.5 Instances of non-compliance

4

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

03/14/2022

D3.VIII.8 Remediation date non-compliance was corrected

11/04/2022

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

57 / 103

D3.VIII.2 Intervention topic

Performance management

D3.VIII.3 Plan name

Reg 7 Detroit Wayne Integrated Health Network

D3.VIII.4 Reason for intervention

Credentialing Standards continue to be met after formal enrollment of the provider

Sanction details

D3.VIII.5 Instances of non-compliance

5

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

03/14/2022

D3.VIII.8 Remediation date non-compliance was corrected

11/04/2022

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

58 / 103

D3.VIII.2 Intervention topic

Performance management

D3.VIII.3 Plan name

Reg 7 Detroit Wayne Integrated Health Network

D3.VIII.4 Reason for intervention

Non Licensed providers meet provider qualifications identified in the Medicaid Provider Manual

Sanction details

D3.VIII.5 Instances of non-compliance

6

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

03/14/2022

D3.VIII.8 Remediation date non-compliance was corrected

11/04/2022

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

59 / 103

D3.VIII.2 Intervention topic

D3.VIII.3 Plan name

Reg 7 Detroit Wayne Integrated Health Network

Performance management

D3.VIII.4 Reason for intervention

Providers meet staff training requirements

Sanction details

D3.VIII.5 Instances of non-compliance

32

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

03/14/2022

D3.VIII.8 Remediation date non-compliance was corrected

11/04/2022

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

60 / 103

D3.VIII.2 Intervention topic

Performance management

D3.VIII.3 Plan name

Reg 7 Detroit Wayne Integrated Health Network

D3.VIII.4 Reason for intervention

Service and supports identified in IPOS address individual's needs

Sanction details

D3.VIII.5 Instances of non-compliance

31

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

03/14/2022

D3.VIII.8 Remediation date non-compliance was corrected

11/04/2022

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

61 / 103

D3.VIII.2 Intervention topic

Performance management

D3.VIII.3 Plan name

Reg 7 Detroit Wayne Integrated Health Network

D3.VIII.4 Reason for intervention

The strategies identified in the IPOS are adequate to address assessed health and safety needs

Sanction details

D3.VIII.5 Instances of non-compliance

15

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

03/14/2022

D3.VIII.8 Remediation date non-compliance was corrected

11/04/2022

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

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D3.VIII.2 Intervention topic

Performance management

D3.VIII.3 Plan name

Reg 7 Detroit Wayne Integrated Health Network

D3.VIII.4 Reason for intervention

The IPOS is developed through a person-centered planning process consistent with Family Driven, Youth Guided Practice, etc

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

03/14/2022

D3.VIII.8 Remediation date non-compliance was corrected

11/04/2022

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

63 / 103

D3.VIII.2 Intervention topic

Performance management

D3.VIII.3 Plan name

Reg 7 Detroit Wayne Integrated Health Network

D3.VIII.4 Reason for intervention

IPOS has been developed in accordance with policies and procedures established by MDHHS

Sanction details

D3.VIII.5 Instances of non-compliance

15

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

03/14/2022

D3.VIII.8 Remediation date non-compliance was corrected

11/04/2022

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

64 / 103

D3.VIII.2 Intervention topic

Performance management

D3.VIII.3 Plan name

Reg 7 Detroit Wayne Integrated Health Network

D3.VIII.4 Reason for intervention

IPOS is modified in response to changes in the individual's needs

Sanction details

D3.VIII.5 Instances of non-compliance

17

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

03/14/2022

D3.VIII.8 Remediation date non-compliance was corrected

11/04/2022

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan 65 / 103

D3.VIII.2 Intervention topic
Performance management

D3.VIII.3 Plan name
Reg 7 Detroit Wayne Integrated Health Network

D3.VIII.4 Reason for intervention

Services and treatment identified in the IPOS are provided as specified in the plan

Sanction details

D3.VIII.5 Instances of non-compliance
35

D3.VIII.6 Sanction amount
$ 0

D3.VIII.7 Date assessed
03/14/2022

D3.VIII.8 Remediation date non-compliance was corrected
11/04/2022

D3.VIII.9 Corrective action plan
Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan 66 / 103

D3.VIII.2 Intervention topic
Performance management

D3.VIII.3 Plan name
Reg 7 Detroit Wayne Integrated Health Network

D3.VIII.4 Reason for intervention

Individual provided information/education on how to report abuse/neglect/exploitation and other critical incidents.

Sanction details

D3.VIII.5 Instances of non-compliance
3

D3.VIII.6 Sanction amount
$ 0

D3.VIII.7 Date assessed

D3.VIII.8 Remediation date non-compliance was corrected

03/14/2022 11/04/2022

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

67 / 103

D3.VIII.2 Intervention topic

Performance management

D3.VIII.3 Plan name

Reg 7 Detroit Wayne Integrated Health Network

D3.VIII.4 Reason for intervention

Individual served received health care appraisal.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

03/14/2022

D3.VIII.8 Remediation date non-compliance was corrected

11/04/2022

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

68 / 103

D3.VIII.2 Intervention topic

Performance management

D3.VIII.3 Plan name

Reg 7 Detroit Wayne Integrated Health Network

D3.VIII.4 Reason for intervention

BTP are developed in accordance with the Technical Requirement for BTPRC

Sanction details

D3.VIII.5 Instances of non-compliance

13

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

03/14/2022

D3.VIII.8 Remediation date non-compliance was corrected

11/04/2022

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

69 / 103

D3.VIII.2 Intervention topic

Performance management

D3.VIII.3 Plan name

Reg 7 Detroit Wayne Integrated Health Network

D3.VIII.4 Reason for intervention

Individual had an ability to choose among various waiver services (approved HSW services only)

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

03/14/2022

D3.VIII.8 Remediation date non-compliance was corrected

11/04/2022

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

70 / 103

D3.VIII.2 Intervention topic

Performance management

D3.VIII.3 Plan name

Reg 7 Detroit Wayne Integrated Health Network

D3.VIII.4 Reason for intervention

Individual had the ability to choose their providers of HSW services (HSW provider only)

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

03/14/2022

D3.VIII.8 Remediation date non-compliance was corrected

11/04/2022

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

71 / 103

D3.VIII.2 Intervention topic

Performance management

D3.VIII.3 Plan name

Reg 7 Detroit Wayne Integrated Health Network

D3.VIII.4 Reason for intervention

Person-centered planning addressed individual's goals, interests and desires

Sanction details

D3.VIII.5 Instances of non-compliance

6

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

03/14/2022

D3.VIII.8 Remediation date non-compliance was corrected

11/04/2022

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

72 / 103

D3.VIII.2 Intervention topic

Performance management

D3.VIII.3 Plan name

Region 10 PIHP

D3.VIII.4 Reason for intervention

Claims are coded in accordance with MDCH policies and procedures

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

08/15/2022

D3.VIII.8 Remediation date non-compliance was corrected

03/23/2023

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

73 / 103

D3.VIII.2 Intervention topic

Performance management

D3.VIII.3 Plan name

Region 10 PIHP

D3.VIII.4 Reason for intervention

Credentialing Standards met prior to enrollment of the provider

Sanction details

D3.VIII.5 Instances of non-compliance

8

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

08/15/2022

D3.VIII.8 Remediation date non-compliance was corrected

03/15/2023

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

74 / 103

D3.VIII.2 Intervention topic

Performance management

D3.VIII.3 Plan name

Region 10 PIHP

D3.VIII.4 Reason for intervention

Credentialing Standards continue to be met after formal enrollment of the provider

Sanction details

D3.VIII.5 Instances of non-compliance
9

D3.VIII.6 Sanction amount
$ 0

D3.VIII.7 Date assessed
08/15/2022

D3.VIII.8 Remediation date non-compliance was corrected
03/15/2023

D3.VIII.9 Corrective action plan
No

Error

D3.VIII.1 Intervention type: Corrective action plan

75 / 103

D3.VIII.2 Intervention topic
Performance management

D3.VIII.3 Plan name
Region 10 PIHP

D3.VIII.4 Reason for intervention

Non Licensed providers meet provider qualifications identified in the Medicaid Provider Manual

Sanction details

D3.VIII.5 Instances of non-compliance
Not answered

D3.VIII.6 Sanction amount
$ Not answered

D3.VIII.7 Date assessed
Not answered

D3.VIII.8 Remediation date non-compliance was corrected
Not answered

D3.VIII.9 Corrective action plan
Not answered

Complete

D3.VIII.1 Intervention type: Corrective action plan

76 / 103

D3.VIII.2 Intervention topic

D3.VIII.3 Plan name
Region 10 PIHP

Performance management

D3.VIII.4 Reason for intervention

Providers meet staff training requirements

Sanction details

D3.VIII.5 Instances of non-compliance

17

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

08/15/2022

D3.VIII.8 Remediation date non-compliance was corrected

03/15/2023

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

77 / 103

D3.VIII.2 Intervention topic

Performance management

D3.VIII.3 Plan name

Region 10 PIHP

D3.VIII.4 Reason for intervention

Service and supports identified in IPOS address individual's needs

Sanction details

D3.VIII.5 Instances of non-compliance

17

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

08/15/2022

D3.VIII.8 Remediation date non-compliance was corrected

03/15/2023

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

78 / 103

D3.VIII.2 Intervention topic

Performance management

D3.VIII.3 Plan name

Region 10 PIHP

D3.VIII.4 Reason for intervention

The strategies identified in the IPOS are adequate to address assessed health an safety needs

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

08/15/2022

D3.VIII.8 Remediation date non-compliance was corrected

03/15/2023

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

79 / 103

D3.VIII.2 Intervention topic

Performance management

D3.VIII.3 Plan name

Region 10 PIHP

D3.VIII.4 Reason for intervention

The IPOS is developed through a person-centered planning process consistent with Family Driven, Youth Guided Practice, etc

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

08/15/2022

D3.VIII.8 Remediation date non-compliance was corrected

03/15/2023

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan 80 / 103

D3.VIII.2 Intervention topic
Performance management

D3.VIII.3 Plan name
Region 10 PIHP

D3.VIII.4 Reason for intervention

IPOS has been developed in accordance with policies and procedures established by MDHHS

Sanction details

D3.VIII.5 Instances of non-compliance
9

D3.VIII.6 Sanction amount
$ 0

D3.VIII.7 Date assessed
08/15/2022

D3.VIII.8 Remediation date non-compliance was corrected
03/15/2023

D3.VIII.9 Corrective action plan
No

Complete

D3.VIII.1 Intervention type: Corrective action plan 81 / 103

D3.VIII.2 Intervention topic
Performance management

D3.VIII.3 Plan name
Region 10 PIHP

D3.VIII.4 Reason for intervention

IPOS is modified in response to changes in the individual's needs

Sanction details

D3.VIII.5 Instances of non-compliance
3

D3.VIII.6 Sanction amount
$ 0

D3.VIII.7 Date assessed
08/15/2022

D3.VIII.8 Remediation date non-compliance was corrected
03/15/2023

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan 82 / 103

D3.VIII.2 Intervention topic
Performance management

D3.VIII.3 Plan name
Region 10 PIHP

D3.VIII.4 Reason for intervention

Services and treatment identified in the IPOS are provided as specified in the plan

Sanction details

D3.VIII.5 Instances of non-compliance
14

D3.VIII.6 Sanction amount
$ 0

D3.VIII.7 Date assessed
08/15/2022

D3.VIII.8 Remediation date non-compliance was corrected
03/15/2023

D3.VIII.9 Corrective action plan
No

Complete

D3.VIII.1 Intervention type: Corrective action plan 83 / 103

D3.VIII.2 Intervention topic
Performance management

D3.VIII.3 Plan name
Region 10 PIHP

D3.VIII.4 Reason for intervention

BTP are developed in accordance with the Technical Requirement for BTPRC

Sanction details

D3.VIII.5 Instances of non-compliance
4

D3.VIII.6 Sanction amount
$ 0

D3.VIII.7 Date assessed
08/15/2022

D3.VIII.8 Remediation date non-compliance was corrected
03/15/2023

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

84 / 103

D3.VIII.2 Intervention topic

Performance management

D3.VIII.3 Plan name

Region 10 PIHP

D3.VIII.4 Reason for intervention

Individual had an ability to choose among various waiver services (approved HSW services only)

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

08/15/2022

D3.VIII.8 Remediation date non-compliance was corrected

03/15/2023

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

85 / 103

D3.VIII.2 Intervention topic

Performance management

D3.VIII.3 Plan name

Region 10 PIHP

D3.VIII.4 Reason for intervention

Individual had the ability to choose their providers of HSW services (HSW provider only)

Sanction details

D3.VIII.5 Instances of non-compliance

4

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

08/15/2022

D3.VIII.8 Remediation date non-compliance was corrected

03/15/2023

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

86 / 103

D3.VIII.2 Intervention topic

Performance management

D3.VIII.3 Plan name

Reg 6 CMH Partnership of Southeast MI

D3.VIII.4 Reason for intervention

Credentialing Standards continue to be met after formal enrollment of the provider

Sanction details

D3.VIII.5 Instances of non-compliance

12

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

10/18/2001

D3.VIII.8 Remediation date non-compliance was corrected

Not answered

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

87 / 103

D3.VIII.2 Intervention topic

Performance management

D3.VIII.3 Plan name

Reg 6 CMH Partnership of Southeast MI

D3.VIII.4 Reason for intervention

Non Licensed providers meet provider qualifications identified in the Medicaid Provider Manual

Sanction details

D3.VIII.5 Instances of non-compliance

14

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

10/18/2001

D3.VIII.8 Remediation date non-compliance was corrected

Not answered

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

88 / 103

D3.VIII.2 Intervention topic

Performance management

D3.VIII.3 Plan name

Reg 6 CMH Partnership of Southeast MI

D3.VIII.4 Reason for intervention

Service and supports identified in IPOS address individual's needs

Sanction details

D3.VIII.5 Instances of non-compliance

23

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

10/18/2001

D3.VIII.8 Remediation date non-compliance was corrected

Not answered

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

89 / 103

D3.VIII.2 Intervention topic

Performance management

D3.VIII.3 Plan name

Reg 6 CMH Partnership of Southeast MI

D3.VIII.4 Reason for intervention

Person-centered planning addressed health and safety

Sanction details

D3.VIII.5 Instances of non-compliance

15

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

10/18/2001

D3.VIII.8 Remediation date non-compliance was corrected

Not answered

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

90 / 103

D3.VIII.2 Intervention topic

Performance management

D3.VIII.3 Plan name

Reg 6 CMH Partnership of Southeast MI

D3.VIII.4 Reason for intervention

Person-centered planning addressed individual's goals, interests and desires

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

10/18/2001

D3.VIII.8 Remediation date non-compliance was corrected

Not answered

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

91 / 103

D3.VIII.2 Intervention topic

Performance management

D3.VIII.3 Plan name

Reg 6 CMH Partnership of Southeast MI

D3.VIII.4 Reason for intervention

IPOS has been developed in accordance with policies and procedures established by MDHHS

Sanction details

D3.VIII.5 Instances of non-compliance

13

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

10/18/2001

D3.VIII.8 Remediation date non-compliance was corrected

Not answered

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

92 / 103

D3.VIII.2 Intervention topic

Performance management

D3.VIII.3 Plan name

Reg 6 CMH Partnership of Southeast MI

D3.VIII.4 Reason for intervention

IPOS is modified in response to changes in the individual's needs

Sanction details

D3.VIII.5 Instances of non-compliance

9

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

10/18/2001

D3.VIII.8 Remediation date non-compliance was corrected

Not answered

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

93 / 103

D3.VIII.2 Intervention topic

Performance management

D3.VIII.3 Plan name

Reg 6 CMH Partnership of Southeast MI

D3.VIII.4 Reason for intervention

Services and treatment identified in the IPOS are provided as specified in the plan

Sanction details

D3.VIII.5 Instances of non-compliance

21

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

10/18/2001

D3.VIII.8 Remediation date non-compliance was corrected

Not answered

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

94 / 103

D3.VIII.2 Intervention topic

Performance management

D3.VIII.3 Plan name

Reg 6 CMH Partnership of Southeast MI

D3.VIII.4 Reason for intervention

Individual provided information/education on how to report abuse/neglect/exploitation and other critical incidents

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

10/18/2001

D3.VIII.8 Remediation date non-compliance was corrected

Not answered

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

95 / 103

D3.VIII.2 Intervention topic

D3.VIII.3 Plan name

Performance management	Reg 6 CMH Partnership of Southeast MI

D3.VIII.4 Reason for intervention

Individual served received health care appraisal

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

10/18/2001

D3.VIII.8 Remediation date non-compliance was corrected

Not answered

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

96 / 103

D3.VIII.2 Intervention topic	D3.VIII.3 Plan name
Performance management	Reg 6 CMH Partnership of Southeast MI

D3.VIII.4 Reason for intervention

BTP are developed in accordance with the Technical Requirement for BTPRC

Sanction details

D3.VIII.5 Instances of non-compliance

10

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

10/18/2001

D3.VIII.8 Remediation date non-compliance was corrected

Not answered

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

97 / 103

D3.VIII.2 Intervention topic

Performance management

D3.VIII.3 Plan name

Reg 6 CMH Partnership of Southeast MI

D3.VIII.4 Reason for intervention

LOC evaluations that are completed accurately

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

10/18/2001

D3.VIII.8 Remediation date non-compliance was corrected

Not answered

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

98 / 103

D3.VIII.2 Intervention topic

Performance management

D3.VIII.3 Plan name

Reg 6 CMH Partnership of Southeast MI

D3.VIII.4 Reason for intervention

Claims are coded in accordance with MDHHS policies and procedures

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

10/18/2001

D3.VIII.8 Remediation date non-compliance was corrected

Not answered

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

99 / 103

D3.VIII.2 Intervention topic

Performance management

D3.VIII.3 Plan name

Reg 6 CMH Partnership of Southeast MI

D3.VIII.4 Reason for intervention

Family or legal guardian informed of their right to choose among the various waiver services

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

10/18/2001

D3.VIII.8 Remediation date non-compliance was corrected

Not answered

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

100 / 103

D3.VIII.2 Intervention topic

Performance management

D3.VIII.3 Plan name

Reg 6 CMH Partnership of Southeast MI

D3.VIII.4 Reason for intervention

The person-centered planning process builds upon the individual's capacity to engage in activities that promote community life.

Sanction details

D3.VIII.5 Instances of non-compliance

3

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

10/18/2001

D3.VIII.8 Remediation date non-compliance was corrected

Not answered

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

101 / 103

D3.VIII.2 Intervention topic

Performance management

D3.VIII.3 Plan name

Reg 6 CMH Partnership of Southeast MI

D3.VIII.4 Reason for intervention

Individuals are provided with ongoing opportunities to provide feedback on how they feel about services, supports and/or treatment they are receiving, and their progress towards attaining valued outcomes.

Sanction details

D3.VIII.5 Instances of non-compliance

3

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

10/18/2001

D3.VIII.8 Remediation date non-compliance was corrected

Not answered

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

102 / 103

D3.VIII.2 Intervention topic

Performance management

D3.VIII.3 Plan name

Reg 6 CMH Partnership of Southeast MI

D3.VIII.4 Reason for intervention

Services requiring physician signed prescription follow Medicaid Provider Manual requirements. (Evidence: Physician-signed prescriptions for OT and PDN services are in the file and include a date, diagnosis, specific service, or item description, start date and the amount or length of time the service is needed).

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

10/18/2001

D3.VIII.8 Remediation date non-compliance was corrected

Not answered

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

103 / 103

D3.VIII.2 Intervention topic

Performance management

D3.VIII.3 Plan name

Reg 6 CMH Partnership of Southeast MI

D3.VIII.4 Reason for intervention

Family was informed of their right to choose amount providers

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$ 0

D3.VIII.7 Date assessed

10/18/2001

D3.VIII.8 Remediation date non-compliance was corrected

Not answered

D3.VIII.9 Corrective action plan

No

Topic X. Program Integrity

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1.X.1	**Dedicated program integrity staff**	**Reg 1 NorthCare** 1

Number	Indicator	Response
	Report or enter the number of dedicated program integrity staff for routine internal monitoring and compliance risks. Refer to 42 CFR 438.608(a)(1)(vii).	**Reg 2 Northern MI Regional Entity** 6 **Reg 3 Lakeshore Regional Entity** 3 **Reg 4 South West Michigan Behavioral Health** 3 **Reg 5 Mid-State Health Network** 13 **Reg 6 CMH Partnership of Southeast MI** 5 **Reg 7 Detroit Wayne Integrated Health Network** 25 **Reg 8 Oakland Community Health Network** 4 **Reg 9 Macomb County CMH Services** 1 **Region 10 PIHP** 49
D1.X.2	**Count of opened program integrity investigations** How many program integrity investigations have been opened by the plan in the past year?	**Reg 1 NorthCare** 46 **Reg 2 Northern MI Regional Entity** 33 **Reg 3 Lakeshore Regional Entity** 34 **Reg 4 South West Michigan Behavioral Health** 680 **Reg 5 Mid-State Health Network** 118 **Reg 6 CMH Partnership of Southeast MI**

Number	Indicator	Response
		63 **Reg 7 Detroit Wayne Integrated Health Network** 10 **Reg 8 Oakland Community Health Network** 13 **Reg 9 Macomb County CMH Services** 159 **Region 10 PIHP** 126
D1.X.3	**Ratio of opened program integrity investigations to enrollees** What is the ratio of program integrity investigations opened by the plan in the past year per 1,000 beneficiaries enrolled in the plan on the first day of the last month of the reporting year?	**Reg 1 NorthCare** 46:80 **Reg 2 Northern MI Regional Entity** 33:121 **Reg 3 Lakeshore Regional Entity** 34:355 **Reg 4 South West Michigan Behavioral Health** 680:263 **Reg 5 Mid-State Health Network** 118:481 **Reg 6 CMH Partnership of Southeast MI** 63:150 **Reg 7 Detroit Wayne Integrated Health Network** 10:07 **Reg 8 Oakland Community Health Network** 13:13 **Reg 9 Macomb County CMH Services** 159:187 **Region 10 PIHP**

Number	Indicator	Response
		126:23
D1.X.4	**Count of resolved program integrity investigations** How many program integrity investigations have been resolved by the plan in the past year?	**Reg 1 NorthCare** 38 **Reg 2 Northern MI Regional Entity** 18 **Reg 3 Lakeshore Regional Entity** 1980 **Reg 4 South West Michigan Behavioral Health** 661 **Reg 5 Mid-State Health Network** 147 **Reg 6 CMH Partnership of Southeast MI** 77 **Reg 7 Detroit Wayne Integrated Health Network** 7 **Reg 8 Oakland Community Health Network** 18 **Reg 9 Macomb County CMH Services** 171 **Region 10 PIHP** 121
D1.X.5	**Ratio of resolved program integrity investigations to enrollees** What is the ratio of program integrity investigations resolved by the plan in the past year per 1,000 beneficiaries enrolled in the plan at the beginning of the reporting year?	**Reg 1 NorthCare** 38:76 **Reg 2 Northern MI Regional Entity** 18:139 **Reg 3 Lakeshore Regional Entity** 1980:336 **Reg 4 South West Michigan Behavioral Health**

Number	Indicator	Response
		661:263 **Reg 5 Mid-State Health Network** 147:455 **Reg 6 CMH Partnership of Southeast MI** 77:140 **Reg 7 Detroit Wayne Integrated Health Network** 7:86 **Reg 8 Oakland Community Health Network** 18:13 **Reg 9 Macomb County CMH Services** 171:180 **Region 10 PIHP** 121:16
D1.X.6	**Referral path for program integrity referrals to the state** What is the referral path that the plan uses to make program integrity referrals to the state? Select one.	**Reg 1 NorthCare** Makes some referrals to the SMA and others directly to the MFCU **Reg 2 Northern MI Regional Entity** Makes some referrals to the SMA and others directly to the MFCU **Reg 3 Lakeshore Regional Entity** Makes some referrals to the SMA and others directly to the MFCU **Reg 4 South West Michigan Behavioral Health** Makes some referrals to the SMA and others directly to the MFCU **Reg 5 Mid-State Health Network** Makes some referrals to the SMA and others directly to the MFCU **Reg 6 CMH Partnership of Southeast MI** Makes some referrals to the SMA and others directly to the MFCU

Number	Indicator	Response
		Reg 7 Detroit Wayne Integrated Health Network Makes some referrals to the SMA and others directly to the MFCU **Reg 8 Oakland Community Health Network** Makes some referrals to the SMA and others directly to the MFCU **Reg 9 Macomb County CMH Services** Makes some referrals to the SMA and others directly to the MFCU **Region 10 PIHP** Makes some referrals to the SMA and others directly to the MFCU
D1.X.7	**Count of program integrity referrals to the state** Enter the count of program integrity referrals that the plan made to the state in the past year. Enter the count of referrals made to the SMA and the MFCU in aggregate.	**Reg 1 NorthCare** 2% **Reg 2 Northern MI Regional Entity** 0 **Reg 3 Lakeshore Regional Entity** 1 **Reg 4 South West Michigan Behavioral Health** 1 **Reg 5 Mid-State Health Network** 2 **Reg 6 CMH Partnership of Southeast MI** 0 **Reg 7 Detroit Wayne Integrated Health Network** 2 **Reg 8 Oakland Community Health Network** 0 **Reg 9 Macomb County CMH Services** 2 **Region 10 PIHP**

Number	Indicator	Response
		4
D1.X.8	**Ratio of program integrity referral to the state** What is the ratio of program integrity referral listed in the previous indicator made to the state in the past year per 1,000 beneficiaries, using the plan's total enrollment as of the first day of the last month of the reporting year (reported in indicator D1.I.2) as the denominator.	**Reg 1 NorthCare** 2:80 **Reg 2 Northern MI Regional Entity** 0:0 **Reg 3 Lakeshore Regional Entity** 1:355 **Reg 4 South West Michigan Behavioral Health** 1:263 **Reg 5 Mid-State Health Network** 2:481 **Reg 6 CMH Partnership of Southeast MI** 0:0 **Reg 7 Detroit Wayne Integrated Health Network** 2:7 **Reg 8 Oakland Community Health Network** 0:0 **Reg 9 Macomb County CMH Services** 2:187 **Region 10 PIHP** 4:121
D1.X.9	**Plan overpayment reporting to the state** Describe the plan's latest annual overpayment recovery report submitted to the state as required under 42 CFR 438.608(d)(3). Include, for example, the following information: • The date of the report (rating period or calendar year). • The dollar amount of overpayments recovered. • The ratio of the dollar amount of overpayments recovered as	**Reg 1 NorthCare** 10/1/21-9/30/22. $4,172.22 recovered from 38 completed investigations. All findings are claim-based. **Reg 2 Northern MI Regional Entity** 10/1/21-9/30/22. $295.19 recovered from 18 completed investigations. All findings are claim-based. **Reg 3 Lakeshore Regional Entity**

Number	Indicator	Response
	a percent of premium revenue as defined in MLR reporting under 438.8(f)(2).	10/1/21-9/30/22. $5,332,905.22 recovered from 1,980 completed investigations. All findings are claim-based. **Reg 4 South West Michigan Behavioral Health** 10/1/21-9/30/22. $688,617.41 recovered from 661 completed investigations. All findings are claim-based. **Reg 5 Mid-State Health Network** 10/1/21-9/30/22. $294,921.31 recovered from 147 completed investigations. All findings are claim-based. **Reg 6 CMH Partnership of Southeast MI** 10/1/21-9/30/22. $24,806.97 recovered from 77 completed investigations. All findings are claim-based. **Reg 7 Detroit Wayne Integrated Health Network** 10/1/21-9/30/22. $27,728.02 recovered from 7 completed investigations. All findings are claim-based. **Reg 8 Oakland Community Health Network** 10/1/21-9/30/22. $18,204.56 recovered from 18 completed investigations. All findings are claim-based. **Reg 9 Macomb County CMH Services** 10/1/21-9/30/22. $20,068.00 recovered from 171 completed investigations. All findings are claim-based. **Region 10 PIHP** 10/1/21-9/30/22. $129,888.60 recovered from 121 completed investigations. All findings are claim-based.
D1.X.10	**Changes in beneficiary circumstances** Select the frequency the plan reports changes in beneficiary circumstances to the state.	**Reg 1 NorthCare** Daily **Reg 2 Northern MI Regional Entity** Daily **Reg 3 Lakeshore Regional Entity**

Number	Indicator	Response
		Daily **Reg 4 South West Michigan Behavioral Health** Daily **Reg 5 Mid-State Health Network** Daily **Reg 6 CMH Partnership of Southeast MI** Daily **Reg 7 Detroit Wayne Integrated Health Network** Daily **Reg 8 Oakland Community Health Network** Daily **Reg 9 Macomb County CMH Services** Daily **Region 10 PIHP** Daily

Section E: BSS Entity Indicators

Topic IX. Beneficiary Support System (BSS) Entities

Per 42 CFR 438.66(e)(2)(ix), the Managed Care Program Annual Report must provide information on and an assessment of the operation of the managed care program including activities and performance of the beneficiary support system. Information on how BSS entities support program-level functions is on the Program-Level BSS page.

Find in the Excel Workbook
E_BSS_Entities

Number	Indicator	Response
E.IX.1	**BSS entity type**	**Reg 1 NorthCare**

Number	Indicator	Response
	What type of entity was contracted to perform each BSS activity? Check all that apply. Refer to 42 CFR 438.71(b).	State Government Entity **Reg 2 Northern MI Regional Entity** State Government Entity **Reg 3 Lakeshore Regional Entity** State Government Entity **Reg 4 South West Michigan Behavioral Health** State Government Entity **Reg 5 Mid-State Health Network** State Government Entity **Reg 6 CMH Partnership of Southeast MI** State Government Entity **Reg 7 Detroit Wayne Integrated Health Network** State Government Entity **Reg 8 Oakland Community Health Network** State Government Entity **Reg 9 Macomb County CMH Services** State Government Entity **Region 10 PIHP** State Government Entity
E.IX.2	**BSS entity role** What are the roles performed by the BSS entity? Check all that apply. Refer to 42 CFR 438.71(b).	**Reg 1 NorthCare** Enrollment Broker/Choice Counseling **Reg 2 Northern MI Regional Entity** Enrollment Broker/Choice Counseling **Reg 3 Lakeshore Regional Entity** Enrollment Broker/Choice Counseling **Reg 4 South West Michigan Behavioral Health** Enrollment Broker/Choice Counseling **Reg 5 Mid-State Health Network** Enrollment Broker/Choice Counseling

Number	Indicator	Response
		Reg 6 CMH Partnership of Southeast MI Enrollment Broker/Choice Counseling **Reg 7 Detroit Wayne Integrated Health Network** Enrollment Broker/Choice Counseling **Reg 8 Oakland Community Health Network** Enrollment Broker/Choice Counseling **Reg 9 Macomb County CMH Services** Enrollment Broker/Choice Counseling **Region 10 PIHP** Enrollment Broker/Choice Counseling