

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

Due date	Last edited	Edited by	Status
03/28/2024	03/27/2024	Audra Parsons	Submitted

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

Section A: Program Information

Point of Contact

**A_Program_Info**

Number	Indicator	Response
A1	State name Auto-populated from your account profile.	Michigan
A2a	Contact name 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.	Audra Parsons
A2b	Contact email address Enter email address. Department or program-wide email addresses ok.	parsonsa@michigan.gov
A3a	Submitter name CMS receives this data upon submission of this MCPAR report.	Audra Parsons
A3b	Submitter email address CMS receives this data upon submission of this MCPAR report.	parsonsa@michigan.gov
A4	Date of report submission CMS receives this date upon submission of this MCPAR report.	03/28/2024

Reporting Period



Find in the Excel Workbook
A_Program_Info

Number	Indicator	Response
A5a	Reporting period start date Auto-populated from report dashboard.	10/01/2022
A5b	Reporting period end date Auto-populated from report dashboard.	09/30/2023
A6	Program name 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.



Find in the Excel Workbook
A_Program_Info

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

Add BSS entities (A.8)

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

Examples of BSS entity types include a: State or Local Government Entity, Ombudsman Program, State Health Insurance Program (SHIP), Aging and Disability Resource Network (ADRN), Center for Independent Living (CIL), Legal Assistance Organization, Community-based Organization, Subcontractor, Enrollment Broker, Consultant, or Academic/Research Organization.



Find in the Excel Workbook

A_Program_Info

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

Section B: State-Level Indicators

Topic I. Program Characteristics and Enrollment



Number	Indicator	Response
BI.1	Statewide Medicaid enrollment 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.	3,165,966
BI.2	Statewide Medicaid managed care enrollment 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.	3,087,551

Topic III. Encounter Data Report



Number	Indicator	Response
BIII.1	<p>Data validation entity</p> <p>Select the state agency/division or contractor tasked with evaluating the validity of encounter data submitted by MCPs.</p> <p>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.</p>	EQRO

Topic X: Program Integrity



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

BX.5	<p>State overpayment reporting monitoring</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>	MDHHS mandate quarterly submissions of overpayment activities, as well as an annual report capturing totals from the FY. OIG provides feedback to the managed care entities from their assessment of these submissions.
BX.6	<p>Changes in beneficiary circumstances</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 system performs an auto look back on a 24 month rolling basis for all changes in enrollment and eligibility sent in our 834 file. When the system see's a change it recoups and repays based on the change sent in the file. For most of our programs we have a daily file but for the Waiver programs we only have the monthly file because we have to receive them from Optum before ingesting into CHAMPS.
BX.7a	<p>Changes in provider circumstances: Monitoring plans</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
BX.7b	<p>Changes in provider circumstances: Metrics</p> <p>Does the state use a metric or indicator to assess plan reporting performance? Select one.</p>	Yes
BX.7c	<p>Changes in provider circumstances: Describe metric</p> <p>Describe the metric or indicator that the state uses.</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.

BX.8a	Federal database checks: Excluded person or entities <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
BX.9a	Website posting of 5 percent or more ownership control <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 §455.104 and required by 42 CFR 438.602(g)(3).</p>	No
BX.10	Periodic audits <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>	Allow plans to retain overpayments.

Section C: Program-Level Indicators

Topic I: Program Characteristics



Number	Indicator	Response
C1I.1	Program contract Enter the title of the contract between the state and plans participating in the managed care program.	Prepaid Inpatient Health Plan Notice of Contract
N/A	Enter the date of the contract between the state and plans participating in the managed care program.	October 1, 2023 - September 30, 2024
C1I.2	Contract URL Provide the hyperlink to the model contract or landing page for executed contracts for the program reported in this program.	https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Doing-Business-with-MDHHS/Contract-and-Subrecipient-Resources/PIHP_Master_Contract_Template.pdf?rev=5225234b83044c27a6ca4ae48f7e426c&hash=AA3C9305928F2CC838FDF734BCA33E48
C1I.3	Program type What is the type of MCPs that contract with the state to provide the services covered under the program? Select one.	Prepaid Inpatient Health Plan (PIHP)
C1I.4a	Special program benefits 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
C1I.4b	Variation in special benefits What are any variations in the availability of special benefits within the program (e.g. by service area or population)? Enter "N/A" if not applicable.	N/A

C11.5	Program enrollment Enter the average number of individuals enrolled in this managed care program per month during the reporting year (i.e., average member months).	2,929,673
C11.6	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.	For most of FY23 Michigan was still operating under the Public Health Emergency guidance which paused Medicaid redeterminations. The redetermination process started back up in July and disenrollments began in August 2023.

Topic III: Encounter Data Report



Number	Indicator	Response
C1III.1	Uses of encounter data For what purposes does the state use encounter data collected from managed care plans (MCPs)? Select one or more. Federal regulations require that states, through their contracts with MCPs, collect and maintain sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees (42 CFR 438.242(c)(1)).	Rate setting Quality/performance measurement Monitoring and reporting Contract oversight Program integrity Policy making and decision support
C1III.2	Criteria/measures to evaluate MCP performance What types of measures are used by the state to evaluate managed care plan performance in encounter data submission and correction? Select one or more. Federal regulations also require that states validate that submitted enrollee encounter data they receive is a complete 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).	Timeliness of initial data submissions Timeliness of data corrections Use of correct file formats Overall data accuracy (as determined through data validation)
C1III.3	Encounter data performance criteria contract language Provide reference(s) to the contract section(s) that describe the criteria by which managed care plan performance on encounter data submission and correction will be measured. Use contract section references, not page numbers.	Encounter Timeliness Calculation
C1III.4	Financial penalties contract language Provide reference(s) to the contract section(s) that describes any financial penalties the state may impose	8. Payment Terms, D. Contractor Performance Bonus, iv & v

on plans for the types of failures to meet encounter data submission and quality standards. Use contract section references, not page numbers.

C1III.5	Incentives for encounter data quality Describe the types of incentives that may be awarded to managed care plans for encounter data quality. Reply with "N/A" if the plan does not use incentives to award encounter data quality.	Contractor Performance Bonus/Penalty if financial reports, encounters not submitted timely.
C1III.6	Barriers to collecting/validating encounter data Describe any barriers to collecting and/or validating managed care plan encounter data that the state has experienced during the reporting 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.	N/A

Topic IV. Appeals, State Fair Hearings & Grievances



Number	Indicator	Response
C1IV.1	<p>State's definition of "critical incident," as used for reporting purposes in its MLTSS program</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; Hospitalization due to Injury or Medication Error; Hospitalization due to injury related to the use of physical management.</p>
C1IV.2	<p>State definition of "timely" resolution for standard appeals</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>Standard Appeal Resolution (timing): The PIHP must resolve the Appeal and provide notice of resolution to the affected parties as expeditiously as the Enrollee's health condition requirement, but not to exceed 30 calendar days from the day the PIHP receives the Appeal.</p>
C1IV.3	<p>State definition of "timely" resolution for expedited appeals</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>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>State definition of "timely" resolution for grievances</p> <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</p>	<p>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.</p>

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.

Topic V. Availability, Accessibility and Network Adequacy

Network Adequacy



Find in the Excel Workbook

C1_Program_Set

Number	Indicator	Response
C1V.1	Gaps/challenges in network adequacy 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.	During FY2023 Network Adequacy reporting, the main challenges noted were direct care/ABA staffing issues, youth and adolescent residential services, and BCBA/Autism service delivery issues.
C1V.2	State response to gaps in network adequacy How does the state work with MCPs to address gaps in network adequacy?	The Contracts Management Section has been working with each PIHP/CMHSP as staffing issues arise, and programs are affected. During FY2023, we assisted entities with technical support, offering phone calls and Teams meetings to discuss options specific to each PIHP's need. In areas where continued gaps were noted, a few PIHPs were given opportunities for improvement with corrective action plans as noted in the D3_Plan_Sanctions tab.

Access Measures

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

Revisions to the Medicaid managed care regulations in 2016 and 2020 built on existing requirements that managed care plans maintain provider networks sufficient to ensure adequate access to covered services by: (1) requiring states to develop quantitative network adequacy standards for at least eight specified provider types if covered under the contract, and to make these standards available online; (2) strengthening network adequacy monitoring requirements; and (3) addressing the needs of people with long-term care service needs (42 CFR 438.66; 42 CFR 438.68).

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



Find in the Excel Workbook
C2_Program_State

Access measure total count: 9



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 office 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 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, 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

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, 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

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, 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

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, 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

6 / 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

Frontier

C2.V.6 Population

Adult

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

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, 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

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

Behavioral health

Rural

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

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

Behavioral health

C2.V.5 Region

Frontier

C2.V.6 Population

Pediatric

C2.V.7 Monitoring Methods

Geomapping, PIHP Network Adequacy Annual Reporting

C2.V.8 Frequency of oversight methods

Annually

Topic IX: Beneficiary Support System (BSS)



Number	Indicator	Response
C1IX.1	BSS website 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.	https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/customer-services/beneficiarysupport@michigan.gov
C1IX.2	BSS auxiliary aids and services How do BSS entities offer services in a manner that is accessible to all beneficiaries who need their services, including beneficiaries with disabilities, as required by 42 CFR 438.71(b)(2)? CFR 438.71 requires that the beneficiary support system be accessible in multiple ways including phone, Internet, in-person, and via auxiliary aids and services when requested.	MDHHS contract with the PIHPs require: All written materials for potential beneficiaries must include taglines in the prevalent non-English languages in the Contractor's region, as well as large print, explaining the availability of written translations or oral interpretation to understand the information provided and the toll-free telephone number of the entity providing choice counseling services as required by §438.71(a) and as defined in 42 CFR Parts 438.10 (d)(3) and 431.10(d)(4). In accordance with 42 CFR Parts 438.10(d)(3) 438.10(d)(6) and 438.10(d)(6)(iv), Large print means printed in a font size no smaller than 18 point. The Health Plans are required to take into consideration the special needs of beneficiaries with disabilities or LEP, the Contractor must ensure that beneficiaries are notified that oral interpretation is available for any language, written information is available in prevalent languages, and auxiliary aids, such as and Teletypewriter/Text Telephone (TTY/TDY) and American Sign Language (ASL), and services are available upon request at no cost, and how to access those services as referenced in 42 CFR Parts 438.10(d)(3) and 438.10(d)(4). The Contractor must also ensure that beneficiaries are notified how to access alternative formats as defined in 42 CFR 438.10(d)(6)(iv). In mental 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.

C1IX.3**BSS LTSS program data**

How do BSS entities assist the state with identifying, remediating, and resolving systemic issues based on a review of LTSS program data such as grievances and appeals or critical incident data? Refer to 42 CFR 438.71(d)(4).

The State of Michigan requires the PIHPs to report critical incident data in the Critical Incident Reporting system (CIRS). The CIRS was implemented in FY2011 and improved the ability of the State of Michigan (MDHHS) and the PIHPs to identify issues at the individual level for remediation, analysis, and trending. This data informs the PIHPs and MDHHS systemic issues that require remediations. Effectiveness of systemic remediations can also be analyzed through ongoing and regular data report pulls. MDHHS uses this information to measure how well the PIHPs and its provider network monitor the care of vulnerable service recipients, including 1915(c) Waiver participants. Effective for FY23, MDHHS moved to a new Critical Incident Reporting system platform through Customer Relationship Management (CRM) system. The new CIR platform will provide real time access and monitoring by to review and address Critical Incident reports. This will result in more immediate remediations at both an individual and systemic level. The State of Michigan delegates responsibility for utilization management (UM) functions to the PIHPs and are well-trained in Medicaid Fair Hearing process and requirements. MDHHS reviews the numbers and types of Medicaid Fair Hearing requests filed as an indicator when UM decisions may not be consistent with policy. Outcomes of hearing requests is monitored and reviewed by MDHHS to analyze issues and trends related to systemic issues. Any individual remediation required to address deficiencies in the UM decisions would be made by the Administrative Law Judge in the form of a Decision & Order.

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) 438.358 of 2002. The QAPIP specifies 1.) an

adequate organizational structure which allows for clear and appropriate administration and evaluation of the QAPIP; 2.) the components and activities of the QAPIP including those as required below; 3.) the role for recipients of service in the QAPIP; and 4.) the mechanisms or procedures to be used for adopting and communicating process and outcome improvement. The updated QAPIP description and associated work plan must be submitted to MDHHS annually by February 28.

Topic X: Program Integrity



Find in the Excel Workbook
C1_Program_Set

Number	Indicator	Response
C1X.3	Prohibited affiliation disclosure Did any plans disclose prohibited affiliations? If the state took action, enter those actions under D: Plan-level Indicators, Section VIII - Sanctions (Corresponds with Tab D3 in the Excel Workbook). Refer to 42 CFR 438.610(d).	No

Section D: Plan-Level Indicators

Topic I. Program Characteristics & Enrollment



Number	Indicator	Response
D1I.1	Plan enrollment Enter the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months).	Reg 1 NorthCare 78,310
		Reg 2 Northern MI Regional Entity 145,170
		Reg 3 Lakeshore Regional Entity 329,376
		Reg 4 South West Michigan Behavioral Health 252,554
		Reg 5 Mid-State Health Network 470,404
		Reg 6 CMH Partnership of Southeast MI 150,797
		Reg 7 Detroit Wayne Integrated Health Network 787,567
		Reg 8 Oakland Community Health Network 227,521
		Reg 9 Macomb County CMH Services 250,668
		Region 10 PIHP 237,306
D1I.2	Plan share of Medicaid What is the plan enrollment (within the specific program) as	Reg 1 NorthCare 2.5%

- a percentage of the state's total Medicaid enrollment?
- Numerator: Plan enrollment (D1.I.1)
- Denominator: Statewide Medicaid enrollment (B.I.1)

Reg 2 Northern MI Regional Entity

4.6%

Reg 3 Lakeshore Regional Entity

10.4%

Reg 4 South West Michigan Behavioral Health

8%

Reg 5 Mid-State Health Network

14.9%

Reg 6 CMH Partnership of Southeast MI

7.8%

Reg 7 Detroit Wayne Integrated Health Network

24.9%

Reg 8 Oakland Community Health Network

7.2%

Reg 9 Macomb County CMH Services

7.9%

Region 10 PIHP

7.5%

D1I.3

Plan share of any Medicaid managed care

What is the plan enrollment (regardless of program) as a percentage of total Medicaid enrollment in any type of managed care?

- Numerator: Plan enrollment (D1.I.1)
- Denominator: Statewide Medicaid managed care enrollment (B.I.2)

Reg 1 NorthCare

2.5%

Reg 2 Northern MI Regional Entity

4.7%

Reg 3 Lakeshore Regional Entity

10.7%

Reg 4 South West Michigan Behavioral Health

8.2%

Reg 5 Mid-State Health Network

15.2%

Reg 6 CMH Partnership of Southeast MI

4.9%

Reg 7 Detroit Wayne Integrated Health Network

25.5%

Reg 8 Oakland Community Health Network

7.4%

Reg 9 Macomb County CMH Services

8.1%

Region 10 PIHP

7.7%

Topic II. Financial Performance



Number	Indicator	Response
D1II.1a	Medical Loss Ratio (MLR) What is the MLR percentage? Per 42 CFR 438.66(e)(2)(i), the Managed Care Program Annual Report must provide information on the Financial performance of each MCO, PIHP, and PAHP, including MLR experience. If MLR data are not available for this reporting period due to data lags, enter the MLR calculated for the most recently available reporting period and indicate the reporting period in item D1.II.3 below. See Glossary in Excel Workbook for the regulatory definition of MLR. Write MLR as a percentage: for example, write 92% rather than 0.92.	Reg 1 NorthCare 76.48%
		Reg 2 Northern MI Regional Entity 88.66%
		Reg 3 Lakeshore Regional Entity 77.36%
		Reg 4 South West Michigan Behavioral Health 85.66%
		Reg 5 Mid-State Health Network 94.01%
		Reg 6 CMH Partnership of Southeast MI 94.02%
		Reg 7 Detroit Wayne Integrated Health Network 95.42%
		Reg 8 Oakland Community Health Network 95.78%
		Reg 9 Macomb County CMH Services 71.81%
		Region 10 PIHP 76.48%
D1II.1b	Level of aggregation What is the aggregation level that best describes the MLR	Reg 1 NorthCare Program-specific regional

being reported in the previous indicator? Select one.
As permitted under 42 CFR 438.8(i), states are allowed to aggregate data for reporting purposes across programs and populations.

Reg 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

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.
See glossary for the regulatory definition of MLR.

Reg 1 NorthCare

We request separate calculations for Traditional Medicaid and the Healthy Michigan Plan.

Reg 2 Northern MI Regional Entity

We request separate calculations for Traditional Medicaid and the Healthy Michigan Plan.

Reg 3 Lakeshore Regional Entity

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.

Does the data reported in item D1.II.1a cover a different time period than the MCPAR report?

Reg 2 Northern MI Regional Entity

Yes

Reg 3 Lakeshore Regional Entity

Yes

Reg 4 South West Michigan Behavioral Health

Yes

Reg 5 Mid-State Health Network

Yes

Reg 6 CMH Partnership of Southeast MI

Yes

Reg 7 Detroit Wayne Integrated Health Network

Yes

Reg 8 Oakland Community Health Network

Yes

Reg 9 Macomb County CMH Services

Yes

Region 10 PIHP

Yes

N/A

Enter the start date.

Reg 1 NorthCare

10/01/2021

Reg 2 Northern MI Regional Entity

10/01/2001

Reg 3 Lakeshore Regional Entity

10/01/2021

Reg 4 South West Michigan Behavioral Health

10/01/2021

Reg 5 Mid-State Health Network

10/01/2021

Reg 6 CMH Partnership of Southeast MI

10/01/2021

Reg 7 Detroit Wayne Integrated Health Network

10/01/2021

Reg 8 Oakland Community Health Network

10/01/2021

Reg 9 Macomb County CMH Services

10/01/2021

Region 10 PIHP

10/01/2021

N/A

Enter the end date.

Reg 1 NorthCare

09/31/2022

Reg 2 Northern MI Regional Entity

09/30/2022

Reg 3 Lakeshore Regional Entity

09/30/2022

Reg 4 South West Michigan Behavioral Health

09/30/2022

Reg 5 Mid-State Health Network

09/30/2022

Reg 6 CMH Partnership of Southeast MI

09/30/2022

**Reg 7 Detroit Wayne Integrated Health
Network**

09/30/2022

Reg 8 Oakland Community Health Network

09/30/2022

Reg 9 Macomb County CMH Services

09/30/2022

Region 10 PIHP

09/30/2022

Topic III. Encounter Data



Number	Indicator	Response
D1III.1	<p>Definition of timely encounter data submissions</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>Reg 1 NorthCare</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</p>

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 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

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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

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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

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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

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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.

timely submission requirements

What percent of the plan's encounter data file submissions (submitted during the reporting year) met state requirements 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.

Reg 2 Northern MI Regional Entity

98%

Reg 3 Lakeshore Regional Entity

88%

Reg 4 South West Michigan Behavioral Health

93%

Reg 5 Mid-State Health Network

95%

Reg 6 CMH Partnership of Southeast MI

99%

Reg 7 Detroit Wayne Integrated Health Network

98%

Reg 8 Oakland Community Health Network

98%

Reg 9 Macomb County CMH Services

99%

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 compliant out of the proportion received from the managed

Reg 1 NorthCare

100%

Reg 2 Northern MI Regional Entity

88%

Reg 3 Lakeshore Regional Entity

99%

Reg 4 South West Michigan Behavioral Health

care plan for the reporting year.

95%

Reg 5 Mid-State Health Network

97%

Reg 6 CMH Partnership of Southeast MI

97%

Reg 7 Detroit Wayne Integrated Health Network

96%

Reg 8 Oakland Community Health Network

96%

Reg 9 Macomb County CMH Services

99%

Region 10 PIHP

97%

Topic IV. Appeals, State Fair Hearings & Grievances

Appeals Overview



Find in the Excel Workbook

D1_Plan_Set

Number	Indicator	Response
D1IV.1	Appeals resolved (at the plan level) 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.	Reg 1 NorthCare 6
		Reg 2 Northern MI Regional Entity 123
		Reg 3 Lakeshore Regional Entity 115
		Reg 4 South West Michigan Behavioral Health 99
		Reg 5 Mid-State Health Network 242
		Reg 6 CMH Partnership of Southeast MI 37
		Reg 7 Detroit Wayne Integrated Health Network 54
		Reg 8 Oakland Community Health Network 18
		Reg 9 Macomb County CMH Services 63
		Region 10 PIHP 17
D1IV.2	Active appeals	Reg 1 NorthCare

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

0

Reg 2 Northern MI Regional Entity

0

Reg 3 Lakeshore Regional Entity

1

Reg 4 South West Michigan Behavioral Health

1

Reg 5 Mid-State Health Network

0

Reg 6 CMH Partnership of Southeast MI

0

Reg 7 Detroit Wayne Integrated Health Network

2

Reg 8 Oakland Community Health Network

1

Reg 9 Macomb County CMH Services

4

Region 10 PIHP

2

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

Reg 1 NorthCare

10

Reg 2 Northern MI Regional Entity

62

Reg 3 Lakeshore Regional Entity

71

actively receiving LTSS at the time that the appeal was filed).

Reg 4 South West Michigan Behavioral Health

31

Reg 5 Mid-State Health Network

155

Reg 6 CMH Partnership of Southeast MI

23

Reg 7 Detroit Wayne Integrated Health Network

6

Reg 8 Oakland Community Health Network

8

Reg 9 Macomb County CMH Services

48

Region 10 PIHP

8

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

Reg 1 NorthCare

6

Reg 2 Northern MI Regional Entity

0

Reg 3 Lakeshore Regional Entity

0

Reg 4 South West Michigan Behavioral Health

1

Reg 5 Mid-State Health Network

0

Reg 6 CMH Partnership of Southeast MI

of the reporting year, enter "N/A".

The appeal and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the appeal need to have been filed in relation to delivery of LTSS — they may have been filed for any reason, related to any service received (or desired) by an LTSS user.

To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed an appeal during the reporting year, and whether the filing of the appeal preceded the filing of the critical incident.

1

Reg 7 Detroit Wayne Integrated Health Network

0

Reg 8 Oakland Community Health Network

1

Reg 9 Macomb County CMH Services

0

Region 10 PIHP

0

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

14

Reg 2 Northern MI Regional Entity

114

Reg 3 Lakeshore Regional Entity

118

Reg 4 South West Michigan Behavioral Health

99

Reg 5 Mid-State Health Network

231

Reg 6 CMH Partnership of Southeast MI

36

Reg 7 Detroit Wayne Integrated Health Network

53

Reg 8 Oakland Community Health Network

14

Reg 9 Macomb County CMH Services

41

Region 10 PIHP

16

D1IV.5b**Expedited appeals for which
timely resolution was
provided**

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.

Reg 1 NorthCare

1

Reg 2 Northern MI Regional Entity

1

Reg 3 Lakeshore Regional Entity

2

**Reg 4 South West Michigan Behavioral
Health**

1

Reg 5 Mid-State Health Network

4

Reg 6 CMH Partnership of Southeast MI

1

**Reg 7 Detroit Wayne Integrated Health
Network**

0

Reg 8 Oakland Community Health Network

5

Reg 9 Macomb County CMH Services

4

Region 10 PIHP

D1IV.6a	Resolved appeals related to denial of authorization or limited authorization of a service	Reg 1 NorthCare
	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).	6
		Reg 2 Northern MI Regional Entity
		38
		Reg 3 Lakeshore Regional Entity
		61
		Reg 4 South West Michigan Behavioral Health
		67
		Reg 5 Mid-State Health Network
		47
		Reg 6 CMH Partnership of Southeast MI
		12
		Reg 7 Detroit Wayne Integrated Health Network
		7
		Reg 8 Oakland Community Health Network
		12
		Reg 9 Macomb County CMH Services
		56
		Region 10 PIHP
		5

D1IV.6b	Resolved appeals related to reduction, suspension, or termination of a previously authorized service	Reg 1 NorthCare
	Enter the total number of appeals resolved by the plan during the reporting year that	10
		Reg 2 Northern MI Regional Entity
		54

were related to the plan's reduction, suspension, or termination of a previously authorized service.

Reg 3 Lakeshore Regional Entity

49

Reg 4 South West Michigan Behavioral Health

32

Reg 5 Mid-State Health Network

212

Reg 6 CMH Partnership of Southeast MI

29

Reg 7 Detroit Wayne Integrated Health Network

49

Reg 8 Oakland Community Health Network

6

Reg 9 Macomb County CMH Services

7

Region 10 PIHP

14

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

2

Reg 3 Lakeshore Regional Entity

1

Reg 4 South West Michigan Behavioral Health

0

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

0

Region 10 PIHP

0

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

1

Reg 3 Lakeshore Regional Entity

4

Reg 4 South West Michigan Behavioral Health

1

Reg 5 Mid-State Health Network

1

Reg 6 CMH Partnership of Southeast MI

3

Reg 7 Detroit Wayne Integrated Health Network

0

Reg 8 Oakland Community Health Network

1

Reg 9 Macomb County CMH Services

0

Region 10 PIHP

0

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

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

D1IV.6g**Resolved appeals related to denial of an enrollee's request to dispute financial liability****Reg 1 NorthCare**

0

Reg 2 Northern MI Regional Entity

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.

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

Appeals by Service

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



Find in the Excel Workbook

D1_Plan_Set

Number	Indicator	Response
D1IV.7a	Resolved appeals related to general inpatient services Enter the total number of appeals resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include appeals related to inpatient behavioral health services – those should be included in indicator D1.IV.7c. If the managed care plan does not cover general inpatient services, enter "N/A".	Reg 1 NorthCare N/A
		Reg 2 Northern MI Regional Entity N/A
		Reg 3 Lakeshore Regional Entity N/A
		Reg 4 South West Michigan Behavioral Health N/A
		Reg 5 Mid-State Health Network N/A
		Reg 6 CMH Partnership of Southeast MI N/A
		Reg 7 Detroit Wayne Integrated Health Network N/A
		Reg 8 Oakland Community Health Network N/A
		Reg 9 Macomb County CMH Services N/A
		Region 10 PIHP

D1IV.7b	Resolved appeals related to general outpatient services	Reg 1 NorthCare
	Enter the total number of appeals resolved by the plan during the reporting year that were related to general outpatient care, including diagnostic and laboratory services. Please do not include appeals related to outpatient behavioral health services – those should be included in indicator D1.IV.7d. If the managed care plan does not cover general outpatient services, enter "N/A".	N/A
		Reg 2 Northern MI Regional Entity
		N/A
		Reg 3 Lakeshore Regional Entity
		N/A
		Reg 4 South West Michigan Behavioral Health
		N/A
		Reg 5 Mid-State Health Network
		N/A
		Reg 6 CMH Partnership of Southeast MI
		N/A
		Reg 7 Detroit Wayne Integrated Health Network
		N/A
		Reg 8 Oakland Community Health Network
		N/A
		Reg 9 Macomb County CMH Services
		N/A
		Region 10 PIHP
		N/A

D1IV.7c	Resolved appeals related to inpatient behavioral health services	Reg 1 NorthCare
	Enter the total number of appeals resolved by the plan during the reporting year that were related to inpatient	0
		Reg 2 Northern MI Regional Entity

mental health and/or substance use services. If the managed care plan does not cover inpatient behavioral health services, enter "N/A".

0

Reg 3 Lakeshore Regional Entity

8

Reg 4 South West Michigan Behavioral Health

37

Reg 5 Mid-State Health Network

16

Reg 6 CMH Partnership of Southeast MI

0

Reg 7 Detroit Wayne Integrated Health Network

5

Reg 8 Oakland Community Health Network

1

Reg 9 Macomb County CMH Services

10

Region 10 PIHP

0

D1IV.7d

Resolved appeals related to outpatient behavioral health services

Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient mental health and/or substance use services. If the managed care plan does not cover outpatient behavioral health services, enter "N/A".

Reg 1 NorthCare

7

Reg 2 Northern MI Regional Entity

23

Reg 3 Lakeshore Regional Entity

33

Reg 4 South West Michigan Behavioral Health

Reg 5 Mid-State Health Network

187

Reg 6 CMH Partnership of Southeast MI

37

Reg 7 Detroit Wayne Integrated Health Network

49

Reg 8 Oakland Community Health Network

17

Reg 9 Macomb County CMH Services

8

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

N/A

Reg 2 Northern MI Regional Entity

N/A

Reg 3 Lakeshore Regional Entity

N/A

Reg 4 South West Michigan Behavioral Health

N/A

Reg 5 Mid-State Health Network

N/A

Reg 6 CMH Partnership of Southeast MI

N/A

Reg 7 Detroit Wayne Integrated Health Network

N/A

Reg 8 Oakland Community Health Network

N/A

Reg 9 Macomb County CMH Services

N/A

Region 10 PIHP

N/A

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

N/A

Reg 2 Northern MI Regional Entity

N/A

Reg 3 Lakeshore Regional Entity

N/A

Reg 4 South West Michigan Behavioral Health

N/A

Reg 5 Mid-State Health Network

N/A

Reg 6 CMH Partnership of Southeast MI

N/A

Reg 7 Detroit Wayne Integrated Health Network

N/A

Reg 8 Oakland Community Health Network

N/A

Reg 9 Macomb County CMH Services

N/A

Region 10 PIHP

N/A

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

3

Reg 2 Northern MI Regional Entity

5

Reg 3 Lakeshore Regional Entity

0

Reg 4 South West Michigan Behavioral Health

17

Reg 5 Mid-State Health Network

74

Reg 6 CMH Partnership of Southeast MI

12

Reg 7 Detroit Wayne Integrated Health Network

6

Reg 8 Oakland Community Health Network

8

Reg 9 Macomb County CMH Services

41

Region 10 PIHP

8

D1IV.7h

Resolved appeals related to dental services

Reg 1 NorthCare

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".

N/A

Reg 2 Northern MI Regional Entity

N/A

Reg 3 Lakeshore Regional Entity

N/A

Reg 4 South West Michigan Behavioral Health

N/A

Reg 5 Mid-State Health Network

N/A

Reg 6 CMH Partnership of Southeast MI

N/A

Reg 7 Detroit Wayne Integrated Health Network

N/A

Reg 8 Oakland Community Health Network

N/A

Reg 9 Macomb County CMH Services

N/A

Region 10 PIHP

N/A

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

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

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

0

Reg 2 Northern MI Regional Entity

1

Reg 3 Lakeshore Regional Entity

1

Reg 4 South West Michigan Behavioral Health

2

Reg 5 Mid-State Health Network

32

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

State Fair Hearings



Find in the Excel Workbook

D1_Plan_Set

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

D1IV.8b	State Fair Hearings resulting in a favorable decision for the enrollee Enter the total number of State Fair Hearing decisions rendered during the reporting year that were partially or fully favorable to the enrollee.	Reg 1 NorthCare
		0
		Reg 2 Northern MI Regional Entity
		4
		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
		1
		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.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
		8
		Reg 3 Lakeshore Regional Entity

5

Reg 4 South West Michigan Behavioral Health

0

Reg 5 Mid-State Health Network

6

Reg 6 CMH Partnership of Southeast MI

4

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

1

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

0

Reg 2 Northern MI Regional Entity

4

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

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

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

N/A

Reg 2 Northern MI Regional Entity

N/A

Reg 3 Lakeshore Regional Entity

N/A

Reg 4 South West Michigan Behavioral Health

N/A

Reg 5 Mid-State Health Network

N/A

Reg 6 CMH Partnership of Southeast MI

N/A

Reg 7 Detroit Wayne Integrated Health Network

N/A

Reg 8 Oakland Community Health Network

N/A

Reg 9 Macomb County CMH Services

N/A

Region 10 PIHP

N/A

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

N/A

Reg 2 Northern MI Regional Entity

N/A

Reg 3 Lakeshore Regional Entity

N/A

**Reg 4 South West Michigan Behavioral
Health**

N/A

Reg 5 Mid-State Health Network

N/A

Reg 6 CMH Partnership of Southeast MI

N/A

**Reg 7 Detroit Wayne Integrated Health
Network**

N/A

Reg 8 Oakland Community Health Network

N/A

Reg 9 Macomb County CMH Services

N/A

Region 10 PIHP

N/A

Grievances Overview



Find in the Excel Workbook

D1_Plan_Set

Number	Indicator	Response
D1IV.10	Grievances resolved Enter the total number of grievances resolved by the plan during the reporting year. A grievance is "resolved" when it has reached completion and been closed by the plan.	Reg 1 NorthCare 43
		Reg 2 Northern MI Regional Entity 187
		Reg 3 Lakeshore Regional Entity 172
		Reg 4 South West Michigan Behavioral Health 196
		Reg 5 Mid-State Health Network 159
		Reg 6 CMH Partnership of Southeast MI 93
		Reg 7 Detroit Wayne Integrated Health Network 114
		Reg 8 Oakland Community Health Network 125
		Reg 9 Macomb County CMH Services 37
		Region 10 PIHP 154
D1IV.11	Active grievances	Reg 1 NorthCare

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

0

Reg 2 Northern MI Regional Entity

0

Reg 3 Lakeshore Regional Entity

1

Reg 4 South West Michigan Behavioral Health

4

Reg 5 Mid-State Health Network

1

Reg 6 CMH Partnership of Southeast MI

0

Reg 7 Detroit Wayne Integrated Health Network

12

Reg 8 Oakland Community Health Network

0

Reg 9 Macomb County CMH Services

3

Region 10 PIHP

1

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 whether the enrollee was

Reg 1 NorthCare

46

Reg 2 Northern MI Regional Entity

152

Reg 3 Lakeshore Regional Entity

3

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

Reg 4 South West Michigan Behavioral Health

105

Reg 5 Mid-State Health Network

94

Reg 6 CMH Partnership of Southeast MI

88

Reg 7 Detroit Wayne Integrated Health Network

14

Reg 8 Oakland Community Health Network

85

Reg 9 Macomb County CMH Services

13

Region 10 PIHP

148

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 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

Reg 1 NorthCare

5

Reg 2 Northern MI Regional Entity

0

Reg 3 Lakeshore Regional Entity

0

Reg 4 South West Michigan Behavioral Health

2

Reg 5 Mid-State Health Network

4

Reg 6 CMH Partnership of Southeast MI

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.

0

Reg 7 Detroit Wayne Integrated Health Network

1

Reg 8 Oakland Community Health Network

1

Reg 9 Macomb County CMH Services

0

Region 10 PIHP

0

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

48

Reg 2 Northern MI Regional Entity

177

Reg 3 Lakeshore Regional Entity

173

Reg 4 South West Michigan Behavioral Health

196

Reg 5 Mid-State Health Network

158

Reg 6 CMH Partnership of Southeast MI

93

Reg 7 Detroit Wayne Integrated Health Network

114

Reg 8 Oakland Community Health Network

125

Reg 9 Macomb County CMH Services

37

Region 10 PIHP

154

Grievances by Service

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



Find in the Excel Workbook

D1_Plan_Set

Number	Indicator	Response
D1IV.15a	Resolved grievances related to general inpatient services Enter the total number of grievances resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include grievances related to inpatient behavioral health services — those should be included in indicator D1.IV.15c. If the managed care plan does not cover this type of service, enter "N/A".	Reg 1 NorthCare N/A
		Reg 2 Northern MI Regional Entity N/A
		Reg 3 Lakeshore Regional Entity N/A
		Reg 4 South West Michigan Behavioral Health N/A
		Reg 5 Mid-State Health Network N/A
		Reg 6 CMH Partnership of Southeast MI N/A
		Reg 7 Detroit Wayne Integrated Health Network N/A
		Reg 8 Oakland Community Health Network N/A
		Reg 9 Macomb County CMH Services N/A
		Region 10 PIHP

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

D1IV.15c	Resolved grievances related to inpatient behavioral health services	Reg 1 NorthCare
		0
		Reg 2 Northern MI Regional Entity
		0

mental health and/or substance use services. If the managed care plan does not cover this type of service, enter "N/A".

Reg 3 Lakeshore Regional Entity

6

Reg 4 South West Michigan Behavioral Health

5

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

1

Reg 9 Macomb County CMH Services

1

Region 10 PIHP

2

D1IV.15d

Resolved grievances related to outpatient behavioral health services

Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter "N/A".

Reg 1 NorthCare

1

Reg 2 Northern MI Regional Entity

1

Reg 3 Lakeshore Regional Entity

5

Reg 4 South West Michigan Behavioral Health

159

Reg 5 Mid-State Health Network

46

Reg 6 CMH Partnership of Southeast MI

93

Reg 7 Detroit Wayne Integrated Health Network

114

Reg 8 Oakland Community Health Network

111

Reg 9 Macomb County CMH Services

12

Region 10 PIHP

5

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

N/A

Reg 2 Northern MI Regional Entity

N/A

Reg 3 Lakeshore Regional Entity

N/A

Reg 4 South West Michigan Behavioral Health

N/A

Reg 5 Mid-State Health Network

N/A

Reg 6 CMH Partnership of Southeast MI

N/A

Reg 7 Detroit Wayne Integrated Health Network

N/A

Reg 8 Oakland Community Health Network

N/A

Reg 9 Macomb County CMH Services

N/A

Region 10 PIHP

N/A

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

N/A

Reg 2 Northern MI Regional Entity

N/A

Reg 3 Lakeshore Regional Entity

N/A

Reg 4 South West Michigan Behavioral Health

N/A

Reg 5 Mid-State Health Network

N/A

Reg 6 CMH Partnership of Southeast MI

N/A

Reg 7 Detroit Wayne Integrated Health Network

N/A

Reg 8 Oakland Community Health Network

N/A

Reg 9 Macomb County CMH Services

N/A

Region 10 PIHP

N/A

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

0

Reg 2 Northern MI Regional Entity

15

Reg 3 Lakeshore Regional Entity

15

Reg 4 South West Michigan Behavioral Health

54

Reg 5 Mid-State Health Network

13

Reg 6 CMH Partnership of Southeast MI

0

Reg 7 Detroit Wayne Integrated Health Network

0

Reg 8 Oakland Community Health Network

113

Reg 9 Macomb County CMH Services

8

Region 10 PIHP

147

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.

Reg 1 NorthCare

N/A

Reg 2 Northern MI Regional Entity

If the managed care plan does not cover this type of service, enter "N/A".

N/A

Reg 3 Lakeshore Regional Entity

N/A

Reg 4 South West Michigan Behavioral Health

N/A

Reg 5 Mid-State Health Network

N/A

Reg 6 CMH Partnership of Southeast MI

N/A

Reg 7 Detroit Wayne Integrated Health Network

N/A

Reg 8 Oakland Community Health Network

N/A

Reg 9 Macomb County CMH Services

N/A

Region 10 PIHP

N/A

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

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

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

1

Reg 3 Lakeshore Regional Entity

1

Reg 4 South West Michigan Behavioral Health

14

Reg 5 Mid-State Health Network

7

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

Grievances by Reason

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



Find in the Excel Workbook

D1_Plan_Set

Number	Indicator	Response
D1IV.16a	Resolved grievances related to plan or provider customer service Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider customer service. Customer service grievances include complaints about interactions with the plan's Member Services department, provider offices or facilities, plan marketing agents, or any other plan or provider representatives.	Reg 1 NorthCare 0
		Reg 2 Northern MI Regional Entity 0
		Reg 3 Lakeshore Regional Entity 20
		Reg 4 South West Michigan Behavioral Health 39
		Reg 5 Mid-State Health Network 3
		Reg 6 CMH Partnership of Southeast MI 0
		Reg 7 Detroit Wayne Integrated Health Network 63
		Reg 8 Oakland Community Health Network 20
		Reg 9 Macomb County CMH Services 4
		Region 10 PIHP

D1IV.16b	Resolved grievances related to plan or provider care management/case management	Reg 1 NorthCare
		2
		Reg 2 Northern MI Regional Entity
		16
		Reg 3 Lakeshore Regional Entity
		1
		Reg 4 South West Michigan Behavioral Health
		24
		Reg 5 Mid-State Health Network
		11
	<p>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.</p> <p>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.</p>	Reg 6 CMH Partnership of Southeast MI
		21
		Reg 7 Detroit Wayne Integrated Health Network
		25
		Reg 8 Oakland Community Health Network
		15
		Reg 9 Macomb County CMH Services
		0
		Region 10 PIHP
		38

D1IV.16c	Resolved grievances related to access to care/services from plan or provider	Reg 1 NorthCare
		10
	<p>Enter the total number of grievances resolved by the plan during the reporting year that were related to access to care.</p>	Reg 2 Northern MI Regional Entity
		19

Access to care grievances include complaints about difficulties finding qualified in-network providers, excessive travel or wait times, or other access issues.

Reg 3 Lakeshore Regional Entity

46

Reg 4 South West Michigan Behavioral Health

29

Reg 5 Mid-State Health Network

34

Reg 6 CMH Partnership of Southeast MI

5

Reg 7 Detroit Wayne Integrated Health Network

34

Reg 8 Oakland Community Health Network

47

Reg 9 Macomb County CMH Services

34

Region 10 PIHP

25

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

19

Reg 2 Northern MI Regional Entity

8

Reg 3 Lakeshore Regional Entity

69

Reg 4 South West Michigan Behavioral Health

68

Reg 5 Mid-State Health Network

46

Reg 6 CMH Partnership of Southeast MI

71

Reg 7 Detroit Wayne Integrated Health Network

3

Reg 8 Oakland Community Health Network

27

Reg 9 Macomb County CMH Services

1

Region 10 PIHP

111

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

7

Reg 2 Northern MI Regional Entity

11

Reg 3 Lakeshore Regional Entity

0

Reg 4 South West Michigan Behavioral Health

6

Reg 5 Mid-State Health Network

49

Reg 6 CMH Partnership of Southeast MI

0

Reg 7 Detroit Wayne Integrated Health Network

0

Reg 8 Oakland Community Health Network

1

Reg 9 Macomb County CMH Services

0

Region 10 PIHP

1

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

2

Reg 3 Lakeshore Regional Entity

7

Reg 4 South West Michigan Behavioral Health

0

Reg 5 Mid-State Health Network

3

Reg 6 CMH Partnership of Southeast MI

0

Reg 7 Detroit Wayne Integrated Health Network

1

Reg 8 Oakland Community Health Network

2

Reg 9 Macomb County CMH Services

2

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

D1IV.16h	Resolved grievances related to abuse, neglect or exploitation Enter the total number of grievances resolved by the plan	Reg 1 NorthCare
		0
		Reg 2 Northern MI Regional Entity

during the reporting year that were related to abuse, neglect or exploitation.
Abuse/neglect/exploitation grievances include cases involving potential or actual patient harm.

0

Reg 3 Lakeshore Regional Entity

4

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

4

Reg 9 Macomb County CMH Services

0

Region 10 PIHP

1

D1IV.16i

Resolved grievances related to lack of timely plan response to a service authorization or appeal (including requests to expedite or extend appeals)

Enter the total number of grievances resolved 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).

Reg 1 NorthCare

0

Reg 2 Northern MI Regional Entity

0

Reg 3 Lakeshore Regional Entity

0

Reg 4 South West Michigan Behavioral Health

1

Reg 5 Mid-State Health Network

0

Reg 6 CMH Partnership of Southeast MI

0

Reg 7 Detroit Wayne Integrated Health Network

0

Reg 8 Oakland Community Health Network

0

Reg 9 Macomb County CMH Services

0

Region 10 PIHP

1

D1IV.16j**Resolved grievances related to plan denial of expedited appeal**

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 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

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

5

Reg 2 Northern MI Regional Entity

105

Reg 3 Lakeshore Regional Entity

12

Reg 4 South West Michigan Behavioral Health

30

Reg 5 Mid-State Health Network

12

Reg 6 CMH Partnership of Southeast MI

1

Reg 7 Detroit Wayne Integrated Health Network

6

Reg 8 Oakland Community Health Network

9

Reg 9 Macomb County CMH Services

Topic VII: Quality & Performance Measures

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



Find in the Excel Workbook

D2_Plan_Measures

Quality & performance measure total count: 15



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 / 15

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

98.90

Reg 3 Lakeshore Regional Entity

98.20

Reg 4 South West Michigan Behavioral Health

98.86

Reg 5 Mid-State Health Network

98.49

Reg 6 CMH Partnership of Southeast MI

99.68

Reg 7 Detroit Wayne Integrated Health Network

98.92

Reg 8 Oakland Community Health Network

97.38

Reg 9 Macomb County CMH Services

99.12

Region 10 PIHP

99.92



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 / 15

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

62.31

Reg 2 Northern MI Regional Entity

53.15

Reg 3 Lakeshore Regional Entity

56.67

Reg 4 South West Michigan Behavioral Health

66.85

Reg 5 Mid-State Health Network

60.70

Reg 6 CMH Partnership of Southeast MI

56.72

Reg 7 Detroit Wayne Integrated Health Network

48.38

Reg 8 Oakland Community Health Network

43.69

Reg 9 Macomb County CMH Services

16.85



Complete

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

3 / 15

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 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

68.19

Reg 2 Northern MI Regional Entity

64.98

Reg 3 Lakeshore Regional Entity

59.15

Reg 4 South West Michigan Behavioral Health

56.78

Reg 5 Mid-State Health Network

62.54

Reg 6 CMH Partnership of Southeast MI

71.87

Reg 7 Detroit Wayne Integrated Health Network

89.46

Reg 8 Oakland Community Health Network

98.76

Reg 9 Macomb County CMH Services

70.80

Region 10 PIHP

81.56



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 / 15

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

95.96

Reg 2 Northern MI Regional Entity

91.92

Reg 3 Lakeshore Regional Entity

95.56

Reg 4 South West Michigan Behavioral Health

97.13

Reg 5 Mid-State Health Network

96.14

Reg 6 CMH Partnership of Southeast MI

95.43

Reg 7 Detroit Wayne Integrated Health Network

97.94

Reg 8 Oakland Community Health Network

95.95

Reg 9 Macomb County CMH Services

47.57

Region 10 PIHP

96.30



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 / 15

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**

94.57

Reg 2 Northern MI Regional Entity

94.08

Reg 3 Lakeshore Regional Entity

97.05

Reg 4 South West Michigan Behavioral Health

98.25

Reg 5 Mid-State Health Network

97.48

Reg 6 CMH Partnership of Southeast MI

97.36

Reg 7 Detroit Wayne Integrated Health Network

99.54

Reg 8 Oakland Community Health Network

97.21

Reg 9 Macomb County CMH Services

98.22

Region 10 PIHP

94.08



Complete

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

6 / 15

D2.VII.2 Measure Domain

Behavioral health care

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

n/a

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

Program-specific rate

D2.VII.6 Measure Set

State-specific

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

Yes

D2.VII.8 Measure Description

"Numerator - the number of Medicaid eligibles receiving at least one PIHP managed Medicaid service during the quarter. denominator - the number of Medicaid eligibles for which the PIHP was paid during the quarter.

Calculation = Penetration Rate"

Measure results

Reg 1 NorthCare

6.69

Reg 2 Northern MI Regional Entity

7.56

Reg 3 Lakeshore Regional Entity

5.23

Reg 4 South West Michigan Behavioral Health

6.74

Reg 5 Mid-State Health Network

7.14

Reg 6 CMH Partnership of Southeast MI

6.28

Reg 7 Detroit Wayne Integrated Health Network

5.84

Reg 8 Oakland Community Health Network

7.43

Reg 9 Macomb County CMH Services

4.62

Region 10 PIHP

6.93



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 / 15

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

98.28

Reg 2 Northern MI Regional Entity

96.13

Reg 3 Lakeshore Regional Entity

94.93

Reg 4 South West Michigan Behavioral Health

92.09

Reg 5 Mid-State Health Network

87.08

Reg 6 CMH Partnership of Southeast MI

91.44

Reg 7 Detroit Wayne Integrated Health Network

89.08

Reg 8 Oakland Community Health Network

94.15

Reg 9 Macomb County CMH Services

94.70

Region 10 PIHP

97.15

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

D2.VII.2 Measure Domain

Behavioral health care

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

n/a

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

Program-specific rate

D2.VII.6 Measure Set

State-specific

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

Yes

D2.VII.8 Measure Description

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

Measure results

Reg 1 NorthCare

17.41

Reg 2 Northern MI Regional Entity

22.37

Reg 3 Lakeshore Regional Entity

18.39

Reg 4 South West Michigan Behavioral Health

21.03

Reg 5 Mid-State Health Network

18.98

Reg 6 CMH Partnership of Southeast MI

16

Reg 7 Detroit Wayne Integrated Health Network

15.73

Reg 8 Oakland Community Health Network

21.5

Reg 9 Macomb County CMH Services

17.14

Region 10 PIHP

15.22



Complete

D2.VII.1 Measure Name: The percent of (a) adults with mental illness, the percent of (b) adults with intellectual or developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/ intellectual or developmental disability served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities. 9 / 15

D2.VII.2 Measure Domain

Behavioral health care

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

n/a

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

Program-specific rate

D2.VII.6 Measure Set

State-specific

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

Yes

D2.VII.8 Measure Description

CMHSP Numerator - the total number of (a) adults with mental illness

denominator - the total number of adults with developmental disabilities

Calculation = adults dually diagnosed with mental illness/developmental disability, who received Michigan's minimum wage or more from employment activities

PIHP Numerator - the total number of adult Medicaid beneficiaries with mental illness

denominator - the total number of adult Medicaid beneficiaries with developmental disabilities

Calculation = the

total number of adult Medicaid beneficiaries dually diagnosed with mental illness/developmental disability served by the PIHP.

Measure results

Reg 1 NorthCare

98.79

Reg 2 Northern MI Regional Entity

96.13

Reg 3 Lakeshore Regional Entity

98.88

Reg 4 South West Michigan Behavioral Health

99.29

Reg 5 Mid-State Health Network

99.05

Reg 6 CMH Partnership of Southeast MI

100

Reg 7 Detroit Wayne Integrated Health Network

99.34

Reg 8 Oakland Community Health Network

96.66

Reg 9 Macomb County CMH Services

99.28

Region 10 PIHP

99.18

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

D2.VII.2 Measure Domain

Behavioral health care

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

n/a

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

Program-specific rate

D2.VII.6 Measure Set

State-specific

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

Yes

D2.VII.8 Measure Description

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

Measure results

Reg 1 NorthCare

11.80

Reg 2 Northern MI Regional Entity

13.22

Reg 3 Lakeshore Regional Entity

14.72

Reg 4 South West Michigan Behavioral Health

11.78

Reg 5 Mid-State Health Network

15.25

Reg 6 CMH Partnership of Southeast MI

13.62

Reg 7 Detroit Wayne Integrated Health Network

17.85

Reg 8 Oakland Community Health Network

13.43

Reg 9 Macomb County CMH Services

14.61

Region 10 PIHP

15.93



Complete

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

11 / 15

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, 10/01/2001 - 09/30/2022

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

19.47

Reg 2 Northern MI Regional Entity

25.61

Reg 3 Lakeshore Regional Entity

17.53

Reg 4 South West Michigan Behavioral Health

19.14

Reg 5 Mid-State Health Network

22.40

Reg 6 CMH Partnership of Southeast MI

26.53

Reg 7 Detroit Wayne Integrated Health Network

23.14

Reg 8 Oakland Community Health Network

21.15

Reg 9 Macomb County CMH Services

17.01

Region 10 PIHP

20.20



Complete

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

12 / 15

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, 10/01/2021 - 09/30/2022

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

54.40

Reg 2 Northern MI Regional Entity

50.36

Reg 3 Lakeshore Regional Entity

45.11

Reg 4 South West Michigan Behavioral Health

48.25

Reg 5 Mid-State Health Network

78.77

Reg 6 CMH Partnership of Southeast MI

35.86

Reg 7 Detroit Wayne Integrated Health Network

39.44

Reg 8 Oakland Community Health Network

33.64

Reg 9 Macomb County CMH Services

46.59

Region 10 PIHP

46.36



Complete

D2.VII.1 Measure Name: FUH-30 CCBHC

13 / 15

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

Medicaid Child Core Set

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

Yes

D2.VII.8 Measure Description

The percentage of discharges for beneficiaries six 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

N/A

Reg 2 Northern MI Regional Entity

N/A

Reg 3 Lakeshore Regional Entity

87.86

Reg 4 South West Michigan Behavioral Health

89.53

Reg 5 Mid-State Health Network

91.91

Reg 6 CMH Partnership of Southeast MI

80.23

Reg 7 Detroit Wayne Integrated Health Network

70.73

Reg 8 Oakland Community Health Network

95.71

Reg 9 Macomb County CMH Services

80.40

Region 10 PIHP

89.04



Complete

D2.VII.1 Measure Name: IET-14 CCBHC

14 / 15

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

Medicaid Adult Core Set

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

Yes

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: 1. Initiation of AOD Treatment: The percentage of beneficiaries who initiate treatment within 14 calendar days of the diagnosis. 2. 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**

N/A

Reg 2 Northern MI Regional Entity

N/A

Reg 3 Lakeshore Regional Entity

23.73

Reg 4 South West Michigan Behavioral Health

36

Reg 5 Mid-State Health Network

38.20

Reg 6 CMH Partnership of Southeast MI

47.62

Reg 7 Detroit Wayne Integrated Health Network

57.25

Reg 8 Oakland Community Health Network

42.22

Reg 9 Macomb County CMH Services

38.81

Region 10 PIHP

23.81



Complete

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

15 / 15

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
Yes

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

N/A

Reg 2 Northern MI Regional Entity

N/A

Reg 3 Lakeshore Regional Entity

52.35

Reg 4 South West Michigan Behavioral Health

53.02

Reg 5 Mid-State Health Network

60.06

Reg 6 CMH Partnership of Southeast MI

56.25

Reg 7 Detroit Wayne Integrated Health Network

64

Reg 8 Oakland Community Health Network

50.18

Reg 9 Macomb County CMH Services

54.66

Region 10 PIHP

56.91

Topic VIII. Sanctions

Describe sanctions that the state has issued for each plan. Report all known actions across the following domains: sanctions, administrative penalties, corrective action plans, other. Include any pending or unresolved actions.

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



Find in the Excel Workbook

D3_Plan_Sanctions

Sanction total count: 21



Complete

D3.VIII.1 Intervention type: Corrective action plan

1 / 21

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

Performance improvement Reg 1 NorthCare

D3.VIII.4 Reason for intervention

PIHP received less than full compliance within one or more compliance review standard assessed during the SFY.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

\$0

D3.VIII.7 Date assessed

11/04/2022

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

2 / 21

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

Performance improvement Reg 2 Northern MI Regional Entity

D3.VIII.4 Reason for intervention

PIHP received less than full compliance within one or more compliance review standard assessed during the SFY.

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

1

D3.VIII.6 Sanction amount

\$0

D3.VIII.7 Date assessed

11/04/2022

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 / 21

D3.VIII.2 Intervention topic

Performance improvement

D3.VIII.3 Plan name

Reg 3 Lakeshore Regional Entity

D3.VIII.4 Reason for intervention

PIHP received less than full compliance within one or more compliance review standard assessed during the SFY.

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

1

D3.VIII.6 Sanction amount

\$0

D3.VIII.7 Date assessed

11/04/2022

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

4 / 21

D3.VIII.2 Intervention topic

Performance
improvement

D3.VIII.3 Plan name

Reg 4 South West Michigan Behavioral Health

D3.VIII.4 Reason for intervention

PIHP received less than full compliance within one or more compliance review standard assessed during the SFY.

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

1

D3.VIII.6 Sanction amount

\$0

D3.VIII.7 Date assessed

11/04/2022

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

5 / 21

D3.VIII.2 Intervention topic

Performance
improvement

D3.VIII.3 Plan name

Reg 5 Mid-State Health Network

D3.VIII.4 Reason for intervention

PIHP received less than full compliance within one or more compliance review standard assessed during the SFY.

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

1

D3.VIII.6 Sanction amount

\$0

D3.VIII.7 Date assessed

11/04/2022

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

6 / 21

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

Performance improvement Reg 6 CMH Partnership of Southeast MI

D3.VIII.4 Reason for intervention

PIHP received less than full compliance within one or more compliance review standard assessed during the SFY.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

\$0

D3.VIII.7 Date assessed

11/04/2022

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 / 21

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

Performance improvement Reg 7 Detroit Wayne Integrated Health Network

D3.VIII.4 Reason for intervention

PIHP received less than full compliance within one or more compliance review standard assessed during the SFY.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

\$0

D3.VIII.7 Date assessed

11/04/2022

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

8 / 21

D3.VIII.2 Intervention topic

Performance
improvement

D3.VIII.3 Plan name

Reg 8 Oakland Community Health Network

D3.VIII.4 Reason for intervention

PIHP received less than full compliance within one or more compliance review standard assessed during the SFY.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

\$0

D3.VIII.7 Date assessed

11/04/2022

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

9 / 21

D3.VIII.2 Intervention topic

Performance
improvement

D3.VIII.3 Plan name

Reg 9 Macomb County CMH Services

D3.VIII.4 Reason for intervention

PIHP received less than full compliance within one or more compliance review standard assessed during the SFY.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

\$0

D3.VIII.7 Date assessed

11/04/2022

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

10 / 21

D3.VIII.2 Intervention topic

Performance improvement

D3.VIII.3 Plan name

Region 10 PIHP

D3.VIII.4 Reason for intervention

PIHP received less than full compliance within one or more compliance review standard assessed during the SFY.

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

1

D3.VIII.6 Sanction amount

\$0

D3.VIII.7 Date assessed

11/04/2022

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

11 / 21

D3.VIII.2 Intervention topic

Timely access

D3.VIII.3 Plan name

Reg 3 Lakeshore Regional Entity

D3.VIII.4 Reason for intervention

Waiting List for ABA Services in Kent County

Sanction details

D3.VIII.5 Instances of non-compliance

3

D3.VIII.6 Sanction amount

\$0

D3.VIII.7 Date assessed

01/20/2023

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

12 / 21

D3.VIII.2 Intervention topic

Performance improvement

D3.VIII.3 Plan name

Reg 7 Detroit Wayne Integrated Health Network

D3.VIII.4 Reason for intervention

Service delivery concerns with ABA Providers

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

1

D3.VIII.6 Sanction amount

\$0

D3.VIII.7 Date assessed

01/03/2023

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

Yes, remediated 03/31/2023

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: Corrective action plan

13 / 21

D3.VIII.2 Intervention topic

Timely access

D3.VIII.3 Plan name

Reg 7 Detroit Wayne Integrated Health Network

D3.VIII.4 Reason for intervention

Service Delivery concerns for enrollee

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

\$0

D3.VIII.7 Date assessed

01/23/2023

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

Yes, remediated 05/08/2023

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: Corrective action plan

14 / 21

D3.VIII.2 Intervention topic

Timely access

D3.VIII.3 Plan name

Reg 2 Northern MI Regional Entity

D3.VIII.4 Reason for intervention

Service delivery concerns with ABA Providers

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

\$0

D3.VIII.7 Date assessed

04/05/2023

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

Yes, remediated 05/23/2023

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: Corrective action plan

15 / 21

D3.VIII.2 Intervention topic

Timely access

D3.VIII.3 Plan name

Reg 4 South West Michigan Behavioral Health

D3.VIII.4 Reason for intervention

Service Delivery concerns for enrollee

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

\$0

D3.VIII.7 Date assessed

05/05/2023

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

Yes, remediated 11/16/2023

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: Corrective action plan

16 / 21

D3.VIII.2 Intervention topic

Timely access

D3.VIII.3 Plan name

Reg 2 Northern MI Regional Entity

D3.VIII.4 Reason for intervention

Wraparound service delivery

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

1

D3.VIII.6 Sanction amount

\$0

D3.VIII.7 Date assessed

08/11/2023

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

Yes, remediated 10/26/2023

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: Corrective action plan

17 / 21

D3.VIII.2 Intervention topic

Performance improvement

D3.VIII.3 Plan name

Reg 3 Lakeshore Regional Entity

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 had the ability to choose their providers of HSW services (HSW provider only) • Individual provided information/education on how to report abuse/neglect/exploitation and other critical incidents. • BTP are developed in accordance with the Technical Requirement for BTPRC. • LOC evaluations that are completed accurately. • Claims are coded in accordance with MDHHS policies and procedures • The IPOS is developed through a person-centered planning process consistent with Family Driven, Youth Guided Practice, etc.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

\$0

D3.VIII.7 Date assessed

10/19/2022

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

Yes, remediated 09/28/2023

D3.VIII.9 Corrective action plan

Yes



Complete

D3.VIII.1 Intervention type: Corrective action plan

18 / 21

D3.VIII.2 Intervention topic

Performance improvement

D3.VIII.3 Plan name

Reg 9 Macomb County CMH Services

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 had the ability to choose their providers of HSW services (HSW provider only)
- Individual provided information/education on how to report abuse/neglect/exploitation and other critical incidents.
- BTP are developed in accordance with the Technical Requirement for BTPRC.
- LOC evaluations that are completed accurately.
- Claims are coded in accordance with MDHHS policies and procedures
- The IPOS is developed through a person-centered planning process consistent with Family Driven, Youth Guided Practice, etc.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

\$0

D3.VIII.7 Date assessed

01/18/2023

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

Yes, remediated 08/16/2023

D3.VIII.9 Corrective action plan

Yes



Complete

D3.VIII.1 Intervention type: Corrective action plan

19 / 21

D3.VIII.2 Intervention topic

Performance improvement

D3.VIII.3 Plan name

Reg 1 NorthCare

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. • BTP are developed in accordance with the Technical Requirement for BTPRC. • LOC evaluations that are completed accurately. • Claims are coded in accordance with MDHHS policies and procedures. • The IPOS is developed through a person-centered planning process consistent with Family Driven, Youth Guided Practice, etc.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

\$0

D3.VIII.7 Date assessed

08/21/2023

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

Yes, remediated 03/04/2024

D3.VIII.9 Corrective action plan

Yes



Complete

D3.VIII.1 Intervention type: Corrective action plan

20 / 21

D3.VIII.2 Intervention topic

Performance improvement

D3.VIII.3 Plan name

Reg 2 Northern MI Regional Entity

D3.VIII.4 Reason for intervention

Prior Authorization Process followed for Waiver Home Mods & Equip (not for Medicare & Medicaid) • 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 provided information/education on how to report abuse/neglect/exploitation and other critical incidents. • BTP are developed in accordance with the Technical Requirement for BTPRC. • The IPOS is developed through a person-centered planning process consistent with Family Driven, Youth Guided Practice, etc.

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

1

D3.VIII.6 Sanction amount

\$0

D3.VIII.7 Date assessed

04/10/2023

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

D3.VIII.9 Corrective action plan

Yes



Complete

D3.VIII.1 Intervention type: Corrective action plan

21 / 21

D3.VIII.2 Intervention topic

Performance improvement

D3.VIII.3 Plan name

Reg 4 South West Michigan Behavioral Health

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

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

1

D3.VIII.6 Sanction amount

\$0

D3.VIII.7 Date assessed

06/20/2023

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

Yes, remediated 02/23/2024

D3.VIII.9 Corrective action plan

Yes



Number	Indicator	Response
D1X.1	Dedicated program integrity staff Report or enter the number of dedicated program integrity staff for routine internal monitoring and compliance risks. Refer to 42 CFR 438.608(a)(1)(vii).	Reg 1 NorthCare 1
		Reg 2 Northern MI Regional Entity 1
		Reg 3 Lakeshore Regional Entity 1
		Reg 4 South West Michigan Behavioral Health 3
		Reg 5 Mid-State Health Network 5
		Reg 6 CMH Partnership of Southeast MI 5
		Reg 7 Detroit Wayne Integrated Health Network 5
		Reg 8 Oakland Community Health Network 3
		Reg 9 Macomb County CMH Services 1
		Region 10 PIHP 3.5
D1X.2	Count of opened program integrity investigations	Reg 1 NorthCare 15

How many program integrity investigations were opened by the plan during the reporting year?

Reg 2 Northern MI Regional Entity

18

Reg 3 Lakeshore Regional Entity

122

Reg 4 South West Michigan Behavioral Health

243

Reg 5 Mid-State Health Network

106

Reg 6 CMH Partnership of Southeast MI

58

Reg 7 Detroit Wayne Integrated Health Network

14

Reg 8 Oakland Community Health Network

15

Reg 9 Macomb County CMH Services

37

Region 10 PIHP

347

D1X.3

Ratio of opened program integrity investigations to enrollees

What is the ratio of program integrity investigations opened by the plan in the past year 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

0.19:1,000

Reg 2 Northern MI Regional Entity

0.12:1,000

Reg 3 Lakeshore Regional Entity

0.12:1,000

Reg 4 South West Michigan Behavioral Health

0.96:1,000

Reg 5 Mid-State Health Network

0.23:1,000

Reg 6 CMH Partnership of Southeast MI

0.38:1,000

Reg 7 Detroit Wayne Integrated Health Network

0.02:1,000

Reg 8 Oakland Community Health Network

0.07:1,000

Reg 9 Macomb County CMH Services

0.15:1,000

Region 10 PIHP

1.46:1,000

D1X.4

Count of resolved program integrity investigations

How many program integrity investigations were resolved by the plan during the reporting year?

Reg 1 NorthCare

18

Reg 2 Northern MI Regional Entity

20

Reg 3 Lakeshore Regional Entity

20

Reg 4 South West Michigan Behavioral Health

262

Reg 5 Mid-State Health Network

174

Reg 6 CMH Partnership of Southeast MI

68

Reg 7 Detroit Wayne Integrated Health Network

14

Reg 8 Oakland Community Health Network

12

Reg 9 Macomb County CMH Services

29

Region 10 PIHP

344

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

0.23:1,000

Reg 2 Northern MI Regional Entity

0.14:1,000

Reg 3 Lakeshore Regional Entity

0.14:1,000

Reg 4 South West Michigan Behavioral Health

1.04:1,000

Reg 5 Mid-State Health Network

0.37:1,000

Reg 6 CMH Partnership of Southeast MI

0.45:1,000

Reg 7 Detroit Wayne Integrated Health Network

0.02:1,000

Reg 8 Oakland Community Health Network

0.05:1,000

Reg 9 Macomb County CMH Services

0.12:1,000

Region 10 PIHP

1.45:1,000

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 State Medicaid Agency (SMA) and MFCU concurrently

Reg 2 Northern MI Regional Entity

Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently

Reg 3 Lakeshore Regional Entity

Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently

Reg 4 South West Michigan Behavioral Health

Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently

Reg 5 Mid-State Health Network

Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently

Reg 6 CMH Partnership of Southeast MI

Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently

Reg 7 Detroit Wayne Integrated Health Network

Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently

Reg 8 Oakland Community Health Network

Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently

Reg 9 Macomb County CMH Services

Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently

Region 10 PIHP

Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently

D1X.7

Count of program integrity referrals to the state

Enter the total number of program integrity referrals made during the reporting year.

Reg 1 NorthCare

0

Reg 2 Northern MI Regional Entity

1

Reg 3 Lakeshore Regional Entity

1

Reg 4 South West Michigan Behavioral Health

2

Reg 5 Mid-State Health Network

1

Reg 6 CMH Partnership of Southeast MI

0

Reg 7 Detroit Wayne Integrated Health Network

2

Reg 8 Oakland Community Health Network

0

Reg 9 Macomb County CMH Services

1

Region 10 PIHP

0

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 0.01:1,000 Reg 3 Lakeshore Regional Entity 0.01:1,000 Reg 4 South West Michigan Behavioral Health 0.01:1,000 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 0:1,000 Reg 9 Macomb County CMH Services 0:1,000 Region 10 PIHP 0:1,000
D1X.9	Plan overpayment reporting to the state Describe the plan's latest annual overpayment recovery report submitted to the state as required under 42 CFR 438.608(d)(3). Include, at minimum, the following information: <ul style="list-style-type: none"> • The date of the report (rating period or calendar year). 	Reg 1 NorthCare 10/1/22-9/30/23. \$15,652.06 recovered from 18 completed investigations. Approximate ratio of recoveries to premium revenue - 1:8,000. No cost avoidance figures reported. Reg 2 Northern MI Regional Entity

- The dollar amount of overpayments recovered.
- The ratio of the dollar amount of overpayments recovered as a percent of premium revenue as defined in MLR reporting under 42 CFR 438.8(f)(2).

10/1/22-9/30/23. \$4,247.58 recovered from 20 completed investigations. Approximate ratio of recoveries to premium revenue - 1:53,000. No cost avoidance figures reported.

Reg 3 Lakeshore Regional Entity

10/1/22-9/30/23. \$4,247.58 recovered from 20 completed investigations. Approximate ratio of recoveries to premium revenue - 1:53,000. No cost avoidance figures reported.

Reg 4 South West Michigan Behavioral Health

10/1/22-9/30/23. \$459,911.03 recovered from 262 completed investigations. Approximate ratio of recoveries to premium revenue - 1:625. Pre-payment activities and for-cause terminations resulted in \$201,174.42 of cost avoidance.

Reg 5 Mid-State Health Network

10/1/22-9/30/23. \$840,144.30 recovered from 106 completed investigations. Approximate ratio of recoveries to premium revenue - 1:900. Pre-payment activities and for-cause terminations resulted in \$16,462.14 of cost avoidance.

Reg 6 CMH Partnership of Southeast MI

10/1/22-9/30/23. \$178,654.19 recovered from 68 completed investigations. Approximate ratio of recoveries to premium revenue - 1:1,200. Pre-payment activities and for-cause terminations resulted in \$127,900 of cost avoidance.

Reg 7 Detroit Wayne Integrated Health Network

10/1/22-9/30/23. \$31,914.84 recovered from 14 completed investigations. Approximate ratio of recoveries to premium revenue - 1:30,000. Pre-payment activities and for-cause terminations resulted in \$569,279.39 of cost avoidance.

Reg 8 Oakland Community Health Network

10/1/22-9/30/23. \$48,975.90 recovered from 12 completed investigations. Approximate ratio of recoveries to premium revenue - 1:8,000. No cost avoidance figures reported.

Reg 9 Macomb County CMH Services

10/1/22-9/30/23. \$115,370.98 recovered from 37 completed investigations. Approximate ratio of recoveries to premium revenue - 1:2,750. No cost avoidance figures reported.

Region 10 PIHP

10/1/22-9/30/23. \$744,988.18 recovered from 344 completed investigations. Approximate ratio of recoveries to premium revenue - 1:500. No cost avoidance figures reported.

D1X.10

Changes in beneficiary circumstances

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

Reg 1 NorthCare

Daily

Reg 2 Northern MI Regional Entity

Daily

Reg 3 Lakeshore Regional Entity

Daily

Reg 4 South West Michigan Behavioral Health

Daily

Reg 5 Mid-State Health Network

Daily

Reg 6 CMH Partnership of Southeast MI

Daily

Reg 7 Detroit Wayne Integrated Health Network

Daily

Reg 8 Oakland Community Health Network

Daily

Reg 9 Macomb County CMH Services

Daily

Region 10 PIHP

Daily

Section E: BSS Entity Indicators

Topic IX. Beneficiary Support System (BSS) Entities

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



Find in the Excel Workbook

E_BSS_Entities

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

EIX.2**BSS entity role**

What are the roles performed by the BSS entity? Check all that apply. Refer to 42 CFR 438.71(b).

Reg 1 NorthCare

Enrollment Broker/Choice Counseling

Reg 2 Northern MI Regional Entity

Enrollment Broker/Choice Counseling

Reg 3 Lakeshore Regional Entity

Enrollment Broker/Choice Counseling

Reg 4 South West Michigan Behavioral Health

Enrollment Broker/Choice Counseling

Reg 5 Mid-State Health Network

Enrollment Broker/Choice Counseling

Reg 6 CMH Partnership of Southeast MI

Enrollment Broker/Choice Counseling

Reg 7 Detroit Wayne Integrated Health Network

Enrollment Broker/Choice Counseling

Reg 8 Oakland Community Health Network

Enrollment Broker/Choice Counseling

Reg 9 Macomb County CMH Services

Enrollment Broker/Choice Counseling

Region 10 PIHP

Enrollment Broker/Choice Counseling
