STATE OF MICHIGAN PROCUREMENT

Department of Health and Human Services
235 South Grand Ave., Suite 1201, Lansing, MI 48933
Grand Tower Building, Suite 1201, P.O. Box 30037, Lansing, MI 48909

CONTRACT CHANGE NOTICE

Change Notice Number **7**
to
Contract Number **MA 200000002095**

CONTRACTOR	
	Detroit Wayne Integrated Health Network
	707 West Milwaukee
	Detroit, MI 48202
	Eric Doeh
	313-833-2500
	Edoeh1@dwihn.org
	CV0054897

STATE			
	Program Manager	Jeff Wieferich	MDHHS
		517-335-0499	
		wieferichJ@michigan.gov	
	Contract Administrator	Danielle Walsh	MDHHS
		517-284-0183	
		Walshd4@michigan.gov	

CONTRACT SUMMARY			
DESCRIPTION: Prepaid Inpatient Health Plan (PIHP)			
INITIAL EFFECTIVE DATE	**INITIAL EXPIRATION DATE**	**INITIAL AVAILABLE OPTIONS**	**EXPIRATION DATE BEFORE CHANGE(S) NOTED BELOW**
October 1, 2020	September 30, 2021	Seven, one-year	September 30, 2023
PAYMENT TERMS		**DELIVERY TIMEFRAME**	
Net 45		As Needed	
ALTERNATE PAYMENT OPTIONS			**EXTENDED PURCHASING**
☐ P-card ☐ Payment Request (PRC) ☐ Other			☐ Yes ☐ No
MINIMUM DELIVERY REQUIREMENTS			
N/A			

DESCRIPTION OF CHANGE NOTICE				
OPTION	**LENGTH OF OPTION**	**EXTENSION**	**LENGTH OF EXTENSION**	**REVISED EXP. DATE**
☐		☐	N/A	N/A
CURRENT VALUE	**VALUE OF CHANGE NOTICE**		**ESTIMATED AGGREGATE CONTRACT VALUE**	
$2,763,557,881.00	$12,965,073.00		$2,776,522,954.00	

DESCRIPTION: Effective October 1, 2022, this amendment increases the total contract value, revises Schedule A, G and H replaces Schedule D and E.

FOR THE CONTRACTOR:

Detroit Wayne Integrated Health Network
Company Name

E-SIGNED by Eric Doeh
on 2022-11-03 20:03:36 EDT

Authorized Agent Signature

Eric Doeh
Authorized Agent (Print or Type)

2022-11-03 20:03:36 UTC

Date

FOR THE STATE:

E-SIGNED by Christine H. Sanches
on 2022-11-16 09:17:03 EST

Signature

Christine H. Sanches, Director,
Bureau of Grants and Purchasing
Name & Title

Michigan Department of Health and Human Services
Agency

2022-11-16 09:17:03 UTC

Date

1. Schedule A, Statement of Work
Section 1. General Requirements, F. Covered Services, 1. General letter d. is hereby deleted and replaced in its entirety with the following:
   d. The Contractor will be responsible for the Reciprocity Standards policy which can be found on the MDHHS Policies & Practice Guidelines website, https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/practiceguidelines

2. Section 1. General Requirements, L. Grievance and Appeals Process for Beneficiaries, 1. Grievance and Appeals Policies and Procedures, letter d. is hereby deleted and replaced in its entirety with the following:
   d. Contractor must have written policies and procedures governing the resolution of Grievances and Appeals; A beneficiary, or a third party acting on behalf of a beneficiary, may file a Grievance or Appeal, orally or in writing, on any aspect of Covered services as specified in the definitions of Grievance and Appeal.

3. Section 1. General Requirements, N. Provider Services, 10. Substance Use Disorder (SUD) Services, letter a, item iv. is hereby deleted and replaced in its entirety with the following:
      iv. On request from MDHHS or LARA, subject to applicable regulations, collect and transfer data and financial information from local programs to the LARA.

4. Section 1. General Requirements, R. Program Integrity is hereby deleted and replaced in its entirety with the following:
   R. Program Integrity
   The State, MDHHS-Office of Inspector General (OIG) is responsible for overseeing the program integrity activities of the Contractor and all subcontracted entities.
      1. General:
         a. To the extent consistent with applicable Federal and State law, including, but not limited to 42 CFR Part 2, HIPAA, and the Michigan Mental Health Code, the Contractor must disclose protected health information to MDHHS-OIG or the Department of Attorney General upon their written request, without first obtaining authorization from the beneficiary to disclose such information.
         b. The Contractor must have administrative and management arrangements or procedures for compliance with 42 CFR 438.608. Such arrangements or procedures must identify program integrity compliance activities that will be delegated and how the Contractor will monitor those activities.
         c. The Contractor must provide prompt notification to the State, MDHHS BPHASA when it receives information about changes in a beneficiary's circumstances that may affect the beneficiary's eligibility including, changes in the beneficiary's residence and the death of a beneficiary.
         d. The Contractor that makes or receives annual payments under this Contract of at least $5,000,000 to a Provider, must make provision for written policies for all employees of the entity, and of any contractor or agent of the entity, that provide detailed information about the False Claims Act and other Federal and State laws described in Section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers.
         e. The Contractor must require all contracted Providers that make or receive annual payments under this Contract of at least $5,000,000 to agree to comply with Section 6032 of the Deficit Reduction Act (DRA) of 2005.
         f. The Contractor must have a program integrity compliance program as defined in 42 CFR 438.608. The program integrity compliance program must include the following:
            i. Written policies and procedures that describe the Contractor's commitment to comply with Federal and State fraud, waste and abuse standards enforced through well-publicized disciplinary guidelines.
            ii. The designation of a Compliance Officer who reports directly to the Chief Executive Officer and the Board of Directors, and a compliance committee, accountable to the senior management or Board of Directors, with effective lines of communication to the Contractor's employees.
            iii. A system for training and education for the Compliance Officer, the Contractor's senior management, and the Contractor's employees regarding fraud, waste and abuse, and the federal and State standards and requirements under this Contract. While the compliance

officer may provide training to Contractor employees, “effective” training for the compliance officer means it cannot be conducted by the compliance officer to himself/herself.

iv. Provisions for internal monitoring and auditing of compliance risks. Audits must include post payment reviews of paid claims to verify that services were billed appropriately (e.g., correct procedure codes, modifiers, quantities). Acceptable audit methodology examples include:
   a. Record review, including statistically valid random sampling and extrapolation to identify and recover overpayments made to providers
   b. Beneficiary interviews to confirm services rendered.
   c. Provider self-audit protocols.
   d. The frequency and quantity of audits performed should be dependent on the number of fraud, waste, and abuse complaints received, as well as high risk activities identified through data mining and analysis of paid claims.

v. Provisions for the Contractor’s prompt response to detected offenses and for the development of corrective action plans. “Prompt Response” is defined in this Contract as action taken within 15 business days of receipt and identification by the Contractor of the information regarding a potential compliance problem.

g. Dissemination of the contact information (addresses and toll-free telephone numbers) for reporting fraud, waste, or abuse by subcontractors of Contractor to both the Contractor and the MDHHS-OIG. Dissemination of this information must be made to all Contractor subcontractors and members annually. The Contractor must indicate that reporting of fraud, waste or abuse may be made anonymously.

2. Biannual meetings will be held between MDHHS-OIG and all Contractor Compliance Officers to train and discuss fraud, waste, and abuse.
3. Subcontracted Entities
   a. The Contractor must include program integrity compliance provisions and guidelines in all contracts with subcontracted entities.
   b. If program integrity compliance activities are delegated to subcontractors, the subcontract must contain the following:
      i. Designation of a compliance officer
      ii. Submission to the Contractor of quarterly reports detailing program integrity compliance activities
      iii. Assistance and guidance by the Contractor with audits and investigations, upon request of the subcontracted entity
      iv. Provisions for routine internal monitoring of program integrity compliance activities
      v. Prompt Response to potential offenses and implementation of corrective action plans
      vi. Prompt reporting of fraud, waste, and abuse to the Contractor
      vii. Implementation of training procedures regarding fraud, waste, and abuse for the subcontracted entities’ employees at all levels.
   c. Annually, the Contractor must submit a list of subcontracted entities using the template created by MDHHS-OIG.
      i. The Contractor must maintain a list that contains all facility locations where services are provided, or business is conducted. This list must contain Billing Provider NPI numbers assigned to the entity, what services the entity is subcontracted to provide, and Provider email address(es).
4. Investigations
   a. The Contractor must investigate program integrity compliance complaints to determine whether a potential credible allegation of fraud exists. If a potential credible allegation of fraud exists, the Contractor must refer the matter to MDHHS-OIG (see Reporting of Fraud, Waste, or Abuse) and pause any recoupment/recovery in connection with the potential credible allegation of fraud until receiving further instruction from MDHHS-OIG.
   b. To the extent consistent with applicable law, including but not limited to 42 CFR Part 2, HIPAA, and the Michigan Mental Health Code, the Contractor must cooperate fully in any investigation or prosecution by any duly authorized government agency, including but not limited to: MDHHS-OIG or the Department of Attorney General, whether administrative, civil, or criminal. Such cooperation shall include providing, upon request, information, access to records, and access to schedule interviews with designated Contractor employees and consultants, including but not

limited to those with expertise in the administration of the program and/or in medical or pharmaceutical questions or in any matter related to the investigation or prosecution.

i. Contractor must maintain written policies and procedures pertaining to cooperation in investigations or prosecutions.

5. Reporting Fraud, Waste, or Abuse
   a. Upon receipt of allegations involving fraud, waste, or abuse regardless of entity (i.e., Contractor, employee, subcontracted entity, provider, or member), the Contractor must perform a preliminary investigation. Upon completion of the preliminary investigation, if the Contractor determines a potential credible allegation of fraud exists, and an overpayment of $5,000 or greater is identified (cases under this amount shall not be referred to OIG), the Contractor must promptly refer the matter to MDHHS-OIG. These referrals must be made using the Contractor fraud referral template and be shared with MDHHS-OIG via secure File Transfer Process (sFTP) using the Contractor's applicable MDHHS-OIG sFTP area. After reporting a potential credible allegation of fraud, the Contractor shall not take any of the following actions unless otherwise instructed by OIG:
      i. Contact the subject of the referral about any matters related to the referral.
      ii. Enter into or attempt to negotiate any settlement or agreement regarding the referral with the subject of the referral; or
      iii. Accept any monetary or other thing of valuable consideration offered by the subject of the referral in connection with the findings/overpayment.
      iv. If the State makes a recovery from an investigation and/or corresponding legal action where the Contractor has sustained a documented loss, the State shall not be obligated to repay any monies recovered to Contractor.
   b. The Contractor must report all suspicion of waste or abuse on the Quarterly Submission described in Section R.7. Quarterly Submissions below.
   c. Questions regarding whether suspicions should be classified as fraud, waste or abuse should be presented to MDHHS-OIG for clarification prior to making the referral.
   d. Documents containing protected health information or protected personal information must be submitted in a manner that is compliant with applicable Federal and State privacy rules and regulations, including but not limited to HIPAA.
6. Overpayments
   The Contractor must report overpayments due to fraud, waste, or abuse to MDHHS-OIG.
   a. If the Contractor identifies an overpayment involving potential fraud prior to identification by MDHHS-OIG, the Contractor refers the findings to MDHHS-OIG and waits for further instruction from MDHHS-OIG prior to recovering the overpayment.
   b. If the Contractor identifies an overpayment involving waste or abuse prior to identification by MDHHS- OIG, the Contractor must void or correct applicable encounters, should recover the overpayment, and must report the overpayment on its quarterly submission (see Section R.7. Quarterly Submissions below).
   c. If a Network Provider identifies an overpayment, they must agree to:
      i. Notify the Contractor, in writing, of the reason for the overpayment and the date the overpayment was identified.
      ii. Return the overpayment to the Contractor within 60 calendar days of the date the overpayment was identified.
   d. These overpayment provisions do not apply to any amount of a recovery to be retained under False Claims Act cases or through other investigations.
7. Quarterly Submissions
   a. The Contractor must provide information on program integrity compliance activities performed quarterly using the template provided by the MDHHS-OIG. Program integrity compliance activities include, but are not limited to:
      i. Tips/grievances received
      ii. Data mining and analysis of paid claims, including audits performed based on the results
      iii. Audits performed
      iv. Overpayments collected
      v. Identification and investigation of fraud, waste, and abuse (as these terms are defined in the "Definitions" section of this contract
      vi. Corrective action plans implemented
      vii. Provider dis-enrollments

viii. Contract terminations

b. All program integrity activities performed each quarter must be reported to OIG according to the following schedule:
   i. Activities performed January through March must be reported by May 15; activities performed April through June must be reported by August 15; activities performed July through September must be reported by November 15; and activities performed October through December must be reported by February 15.
c. The Contractor must provide MDHHS-OIG with documentation to support that these program integrity compliance activities were performed by its subcontractors in its quarterly submission to the MDHHS-OIG.
d. The Contractor must include any improper payments identified and amounts adjusted in encounter data and/or overpayments recovered by the Contractor during the course of its program integrity activities. It is understood that identified overpayment recoveries may span multiple reporting periods. This report also includes a list of the individual encounters corrected. To ensure accuracy of reported adjustments, Contractor must:
   i. Purchase at minimum one (1) license for MDHHS-OIG's case management software. This license will be utilized to upload report submissions to the case management system and to check the completeness and accuracy of report submissions.
   ii. For medical equipment, supplies, or prescription provided, adjust any encounter for an enrollee to zero dollars paid. If the encounter with a dollar amount cannot be adjusted to zero dollars paid, then the encounters with dollars paid must be voided and resubmitted with zero dollars paid.
   iii. Specify if overpayment amounts were determined via sample and extrapolation or claim-based review. In instances where extrapolation occurs, Contractor may elect to correct claims, and thus encounters, as they see fit.
   iv. Specify encounters unavailable for adjustment in CHAMPS due to the encounter aging out or any other issue.
      a. These encounters must be identified by the Contractor and reported to MDHHS-OIG. MDHHS-OIG will record a gross adjustment to be taken out of the Contractor's next capitation payment.
   v. Report only corrected encounters associated with post payment evaluations that resulted in a determined overpayment amount.

8. MDHHS-OIG Sanctions
   When MDHHS-OIG sanctions (suspends and/or terminates from the Medicaid Program) providers, including for a credible allegation of fraud under 42 CFR § 455.23, the Contractor must, at minimum, apply the same sanction to the provider upon receipt of written notification of the sanction from MDHHS-OIG. The Contractor may pursue additional measures/remedies independent of the State. If MDHHS OIG lifts a sanction, the Contractor may elect to do the same.
9. MDHHS-OIG Onsite Reviews
   a. MDHHS-OIG may conduct onsite reviews of Contractor and/or its subcontracted entities.
   b. To the extent consistent with applicable law, including, but not limited to 42 CFR Part 2, HIPAA, and the Michigan Mental Health Code, the Contractor is required to comply with MDHHS-OIG's requests for documentation and information related to program integrity and compliance.
10. Contractor Ownership and Control Interest
   a. A Contractor may not knowingly have a relationship of the type described in paragraph (c) of this section with the following:
      i. An individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.
      ii. An individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation at 48 CFR §2.101, of a person described in paragraph (a)(i) of this section.
   b. A Contractor may not knowingly have a relationship with an individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Act.
   c. The relationships described in paragraph (a) of this section, are as follows:
      i. A director, officer, or partner of the Contractor.
      ii. A subcontractor of the Contractor, as governed by 42 CFR §438.230.
      iii. A person with beneficial ownership of five percent (5%) or more of the Contractor's equity.

iv. A network provider or person with an employment, consulting, or other arrangement with the Contractor for the provision of items and services that are significant and material to the Contractor's obligations under its Contract with the State.

d. The Contractor must comply with the Federal regulations to obtain, maintain, disclose, and furnish required information about ownership and control interests, business transactions, and criminal convictions as specified in 42 CFR §455.104-106. In addition, the Contractor must ensure that any and all contracts, agreements, purchase orders, or leases to obtain space, supplies, equipment, or services provided under the Medicaid agreement require compliance with 42 CFR §455.104-106. Pursuant to 42 CFR §455.104: the State will review ownership and control disclosures submitted by the Contractor and any of the Contractor's Subcontractors.

5. Section 8. Payment Terms, B. State Funding, 9. Premium Pay Hourly Wage Increase for Direct Care Workers (DCW) is hereby deleted and replaced in its entirety with the following:

9. Premium Pay Hourly Wage Increase for Direct Care Workers (DCW)

a. A premium pay hourly wage increase for direct care workers is in effect from October 1, 2020, through September 30, 2023. Rate increases are in effect for contract time periods for hours billed as follows:
   i. October 1, 2020 – February 28, 2021: A $2.00 per hour increase in direct care worker wages, plus an additional $0.24 per hour increase to cover additional provider agency costs associated with implementing the wage increase.
   ii. March 1, 2021 - September 30, 2021: A $2.25 per hour increase in direct care worker wages, plus an additional $0.27 per hour increase to cover additional provider agency costs associated with implementing the wage increase.
   iii. October 1, 2021 – September 30, 2022: A $2.35 per hour increase in direct care worker wages, plus an additional $0.29 per hour increase to cover additional provider agency costs associated with implementing the wage increase.
   iv. October 1, 2022 – September 30, 2023: A $2.35 per hour increase in direct care worker wages, plus an additional $0.29 per hour increase to cover additional provider agency costs associated with implementing the wage increase.

b. The Contractor must implement the hourly wage increase, referred to as Premium Pay, provisions of MSA L letters specific to the premium pay increase. The L letters are located at: https://www.michigan.gov/mdhhs/doing-business/providers/providers/medicaid/communicationtraining/173142. MDHHS will provide increased capitation rates during the Premium Pay period to cover the actual cost of mandatory premium pay increases. The Contractor must disperse these funds to eligible contracted providers employing individuals that qualify for the increase.

c. Providers of the following services are eligible for the DCW wage increase:
   - Community Living Supports (HCPCS Codes H2015, H2016)
   - Overnight Health and Safety Supports (HCPCS Code T2027)
   - Personal Care (HCPCS Code T1020)
   - Prevocational Services (HCPCS Code T2015)
   - Respite (HCPCS Codes S5151, T1005)
   - Skill Building (HCPCS Code H2014)
   - ABA Adaptive Behavior Treatment (HCPCS Code 97153)
   - ABA Group Adaptive Behavior Treatment (HCPCS Code 97154)
   - ABA Exposure Adaptive Treatment (HCPCS Code 0373T)
   - Crisis Residential Services (HCPCS Code H0018)
   - Residential Services –SUD (HCPCS Codes H0018, H0019)
   - Residential Services – Co-occurring SUD/MH (HCPCS Codes H0018, H0019)
   - Withdrawal Management – SUD (HCPCS Codes H0010, H0012, H0014)
   - Supported Employment (HCPCS Code H2023)

d. The Contractor is to ensure to the greatest extent possible that the full amount for funds appropriated for a direct care worker wage increase, except for costs incurred by the employer, including payroll taxes, resulting from the increase to direct care worker wages, is provided to direct care workers through sustained increased wages.

e. DCW wage increase funding will be a component of monthly capitation payments made to the Contractor. The Contractor will pay the increase to eligible providers that employ eligible individuals on an as-invoiced basis, through increased contracted rates for eligible services, or other means approved by the MDHHS.
f. The Contractor is responsible for maintaining a record of DCW wage increase payments and is subject to the risk corridor cost settlement procedures outlined in Schedule A Subsection 7 Risk Corridor of this contract.
g. All wage increase payments are subject to audit and potential recoupment. Providers should retain documentation that demonstrates the distribution of payments to eligible staff.
h. The Contractor will ensure to the greatest extent possible that all employees, agents, and subcontractors of the Contractor, if any, comply with all of the foregoing as well as tracking and annual reporting per legislative and MDHHS requirements.

6. Section 8. Payment Terms, D. Contractor Performance Bonus, 1. Withhold Arrangements, letter b. is hereby deleted and replaced in its entirety with the following:

b. Performance Bonus Incentive Pool (PBIP)
   i. Withhold and Metrics
   The State will withhold 0.75% of BHMA, BHMA-MHP, BHHMP, BHHMP-MHP, HSW-MC, CWP-MC, and SEDW-MC payments for the purpose of establishing a PBIP. Distribution of funds from the PBIP is contingent on the Contractor's results from the joint metrics, the narrative report, and the Contractor-only metrics available on the MDHHS reporting requirements website located at https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/reporting
   ii. Assessment and Distribution
   PBIP funding awarded to the Contractor will be treated as restricted local funding. Restricted local funding must be utilized for the benefit of the public behavioral health system. The 0.75% PBIP withhold will be distributed as follows:
      a. Contractor-only Pay for Performance Measure(s): 45%
      b. Contractor Narrative Reports: 25%
      c. MHP/Contractor Joint Metrics: 30%
      d. The State will distribute earned funds by April 30 of each year.

7. Section 8. Payment Terms, D. Contractor Performance Bonus, 2. Contractor-only Pay for Performance (P4P) Measures (45% of total withhold) is hereby removed.

8. Section 8. Payment Terms, D. Contractor Performance Bonus, 3. MHP/Contractor Joint Metrics (30% of total withhold) is hereby removed.

9. Schedule D, PIHP- MHP Model Agreement is hereby deleted and replaced with the following.

SCHEDULE D
PIHP-MHP MODEL AGREEMENT

Coordinating Agreement Between
<PIHP> and <MHP> For the county(ies) of:
<X>

<DATE>

This agreement is made and entered into this____day of_____, in the year_____by and between _____(Health Plan) and_____(PIHP) for the county(ies) of X, Y, Z.

RECITALS

Whereas, PIHPs are designated as providers of specialized mental health and developmental disability services under contractwith the MDHHS consistent with the Mental Health Code; and

Whereas, PIHPs manage the Medicaid Specialty Services and Supports in a specified geographic service area; and

Whereas, MHPs and PIHPs desire to coordinate and collaborate their efforts in order to protect and promote the health of theshared Medicaid-enrolled population;

Now, therefore, the MHP and the PIHP agree as follows.

A. Definitions
"MDHHS" means the Michigan Department of Health and Human Services."MHP" means Medicaid (Medical) Health Plan.
"PCP" means Primary Care Physician/Practitioner."PIHP" means Prepaid Inpatient Health Plan.

B. Roles and Responsibilities

The parties acknowledge that the primary guidance concerning their respective roles and responsibilities stem fromthe following, as applicable:

- Medicaid Waivers
- Medicaid State Plan and Amendments
- Medicaid Manual
- MHHS, MHP and PIHP Contracts. See Attachment A for specific provisions of said contracts.
- Medical Services Administration (MSA) Medicaid *L-Letter 10-21*
- https://www.michigan.gov/documents/mdch/L_10-21_with_attachment_322809_7.pdf

C. Term of Agreement, Amendments and Cancellation

This Agreement is effective the date upon which the last party signs this Agreement until amended or cancelled. TheAgreement is subject to amendment due to changes in the contracts between the MDHHS and the MHP or the PIHP.All Amendments shall be executed in writing. Either party may cancel the agreement upon thirty (30) days written notice.

D. Purpose, Administration and Point of Authority

The purpose of this Agreement is to address the integration of physical and mental health services provided by theMHP and PIHP for common Medicaid beneficiaries. Specifically, to improve Medicaid beneficiaries' health status, improve the Medicaid beneficiaries' experience of care, and to reduce unnecessary costs.

The MHP and PIHP designate below the respective persons who have authority to administer this Agreement onbehalf of the MHP and PIHP:

<MHP Name, Address, Phone, Signatory, and Agreement Authority with contact information>

<PIHP Name, Address, Phone, Signatory, and Agreement Authority with contact information>

E. Areas of Shared Responsibility

1. Exchange of Information
   a. Each party shall inform the other of current contact information for their respective Medicaid beneficiary Service Departments.
   b. MHP shall make electronically available to the PIHP its enrolled common/shared Medicaid beneficiary list together with their enrolled Medicaid beneficiaries' PCP and PCP contact information, on a monthly basis.
   c. The parties shall explore the prudence and cost-benefits of Medicaid beneficiary information exchange efforts. If Protected and/or Confidential Medicaid beneficiary Information are to be exchanged, such exchanges shall be in accordance with all applicable federal and state statutes and regulations.
   d. The parties shall encourage and support their staff, PCPs and provider networks in maintaining integrative communication regarding mutually served Medicaid beneficiaries.
   e. Prior to exchanging any Medicaid beneficiary information, the parties shall obtain a release from the Medicaid beneficiary, as required by federal and/or state law.
2. Referral Procedures
   a. The PIHP shall exercise reasonable efforts to assist Medicaid beneficiaries in understanding the role ofthe MHP and how to contact the MHP. The PIHP shall exercise reasonable efforts to support Medicaid beneficiaries in selecting and seeing a PCP.
   b. The MHP shall exercise reasonable efforts to assist Medicaid beneficiaries in understanding the role ofthe PIHP and how to contact the PIHP. The MHP shall exercise reasonable efforts to support Medicaid beneficiaries in selecting and seeing a PCP.
   c. Each party shall exercise reasonable efforts to rapidly determine and provide the appropriate type,amount, scope and duration of medically necessary services as guided by the Medicaid Manual.
   d. When making a referral to an MHP, the Contractor must communicate with the MHP who is receiving the call that the Contractor is about to transfer the enrollee. The MHP team should be supplied with the relevant background information and should have the necessary expertise to assist the enrollee. The Contractor agrees to track referrals and conduct further outreach if necessary
3. Medical and Care Coordination; Emergency Services; Pharmacy and Laboratory Services Coordination; Quality Assurance Coordination
   a. Each party shall exercise reasonable efforts to support Medicaid beneficiary and systemic coordination ofcare. The parties shall explore and consider the prudence and cost-benefits of systemic and Medicaid beneficiary focused care coordination efforts. If care coordination efforts involve the exchange of Medicaid beneficiaries' health information, the exchange shall be in accordance with applicable federal and state statutes and regulations related thereto. Each shall make available to the other contact information for case level medical and care coordination.
   b. Neither party shall withhold emergency services and each shall resolve payment disputes in good faith.
   c. Each party shall take steps to reduce duplicative pharmacy and laboratory services and agree to abideby L-Letter 10-21 and other related guidance for payment purposes.
   d. Each party agrees to consider and may implement by mutual agreement Quality Assurance Coordination efforts.

F. Grievance and Appeal Resolution

Each agrees to fulfill its Medicaid beneficiary rights and protections grievance and appeal obligations with Medicaid beneficiaries, and to coordinate resolutions as necessary and appropriate.

G. Dispute Resolution

The parties specify below the steps that each shall follow to dispute a decision or action by the other party related to this Agreement:

1) Submission of a written request to the other party's Agreement Administrator for reconsideration of the disputed decision or action. The submission shall reference the applicable Agreement section(s), known related facts, argument(s) and proposed resolution/remedy; and
2) In the event this process does not resolve the dispute, either party may appeal to their applicable MDHHS Administration Contract Section representative.

Where the dispute affects a Medicaid beneficiaries' current care, good faith efforts will be made to resolve the dispute with all due haste and the receiving party shall respond in writing within three (3) business days.

Where the dispute is in regards to an administrative or retrospective matter the receiving party shall respond in writing within thirty (30) business days.

H. Governing Laws

Both parties agree that performance under this agreement will be conducted in compliance with all applicable federal,

state, and local statutes and regulations. Where federal or state statute, regulation or policy is contrary to the terms and conditions herein, statute, regulation and policy shall prevail without necessity of amendment to this Agreement.

I. Merger and Integration

This Agreement expresses the final understanding of the parties regarding the obligations and commitments which areset forth herein, and supersedes all prior and contemporaneous negotiations, discussions, understandings, and agreements between them relating to the services, representations and duties which are articulated in this Agreement.

J. Notices

All notices or other communications authorized or required under this Agreement shall be given in writing, either by personal delivery or by certified mail (return receipt requested). A notice to the parties shall be deemed given upon delivery or by certified mail directed to the addresses shown below.

Address of the PIHP:

_____
_____
_____
Attention: _____

Address of the MHP:

_____
_____
_____

Attention_____

K. Headings

The headings contained in this Agreement have been inserted and used solely for ease of reference and shall not beconsidered in the interpretation or construction of this Agreement.

L. Severability

In the event any provision of this Agreement, in whole or in part (or the application of any provision to a specific situation) is held to be invalid or unenforceable, such provision shall, if possible, be deemed written and revised in a manner which eliminates the offending language but maintains the overall intent of the Agreement. However, if that isnot possible, the offending language shall be deemed removed with the Agreement otherwise remaining in effect, so long as doing so would not result in substantial unfairness or injustice to either of the parties. Otherwise, the party adversely affected may terminate the Agreement immediately.

M. No Third Party Rights

Nothing in this Agreement, express or implied, is intended to or shall be construed to confer upon, or to give to, anyperson or organization other than the parties any right, remedy or claim under this Agreement as a third party beneficiary.

N. Assignment

This Agreement shall not be assigned by any party without the prior written consent of the other party.

O. Counterparts

This Agreement may be executed in one or more counterparts, each of which shall be deemed an original, but all ofwhich together shall constitute the one in the same instrument.

P. Signatures

The parties by and through their duly authorized representatives have executed and delivered this Agreement. Eachperson signing this Agreement on behalf of a party represents that he or she has full authority to execute and deliverthis Agreement on behalf of that party with the effect of binding the party.

IN WITNESS WHEREOF, the parties hereto have entered into, executed, and delivered this Agreement as of the dayand year first written above.

PIHP

By:_____
Its:_____
Date:_____

MHP

By:_____
Its:_____
Date:_____

10. Schedule E, Reporting Requirements is hereby deleted and replaced with the following.

SCHEDULE E
CONTRACTOR FINANCIAL REPORTING REQUIREMENTS

FINANCIAL PLANNING, REPORTING AND SETTLEMENT

The Contractor must provide the following financial reports to the State as listed below.

Mental Health and Substance Abuse (Non-Medicaid) Reporting Requirements, which includes forms, instructions, and other essential resources, are located on the MDHHS website at: https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/reporting

Unless otherwise noted in the Reporting Mailbox column below, submit completed reports electronically (Microsoft Excel or Microsoft Word) to: MDHHS-BHDDA-Contracts-MGMT@michigan.gov

Due Date	Report Title	Report Period	Reporting Mailbox
February 28	SUD – Legislative Report/Section 904	Annually October 1 to September 30	MDHHS-BHDDA-Contracts-MGMT@michigan.gov
February 28	PIHP Medicaid FSR Bundle - MA. HMP, Autism & SUD	Final (Use tab in FSR Bundle) October 1 to September 30	MDHHS-BHDDA-Contracts-MGMT@michigan.gov
February 28	Encounter Quality Initiative Report (EQI)	Annually October 1 to September 30	QMPMeasures@michigan.gov
February 28	PIHP Executive Administrative Expenditures Survey for Sec. 904(2)(k)	Annually October 1 to September 30	MDHHS-BHDDA-Contracts-MGMT@michigan.gov
February 28	Medical Loss Ratio	Annually October 1 to September 30	MDHHS-BHDDA-Contracts-MGMT@michigan.gov
February 28	Attestation to accuracy, completeness, and truthfulness of claims and payment data	Annually For the prior fiscal year ending September 30	QMPMeasures@michigan.gov
March 31	SUD – Maintenance of Effort (MOE) Report	Annually October 1 to September 30	MDHHS-BHDDA-Contracts-MGMT@michigan.gov
April 30	DHHS Incentive Payment DHIP Report and Narrative	Annually October 1 to September 30	Electronic version of the DHIP CAFAS report (and if applicable PECAFAS report) for each CMHSP to MDHHS-BHDDA-Contracts-MGMT@michigan.gov
May 31	Mid-Year Status Report	Mid-Year October 1 to March 31	MDHHS-BHDDA-Contracts-MGMT@michigan.gov
May 31	Encounter Quality Initiative Report (EQI)	Four months October to January	QMPMeasures@michigan.gov
June 30	SUD – Audit Report	Annually October 1 to September 30	MDHHS-AuditReports@michigan.gov

Due Date	Report Title	Report Period	Reporting Mailbox
		(Due 9 months after close of fiscal year)	
August 15	PIHP Medicaid FSR Bundle MA, HMP, Autism & SUD	Projection (Use tab in FSR Bundle) October 1 to September 30	MDHHS-BHDDA-Contracts-MGMT@michigan.gov
September 30	Encounter Quality Initiative Report (EQI)	Eight Months October to May	QMPMeasures@michigan.gov
October 1	Medicaid YEC Accrual	Final October 1 to September 30	MDHHS-BHDDA-Contracts-MGMT@michigan.gov
October 1	SUD YEC Accrual	Final October 1 to September 30	MDHHS-BHDDA-Contracts-MGMT@michigan.gov
November 1	PIHP Medicaid FSR Bundle MA, HMP, Autism & SUD	Interim (Use tab in FSR Bundle) October 1 to September 30 - Interim	MDHHS-BHDDA-Contracts-MGMT@michigan.gov
December 3	Risk Management Strategy	Annually To cover the current fiscal year	MDHHS-BHDDA-Contracts-MGMT@michigan.gov
December 31	Medicaid Services Verification Report	Annually October 1 to September 30	MDHHS-BHDDA-Contracts-MGMT@michigan.gov
30 Days after submission	Annual Audit Report, Management Letter, and CMHSP Response to the Management Letter.	Annually October 1 to September 30	MDHHS-AuditReports@michigan.gov
30 Days after submission	Compliance exam and plan of correction	Annually October 1 to September 30	MDHHS-AuditReports@michigan.gov

SCHEDULE E

CONTRACTOR NON-FINANCIAL REPORTING REQUIREMENTS

NON-FINANCIAL REPORTING REQUIREMENTS SCHEDULE

The Contractor must provide the following reports to the State as listed below.

Mental Health and Substance Abuse (Non-Medicaid) Reporting Requirements, which includes forms, instructions, and other essential resources, are located on the MDHHS website at: https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/reporting

Unless otherwise noted in the Reporting Mailbox column below, submit completed reports electronically (Microsoft Excel or Microsoft Word) to: MDHHS-BHDDA-Contracts-MGMT@michigan.gov

Due Date	Report Title	Report Period	Reporting Mailbox
January 27	Managed Care Program Annual Report (MCPAR)	October 1 through September 30 prior fiscal year	Submit through: DCH-File Transfer Notify Audra Parsons at ParsonsA@michigan.gov
January 31	Comparison of total number of individual veterans reported on BH-TEDS and the VSN Form	Resubmission of October 1 through March 31 Submission of April 1 through September 30	Submit through: DCH-File Transfer
February 15	Member Grievances	Feb 15 for 1Q data	Submit through: DCH-File Transfer Notify Audra Parsons at ParsonsA@michigan.gov
February 15	Service Authorization Denials	Feb 15 for 1Q data	Submit through: DCH-File Transfer Notify Audra Parsons at ParsonsA@michigan.gov
February 15	Member Appeals	Feb 15 for 1Q data	Submit through: DCH-File Transfer Notify Audra Parsons at ParsonsA@michigan.gov
February 15	Program Integrity Activities	October 1 to December 31	Contractor's MDHHS-OIG's Case Management System
February 28	Quality Assessment Performance Improvement Program (QAPIP)	October 1 to September 30	Submit through: DCH-File Transfer Notify Audra Parsons at ParsonsA@michigan.gov
February 28	Network Adequacy Certification Report	October 1 to September 30	MDHHS-BHDDA-Contracts-MGMT@michigan.gov
March 31	Performance Indicators	October 1 to December 31	QMPMeasures@michigan.gov
April 30	SUD - Sentinel Events Data Report	October 1 to March 31	Submit through: EGrAMS
May 15	Provider Credentialing	May 15 for 1Q and 2Q data	Submit through: DCH-File Transfer Notify Audra Parsons at ParsonsA@michigan.gov
May 15	Member Grievances	May 15 for 1Q and 2Q data	Submit through: DCH-File Transfer Notify Audra Parsons at ParsonsA@michigan.gov
May 15	Member Appeals	May 15 for 1Q and 2Q data	Submit through: DCH-File Transfer Notify Audra Parsons at ParsonsA@michigan.gov
May 15	Service Authorization Denials	May 15 for 1Q and 2Q data	Submit through: DCH-File Transfer Notify Audra Parsons at ParsonsA@michigan.gov
May 15	Program Integrity Activities	January 1 to March 31	Contractor's MDHHS-OIG's Case Management System
June 30	Performance Indicators	January 1 to March 31	QMPMeasures@michigan.gov
July 1	Narrative report on findings and any actions taken to improve data quality on BH-TEDS military and veteran fields.	October 1 to March 31	Submit through: DCH-File Transfer

Due Date	Report Title	Report Period	Reporting Mailbox
July 31	Increased data sharing with other providers/ ADT Narrative	October 1 to June 30	Submit through: DCH-File Transfer
August 15	Member Grievances	Aug 15 for 1Q, 2Q & 3Q data	Submit through: DCH-File Transfer Notify Audra Parsons at ParsonsA@michigan.gov
August 15	Member Appeals	Aug 15 for 1Q, 2Q & 3Q data	Submit through: DCH-File Transfer Notify Audra Parsons at ParsonsA@michigan.gov
August 15	Service Authorization Denials	Aug 15 for 1Q, 2Q & 3Q data	Submit through: DCH-File Transfer Notify Audra Parsons at ParsonsA@michigan.gov
August 15	Program Integrity Activities	April 1 to June 30	Contractor's MDHHS-OIG's Case Management System
September 30	Performance Indicators	April 1 to June 30	QMPMeasures@michigan.gov
October 30	Intensive Crisis Stabilization Services (ICSS) for Children Annual Data Report	October 1 to September 30	MDHHS-BCCHPS-Reporting@michigan.gov
October 31	SUD - Sentinel Events Data Report	April 1 to September 30	Submit through: EGrAMS
November 15	Provider Credentialing	Nov 15 for 1Q, 2Q, 3Q & 4Q data	Submit through: DCH-File Transfer Notify Audra Parsons at ParsonsA@michigan.gov
November 15	Performance Bonus Incentive Narrative on "Increased participation in patient-centered medical homes characteristics."	October 1 to September 30	MDHHS-BHDDA-Contracts-MGMT@michigan.gov
November 15	Member Grievances	Nov 15 for 1Q, 2Q, 3Q & 4Q data	Submit through: DCH-File Transfer Notify Audra Parsons at ParsonsA@michigan.gov
November 15	Member Appeals	Nov 15 for 1Q, 2Q, 3Q & 4Q data	Submit through: DCH-File Transfer Notify Audra Parsons at ParsonsA@michigan.gov
November 15	Service Authorization Denials	Nov 15 for 1Q, 2Q, 3Q & 4Q data	Submit through: DCH-File Transfer Notify Audra Parsons at ParsonsA@michigan.gov
November 15	Program Integrity Activities	July 1 to September 30	Contractor's MDHHS-OIG's Case Management System
November 15	Complete Subcontracted Entity List	Annually Current	Contractor's MDHHS OIG sFTP Area
December 31	Performance Indicators	July 1 to September 30	QMPMeasures@michigan.gov

Due Date	Report Title	Report Period	Reporting Mailbox
On request	Provider Network Stability Plan Report	October 1 to September 30	WieferichJ@michigan.gov
Within 120 calendar days	IET Data Files	PIHPs will be provided the IET data files by January 31 and within 120 calendar days return their data validation	Submit via DEG at: https://milogintp.michigan.gov
Monthly	SUD – Behavioral Health Treatment Episode Data Set (BH-TEDS)	October 1 to September 30 Due last day of each month. See resources at: https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/reporting	Submit via DEG at: https://milogintp.michigan.gov
Monthly (minimum 12 submissions per year)	SUD - Encounter Reporting via HIPPA 837 Standard Transactions	October 1 to September 30 See resources at: https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/reporting	Submit via DEG at: https://milogintp.michigan.gov
Monthly*	Consumer-Level Data 1. Quality Improvement 2. Encounters	October 1 to September 30. See resources at: https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/reporting	MDHHS-BHDDA-Contracts-MGMT@michigan.gov
Monthly	Critical Incidents	As identified in the Critical Incident Reporting and Event Notification Requirements https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/practiceguidelines	Submit to PIHP Incident Warehouse at: https://mipihpwarehouse.org/MVC/Documentation

*Reports required if the Contractor is participating in pilot and/or optional programs.

NOTE: To submit via Data Exchange Gateway (DEG) to the State/MIS Operations Client Admission and Discharge client records must be sent electronically to:

Michigan Department of Health and Human Services
Michigan Department of Technology, Management & Budget
Data Exchange Gateway (DEG)
For admissions: use c:/4823 4823@dchbull
For discharges: use c:/4824 4824@dchbull

Behavioral Health-Treatment Episode Data Set (BH-TEDS) collection/recording and reporting requirements including technical specifications, file formats, error descriptions, edit/error criteria, and explanatory materials on record submission are located on MDHHS's website at: https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/reporting

The PIHP Policies and Practice Guidelines are located on the MDHHS website at https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/practiceguidelines

11. FY2023 Local Funding Obligation is hereby added to Schedule G as follows. Schedule G narrative is hereby deleted and replaced in its entirety with the following.

SCHEDULE G

LOCAL FUNDING OBLIGATION SCHEDULE

Attachments to Schedule G: Local Funding Obligation Schedule include:

a. FY2022 Local Funding Obligation Schedule
b. FY2023 Local Funding Obligation Schedule

12. SFY 2023 Behavioral Health Capitation Rate Certification and SFY 2023 Behavioral Health Entity Specific Factor Development are hereby added to Schedule H as follows. Schedule H narrative is hereby deleted and replaced in its entirety with the following.

SCHEDULE H
BEHAVIORAL HEALTH CAPITATION RATE CERTIFICATION

The Medicaid PEPM rates effective October 1 is included as follows. The actual number of Medicaid beneficiaries will be determined monthly, and the Contractor will be notified of the beneficiaries in their service area via the pre-payment process. In the attached, SFY 2022 Behavioral Health Capitation Rate Certification- Hazard Pay Amendment the Executive Summary section, outlines the PIHP Direct Care Worker (DCW) wage increase funding. DCW wage increase funding includes both the hourly wage increase ($2.35) and associated employer related expenses/ERE ($0.29). The $2.64 per hour amount is discussed on page 4 of the attached rate letter, under the Executive Summary section. This reflects the ERE gross up increasing from 7.65% to 12% of the $2.35/hour wage increase. This revised DCW wage increase funding aligns with current MDHHS policy for MI Choice Waiver, MI Health Link, and Behavioral Health providers receiving an additional $0.29 per hour for agencies to cover their additional costs associated with implementing the DCW wage increase.

Attachments to Schedule H: Behavioral Health Capitation Rate Certification include:

a. SFY2021 October 2020 to September 30, 2021, Behavioral Health Rate Certification
b. SFY2021 March 2021 to September 2021 Behavioral Health Rate Certification
c. SFY2022 Behavioral Health Capitated Rate Certification
d. May to September 2022 Behavioral Health Capitation Rate Methodology
e. SFY 2022 Behavioral Health Capitation Rate Certification – Hazard Pay Amendment
f. SFY 2023 Behavioral Health Capitation Rate Certification
g. SFY 2023 Behavioral Health Entity Specific Factor Development