

# Managed Care Program Annual Report (MCPAR) for Michigan: Pre-Paid Inpatient Health Plans

<b>Due date</b>	<b>Last edited</b>	<b>Edited by</b>	<b>Status</b>
03/29/2025	03/27/2025	Sandra Gettel	Submitted
<b>Indicator</b>		<b>Response</b>	
<b>Exclusion of CHIP from MCPAR</b>		Not Selected	
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.			

## Section A: Program Information

### Point of Contact

Number	Indicator	Response
A1	<b>State name</b> Auto-populated from your account profile.	Michigan
A2a	<b>Contact name</b> 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.	Sandra Gettel
A2b	<b>Contact email address</b> Enter email address. Department or program-wide email addresses ok.	gettels@michigan.gov
A3a	<b>Submitter name</b> CMS receives this data upon submission of this MCPAR report.	Sandra Gettel
A3b	<b>Submitter email address</b> CMS receives this data upon submission of this MCPAR report.	gettels@michigan.gov
A4	<b>Date of report submission</b> CMS receives this date upon submission of this MCPAR report.	03/27/2025

## Reporting Period

Number	Indicator	Response
A5a	<b>Reporting period start date</b> Auto-populated from report dashboard.	10/01/2023
A5b	<b>Reporting period end date</b> Auto-populated from report dashboard.	09/30/2024
A6	<b>Program name</b> Auto-populated from report dashboard.	Pre-Paid Inpatient Health Plans

## Add plans (A.7)

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

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 Independent Living (CIL), Legal Assistance Organization, Community-based Organization, Subcontractor, Enrollment Broker, Consultant, or Academic/Research Organization.

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

## Add In Lieu of Services and Settings (A.9)

**⚠ Beginning December 2025, this section must be completed by states that authorize ILOS. Submission of this data before December 2025 is optional.**

This section must be completed if any ILOSs *other than short term stays in an Institution for Mental Diseases (IMD)* are authorized for this managed care program. **Enter the name of each ILOS offered as it is identified in the managed care plan contract(s).** [Guidance on In Lieu of Services on Medicaid.gov](#).

Indicator	Response
ILOS name	

## Section B: State-Level Indicators

### Topic I. Program Characteristics and Enrollment

Number	Indicator	Response
BI.1	<b>Statewide Medicaid enrollment</b>  Enter the average number of individuals enrolled in Medicaid per month during the reporting year (i.e., average member months). Include all FFS and managed care enrollees and count each person only once, regardless of the delivery system(s) in which they are enrolled.	2,723,376
BI.2	<b>Statewide Medicaid managed care enrollment</b>  Enter the average number of individuals enrolled in any type of Medicaid managed care per month during the reporting year (i.e., average member months). Include all managed care programs and count each person only once, even if they are enrolled in multiple managed care programs or plans.	2,646,936

## Topic III. Encounter Data Report

Number	Indicator	Response
<b>BIII.1</b>	<b>Data validation entity</b>  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.	EQRO

## Topic X: Program Integrity

Number	Indicator	Response
<b>BX.1</b>	<p><b>Payment risks between the state and plans</b></p> <p>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. If no PI activities were performed, enter "No PI activities were performed during the reporting period" as your response. "N/A" is not an acceptable response.</p>	<p>The State did not conduct service-specific or other focused PI activities during the past year. Focused PI activities were performance by the PIHPs and monitored by the State. There are ongoing discussions to incorporate this into future contract language.</p>
<b>BX.2</b>	<p><b>Contract standard for overpayments</b></p> <p>Does the state allow plans to retain overpayments, require the return of overpayments, or has established a hybrid system? Select one.</p>	<p>Allow plans to retain overpayments</p>
<b>BX.3</b>	<p><b>Location of contract provision stating overpayment standard</b></p> <p>Describe where the overpayment standard in the previous indicator is located in plan contracts, as required by 42 CFR 438.608(d)(1)(i).</p>	<p>PIHP: 1.R - General Requirements - Program Integrity</p>
<b>BX.4</b>	<p><b>Description of overpayment contract standard</b></p> <p>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.</p>	<p>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.</p>
<b>BX.5</b>	<p><b>State overpayment reporting monitoring</b></p>	<p>MDHHS mandates quarterly submissions of overpayment activities, including an annual report capturing totals from the FY. OIG</p>



	<p>Describe how the state monitors plan performance in reporting overpayments to the state, e.g. does the state track compliance with this requirement and/or timeliness of reporting?</p> <p>The regulations at 438.604(a)(7), 608(a)(2) and 608(a)(3) require plan reporting to the state on various overpayment topics (whether annually or promptly). This indicator is asking the state how it monitors that reporting.</p>	provides feedback to the managed care entities from their assessment of these submissions.
<b>BX.6</b>	<p><b>Changes in beneficiary circumstances</b></p> <p>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).</p>	The State sends both an audit file and a payment file for the plans to compare and ensure they are getting capitation payments/recoupments for each of the members on the audit file.
<b>BX.7a</b>	<p><b>Changes in provider circumstances: Monitoring plans</b></p> <p>Does the state monitor whether plans report provider “for cause” terminations in a timely manner under 42 CFR 438.608(a)(4)? Select one.</p>	Yes
<b>BX.7b</b>	<p><b>Changes in provider circumstances: Metrics</b></p> <p>Does the state use a metric or indicator to assess plan reporting performance? Select one.</p>	Yes
<b>BX.7c</b>	<p><b>Changes in provider circumstances: Describe metric</b></p> <p>Describe the metric or indicator that the state uses.</p>	<p>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. OIG is able to see when the provider was terminated vs. when notice was sent to the state, and feedback can be given, as necessary</p>

<b>BX.8a</b>	<p><b>Federal database checks: Excluded person or entities</b></p> <p>During the state’s federal database checks, did the state find any person or entity 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.</p>	No
<b>BX.9a</b>	<p><b>Website posting of 5 percent or more ownership control</b></p> <p>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 42 CFR 438.602(g)(3) and 455.104.</p>	No
<b>BX.10</b>	<p><b>Periodic audits</b></p> <p>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, provide the link(s) to the audit results. Refer to 42 CFR 438.602(e). If no audits were conducted, please enter “No such audits were conducted during the reporting year” as your response. “N/A” is not an acceptable response.</p>	<p><a href="https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Keeping-Michigan-Healthy/BH-DD/Mental-Health/Stats-and-Reports/MI_SF2023_PIHP_EDV_Aggregate_Report.pdf?rev=3df7fdf14d514f5d91b96cb53bc526a8&amp;hash=35CED7E6861BE65E3F930A93FA382BC2">https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Keeping-Michigan-Healthy/BH-DD/Mental-Health/Stats-and-Reports/MI_SF2023_PIHP_EDV_Aggregate_Report.pdf?rev=3df7fdf14d514f5d91b96cb53bc526a8&amp;hash=35CED7E6861BE65E3F930A93FA382BC2</a></p>

## Topic XIII. Prior Authorization

**⚠ Beginning June 2026, Indicators B.XIII.1a-b-2a-b must be completed. Submission of this data before June 2026 is optional.**

Number	Indicator	Response
N/A	<b>Are you reporting data prior to June 2026?</b>	Yes
<b>BXIII.1a</b>	<b>Timeframes for standard prior authorization decisions</b>  Plans must provide notice of their decisions on prior authorization requests as expeditiously as the enrollee's condition requires and within state-established timeframes. For rating periods that start before January 1, 2026, a state's time frame may not exceed 14 calendar days after receiving the request. For rating periods that start on or after January 1, 2026, a state's time frame may not exceed 7 calendar days after receiving the request. Does the state set timeframes shorter than these maximum timeframes for standard prior authorization requests?	No
<b>BXIII.2a</b>	<b>Timeframes for expedited prior authorization decisions</b>  Plans must provide notice of their decisions on prior authorization requests as expeditiously as the enrollee's condition requires and no later than 72 hours after receipt of the request for service. Does the state set timeframes shorter than the maximum timeframe for expedited prior authorization requests?	No

## Section C: Program-Level Indicators

### Topic I: Program Characteristics

Number	Indicator	Response
C11.1	<b>Program contract</b> Enter the title of the contract between the state and plans participating in the managed care program.	Prepaid Inpatient Health Plan Notice of Contract October 1, 2023-September 30, 2024.
N/A	Enter the date of the contract between the state and plans participating in the managed care program.	10/01/2023
C11.2	<b>Contract URL</b> Provide the hyperlink to the model contract or landing page for executed contracts for the program reported in this program.	<a href="https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Doing-Business-with-MDHHS/Contract-and-Subrecipient-Resources/PIHP_Master_Contract_Template.pdf?rev=5225234b83044c27a6ca4ae48f7e426c&amp;hash=AA3C9305928F2CC838FDF734BCA33E48">https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Doing-Business-with-MDHHS/Contract-and-Subrecipient-Resources/PIHP_Master_Contract_Template.pdf?rev=5225234b83044c27a6ca4ae48f7e426c&amp;hash=AA3C9305928F2CC838FDF734BCA33E48</a>
C11.3	<b>Program type</b> 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)
C11.4a	<b>Special program benefits</b> Are any of the four special 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.	Behavioral health Long-term services and supports (LTSS) Transportation
C11.4b	<b>Variation in special benefits</b> 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
C11.5	<b>Program enrollment</b>	2,522,934

Enter the average number of individuals enrolled in this managed care program per month during the reporting year (i.e., average member months).

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**C1I.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. If there were no major changes, please enter "There were no major changes to the population or benefits during the reporting year" as your response. "N/A" is not an acceptable response.

The ending of the Public Health Emergency guidance triggered Medicaid redeterminations causing individuals to be determined to not be eligible for Medicaid and thus a drop in the number of individuals enrolled.

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## Topic III: Encounter Data Report

Number	Indicator	Response
C1III.1	<p><b>Uses of encounter data</b></p> <p>For what purposes does the state use encounter data collected from managed care plans (MCPs)? Select one or more.</p> <p>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)).</p>	<p>Rate setting</p> <p>Quality/performance measurement</p> <p>Monitoring and reporting</p> <p>Contract oversight</p> <p>Program integrity</p> <p>Policy making and decision support</p>
C1III.2	<p><b>Criteria/measures to evaluate MCP performance</b></p> <p>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.</p> <p>Federal regulations also require that states validate that submitted enrollee encounter data they receive is a complete 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).</p>	<p>Timeliness of initial data submissions</p> <p>Timeliness of data corrections</p> <p>Use of correct file formats</p> <p>Provider ID field complete</p> <p>Overall data accuracy (as determined through data validation)</p>
C1III.3	<p><b>Encounter data performance criteria contract language</b></p> <p>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.</p>	<p>Encounter Timeliness Calculation</p>

<b>C1III.4</b>	<b>Financial penalties contract language</b>  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 & v)
<b>C1III.5</b>	<b>Incentives for encounter data quality</b>  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.	Contractor Performance Bonus/Penalty if financial reports and/or encounters are not submitted timely.
<b>C1III.6</b>	<b>Barriers to collecting/validating encounter data</b>  Describe any barriers to collecting and/or validating managed care plan encounter data that the state has experienced during the reporting year. If there were no barriers, please enter "The state did not experience any barriers to collecting or validating encounter data during the reporting year" as your response. "N/A" is not an acceptable response.	The state did not experience any barriers to collecting or validating encounter data during the reporting year.

## Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response
C1IV.1	<p><b>State’s definition of “critical incident”, as used for reporting purposes in its MLTSS program</b></p> <p>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.</p>	<p>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 from the use of physical management or fall; Hospitalization due to Injury or Medication Error; Hospitalization due to injury related to the use of physical management or fall.</p>
C1IV.2	<p><b>State definition of “timely” resolution for standard appeals</b></p> <p>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.</p>	<p>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 requires, but not to exceed 30 calendar days from the day the PIHP receives the Appeal.</p>
C1IV.3	<p><b>State definition of “timely” resolution for expedited appeals</b></p> <p>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.</p>	<p>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 the PIHP receives the request for expedited resolution of the Appeal. 42 CFR 438.408.</p>
C1IV.4	<p><b>State definition of “timely” resolution for grievances</b></p>	<p>MDHHS/PIHP Contract, Schedule A, Statement of Work; 1. General Requirements; L. Grievance</p>



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.

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. 42 CFR 438.408 (b)(1)

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## **Topic V. Availability, Accessibility and Network Adequacy**

### **Network Adequacy**

Number	Indicator	Response
C1V.1	<p><b>Gaps/challenges in network adequacy</b></p> <p>What are the state's biggest challenges? Describe any challenges MCPs have maintaining adequate networks and meeting access standards. If the state and MCPs did not encounter any challenges, please enter "No challenges were encountered" as your response. "N/A" is not an acceptable response.</p>	<p>The most frequently reported challenge is staffing shortages and insufficient workforces. Most commonly this is noted to impact Pediatric services, Applied Behavioral Analysis (ABA), Home-Based, and Wraparound as well as CLS and SRS service providers. Staffing shortages appear to be exacerbated in more rural and frontier areas. It is challenging to find providers able to serve individuals with high/severe needs as well as obtain and retain Direct Care Workers and master Level Clinicians. many PIHPs reported responding to these challenges with advocacy and procurement efforts, recruitment strategies, and retention incentives.</p>
C1V.2	<p><b>State response to gaps in network adequacy</b></p> <p>How does the state work with MCPs to address gaps in network adequacy?</p>	<p>As issues with programs and staffing issues arise, the Contracts Management Section and applicable staff have been working with each PIHP/CMHSP to resolve these matters. During FY2024, we assisted entities with technical support, offering phone calls and Teams meeting to discuss options specific to each PIHP's need in areas where continued gaps were noted, one PIHP was given opportunities for improvement with a corrective action plan as noted in the D3_Plan_Sanction tab. As noted above, access to ABA services is a common barrier. As such, MDHHS effectuated a legislatively mandated provider payment for ABA services. MDHHS has modified and implemented network adequacy standards for FY24 (pending submission and data analysis) based on data collect in FY2024, MDHHS has taken responsibility for calculating time/distance and provider to enrollee ratios in order to ensure consistency in methodology and informed decision making moving forward. MDHHS continues efforts to compile and analyze data related to wait times to services and capacity matters.</p>

## 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.



Complete

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

1 / 9

### C2.V.2 Measure standard

Adult and Pediatric enrollees must have access to a behavioral health/SUD provider within 30 minutes and 30 miles of their residence.

### C2.V.3 Standard type

Maximum distance to travel

#### C2.V.4 Provider

Behavioral health

#### C2.V.5 Region

Urban

#### C2.V.6 Population

Adult and pediatric

### C2.V.7 Monitoring Methods

Geomapping, PIHP Network Adequacy Annual Reporting

### C2.V.8 Frequency of oversight methods

Annually



Complete

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

2 / 9

### C2.V.2 Measure standard

Adult and Pediatric enrollees must have access to a behavioral health/SUD provider office within 60 minutes and 60 miles of their residence

### C2.V.3 Standard type

Maximum time or distance

#### C2.V.4 Provider

Behavioral health

#### C2.V.5 Region

Rural

#### C2.V.6 Population

Adult and pediatric

### C2.V.7 Monitoring Methods

Geomapping, Network Adequacy Annual Reporting

### C2.V.8 Frequency of oversight methods

Annually



Complete

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

3 / 9

### **C2.V.2 Measure standard**

Adult and Pediatric enrollees must have access to a behavioral health/SUD provider office within 90 minutes and 90 miles of their residence

### **C2.V.3 Standard type**

Maximum time or distance

#### **C2.V.4 Provider**

Behavioral health

#### **C2.V.5 Region**

Frontier

#### **C2.V.6 Population**

Adult and pediatric

### **C2.V.7 Monitoring Methods**

Geomapping, Network Adequacy Annual Reporting

### **C2.V.8 Frequency of oversight methods**

Annually



Complete

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

4 / 9

### **C2.V.2 Measure standard**

Adult enrollees must have access to an inpatient psychiatric facility within 30 minutes and 30 miles of their residence

### **C2.V.3 Standard type**

Maximum time or distance

#### **C2.V.4 Provider**

Behavioral health

#### **C2.V.5 Region**

Urban

#### **C2.V.6 Population**

Adult

### **C2.V.7 Monitoring Methods**

Geomapping, Network Adequacy Annual Reporting

### **C2.V.8 Frequency of oversight methods**

Annually



Complete

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

5 / 9

**C2.V.2 Measure standard**

Adult enrollees must have access to an inpatient psychiatric facility within 90 minutes and 60 miles of their residence

**C2.V.3 Standard type**

Maximum time or distance

**C2.V.4 Provider**

Behavioral health

**C2.V.5 Region**

Rural

**C2.V.6 Population**

Adult

**C2.V.7 Monitoring Methods**

Geomapping, Network Adequacy Annual Reporting

**C2.V.8 Frequency of oversight methods**

Annually



Complete

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

6 / 9

**C2.V.2 Measure standard**

Adult enrollees must have access to an inpatient psychiatric facility within 150 minutes and 125 miles of their residence

**C2.V.3 Standard type**

Maximum time or distance

**C2.V.4 Provider**

Behavioral health

**C2.V.5 Region**

Frontier

**C2.V.6 Population**

Adult

**C2.V.7 Monitoring Methods**

Geomapping, Network Adequacy Annual Reporting

**C2.V.8 Frequency of oversight methods**

Annually



Complete

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

7 / 9

**C2.V.2 Measure standard**

Pediatric enrollees must have access to an inpatient psychiatric facility within 60 minutes and 60 miles of their residence

**C2.V.3 Standard type**

Maximum time or distance

**C2.V.4 Provider**

Behavioral health

**C2.V.5 Region**

Urban

**C2.V.6 Population**

Pediatric

**C2.V.7 Monitoring Methods**

Geomapping, Network Adequacy Annual Reporting

**C2.V.8 Frequency of oversight methods**

Annually



Complete

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

8 / 9

**C2.V.2 Measure standard**

Pediatric enrollees must have access to an inpatient psychiatric facility within 120 minutes and 125 miles of their residence

**C2.V.3 Standard type**

Maximum time or distance

**C2.V.4 Provider**

Behavioral health

**C2.V.5 Region**

Rural

**C2.V.6 Population**

Pediatric

**C2.V.7 Monitoring Methods**

Geomapping, Network Adequacy Annual Reporting

**C2.V.8 Frequency of oversight methods**

Annually



Complete

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

9 / 9

**C2.V.2 Measure standard**

Pediatric enrollees must have access to an inpatient psychiatric facility within 330 minutes and 355 miles of their residence

**C2.V.3 Standard type**

Maximum time or distance

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

**C2.V.7 Monitoring Methods**

Geomapping, Network Adequacy Annual Reporting

**C2.V.8 Frequency of oversight methods**

Annually

## Topic IX: Beneficiary Support System (BSS)



Number	Indicator	Response
C1IX.1	<p><b>BSS website</b></p> <p>List the website(s) and/or email address(es) that beneficiaries use to seek assistance from the BSS through electronic means. Separate entries with commas.</p>	<p><a href="https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/customer-services/beneficiarysupport@michigan.gov">https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/customer-services/beneficiarysupport@michigan.gov</a></p>
C1IX.2	<p><b>BSS auxiliary aids and services</b></p> <p>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)?</p> <p>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.</p>	<p>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 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.</p>
C1IX.3	<p><b>BSS LTSS program data</b></p> <p>How do BSS entities assist the state with identifying, remediating, and resolving systemic issues based on a</p>	<p>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</p>

review of LTSS program data such as grievances and appeals or critical incident data? Refer to 42 CFR 438.71(d)(4).

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.

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**C1IX.4****State evaluation of BSS entity performance**

What are steps taken by the state to evaluate the quality, effectiveness, and efficiency of the BSS entities' performance?

The State of Michigan requires that each Prepaid Inpatient Health Plan (PIHP) have a 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) 438.330 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.

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## Topic X: Program Integrity

Number	Indicator	Response
C1X.3	<b>Prohibited affiliation disclosure</b>  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

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## Topic XII. Mental Health and Substance Use Disorder Parity

Number	Indicator	Response
C1XII.4	<p><b>Does this program include MCOs?</b></p> <p>If “Yes”, please complete the following questions.</p>	Yes
C1XII.5	<p><b>Are ANY services provided to MCO enrollees by a PIHP, PAHP, or FFS delivery system?</b></p> <p>(i.e. some services are delivered via fee for service (FFS), prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP) delivery system)</p>	Yes
C1XII.6	<p><b>Did the State or MCOs complete the most recent parity analysis(es)?</b></p>	State
C1XII.7a	<p><b>Have there been any events in the reporting period that necessitated an update to the parity analysis(es)?</b></p> <p>(e.g. changes in benefits, quantitative treatment limits (QTLs), non-quantitative treatment limits (NQTLs), or financial requirements; the addition of a new managed care plan (MCP) providing services to MCO enrollees; and/or deficiencies corrected)</p>	Yes
C1XII.7b	<p><b>Describe the event(s) that necessitated an update to the parity analysis(es).</b></p> <p>Select all that apply.</p>	Changes in benefits
C1XII.8	<p><b>When was the last parity analysis(es) for this program completed?</b></p> <p>States with ANY services provided to MCO enrollees by an entity other than an MCO should report the date the state completed its most recent summary parity analysis report. States with NO services provided to MCO enrollees by an entity other than an MCO should report the most recent date any MCO sent the state its parity analysis (the state may</p>	04/23/2018

have multiple reports, one for each MCO).

<b>C1XII.9</b>	<b>When was the last parity analysis(es) for this program submitted to CMS?</b>  States with ANY services provided to MCO enrollees by an entity other than an MCO should report the date the state's most recent summary parity analysis report was submitted to CMS. States with NO services provided to MCO enrollees by an entity other than an MCO should report the most recent date the state submitted any MCO's parity report to CMS (the state may have multiple parity reports, one for each MCO).	04/23/2018
<b>C1XII.10a</b>	<b>In the last analysis(es) conducted, were any deficiencies identified?</b>	Yes
<b>C1XII.10b</b>	<b>In the last analysis(es) conducted, describe all deficiencies identified.</b>	The only financial requirements applied to any Mental health/Substance use Disorder (MH/SUD) benefit are prescription copays. Co-pays are not applied to substantially all of the medical and surgical (M/S) benefit in the prescription drug classification, and will therefore be discontinued in the MH/SUD benefit. No annual dollar limits or aggregate lifetime limits are applied to any classification of the MH/SUD benefit. No quantitative treatment limitation have been identified in any classification of the MH/SUD Benefit. The following non-quantitative treatment limitation were assessed: Medical necessity determination/service authorizations, Continuing authorizations, Step Therapy or Fail First practices, Out of Network Provider Access, Provider Credentialing and Licensing Requirements, Refusal to Pay if Treatment not Completed Other Limitations to Treatment. It was determined that the medical necessity determination/authorization processes used in the Inpatient and Outpatient classifications of the MH/SUD benefit were not comparable to those used in the same classifications of the M/S benefit. This involves practices of the PIHPs. a plan to address this has been developed and is being implemented.

<b>C1XII.11a</b>	<b>As of the end of this reporting period, have these deficiencies been resolved for all plans?</b>	Yes
<b>C1XII.12a</b>	<p><b>Has the state posted the current parity analysis(es) covering this program on its website?</b></p> <p>The current parity analysis/analyses must be posted on the state Medicaid program website. States with ANY services provided to MCO enrollees by an entity other than MCO should have a single state summary parity analysis report.</p> <p>States with NO services provided to MCO enrollees by an entity other than the MCO may have multiple parity reports (by MCO), in which case all MCOs' separate analyses must be posted. A "Yes" response means that the parity analysis for either the state or for ALL MCOs has been posted.</p>	Yes
<b>C1XII.12b</b>	<p><b>Provide the URL link(s).</b></p> <p>Response must be a valid hyperlink/URL beginning with "http://" or "https://". Separate links with commas.</p>	<p><a href="https://www.michigan.gov/mdhhs/assistance-programs/medicaid/portalthome/reports/mental-health-and-substance-use-disorder-parity-report">https://www.michigan.gov/mdhhs/assistance-programs/medicaid/portalthome/reports/mental-health-and-substance-use-disorder-parity-report</a></p>

## Section D: Plan-Level Indicators

### Topic I. Program Characteristics & Enrollment

Number	Indicator	Response
D1I.1	<b>Plan enrollment</b>  Enter the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months).	<b>Reg 1 NorthCare</b>
		66,950
		<b>Reg 2 Northern MI Regional Entity</b>
		122,802
		<b>Reg 3 Lakeshore Regional Entity</b>
		280,165
		<b>Reg 4 South West Michigan Behavioral Health</b>
		215,628
		<b>Reg 5 Mid-State Health Network</b>
		406,907
		<b>Reg 6 CMH Partnership of Southeast MI</b>
		128,807
		<b>Reg 7 Detroit Wayne Integrated Health Network</b>
		685,782
		<b>Reg 8 Oakland Community Health Network</b>
		192,458
		<b>Reg 9 Macomb County CMH Services</b>
		218,537
		<b>Region 10 PIHP</b>
		204,900
D1I.2	<b>Plan share of Medicaid</b>  What is the plan enrollment (within the specific program) as	<b>Reg 1 NorthCare</b>
		2.5%

<ul style="list-style-type: none"> <li>a percentage of the state's total Medicaid enrollment?</li> <li>Numerator: Plan enrollment (D1.I.1)</li> <li>Denominator: Statewide Medicaid enrollment (B.I.1)</li> </ul>		<b>Reg 2 Northern MI Regional Entity</b>
		4.5%
		<b>Reg 3 Lakeshore Regional Entity</b>
		10.3%
		<b>Reg 4 South West Michigan Behavioral Health</b>
		7.9%
		<b>Reg 5 Mid-State Health Network</b>
		14.9%
		<b>Reg 6 CMH Partnership of Southeast MI</b>
		4.7%
		<b>Reg 7 Detroit Wayne Integrated Health Network</b>
		25.2%
		<b>Reg 8 Oakland Community Health Network</b>
		7.1%
		<b>Reg 9 Macomb County CMH Services</b>
		8%
		<b>Region 10 PIHP</b>
		7.5%

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<b>D1I.3</b>	<b>Plan share of any Medicaid managed care</b>	<b>Reg 1 NorthCare</b>
	What is the plan enrollment (regardless of program) as a percentage of total Medicaid enrollment in any type of managed care?	2.5%
	<ul style="list-style-type: none"> <li>Numerator: Plan enrollment (D1.I.1)</li> <li>Denominator: Statewide Medicaid managed care</li> </ul>	<b>Reg 2 Northern MI Regional Entity</b>
		4.6%
		<b>Reg 3 Lakeshore Regional Entity</b>



enrollment (B.I.2)

10.6%

**Reg 4 South West Michigan Behavioral Health**

8.1%

**Reg 5 Mid-State Health Network**

15.4%

**Reg 6 CMH Partnership of Southeast MI**

4.9%

**Reg 7 Detroit Wayne Integrated Health Network**

25.9%

**Reg 8 Oakland Community Health Network**

7.3%

**Reg 9 Macomb County CMH Services**

8.3%

**Region 10 PIHP**

7.7%

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## **Topic II. Financial Performance**

Number	Indicator	Response
D1II.1a	<b>Medical Loss Ratio (MLR)</b>  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. Write MLR as a percentage: for example, write 92% rather than 0.92.	<b>Reg 1 NorthCare</b>
		101.6%
		<b>Reg 2 Northern MI Regional Entity</b>
		99.3%
		<b>Reg 3 Lakeshore Regional Entity</b>
		93%
		<b>Reg 4 South West Michigan Behavioral Health</b>
		90%
		<b>Reg 5 Mid-State Health Network</b>
		96.3%
D1II.1b	<b>Level of aggregation</b>  What is the aggregation level that best describes the MLR being reported in the previous	<b>Reg 6 CMH Partnership of Southeast MI</b>
		95.4%
		<b>Reg 7 Detroit Wayne Integrated Health Network</b>
		97.6%
		<b>Reg 8 Oakland Community Health Network</b>
		99%
		<b>Reg 9 Macomb County CMH Services</b>
		85.9%
		<b>Region 10 PIHP</b>
		89.5%
D1II.1b	<b>Level of aggregation</b>  What is the aggregation level that best describes the MLR being reported in the previous	<b>Reg 1 NorthCare</b>
		Program-specific regional

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 2 Northern MI Regional Entity**

Program-specific regional

**Reg 3 Lakeshore Regional Entity**

Program-specific regional

**Reg 4 South West Michigan Behavioral Health**

Program-specific regional

**Reg 5 Mid-State Health Network**

Program-specific regional

**Reg 6 CMH Partnership of Southeast MI**

Program-specific regional

**Reg 7 Detroit Wayne Integrated Health Network**

Program-specific regional

**Reg 8 Oakland Community Health Network**

Program-specific regional

**Reg 9 Macomb County CMH Services**

Program-specific regional

**Region 10 PIHP**

Program-specific regional

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**D1II.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.

**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**

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.

<b>D1II.3</b>	<b>MLR reporting period discrepancies</b>  Does the data reported in item D1.II.1a cover a different time period than the MCPAR report?	<b>Reg 1 NorthCare</b>
		Yes
		<b>Reg 2 Northern MI Regional Entity</b>
		Yes
		<b>Reg 3 Lakeshore Regional Entity</b>
		Yes
		<b>Reg 4 South West Michigan Behavioral Health</b>
		Yes
		<b>Reg 5 Mid-State Health Network</b>
		Yes
<b>N/A</b>	Enter the start date.	<b>Reg 6 CMH Partnership of Southeast MI</b>
		Yes
		<b>Reg 7 Detroit Wayne Integrated Health Network</b>
		Yes
		<b>Reg 8 Oakland Community Health Network</b>
		Yes
		<b>Reg 9 Macomb County CMH Services</b>
		Yes
		<b>Region 10 PIHP</b>
		Yes
<b>N/A</b>	Enter the start date.	<b>Reg 1 NorthCare</b>
		10/01/2022

**Reg 2 Northern MI Regional Entity**

10/01/2022

**Reg 3 Lakeshore Regional Entity**

10/01/2022

**Reg 4 South West Michigan Behavioral Health**

10/01/2022

**Reg 5 Mid-State Health Network**

10/01/2022

**Reg 6 CMH Partnership of Southeast MI**

10/01/2022

**Reg 7 Detroit Wayne Integrated Health Network**

10/01/2022

**Reg 8 Oakland Community Health Network**

10/01/2022

**Reg 9 Macomb County CMH Services**

10/01/2022

**Region 10 PIHP**

10/01/2022

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**N/A**

Enter the end date.

**Reg 1 NorthCare**

09/30/2023

**Reg 2 Northern MI Regional Entity**

09/30/2023

**Reg 3 Lakeshore Regional Entity**

09/30/2023

**Reg 4 South West Michigan Behavioral Health**

09/30/2023

**Reg 5 Mid-State Health Network**

09/30/2023

**Reg 6 CMH Partnership of Southeast MI**

09/30/2023

**Reg 7 Detroit Wayne Integrated Health Network**

09/30/2023

**Reg 8 Oakland Community Health Network**

09/30/2023

**Reg 9 Macomb County CMH Services**

09/30/2023

**Region 10 PIHP**

09/30/2023

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## **Topic III. Encounter Data**

Number	Indicator	Response
D1III.1	<p><b>Definition of timely encounter data submissions</b></p> <p>Describe the state's standard for timely encounter data submissions used in this program.</p> <p>If reporting frequencies and standards differ by type of encounter within this program, please explain.</p>	<p><b>Reg 1 NorthCare</b></p> <p>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</p>



(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.

## **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 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.

### **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 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.

#### **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 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.

### **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 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.

## **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 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.

## **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 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.

## **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 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.

### **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 this way, PIHPs will not be discouraged from reporting replacements that require additional time to research or resolve.

## **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. 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.

## D1III.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 year) met state requirements

### **Reg 1 NorthCare**

100%

### **Reg 2 Northern MI Regional Entity**

for timely submission? If the state has not yet received any encounter data file submissions for the entire contract year 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 year.

97%

**Reg 3 Lakeshore Regional Entity**

84%

**Reg 4 South West Michigan Behavioral Health**

99%

**Reg 5 Mid-State Health Network**

94%

**Reg 6 CMH Partnership of Southeast MI**

93%

**Reg 7 Detroit Wayne Integrated Health Network**

95%

**Reg 8 Oakland Community Health Network**

99%

**Reg 9 Macomb County CMH Services**

97%

**Region 10 PIHP**

99%

**D1III.3**

**Share of encounter data submissions that were HIPAA compliant**

What percent of the plan's encounter data submissions (submitted during the reporting year) 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

**Reg 1 NorthCare**

100%

**Reg 2 Northern MI Regional Entity**

100%

**Reg 3 Lakeshore Regional Entity**

100%

compliant out of the proportion received from the managed care plan for the reporting year.

**Reg 4 South West Michigan Behavioral Health**

99%

**Reg 5 Mid-State Health Network**

100%

**Reg 6 CMH Partnership of Southeast MI**

82%

**Reg 7 Detroit Wayne Integrated Health Network**

97%

**Reg 8 Oakland Community Health Network**

100%

**Reg 9 Macomb County CMH Services**

100%

**Region 10 PIHP**

100%

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## Topic IV. Appeals, State Fair Hearings & Grievances

**⚠ Beginning June 2025, Indicators D1.IV.1a-c must be completed. Submission of this data before June 2025 is optional; if you choose not to respond prior to June 2025, enter “N/A”.**

### Appeals Overview

Number	Indicator	Response
D1IV.1	<b>Appeals resolved (at the plan level)</b>  Enter the total number of appeals resolved during 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.	<b>Reg 1 NorthCare</b>
		33
		<b>Reg 2 Northern MI Regional Entity</b>
		76
		<b>Reg 3 Lakeshore Regional Entity</b>
		117
		<b>Reg 4 South West Michigan Behavioral Health</b>
		150
		<b>Reg 5 Mid-State Health Network</b>
		275
		<b>Reg 6 CMH Partnership of Southeast MI</b>
		35
		<b>Reg 7 Detroit Wayne Integrated Health Network</b>
		52
		<b>Reg 8 Oakland Community Health Network</b>
		25
		<b>Reg 9 Macomb County CMH Services</b>
		72
		<b>Region 10 PIHP</b>
		10
D1IV.1a	<b>Appeals denied</b>  Enter the total number of appeals resolved during the reporting period (D1.IV.1) that	<b>Reg 1 NorthCare</b>
		NA

were denied (adverse) to the enrollee. If you choose not to respond prior to June 2025, enter “N/A”.

**Reg 2 Northern MI Regional Entity**

NA

**Reg 3 Lakeshore Regional Entity**

NA

**Reg 4 South West Michigan Behavioral Health**

NA

**Reg 5 Mid-State Health Network**

NA

**Reg 6 CMH Partnership of Southeast MI**

NA

**Reg 7 Detroit Wayne Integrated Health Network**

NA

**Reg 8 Oakland Community Health Network**

NA

**Reg 9 Macomb County CMH Services**

NA

**Region 10 PIHP**

NA

**D1IV.1b**

**Appeals resolved in partial favor of enrollee**

Enter the total number of appeals (D1.IV.1) resolved during the reporting period in partial favor of the enrollee. If you choose not to respond prior to June 2025, enter “N/A”.

**Reg 1 NorthCare**

NA

**Reg 2 Northern MI Regional Entity**

NA

**Reg 3 Lakeshore Regional Entity**

NA

**Reg 4 South West Michigan Behavioral Health**

NA

**Reg 5 Mid-State Health Network**

NA

**Reg 6 CMH Partnership of Southeast MI**

NA

**Reg 7 Detroit Wayne Integrated Health Network**

NA

**Reg 8 Oakland Community Health Network**

NA

**Reg 9 Macomb County CMH Services**

NA

**Region 10 PIHP**

NA

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**D1IV.1c**

**Appeals resolved in favor of enrollee**

Enter the total number of appeals (D1.IV.1) resolved during the reporting period in favor of the enrollee. If you choose not to respond prior to June 2025, enter "N/A".

**Reg 1 NorthCare**

NA

**Reg 2 Northern MI Regional Entity**

NA

**Reg 3 Lakeshore Regional Entity**

NA

**Reg 4 South West Michigan Behavioral Health**

NA

**Reg 5 Mid-State Health Network**

NA

**Reg 6 CMH Partnership of Southeast MI**

NA

**Reg 7 Detroit Wayne Integrated Health Network**

NA

**Reg 8 Oakland Community Health Network**

NA

**Reg 9 Macomb County CMH Services**

NA

**Region 10 PIHP**

NA

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**D1IV.2**

**Active appeals**

Enter the total number of appeals still pending or in process (not yet resolved) as of the end of the reporting year.

**Reg 1 NorthCare**

0

**Reg 2 Northern MI Regional Entity**

0

**Reg 3 Lakeshore Regional Entity**

0

**Reg 4 South West Michigan Behavioral Health**

10

**Reg 5 Mid-State Health Network**

4



**Reg 6 CMH Partnership of Southeast MI**

0

**Reg 7 Detroit Wayne Integrated Health Network**

8

**Reg 8 Oakland Community Health Network**

0

**Reg 9 Macomb County CMH Services**

0

**Region 10 PIHP**

2

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**D1IV.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**

11

**Reg 2 Northern MI Regional Entity**

33

**Reg 3 Lakeshore Regional Entity**

70

**Reg 4 South West Michigan Behavioral Health**

41

**Reg 5 Mid-State Health Network**

138

**Reg 6 CMH Partnership of Southeast MI**

30

**Reg 7 Detroit Wayne Integrated Health Network**

**Reg 8 Oakland Community Health Network**

11

**Reg 9 Macomb County CMH Services**

79

**Region 10 PIHP**

7

**D1IV.4****Number of critical incidents filed during the reporting year 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 year 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

**Reg 1 NorthCare**

0

**Reg 2 Northern MI Regional Entity**

0

**Reg 3 Lakeshore Regional Entity**

3

**Reg 4 South West Michigan Behavioral Health**

1

**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**

0

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 9 Macomb County CMH Services**

1

**Region 10 PIHP**

0

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**D1IV.5a**

**Standard appeals for which timely resolution was provided**

Enter the total number of standard appeals for which timely resolution was provided by plan within the reporting year.  
See 42 CFR §438.408(b)(2) for requirements related to timely resolution of standard appeals.

**Reg 1 NorthCare**

28

**Reg 2 Northern MI Regional Entity**

79

**Reg 3 Lakeshore Regional Entity**

141

**Reg 4 South West Michigan Behavioral Health**

153

**Reg 5 Mid-State Health Network**

265

**Reg 6 CMH Partnership of Southeast MI**

33

**Reg 7 Detroit Wayne Integrated Health Network**

49

**Reg 8 Oakland Community Health Network**

23

**Reg 9 Macomb County CMH Services**

83

**Region 10 PIHP**

<b>D1IV.5b</b>	<b>Expedited appeals for which timely resolution was provided</b>  Enter the total number of expedited appeals for which timely resolution was provided by plan within the reporting year. See 42 CFR §438.408(b)(3) for requirements related to timely resolution of standard appeals.	<b>Reg 1 NorthCare</b>
		8
		<b>Reg 2 Northern MI Regional Entity</b>
		4
		<b>Reg 3 Lakeshore Regional Entity</b>
		6
		<b>Reg 4 South West Michigan Behavioral Health</b>
		7
		<b>Reg 5 Mid-State Health Network</b>
		3
		<b>Reg 6 CMH Partnership of Southeast MI</b>
		2
		<b>Reg 7 Detroit Wayne Integrated Health Network</b>
		6
		<b>Reg 8 Oakland Community Health Network</b>
		2
		<b>Reg 9 Macomb County CMH Services</b>
		2
		<b>Region 10 PIHP</b>
		0
<b>D1IV.6a</b>	<b>Resolved appeals related to denial of authorization or</b>	<b>Reg 1 NorthCare</b>
		13

**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 2 Northern MI Regional Entity**

35

**Reg 3 Lakeshore Regional Entity**

71

**Reg 4 South West Michigan Behavioral Health**

101

**Reg 5 Mid-State Health Network**

51

**Reg 6 CMH Partnership of Southeast MI**

14

**Reg 7 Detroit Wayne Integrated Health Network**

23

**Reg 8 Oakland Community Health Network**

20

**Reg 9 Macomb County CMH Services**

86

**Region 10 PIHP**

6

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**D1IV.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**

23

**Reg 2 Northern MI Regional Entity**

47

**Reg 3 Lakeshore Regional Entity**

54

**Reg 4 South West Michigan Behavioral Health**

59

**Reg 5 Mid-State Health Network**

222

**Reg 6 CMH Partnership of Southeast MI**

19

**Reg 7 Detroit Wayne Integrated Health Network**

32

**Reg 8 Oakland Community Health Network**

5

**Reg 9 Macomb County CMH Services**

0

**Region 10 PIHP**

6

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**D1IV.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**

1

**Reg 2 Northern MI Regional Entity**

0

**Reg 3 Lakeshore Regional Entity**

1

**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**

3

**Region 10 PIHP**

0

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**D1IV.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**

17

**Reg 4 South West Michigan Behavioral Health**

0

**Reg 5 Mid-State Health Network**

1

**Reg 6 CMH Partnership of Southeast MI**

2

**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

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**D1IV.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**

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

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**D1IV.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 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).

**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

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**D1IV.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**

0

**Reg 8 Oakland Community Health Network**

0

**Reg 9 Macomb County CMH Services**

0

**Region 10 PIHP**

## **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.

Number	Indicator	Response
D1IV.7a	<b>Resolved appeals related to general inpatient services</b>  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”.	<b>Reg 1 NorthCare</b>
		NA
		<b>Reg 2 Northern MI Regional Entity</b>
		NA
		<b>Reg 3 Lakeshore Regional Entity</b>
		NA
		<b>Reg 4 South West Michigan Behavioral Health</b>
		NA
		<b>Reg 5 Mid-State Health Network</b>
		NA
D1IV.7b	<b>Resolved appeals related to general outpatient services</b>  Enter the total number of appeals resolved by the plan	<b>Reg 6 CMH Partnership of Southeast MI</b>
		NA
		<b>Reg 7 Detroit Wayne Integrated Health Network</b>
		NA
		<b>Reg 8 Oakland Community Health Network</b>
		NA
		<b>Reg 9 Macomb County CMH Services</b>
		NA
		<b>Region 10 PIHP</b>
		NA
D1IV.7a	<b>Resolved appeals related to general inpatient services</b>  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”.	<b>Reg 1 NorthCare</b>
		NA

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 2 Northern MI Regional Entity**

NA

**Reg 3 Lakeshore Regional Entity**

NA

**Reg 4 South West Michigan Behavioral Health**

NA

**Reg 5 Mid-State Health Network**

NA

**Reg 6 CMH Partnership of Southeast MI**

NA

**Reg 7 Detroit Wayne Integrated Health Network**

NA

**Reg 8 Oakland Community Health Network**

NA

**Reg 9 Macomb County CMH Services**

NA

**Region 10 PIHP**

NA

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<b>D1IV.7c</b>	<b>Resolved appeals related to inpatient behavioral health services</b>  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".	<b>Reg 1 NorthCare</b>
		6
		<b>Reg 2 Northern MI Regional Entity</b>
		1
		<b>Reg 3 Lakeshore Regional Entity</b>
		10
		<b>Reg 4 South West Michigan Behavioral Health</b>
		58
		<b>Reg 5 Mid-State Health Network</b>
		9
		<b>Reg 6 CMH Partnership of Southeast MI</b>
		0
		<b>Reg 7 Detroit Wayne Integrated Health Network</b>
		1
		<b>Reg 8 Oakland Community Health Network</b>
		2
		<b>Reg 9 Macomb County CMH Services</b>
		3
		<b>Region 10 PIHP</b>
		0

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<b>D1IV.7d</b>	<b>Resolved appeals related to outpatient behavioral health services</b>  Enter the total number of appeals resolved by the plan during the reporting year that	<b>Reg 1 NorthCare</b>
		20
		<b>Reg 2 Northern MI Regional Entity</b>

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".

19

**Reg 3 Lakeshore Regional Entity**

63

**Reg 4 South West Michigan Behavioral Health**

102

**Reg 5 Mid-State Health Network**

188

**Reg 6 CMH Partnership of Southeast MI**

35

**Reg 7 Detroit Wayne Integrated Health Network**

1

**Reg 8 Oakland Community Health Network**

23

**Reg 9 Macomb County CMH Services**

83

**Region 10 PIHP**

11

**D1IV.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**

NA

**Reg 2 Northern MI Regional Entity**

NA

**Reg 3 Lakeshore Regional Entity**

NA

**Reg 4 South West Michigan Behavioral Health**

NA

**Reg 5 Mid-State Health Network**

NA

**Reg 6 CMH Partnership of Southeast MI**

NA

**Reg 7 Detroit Wayne Integrated Health Network**

NA

**Reg 8 Oakland Community Health Network**

NA

**Reg 9 Macomb County CMH Services**

NA

**Region 10 PIHP**

NA

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**D1IV.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**

NA

**Reg 2 Northern MI Regional Entity**

NA

**Reg 3 Lakeshore Regional Entity**

NA

**Reg 4 South West Michigan Behavioral Health**

NA

**Reg 5 Mid-State Health Network**



NA

**Reg 6 CMH Partnership of Southeast MI**

NA

**Reg 7 Detroit Wayne Integrated Health Network**

NA

**Reg 8 Oakland Community Health Network**

NA

**Reg 9 Macomb County CMH Services**

NA

**Region 10 PIHP**

NA

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**D1IV.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 personal care and self-directed services. If the managed care plan does not cover LTSS services, enter "N/A".

**Reg 1 NorthCare**

7

**Reg 2 Northern MI Regional Entity**

18

**Reg 3 Lakeshore Regional Entity**

20

**Reg 4 South West Michigan Behavioral Health**

26

**Reg 5 Mid-State Health Network**

52

**Reg 6 CMH Partnership of Southeast MI**

22

**Reg 7 Detroit Wayne Integrated Health Network**

0

**Reg 8 Oakland Community Health Network**

0

**Reg 9 Macomb County CMH Services**

79

**Region 10 PIHP**

7

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**D1IV.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**

NA

**Reg 2 Northern MI Regional Entity**

NA

**Reg 3 Lakeshore Regional Entity**

NA

**Reg 4 South West Michigan Behavioral Health**

NA

**Reg 5 Mid-State Health Network**

NA

**Reg 6 CMH Partnership of Southeast MI**

NA

**Reg 7 Detroit Wayne Integrated Health Network**

NA

**Reg 8 Oakland Community Health Network**

NA

**Reg 9 Macomb County CMH Services**

NA

**Region 10 PIHP**

NA

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**D1IV.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**

NA

**Reg 2 Northern MI Regional Entity**

0

**Reg 3 Lakeshore Regional Entity**

0

**Reg 4 South West Michigan Behavioral Health**

NA

**Reg 5 Mid-State Health Network**

2

**Reg 6 CMH Partnership of Southeast MI**

0

**Reg 7 Detroit Wayne Integrated Health Network**

NA

**Reg 8 Oakland Community Health Network**

0

**Reg 9 Macomb County CMH Services**

NA

**Region 10 PIHP**

0

**D1IV.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 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 paid primarily by Medicaid, enter "N/A".

**Reg 1 NorthCare**

6

**Reg 2 Northern MI Regional Entity**

1

**Reg 3 Lakeshore Regional Entity**

0

**Reg 4 South West Michigan Behavioral Health**

NA

**Reg 5 Mid-State Health Network**

24

**Reg 6 CMH Partnership of Southeast MI**

13

**Reg 7 Detroit Wayne Integrated Health Network**

NA

**Reg 8 Oakland Community Health Network**

0

**Reg 9 Macomb County CMH Services**

NA

**Region 10 PIHP**

1

## State Fair Hearings

Number	Indicator	Response
D1IV.8a	<b>State Fair Hearing requests</b>  Enter the total number of State Fair Hearing requests filed during the reporting year with the plan that issued an adverse benefit determination.	<b>Reg 1 NorthCare</b>
		0
		<b>Reg 2 Northern MI Regional Entity</b>
		1
		<b>Reg 3 Lakeshore Regional Entity</b>
		13
		<b>Reg 4 South West Michigan Behavioral Health</b>
		7
		<b>Reg 5 Mid-State Health Network</b>
		14
		<b>Reg 6 CMH Partnership of Southeast MI</b>
		9
		<b>Reg 7 Detroit Wayne Integrated Health Network</b>
		2
		<b>Reg 8 Oakland Community Health Network</b>
		3
		<b>Reg 9 Macomb County CMH Services</b>
		16
		<b>Region 10 PIHP</b>
		3
D1IV.8b	<b>State Fair Hearings resulting in a favorable decision for the enrollee</b>	<b>Reg 1 NorthCare</b>  0

Enter the total number of State Fair Hearing decisions rendered during the reporting year that were partially or fully favorable to the enrollee.

**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**

3

**Reg 6 CMH Partnership of Southeast MI**

2

**Reg 7 Detroit Wayne Integrated Health Network**

0

**Reg 8 Oakland Community Health Network**

0

**Reg 9 Macomb County CMH Services**

1

**Region 10 PIHP**

0

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**D1IV.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**

0

**Reg 2 Northern MI Regional Entity**

0

**Reg 3 Lakeshore Regional Entity**

5

**Reg 4 South West Michigan Behavioral Health**

4

**Reg 5 Mid-State Health Network**

8

**Reg 6 CMH Partnership of Southeast MI**

3

**Reg 7 Detroit Wayne Integrated Health Network**

1

**Reg 8 Oakland Community Health Network**

3

**Reg 9 Macomb County CMH Services**

7

**Region 10 PIHP**

2

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**D1IV.8d**

**State Fair Hearings retracted prior to 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) during the reporting year prior to reaching a decision.

**Reg 1 NorthCare**

1

**Reg 2 Northern MI Regional Entity**

0

**Reg 3 Lakeshore Regional Entity**

2

**Reg 4 South West Michigan Behavioral Health**



3

**Reg 5 Mid-State Health Network**

2

**Reg 6 CMH Partnership of Southeast MI**

0

**Reg 7 Detroit Wayne Integrated Health Network**

1

**Reg 8 Oakland Community Health Network**

0

**Reg 9 Macomb County CMH Services**

2

**Region 10 PIHP**

0

**D1IV.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**

NA

**Reg 2 Northern MI Regional Entity**

NA

**Reg 3 Lakeshore Regional Entity**

NA

**Reg 4 South West Michigan Behavioral Health**

NA

**Reg 5 Mid-State Health Network**

NA

**Reg 6 CMH Partnership of Southeast MI**

NA

**Reg 7 Detroit Wayne Integrated Health Network**

NA

**Reg 8 Oakland Community Health Network**

NA

**Reg 9 Macomb County CMH Services**

NA

**Region 10 PIHP**

NA

**D1IV.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**

NA

**Reg 2 Northern MI Regional Entity**

NA

**Reg 3 Lakeshore Regional Entity**

NA

**Reg 4 South West Michigan Behavioral Health**

NA

**Reg 5 Mid-State Health Network**

NA

**Reg 6 CMH Partnership of Southeast MI**

NA

**Reg 7 Detroit Wayne Integrated Health Network**

NA

**Reg 8 Oakland Community Health Network**

NA

**Reg 9 Macomb County CMH Services**

NA

**Region 10 PIHP**

NA

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**Grievances Overview**

Number	Indicator	Response
D1IV.10	<b>Grievances resolved</b>  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.	<b>Reg 1 NorthCare</b>
		49
		<b>Reg 2 Northern MI Regional Entity</b>
		239
		<b>Reg 3 Lakeshore Regional Entity</b>
		232
		<b>Reg 4 South West Michigan Behavioral Health</b>
		154
		<b>Reg 5 Mid-State Health Network</b>
		123
D1IV.11	<b>Active grievances</b>  Enter the total number of grievances still pending or in	<b>Reg 6 CMH Partnership of Southeast MI</b>
		90
		<b>Reg 7 Detroit Wayne Integrated Health Network</b>
		91
		<b>Reg 8 Oakland Community Health Network</b>
		91
		<b>Reg 9 Macomb County CMH Services</b>
		47
		<b>Region 10 PIHP</b>
		175
D1IV.11	<b>Active grievances</b>  Enter the total number of grievances still pending or in	<b>Reg 1 NorthCare</b>
		0

process (not yet resolved) as of the end of the reporting year.

**Reg 2 Northern MI Regional Entity**

2

**Reg 3 Lakeshore Regional Entity**

0

**Reg 4 South West Michigan Behavioral Health**

12

**Reg 5 Mid-State Health Network**

9

**Reg 6 CMH Partnership of Southeast MI**

0

**Reg 7 Detroit Wayne Integrated Health Network**

16

**Reg 8 Oakland Community Health Network**

3

**Reg 9 Macomb County CMH Services**

0

**Region 10 PIHP**

0

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**D1IV.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

**Reg 1 NorthCare**

13

**Reg 2 Northern MI Regional Entity**

125

**Reg 3 Lakeshore Regional Entity**

whether the enrollee was actively receiving LTSS at the time that the grievance was filed). If this does not apply, enter N/A.

136

**Reg 4 South West Michigan Behavioral Health**

64

**Reg 5 Mid-State Health Network**

49

**Reg 6 CMH Partnership of Southeast MI**

71

**Reg 7 Detroit Wayne Integrated Health Network**

40

**Reg 8 Oakland Community Health Network**

78

**Reg 9 Macomb County CMH Services**

34

**Region 10 PIHP**

26

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**D1IV.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 year 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

**Reg 1 NorthCare**

0

**Reg 2 Northern MI Regional Entity**

1

**Reg 3 Lakeshore Regional Entity**

1

**Reg 4 South West Michigan Behavioral Health**

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 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.

1

#### **Reg 5 Mid-State Health Network**

4

#### **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**

1

#### **Region 10 PIHP**

2

### **D1IV.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 year.

See 42 CFR §438.408(b)(1) for requirements related to the timely resolution of grievances.

#### **Reg 1 NorthCare**

56

#### **Reg 2 Northern MI Regional Entity**

249

#### **Reg 3 Lakeshore Regional Entity**

249

#### **Reg 4 South West Michigan Behavioral Health**

154

**Reg 5 Mid-State Health Network**

122

**Reg 6 CMH Partnership of Southeast MI**

90

**Reg 7 Detroit Wayne Integrated Health Network**

95

**Reg 8 Oakland Community Health Network**

91

**Reg 9 Macomb County CMH Services**

47

**Region 10 PIHP**

175

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## **Grievances by Service**

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



Number	Indicator	Response
D1IV.15a	<b>Resolved grievances related to general inpatient services</b>  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”.	<b>Reg 1 NorthCare</b>
		NA
		<b>Reg 2 Northern MI Regional Entity</b>
		NA
		<b>Reg 3 Lakeshore Regional Entity</b>
		NA
		<b>Reg 4 South West Michigan Behavioral Health</b>
		NA
		<b>Reg 5 Mid-State Health Network</b>
		NA
D1IV.15b	<b>Resolved grievances related to general outpatient services</b>	<b>Reg 6 CMH Partnership of Southeast MI</b>
		NA
		<b>Reg 7 Detroit Wayne Integrated Health Network</b>
		NA
		<b>Reg 8 Oakland Community Health Network</b>
		NA
		<b>Reg 9 Macomb County CMH Services</b>
		NA
		<b>Region 10 PIHP</b>
		NA
D1IV.15b	<b>Resolved grievances related to general outpatient services</b>	<b>Reg 1 NorthCare</b>
		NA

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 2 Northern MI Regional Entity**

NA

**Reg 3 Lakeshore Regional Entity**

NA

**Reg 4 South West Michigan Behavioral Health**

NA

**Reg 5 Mid-State Health Network**

NA

**Reg 6 CMH Partnership of Southeast MI**

NA

**Reg 7 Detroit Wayne Integrated Health Network**

NA

**Reg 8 Oakland Community Health Network**

NA

**Reg 9 Macomb County CMH Services**

NA

**Region 10 PIHP**

NA

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<b>D1IV.15c</b>	<b>Resolved grievances related to inpatient behavioral health services</b>  Enter the total number of grievances 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 this type of service, enter "N/A".	<b>Reg 1 NorthCare</b>
		0
		<b>Reg 2 Northern MI Regional Entity</b>
		0
		<b>Reg 3 Lakeshore Regional Entity</b>
		6
		<b>Reg 4 South West Michigan Behavioral Health</b>
		8
		<b>Reg 5 Mid-State Health Network</b>
		1
		<b>Reg 6 CMH Partnership of Southeast MI</b>
		0
		<b>Reg 7 Detroit Wayne Integrated Health Network</b>
		NA
		<b>Reg 8 Oakland Community Health Network</b>
		0
		<b>Reg 9 Macomb County CMH Services</b>
		0
		<b>Region 10 PIHP</b>
		2

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<b>D1IV.15d</b>	<b>Resolved grievances related to outpatient behavioral health services</b>  Enter the total number of grievances resolved by the plan during the reporting year that	<b>Reg 1 NorthCare</b>
		5
		<b>Reg 2 Northern MI Regional Entity</b>

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".

0

**Reg 3 Lakeshore Regional Entity**

15

**Reg 4 South West Michigan Behavioral Health**

146

**Reg 5 Mid-State Health Network**

82

**Reg 6 CMH Partnership of Southeast MI**

40

**Reg 7 Detroit Wayne Integrated Health Network**

105

**Reg 8 Oakland Community Health Network**

79

**Reg 9 Macomb County CMH Services**

47

**Region 10 PIHP**

173

**D1IV.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**

NA

**Reg 2 Northern MI Regional Entity**

NA

**Reg 3 Lakeshore Regional Entity**

NA

**Reg 4 South West Michigan Behavioral Health**

NA

**Reg 5 Mid-State Health Network**

NA

**Reg 6 CMH Partnership of Southeast MI**

NA

**Reg 7 Detroit Wayne Integrated Health Network**

NA

**Reg 8 Oakland Community Health Network**

NA

**Reg 9 Macomb County CMH Services**

NA

**Region 10 PIHP**

NA

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**D1IV.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**

NA

**Reg 2 Northern MI Regional Entity**

NA

**Reg 3 Lakeshore Regional Entity**

NA

**Reg 4 South West Michigan Behavioral Health**

NA

**Reg 5 Mid-State Health Network**

NA

**Reg 6 CMH Partnership of Southeast MI**

NA

**Reg 7 Detroit Wayne Integrated Health Network**

NA

**Reg 8 Oakland Community Health Network**

NA

**Reg 9 Macomb County CMH Services**

NA

**Region 10 PIHP**

NA

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**D1IV.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**

2

**Reg 2 Northern MI Regional Entity**

89

**Reg 3 Lakeshore Regional Entity**

23

**Reg 4 South West Michigan Behavioral Health**

32

**Reg 5 Mid-State Health Network**

8

**Reg 6 CMH Partnership of Southeast MI**

3

**Reg 7 Detroit Wayne Integrated Health Network**

11

**Reg 8 Oakland Community Health Network**

12

**Reg 9 Macomb County CMH Services**

34

**Region 10 PIHP**

0

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**D1IV.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**

NA

**Reg 2 Northern MI Regional Entity**

NA

**Reg 3 Lakeshore Regional Entity**

NA

**Reg 4 South West Michigan Behavioral Health**

NA

**Reg 5 Mid-State Health Network**

NA

**Reg 6 CMH Partnership of Southeast MI**

NA

**Reg 7 Detroit Wayne Integrated Health Network**

NA

**Reg 8 Oakland Community Health Network**

NA

**Reg 9 Macomb County CMH Services**

NA

**Region 10 PIHP**

NA

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**D1IV.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**

NA

**Reg 2 Northern MI Regional Entity**

0

**Reg 3 Lakeshore Regional Entity**

0

**Reg 4 South West Michigan Behavioral Health**

NA

**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**

0

**Reg 9 Macomb County CMH Services**

NA



**Region 10 PIHP**

0

**D1IV.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 in items D1.IV.15a-i paid primarily by Medicaid, enter "N/A".

**Reg 1 NorthCare**

0

**Reg 2 Northern MI Regional Entity**

12

**Reg 3 Lakeshore Regional Entity**

11

**Reg 4 South West Michigan Behavioral Health**

NA

**Reg 5 Mid-State Health Network**

27

**Reg 6 CMH Partnership of Southeast MI**

47

**Reg 7 Detroit Wayne Integrated Health Network**

NA

**Reg 8 Oakland Community Health Network**

0

**Reg 9 Macomb County CMH Services**

0

**Region 10 PIHP**

0

## **Grievances by Reason**

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

Number	Indicator	Response
D1IV.16a	<b>Resolved grievances related to plan or provider customer service</b>  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 interactions with the plan's Member Services department, provider offices or facilities, plan marketing agents, or any other plan or provider representatives.	<b>Reg 1 NorthCare</b>
		0
		<b>Reg 2 Northern MI Regional Entity</b>
		0
		<b>Reg 3 Lakeshore Regional Entity</b>
		7
		<b>Reg 4 South West Michigan Behavioral Health</b>
		97
		<b>Reg 5 Mid-State Health Network</b>
		2
		<b>Reg 6 CMH Partnership of Southeast MI</b>
		0
		<b>Reg 7 Detroit Wayne Integrated Health Network</b>
		10
		<b>Reg 8 Oakland Community Health Network</b>
		21
		<b>Reg 9 Macomb County CMH Services</b>
		1
		<b>Region 10 PIHP</b>
		2
D1IV.16b	<b>Resolved grievances related to plan or provider care management/case management</b>	<b>Reg 1 NorthCare</b>
		1

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 2 Northern MI Regional Entity**

10

**Reg 3 Lakeshore Regional Entity**

19

**Reg 4 South West Michigan Behavioral Health**

15

**Reg 5 Mid-State Health Network**

26

**Reg 6 CMH Partnership of Southeast MI**

19

**Reg 7 Detroit Wayne Integrated Health Network**

42

**Reg 8 Oakland Community Health Network**

0

**Reg 9 Macomb County CMH Services**

38

**Region 10 PIHP**

22

**D1IV.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

**Reg 1 NorthCare**

10

**Reg 2 Northern MI Regional Entity**

17

**Reg 3 Lakeshore Regional Entity**

travel or wait times, or other access issues.

7

**Reg 4 South West Michigan Behavioral Health**

18

**Reg 5 Mid-State Health Network**

21

**Reg 6 CMH Partnership of Southeast MI**

7

**Reg 7 Detroit Wayne Integrated Health Network**

46

**Reg 8 Oakland Community Health Network**

33

**Reg 9 Macomb County CMH Services**

0

**Region 10 PIHP**

60

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**D1IV.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. 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.

**Reg 1 NorthCare**

30

**Reg 2 Northern MI Regional Entity**

13

**Reg 3 Lakeshore Regional Entity**

57

**Reg 4 South West Michigan Behavioral Health**

**Reg 5 Mid-State Health Network**

42

**Reg 6 CMH Partnership of Southeast MI**

57

**Reg 7 Detroit Wayne Integrated Health Network**

47

**Reg 8 Oakland Community Health Network**

20

**Reg 9 Macomb County CMH Services**

2

**Region 10 PIHP**

87

**D1IV.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**

4

**Reg 2 Northern MI Regional Entity**

6

**Reg 3 Lakeshore Regional Entity**

30

**Reg 4 South West Michigan Behavioral Health**

3

**Reg 5 Mid-State Health Network**

16

**Reg 6 CMH Partnership of Southeast MI**

19

**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**

3

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**D1IV.16f**

**Resolved grievances related to payment or billing issues**

Enter the total number of grievances resolved by the plan during the reporting year 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**

7

**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**

6

**Reg 8 Oakland Community Health Network**

5

**Reg 9 Macomb County CMH Services**

4

**Region 10 PIHP**

0

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**D1IV.16g**

**Resolved grievances related to suspected fraud**

Enter the total number of grievances resolved by the plan during the reporting year that were related to suspected fraud.

Suspected fraud grievances include suspected cases of financial/payment fraud perpetrated 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**

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

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**D1IV.16h**

**Resolved grievances related to abuse, neglect or exploitation**

Enter the total number of grievances resolved by the plan 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**

0

**Reg 2 Northern MI Regional Entity**

0

**Reg 3 Lakeshore Regional Entity**

3

**Reg 4 South West Michigan Behavioral Health**

1

**Reg 5 Mid-State Health Network**

3

**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**

1

**Region 10 PIHP**

<b>D1IV.16i</b>	<b>Resolved grievances related to lack of timely plan response to a service authorization or appeal (including requests to expedite or extend appeals)</b>  Enter the total number of grievances resolved by the plan 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).	<b>Reg 1 NorthCare</b>
		1
		<b>Reg 2 Northern MI Regional Entity</b>
		2
		<b>Reg 3 Lakeshore Regional Entity</b>
		0
		<b>Reg 4 South West Michigan Behavioral Health</b>
		0
		<b>Reg 5 Mid-State Health Network</b>
		5
		<b>Reg 6 CMH Partnership of Southeast MI</b>
		0
		<b>Reg 7 Detroit Wayne Integrated Health Network</b>
		1
		<b>Reg 8 Oakland Community Health Network</b>
		0
		<b>Reg 9 Macomb County CMH Services</b>
		0
		<b>Region 10 PIHP</b>
		1
<b>D1IV.16j</b>	<b>Resolved grievances related to plan denial of expedited appeal</b>	<b>Reg 1 NorthCare</b>
		0

Enter the total number of grievances resolved by the plan 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 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

**D1IV.16k**

**Resolved grievances filed for other reasons**

Enter the total number of grievances resolved by the plan during the reporting year that were filed for a reason other than the reasons listed above.

**Reg 1 NorthCare**

3

**Reg 2 Northern MI Regional Entity**

14

**Reg 3 Lakeshore Regional Entity**

6

**Reg 4 South West Michigan Behavioral Health**

7

**Reg 5 Mid-State Health Network**

8

**Reg 6 CMH Partnership of Southeast MI**

0

**Reg 7 Detroit Wayne Integrated Health Network**

0

**Reg 8 Oakland Community Health Network**

11

**Reg 9 Macomb County CMH Services**

0

**Region 10 PIHP**

3

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## **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.



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 / 17

**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**

100%

**Reg 2 Northern MI Regional Entity**

98.96%

**Reg 3 Lakeshore Regional Entity**

98.99%

**Reg 4 South West Michigan Behavioral Health**

99.71%

**Reg 5 Mid-State Health Network**

99.33%

**Reg 6 CMH Partnership of Southeast MI**

99.55%

**Reg 7 Detroit Wayne Integrated Health Network**

97.32%

**Reg 8 Oakland Community Health Network**

98.16%

**Reg 9 Macomb County CMH Services**

97.99%

**Region 10 PIHP**

99.39%



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.**

2 / 17

**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**

58.19%

**Reg 2 Northern MI Regional Entity**

59.37%

**Reg 3 Lakeshore Regional Entity**

53.77%

**Reg 4 South West Michigan Behavioral Health**

72.92%

**Reg 5 Mid-State Health Network**

64.90%

**Reg 6 CMH Partnership of Southeast MI**

49.65%

**Reg 7 Detroit Wayne Integrated Health Network**

53.23%

**Reg 8 Oakland Community Health Network**

53.31%

**Reg 9 Macomb County CMH Services**

50.81%

**Region 10 PIHP**

49.72%



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.**

**D2.VII.2 Measure Domain**

Behavioral health care

3 / 17

**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 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**

67.45%

**Reg 2 Northern MI Regional Entity**

69.72%

**Reg 3 Lakeshore Regional Entity**

57.90%

**Reg 4 South West Michigan Behavioral Health**

59.21%

**Reg 5 Mid-State Health Network**

64.86%

**Reg 6 CMH Partnership of Southeast MI**

66.47%

**Reg 7 Detroit Wayne Integrated Health Network**

90.17%

**Reg 8 Oakland Community Health Network**



97.62%

**Reg 9 Macomb County CMH Services**

77.98%

**Region 10 PIHP**

77.57%



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 / 17

**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**

98.16%

**Reg 2 Northern MI Regional Entity**

92.70%

**Reg 3 Lakeshore Regional Entity**

96.35%

**Reg 4 South West Michigan Behavioral Health**

97.21%

**Reg 5 Mid-State Health Network**

96.45%

**Reg 6 CMH Partnership of Southeast MI**

92.93%

**Reg 7 Detroit Wayne Integrated Health Network**

98.25%

**Reg 8 Oakland Community Health Network**

95.30%

**Reg 9 Macomb County CMH Services**

75.50%

**Region 10 PIHP**

95.71%



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 / 17

**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 - 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**

95%

##### **Reg 2 Northern MI Regional Entity**

96.09%

##### **Reg 3 Lakeshore Regional Entity**

98.66%

##### **Reg 4 South West Michigan Behavioral Health**

98.11%

##### **Reg 5 Mid-State Health Network**

94.09%

##### **Reg 6 CMH Partnership of Southeast MI**

98.40%

##### **Reg 7 Detroit Wayne Integrated Health Network**

96.69%

##### **Reg 8 Oakland Community Health Network**

99.32%

##### **Reg 9 Macomb County CMH Services**

100%

##### **Region 10 PIHP**

93.23%



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

6 / 17

**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**

7.71%

**Reg 2 Northern MI Regional Entity**

8.22%

**Reg 3 Lakeshore Regional Entity**

5.89%

**Reg 4 South West Michigan Behavioral Health**

7.94%

**Reg 5 Mid-State Health Network**

7.92%

**Reg 6 CMH Partnership of Southeast MI**

6.90%

**Reg 7 Detroit Wayne Integrated Health Network**

6.24%

**Reg 8 Oakland Community Health Network**

8.12%

**Reg 9 Macomb County CMH Services**

5.12%

**Region 10 PIHP**

7.87%



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 / 17

**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**

98.50%

**Reg 2 Northern MI Regional Entity**

93.04%

**Reg 3 Lakeshore Regional Entity**

95.09%

**Reg 4 South West Michigan Behavioral Health**

96.79%

**Reg 5 Mid-State Health Network**

96.17%

**Reg 6 CMH Partnership of Southeast MI**

93%

**Reg 7 Detroit Wayne Integrated Health Network**

95.38%

**Reg 8 Oakland Community Health Network**

93.68%

**Reg 9 Macomb County CMH Services**

94.37%

**Region 10 PIHP**

97.66%



Complete

**D2.VII.1 Measure Name: The percent of (a) adults with a mental illness, 8 / 17  
an (b)intellectual developmental disability, and (c) adults dually  
diagnosed with a mental illness/an intellectual developmental  
disability served by the 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**

No, 10/01/2022 - 09/30/2023

**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 PIHP  
Calculation = Competitive Employment Rate"

**Measure results****Reg 1 NorthCare**

18.85%

**Reg 2 Northern MI Regional Entity**

22.87%

**Reg 3 Lakeshore Regional Entity**

20.33%

**Reg 4 South West Michigan Behavioral Health**

14%

**Reg 5 Mid-State Health Network**

20.42%

**Reg 6 CMH Partnership of Southeast MI**

17.94%

**Reg 7 Detroit Wayne Integrated Health Network**

16.73%

**Reg 8 Oakland Community Health Network**

23.78%

**Reg 9 Macomb County CMH Services**

19.11%

**Region 10 PIHP**

17.89%



Complete

**D2.VII.1 Measure Name: The percent of adults with (a) mental illness, (b) an intellectual or developmental disability, and (c) dually diagnosed with mental illness/ intellectual or developmental disability served by the PIHPs who earned minimum wage or more from any employment activities.** 9 / 17

**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**

No, 10/01/2022 - 09/30/2023

**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**

91.51%

**Reg 2 Northern MI Regional Entity**

91.62%



**Reg 3 Lakeshore Regional Entity**

96.80%

**Reg 4 South West Michigan Behavioral Health**

99.37%

**Reg 5 Mid-State Health Network**

96%

**Reg 6 CMH Partnership of Southeast MI**

94%

**Reg 7 Detroit Wayne Integrated Health Network**

95.69%

**Reg 8 Oakland Community Health Network**

94.21%

**Reg 9 Macomb County CMH Services**

86.20%

**Region 10 PIHP**

95.14%



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.**

10 / 17

**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**

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

**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**

9.73%

**Reg 2 Northern MI Regional Entity**

13.29%

**Reg 3 Lakeshore Regional Entity**

11.88%

**Reg 4 South West Michigan Behavioral Health**

12.40%

**Reg 5 Mid-State Health Network**

11.01%

**Reg 6 CMH Partnership of Southeast MI**

11.30%

**Reg 7 Detroit Wayne Integrated Health Network**

16.54%

**Reg 8 Oakland Community Health Network**

11.57%

**Reg 9 Macomb County CMH Services**

15.25%

**Region 10 PIHP**

12.72%



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

11 / 17

**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**

No, 10/01/2022 - 09/30/2023

**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**

20.74%

**Reg 2 Northern MI Regional Entity**

24.90%

**Reg 3 Lakeshore Regional Entity**

15.82%

**Reg 4 South West Michigan Behavioral Health**

20.54%

**Reg 5 Mid-State Health Network**

22.55%

**Reg 6 CMH Partnership of Southeast MI**

26.11%

**Reg 7 Detroit Wayne Integrated Health Network**

20.94%

**Reg 8 Oakland Community Health Network**

21.10%

**Reg 9 Macomb County CMH Services**

16.48%

**Region 10 PIHP**

19.60%



Complete

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

12 / 17

**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**

No, 10/01/2022 - 09/30/2023

**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**

54.36%

**Reg 2 Northern MI Regional Entity**

48.61%

**Reg 3 Lakeshore Regional Entity**

40.93%

**Reg 4 South West Michigan Behavioral Health**

47.44%

**Reg 5 Mid-State Health Network**

48%

**Reg 6 CMH Partnership of Southeast MI**

36.71%

**Reg 7 Detroit Wayne Integrated Health Network**

39.62%

**Reg 8 Oakland Community Health Network**

33.80%

**Reg 9 Macomb County CMH Services**

47.30%

**Region 10 PIHP**

43.75%



Complete

**D2.VII.1 Measure Name: FUH-30 Adult**

13 / 17

**D2.VII.2 Measure Domain**

Behavioral health care

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

268

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

Program-specific rate

**D2.VII.6 Measure Set**

HEDIS

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

No, 01/01/2023 - 12/31/2023

**D2.VII.8 Measure Description**

The percentage of discharges for beneficiaries eighteen years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with mental health practitioner within 30 Days.

**Measure results****Reg 1 NorthCare**

80.43%

**Reg 2 Northern MI Regional Entity**

68.21%

**Reg 3 Lakeshore Regional Entity**

64.04%

**Reg 4 South West Michigan Behavioral Health**

69.42%

**Reg 5 Mid-State Health Network**

69.34%

**Reg 6 CMH Partnership of Southeast MI**

68.42%

**Reg 7 Detroit Wayne Integrated Health Network**

56.32%

**Reg 8 Oakland Community Health Network**

69.74%

**Reg 9 Macomb County CMH Services**

59.46%

## Region 10 PIHP

66.04%



Complete

### D2.VII.1 Measure Name: FUH-30 Child

14 / 17

#### D2.VII.2 Measure Domain

Behavioral health care

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

268

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

Program-specific rate

#### D2.VII.6 Measure Set

HEDIS

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

No, 01/01/2023 - 12/31/2023

#### D2.VII.8 Measure Description

The percentage of discharges for beneficiaries six to seventeen years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with mental health practitioner within 30 Days.

#### Measure results

##### Reg 1 NorthCare

93.94%

##### Reg 2 Northern MI Regional Entity

82.35%

##### Reg 3 Lakeshore Regional Entity

80%

##### Reg 4 South West Michigan Behavioral Health

86.25%

##### Reg 5 Mid-State Health Network

85.28%

**Reg 6 CMH Partnership of Southeast MI**

83.69%

**Reg 7 Detroit Wayne Integrated Health Network**

68.46%

**Reg 8 Oakland Community Health Network**

83.76%

**Reg 9 Macomb County CMH Services**

78.63%

**Region 10 PIHP**

80.83%



Complete

**D2.VII.1 Measure Name: IET-14 Initiation Total**

15 / 17

**D2.VII.2 Measure Domain**

Behavioral health care

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

394

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

Program-specific rate

**D2.VII.6 Measure Set**

HEDIS

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

No, 01/01/2023 - 12/31/2023

**D2.VII.8 Measure Description**

"The percentage of adolescents and adults with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following:  
Initiation of AOD Treatment: The percentage of beneficiaries who initiate treatment within 14 calendar days of the diagnosis.

**Measure results**

**Reg 1 NorthCare**

30.02%



**Reg 2 Northern MI Regional Entity**

28.67%

**Reg 3 Lakeshore Regional Entity**

36.75%

**Reg 4 South West Michigan Behavioral Health**

30.58%

**Reg 5 Mid-State Health Network**

37.15%

**Reg 6 CMH Partnership of Southeast MI**

39.96%

**Reg 7 Detroit Wayne Integrated Health Network**

37.18%

**Reg 8 Oakland Community Health Network**

40.33%

**Reg 9 Macomb County CMH Services**

40.84%

**Region 10 PIHP**

37.93%



Complete

**D2.VII.1 Measure Name: IET-34 Engagement Total**

16 / 17

**D2.VII.2 Measure Domain**

Behavioral health care

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

394

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

Program-specific rate

**D2.VII.6 Measure Set**  
HEDIS

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

No, 01/01/2023 - 12/31/2023

**D2.VII.8 Measure Description**

"The percentage of adolescents and adults with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following:  
Engagement of AOD Treatment: The percentage of beneficiaries who initiated treatment and who had two or more additional AOD services or Medication Assisted Treatment (MAT) within 34 calendar days of the initiation visit.

**Measure results**

**Reg 1 NorthCare**

13.22%

**Reg 2 Northern MI Regional Entity**

11.55%

**Reg 3 Lakeshore Regional Entity**

12.26%

**Reg 4 South West Michigan Behavioral Health**

9.7%

**Reg 5 Mid-State Health Network**

13.18%

**Reg 6 CMH Partnership of Southeast MI**

12.78%

**Reg 7 Detroit Wayne Integrated Health Network**

7.11%

**Reg 8 Oakland Community Health Network**

9.69%

**Reg 9 Macomb County CMH Services**

11.37%

**Region 10 PIHP**

15.15%



Complete

**D2.VII.1 Measure Name: SAA-AD**

17 / 17

**D2.VII.2 Measure Domain**

Behavioral health care

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

18

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

Program-specific rate

**D2.VII.6 Measure Set**

Medicaid Adult Core Set

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

No, 01/01/2023 - 12/31/2023

**D2.VII.8 Measure Description**

"Percentage of Adults Age 18 and Older with Schizophrenia or Schizoaffective Disorder who were Dispensed and Remained on an Antipsychotic Medication for at Least 80 Percent of their Treatment Period"

**Measure results**

**Reg 1 NorthCare**

65.75%

**Reg 2 Northern MI Regional Entity**

62.74

**Reg 3 Lakeshore Regional Entity**

58.68%

**Reg 4 South West Michigan Behavioral Health**

64.92%

**Reg 5 Mid-State Health Network**

63.35%

**Reg 6 CMH Partnership of Southeast MI**

60.03%

**Reg 7 Detroit Wayne Integrated Health Network**

53.2%

**Reg 8 Oakland Community Health Network**

57.62%

**Reg 9 Macomb County CMH Services**

59.54%

**Region 10 PIHP**

58.88%

## **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.



Complete

**D3.VIII.1 Intervention type: Corrective action plan**

1 / 7

**D3.VIII.2 Plan performance issue**

Timely access

**D3.VIII.3 Plan name**

Reg 3 Lakeshore Regional Entity

**D3.VIII.4 Reason for intervention**

MDHHS paced LRE on a CAP due to insufficient access to Autism/ABA services. MDHHS was concerned that children were not receiving timely assessments and ABA services and mandated that LRE institute plans to increase access to these services.

**Sanction details****D3.VIII.5 Instances of non-compliance**

1

**D3.VIII.6 Sanction amount**

N/A

**D3.VIII.7 Date assessed**

04/26/2023

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

Yes, remediated 02/04/2025

**D3.VIII.9 Corrective action plan**

No



Complete

**D3.VIII.1 Intervention type: Corrective action plan**

2 / 7

**D3.VIII.2 Plan performance issue**

Reporting

**D3.VIII.3 Plan name**

Reg 1 NorthCare

**D3.VIII.4 Reason for intervention**

In reviewing NorthCare Networks credentialing report due 11.15.2023, 39 files were found to be overdue. Some of which were 6+ years overdue. Additionally, there were credentialing files found to have not been reviewed since 2011 / 2014. MDHHS followed up with NorthCare personnel responsible for oversight of credentialing and it was reported that the delays were surprising as many CMHs were already under a CAP for Credentialing, noting that progress was still underway in working with these organizations on correcting.

**Sanction details**

**D3.VIII.5 Instances of non-compliance**

39

**D3.VIII.6 Sanction amount**

N/A

**D3.VIII.7 Date assessed**

01/04/2024

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

Remediation in progress

**D3.VIII.9 Corrective action plan**

Yes



Complete

### **D3.VIII.1 Intervention type: Corrective action plan**

3 / 7

**D3.VIII.2 Plan performance issue**

Performance improvement

**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. Credentialing Standards continue to be met after formal enrollment of the provider. Non Licensed providers meet provider qualifications identified in the Medicaid Provider Manual. Providers meet staff training requirements. Service and supports identified in IPOS address individual's needs. Person-centered planning addressed health and safety. Person-centered planning addressed individual's goals, interests and desires IPOS has been developed in accordance with policies and procedures established by MDHHS. The IPOS for individuals enrolled is updated within 365 days of their last IPOS. Services and treatment identified in the IPOS are provided as specified in the plan. Individual/Family/Legal Guardian had the ability to choose their providers/waiver services. Individual provided information/education on how to report abuse/neglect/exploitation and other critical incidents. Individual served received health care appraisal. BTP are developed in accordance with the Technical Requirement for BTPRC. LOC evaluations that are completed accurately. Re-evaluation for eligibility was within 365 days of the last eligibility determination. "

#### **Sanction details**

**D3.VIII.5 Instances of non-compliance**

484

**D3.VIII.6 Sanction amount**

N/A

**D3.VIII.7 Date assessed**

12/15/2024

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

Yes, remediated 03/17/2025

**D3.VIII.9 Corrective action plan**

Yes



Complete

**D3.VIII.1 Intervention type: Corrective action plan**

4 / 7

**D3.VIII.2 Plan performance issue**

Performance improvement

**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. Credentialing Standards continue to be met after formal enrollment of the provider. Non Licensed providers meet provider qualifications identified in the Medicaid Provider Manual. Providers meet staff training requirements. Service and supports identified in IPOS address individual's needs. Person-centered planning addressed health and safety. Person-centered planning addressed individual's goals, interests and desires IPOS has been developed in accordance with policies and procedures established by MDHHS. IPOS is modified in response to changes in the individual's needs Services and treatment identified in the IPOS are provided as specified in the plan. Individual had an ability to choose among various waiver services (approved HSW services only). Individual/Family/Legal Guardian had the ability to choose their providers/waiver services. Individual provided information/education on how to report abuse/neglect/exploitation and other critical incidents. Individual served received health care appraisal. BTP are developed in accordance with the Technical Requirement for BTPRC. LOC evaluations that are completed accurately. Claims are coded in accordance with MDCH policies and procedures. Re-evaluation for eligibility was within 365 days of the last eligibility determination. "

**Sanction details****D3.VIII.5 Instances of non-compliance**

303

**D3.VIII.6 Sanction amount**

N/A

**D3.VIII.7 Date assessed**

03/08/2024

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

Yes, remediated 08/31/2024

**D3.VIII.9 Corrective action plan**

Yes



Complete

### D3.VIII.1 Intervention type: Corrective action plan

5 / 7

**D3.VIII.2 Plan performance issue**

Performance improvement

**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. Credentialing Standards continue to be met after formal enrollment of the provider. Non Licensed providers meet provider qualifications identified in the Medicaid Provider Manual. Providers meet staff training requirements. Service and supports identified in IPOS address individual's needs. Person-centered planning addressed health and safety. Person-centered planning addressed individual's goals, interests and desires IPOS has been developed in accordance with policies and procedures established by MDHHS. The IPOS for individuals enrolled is updated within 365 days of their last IPOS. IPOS is modified in response to changes in the individual's needs Services and treatment identified in the IPOS are provided as specified in the plan. Individual/Family/Legal Guardian had the ability to choose their providers/waiver services. Individual provided information/education on how to report abuse/neglect/exploitation and other critical incidents. Individual served received health care appraisal. BTP are developed in accordance with the Technical Requirement for BTPRC. Re-evaluation for eligibility was within 365 days of the last eligibility determination. "

#### Sanction details

**D3.VIII.5 Instances of non-compliance**

480

**D3.VIII.6 Sanction amount**

NA

**D3.VIII.7 Date assessed**

04/26/2024

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

Yes, remediated 02/14/2025

**D3.VIII.9 Corrective action plan**

Yes



Complete

### D3.VIII.1 Intervention type: Corrective action plan

6 / 7

**D3.VIII.2 Plan performance issue**

Performance improvement

**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. Credentialing Standards continue to be met after formal enrollment of the provider. Non Licensed providers meet provider qualifications identified in the Medicaid Provider Manual. Providers meet staff training requirements. Service and supports identified in IPOS address individual's needs. Person-centered planning addressed health and safety. Person-centered planning addressed individual's goals, interests and desires IPOS has been developed in accordance with policies and procedures established by MDHHS. The IPOS for individuals enrolled is updated within 365 days of their last IPOS. IPOS is modified in response to changes in the individual's needs Services and treatment identified in the IPOS are provided as specified in the plan. Individual had an ability to choose among various waiver services. Individual/Family/Legal Guardian had the ability to choose their providers/waiver services. Individual provided information/education on how to report abuse/neglect/exploitation and other critical incidents. Individual served received health care appraisal. BTP are developed in accordance with the Technical Requirement for BTPRC. LOC evaluations that are completed accurately. Claims are coded in accordance with policies and procedures. Re-evaluation for eligibility was within 365 days of the last eligibility determination. "

**Sanction details**

**D3.VIII.5 Instances of non-compliance**  
691

**D3.VIII.6 Sanction amount**  
NA

**D3.VIII.7 Date assessed**  
07/31/2024

**D3.VIII.8 Remediation date non-compliance was corrected**  
Remediation in progress

**D3.VIII.9 Corrective action plan**  
Yes



Complete

**D3.VIII.1 Intervention type: Corrective action plan**

7 / 7

**D3.VIII.2 Plan performance issue**  
Performance improvement

**D3.VIII.3 Plan name**  
Region 10 PIHP

**D3.VIII.4 Reason for intervention**

"Credentialing Standards met prior to enrollment of the provider. Credentialing Standards continue to be met after formal enrollment of the provider. Non Licensed providers meet provider qualifications identified in

the Medicaid Provider Manual. Providers meet staff training requirements. Service and supports identified in IPOS address individual's needs. Person-centered planning addressed health and safety. Person-centered planning addressed individual's goals, interests and desires IPOS has been developed in accordance with policies and procedures established by MDHHS. The IPOS for individuals enrolled is updated within 365 days of their last IPOS. IPOS is modified in response to changes in the individual's needs Services and treatment identified in the IPOS are provided as specified in the plan. Individual/Family/Legal Guardian had the ability to choose their providers/waiver services. Individual provided information/education on how to report abuse/neglect/exploitation and other critical incidents. Individual served received health care appraisal. BTP are developed in accordance with the Technical Requirement for BTPRC. Re-evaluation for eligibility was within 365 days of the last eligibility determination. "

**Sanction details**

<b>D3.VIII.5 Instances of non-compliance</b>	<b>D3.VIII.6 Sanction amount</b>
312	N/A
<b>D3.VIII.7 Date assessed</b>	<b>D3.VIII.8 Remediation date non-compliance was corrected</b>
09/30/2024	Remediation in progress
<b>D3.VIII.9 Corrective action plan</b>	
Yes	

**Topic X. Program Integrity**

Number	Indicator	Response
D1X.1	<b>Dedicated program integrity staff</b>  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).	<b>Reg 1 NorthCare</b>
		2
		<b>Reg 2 Northern MI Regional Entity</b>
		8
		<b>Reg 3 Lakeshore Regional Entity</b>
		8
		<b>Reg 4 South West Michigan Behavioral Health</b>
		11
		<b>Reg 5 Mid-State Health Network</b>
		14
		<b>Reg 6 CMH Partnership of Southeast MI</b>
		15
		<b>Reg 7 Detroit Wayne Integrated Health Network</b>
		1
		<b>Reg 8 Oakland Community Health Network</b>
		4
		<b>Reg 9 Macomb County CMH Services</b>
		2.75
		<b>Region 10 PIHP</b>
		40
D1X.2	<b>Count of opened program integrity investigations</b>  How many program integrity investigations were opened by	<b>Reg 1 NorthCare</b>  5

the plan during the reporting year?

**Reg 2 Northern MI Regional Entity**

4

**Reg 3 Lakeshore Regional Entity**

73

**Reg 4 South West Michigan Behavioral Health**

335

**Reg 5 Mid-State Health Network**

86

**Reg 6 CMH Partnership of Southeast MI**

18

**Reg 7 Detroit Wayne Integrated Health Network**

19

**Reg 8 Oakland Community Health Network**

6

**Reg 9 Macomb County CMH Services**

63

**Region 10 PIHP**

104

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<b>D1X.3</b>	<b>Ratio of opened program integrity investigations to enrollees</b>  What is the ratio of program integrity investigations opened by the plan in the past year to the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months)? Express this as a ratio per 1,000 beneficiaries.	<b>Reg 1 NorthCare</b>
		0.07:1,000
		<b>Reg 2 Northern MI Regional Entity</b>
		0.03:1,000
		<b>Reg 3 Lakeshore Regional Entity</b>
		0.26:1,000
		<b>Reg 4 South West Michigan Behavioral Health</b>
		1.55:1,000
		<b>Reg 5 Mid-State Health Network</b>
		0.21:1,000
		<b>Reg 6 CMH Partnership of Southeast MI</b>
		0.14:1,000
		<b>Reg 7 Detroit Wayne Integrated Health Network</b>
		0.03:1,000
		<b>Reg 8 Oakland Community Health Network</b>
		0.03:1,000
		<b>Reg 9 Macomb County CMH Services</b>
		0.29:1,000
		<b>Region 10 PIHP</b>
		0.51:1,000

---

<b>D1X.4</b>	<b>Count of resolved program integrity investigations</b>  How many program integrity investigations were resolved by the plan during the reporting year?	<b>Reg 1 NorthCare</b>
		6
		<b>Reg 2 Northern MI Regional Entity</b>

**Reg 3 Lakeshore Regional Entity**

95

**Reg 4 South West Michigan Behavioral Health**

386

**Reg 5 Mid-State Health Network**

142

**Reg 6 CMH Partnership of Southeast MI**

38

**Reg 7 Detroit Wayne Integrated Health Network**

15

**Reg 8 Oakland Community Health Network**

7

**Reg 9 Macomb County CMH Services**

42

**Region 10 PIHP**

126

**D1X.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 to the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months)? Express this as a ratio per 1,000 beneficiaries.

**Reg 1 NorthCare**

0.09:1,000

**Reg 2 Northern MI Regional Entity**

0.02:1,000

**Reg 3 Lakeshore Regional Entity**

0.34:1,000

**Reg 4 South West Michigan Behavioral Health**

1.79:1,000

**Reg 5 Mid-State Health Network**

0.35:1,000

**Reg 6 CMH Partnership of Southeast MI**

0.3:1,000

**Reg 7 Detroit Wayne Integrated Health Network**

0.02:1,000

**Reg 8 Oakland Community Health Network**

0.04:1,000

**Reg 9 Macomb County CMH Services**

0.19:1,000

**Region 10 PIHP**

0.61:1,000

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**D1X.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 referrals to the SMA and MFCU concurrently

**Reg 2 Northern MI Regional Entity**

Makes referrals to the SMA and MFCU concurrently

**Reg 3 Lakeshore Regional Entity**

Makes referrals to the SMA and MFCU concurrently

**Reg 4 South West Michigan Behavioral Health**

Makes referrals to the SMA and MFCU concurrently

**Reg 5 Mid-State Health Network**

Makes referrals to the SMA and MFCU concurrently

**Reg 6 CMH Partnership of Southeast MI**

Makes referrals to the SMA and MFCU concurrently

**Reg 7 Detroit Wayne Integrated Health Network**

Makes referrals to the SMA and MFCU concurrently

**Reg 8 Oakland Community Health Network**

Makes referrals to the SMA and MFCU concurrently

**Reg 9 Macomb County CMH Services**

Makes referrals to the SMA and MFCU concurrently

**Region 10 PIHP**

Makes referrals to the SMA and MFCU concurrently

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**D1X.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 unduplicated referrals.

**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**

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**

0

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**D1X.8**

**Ratio of program integrity referral to the state**

What is the ratio of program integrity referrals listed in indicator D1.X.7 made to the state during the reporting year to the number of enrollees? For number of enrollees, use the average number of individuals enrolled in the plan per month during the reporting year (reported in indicator D1.I.1). Express this as a ratio per 1,000 beneficiaries.

**Reg 1 NorthCare**

0:1,000

**Reg 2 Northern MI Regional Entity**

0:1,000

**Reg 3 Lakeshore Regional Entity**

0.01:1,000

**Reg 4 South West Michigan Behavioral Health**

0:1,000

**Reg 5 Mid-State Health Network**

0:1,000

**Reg 6 CMH Partnership of Southeast MI**

0:1,000

**Reg 7 Detroit Wayne Integrated Health Network**

0:1,000

**Reg 8 Oakland Community Health Network**

0.01:1,000

**Reg 9 Macomb County CMH Services**

0:1,000

**Region 10 PIHP**

0:1,000

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**D1X.9a:**

**Plan overpayment reporting to the state: Start Date**

What is the start date of the reporting period covered by the plan's latest overpayment recovery report submitted to the state?

**Reg 1 NorthCare**

10/01/2023

**Reg 2 Northern MI Regional Entity**

10/01/2023

**Reg 3 Lakeshore Regional Entity**

10/01/2023

**Reg 4 South West Michigan Behavioral Health**

10/01/2023

**Reg 5 Mid-State Health Network**

10/01/2023

**Reg 6 CMH Partnership of Southeast MI**

10/01/2023

**Reg 7 Detroit Wayne Integrated Health Network**

10/01/2023

**Reg 8 Oakland Community Health Network**

10/01/2023

**Reg 9 Macomb County CMH Services**

10/01/2023

**Region 10 PIHP**

10/01/2023

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**D1X.9b:**

**Plan overpayment reporting  
to the state: End Date**

What is the end date of the  
reporting period covered by the  
plan's latest overpayment  
recovery report submitted to  
the state?

**Reg 1 NorthCare**

09/30/2024

**Reg 2 Northern MI Regional Entity**

09/30/2024

**Reg 3 Lakeshore Regional Entity**

09/30/2024

**Reg 4 South West Michigan Behavioral  
Health**

09/30/2024

**Reg 5 Mid-State Health Network**

09/30/2024

**Reg 6 CMH Partnership of Southeast MI**

09/30/2024

**Reg 7 Detroit Wayne Integrated Health  
Network**

09/30/2024

**Reg 8 Oakland Community Health Network**

09/30/2024

**Reg 9 Macomb County CMH Services**

09/30/2024

**Region 10 PIHP**

09/30/2024

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**D1X.9c: Plan overpayment reporting to the state: Dollar amount**

From the plan's latest annual overpayment recovery report, what is the total amount of overpayments recovered?

**Reg 1 NorthCare**

\$121,622.90

**Reg 2 Northern MI Regional Entity**

\$0

**Reg 3 Lakeshore Regional Entity**

\$222,140.17

**Reg 4 South West Michigan Behavioral Health**

\$518,383.01

**Reg 5 Mid-State Health Network**

\$552,077.76

**Reg 6 CMH Partnership of Southeast MI**

\$19,166.39

**Reg 7 Detroit Wayne Integrated Health Network**

\$299,691.82

**Reg 8 Oakland Community Health Network**

\$2,124.02

**Reg 9 Macomb County CMH Services**

\$154,414.47

**Region 10 PIHP**

<b>D1X.9d:</b>	<b>Plan overpayment reporting to the state: Corresponding premium revenue</b>	<b>Reg 1 NorthCare</b>
		\$0
	What is the total amount of premium revenue for the corresponding reporting period (D1.X.9a-b)? (Premium revenue as defined in MLR reporting under 438.8(f)(2))	<b>Reg 2 Northern MI Regional Entity</b>
		\$0
		<b>Reg 3 Lakeshore Regional Entity</b>
		\$0
		<b>Reg 4 South West Michigan Behavioral Health</b>
		\$0
		<b>Reg 5 Mid-State Health Network</b>
		\$0
		<b>Reg 6 CMH Partnership of Southeast MI</b>
		\$0
		<b>Reg 7 Detroit Wayne Integrated Health Network</b>
		\$0
		<b>Reg 8 Oakland Community Health Network</b>
		\$0
		<b>Reg 9 Macomb County CMH Services</b>
		\$0
		<b>Region 10 PIHP</b>
		\$0
<b>D1X.10</b>	<b>Changes in beneficiary circumstances</b>	<b>Reg 1 NorthCare</b>
		Daily

Select the frequency the plan reports changes in beneficiary circumstances to the state.

**Reg 2 Northern MI Regional Entity**

Daily

**Reg 3 Lakeshore Regional Entity**

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

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**Topic XI: ILOS**

**⚠ Beginning December 2025, this section must be completed by states that authorize ILOS. Submission of this data before December 2025 is optional.**

If ILOSs are authorized for this program, report for each plan: if the plan offered any ILOS; if “Yes”, which ILOS the plan offered; and utilization data for each ILOS offered. If the plan offered an ILOS during the reporting period but there was no utilization, check that the ILOS was offered but enter “0” for utilization.

Number	Indicator	Response
D4XI.1	<b>ILOSs offered by plan</b>  Indicate whether this plan offered any ILOS to their enrollees.	<b>Reg 1 NorthCare</b>  No ILOSs were offered by this plan
		<b>Reg 2 Northern MI Regional Entity</b>  No ILOSs were offered by this plan
		<b>Reg 3 Lakeshore Regional Entity</b>  No ILOSs were offered by this plan
		<b>Reg 4 South West Michigan Behavioral Health</b>  No ILOSs were offered by this plan
		<b>Reg 5 Mid-State Health Network</b>  No ILOSs were offered by this plan
		<b>Reg 6 CMH Partnership of Southeast MI</b>  No ILOSs were offered by this plan
		<b>Reg 7 Detroit Wayne Integrated Health Network</b>  No ILOSs were offered by this plan
		<b>Reg 8 Oakland Community Health Network</b>  No ILOSs were offered by this plan
		<b>Reg 9 Macomb County CMH Services</b>  No ILOSs were offered by this plan
		<b>Region 10 PIHP</b>  No ILOSs were offered by this plan



## Topic XIII. Prior Authorization

- ⚠ Beginning June 2026, Indicators D1.XIII.1-15 must be completed. Submission of this data including partial reporting on some but not all plans, before June 2026 is optional; if you choose not to respond prior to June 2026, select “Not reporting data”.**

Number	Indicator	Response
N/A	<b>Are you reporting data prior to June 2026?</b>  If “Yes”, please complete the following questions under each plan.	Not reporting data

## Topic XIV. Patient Access API Usage

- ⚠ Beginning June 2026, Indicators D1.XIV.1-2 must be completed. Submission of this data before June 2026 is optional; if you choose not to respond prior to June 2026, select “Not reporting data”.**

Number	Indicator	Response
N/A	<b>Are you reporting data prior to June 2026?</b>  If “Yes”, please complete the following questions under each plan.	Not reporting data

## 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.

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

apply. Refer to 42 CFR  
438.71(b).

LTSS Complaint Access Point  
LTSS Grievance/Appeals Education  
LTSS Grievance/Appeals Assistance  
Review/Oversight of LTSS Data

### **Reg 2 Northern MI Regional Entity**

Enrollment Broker/Choice Counseling  
Beneficiary Outreach  
LTSS Complaint Access Point  
LTSS Grievance/Appeals Education  
LTSS Grievance/Appeals Assistance  
Review/Oversight of LTSS Data

### **Reg 3 Lakeshore Regional Entity**

Enrollment Broker/Choice Counseling  
Beneficiary Outreach  
LTSS Complaint Access Point  
LTSS Grievance/Appeals Education  
LTSS Grievance/Appeals Assistance  
Review/Oversight of LTSS Data

### **Reg 4 South West Michigan Behavioral Health**

Enrollment Broker/Choice Counseling  
Beneficiary Outreach  
LTSS Complaint Access Point  
LTSS Grievance/Appeals Education  
LTSS Grievance/Appeals Assistance  
Review/Oversight of LTSS Data

### **Reg 5 Mid-State Health Network**

Enrollment Broker/Choice Counseling  
Beneficiary Outreach  
LTSS Complaint Access Point  
LTSS Grievance/Appeals Education  
LTSS Grievance/Appeals Assistance  
Review/Oversight of LTSS Data

#### **Reg 6 CMH Partnership of Southeast MI**

Enrollment Broker/Choice Counseling

Beneficiary Outreach

LTSS Complaint Access Point

LTSS Grievance/Appeals Education

LTSS Grievance/Appeals Assistance

Review/Oversight of LTSS Data

#### **Reg 7 Detroit Wayne Integrated Health Network**

Enrollment Broker/Choice Counseling

Beneficiary Outreach

LTSS Complaint Access Point

LTSS Grievance/Appeals Education

LTSS Grievance/Appeals Assistance

Review/Oversight of LTSS Data

#### **Reg 8 Oakland Community Health Network**

Enrollment Broker/Choice Counseling

Beneficiary Outreach

LTSS Complaint Access Point

LTSS Grievance/Appeals Education

LTSS Grievance/Appeals Assistance

Review/Oversight of LTSS Data

#### **Reg 9 Macomb County CMH Services**

Enrollment Broker/Choice Counseling

Beneficiary Outreach

LTSS Complaint Access Point

LTSS Grievance/Appeals Education

LTSS Grievance/Appeals Assistance

Review/Oversight of LTSS Data

#### **Region 10 PIHP**

Enrollment Broker/Choice Counseling

Beneficiary Outreach

LTSS Complaint Access Point

LTSS Grievance/Appeals Education  
LTSS Grievance/Appeals Assistance  
Review/Oversight of LTSS Data

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