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 **6**
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, 2022
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**
☒	1 year	☐	N/A	September 30, 2023
CURRENT VALUE		**VALUE OF CHANGE NOTICE**	**ESTIMATED AGGREGATE CONTRACT VALUE**	
$1,766,549,230.00		$997,008,651.00	$2,763,557,881.00	

DESCRIPTION: Effective upon MDHHS signature, this amendment exercises an option year, increases the total contract value, revises Schedule A and replaces Schedule C and E.

FOR THE CONTRACTOR:

Detroit Wayne Integrated Health Network
Company Name

____
Authorized Agent Signature

Eric Doeh
Authorized Agent (Print or Type)

____
Date

FOR THE STATE:

____
Signature

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

Michigan Department of Health and Human Services
Agency

____
Date

1. Schedule A, Statement of Work
Section 1. General Requirements, S. Fiscal Audits and Compliance Examinations, 9. Financial Management System, letters a., b. and c. are hereby deleted and replaced in its entirety with the following:

    a. The Contractor must maintain all pertinent financial and accounting records and evidence pertaining to this Contract based on financial and statistical records that can be verified by qualified auditors. The Contractor must comply with generally accepted accounting principles (GAAP) for government units when preparing financial statements. The Contractor and their subcontractors must use the principles and standards of 2 CFR 200 Subpart E for determining all costs related to the management and provision of MMSSSP services reported on the financial status report. The accounting and financial systems established by the Contractor must be a double entry system having the capability to identify application of funds to specific funding streams participating in service costs for individuals.
    b. The accounting system must be capable of reporting the use of these specific fund sources by major population groups. In addition, cost accounting methodology used by the Contractor must ensure consistent treatment of costs across different funding sources and assure proper allocation to costs to the appropriate source. The Contractor must comply with the Standard Cost Allocation (SCA) methodology established by MDHHS when assigning the fund source and ensure subcontractor compliance with the SCA methodology.
    c. The Contractor must maintain adequate internal control systems. An annual independent audit must evaluate and report on the adequacy of the accounting system and internal control systems.

2. Schedule A, Statement of Work
Section 2.6. Use of Subcontractors is hereby deleted and replaced in its entirety with the following:

2.6. Use of Subcontractors

A. The Contractor must be able to demonstrate compliance with all contract activities set forth in this Contract either directly or through formal delegation of a specified contract activity to a subcontractor through a written subcontract agreement.
B. The term “subcontract(s)” includes contractual agreements between the Contractor and any other entity, including a provider, that performs any function or service for the Contractor related to securing or fulfilling the Contractor’s required contract activities and obligations under the terms of the Contract. The term does not include network provider agreements that are limited in scope to the provision of covered services to enrollees (i.e., the actual delivery of clinical care). Examples of subcontractor classifications include but are not limited to:
    1. Health Benefit Managers (HBMs) – entities that arrange for the provision of health services covered under this Contract
    2. Administrative Subcontractors – entities that perform administrative functions required by this Contract such as claims payment, delegated credentialing, and utilization management.
C. All subcontracts must be in writing and incorporate the terms and conditions contained in this Contract. The Contractor must comply with all subcontract requirements specified in 42 CFR 438.230 and comply with federal and state laws, Medicaid regulations, and sub regulatory guidance.
D. All subcontracts, if using Medicaid funds, must fulfill the requirements of 42 CFR 434.6. All subcontracts are subject to review by the State at its discretion.
E. The Contractor shall be held fully liable and retain full responsibility for the performance and completion of all Contract requirements regardless of whether the Contractor performs the work or subcontracts for services. The Contractor (and subcontractors, as applicable) must monitor the performance of all subcontractors on an ongoing basis. This includes conducting formal reviews consistent with industry standards. Both the Contractor and subcontractor must take corrective action on any identified deficiencies or areas of improvement.
F. The Contractor must obtain the approval of MDHHS before subcontracting any portion of the Contract requirements and must submit the subcontractor agreement and delegation grid to MDHHS annually, any time there is a material change, or upon request.

G. The Contractor must ensure there is a written agreement that specifies the activities and report responsibilities delegated to Subcontractors and provides for revoking delegation or imposing other sanctions if the Subcontractor's performance is inadequate, see the MDHHS Policies and Practice Guidelines https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/practiceguidelines for a model agreement. All agreements are subject to review by the State at its discretion.
   1. If Contractor determines revocation of a delegation to a subcontractor is appropriate, the Contractor must provide notice of such action to MDHHS ten (10) business days in advance of issuing such notice to the subcontractor.
   2. If Contractor identifies deficiencies or areas for improvement, the Contractor and the Subcontractor must take corrective action, including when appropriate, revoking delegation or imposing other sanctions if the Subcontractor's performance is inadequate. Contractor must provide:
      a. Quarterly report to MDHHS of all subcontractor noncompliance and/or areas of subcontractor performance that were below standards or expectations of this Contract. This notice must include name of subcontractor and delegated functions; a brief description of specific non-compliance or performance deficiency; what action Contractor took to resolve the concerns; including specific monitoring is being completed by the Contractor; whether the concern has been resolved; and if not fully resolved what actions are occurring or planned to resolve the issue.
      b. Any information or documentation related to subcontractor deficiency, inadequacy, or non-compliance to MDHHS upon request. Responsive information to such request by MDHHS must be produced to MDHHS within ten (10) business days

H. The Contractor must develop, maintain, and submit policies and procedures addressing auditing and monitoring subcontractors' performance, data, and data submission, including evaluation of prospective subcontractors' abilities prior to contracting with the subcontractor to perform services, collection of performance and financial data to monitor performance on an ongoing basis and conducting formal, periodic, and random reviews. The Contractor must incorporate all subcontractors' data into the Contractor's performance and financial data for a comprehensive evaluation and identify subcontractor improvement areas.

I. Fiscal Viability of Subcontractors. Contractor must maintain a system to evaluate and monitor the financial viability of all subcontractors and risk bearing provider groups, including but not limited to CMHSPs. At least annually, the Contractor must make documentation of its review available to MDHHS upon request. MDHHS reserves the right to review these documents during Contactor site visits.

J. Delegation of Network Development. When the Contractor delegates network development responsibilities to a subcontractor, including a CMHSP or other network provider, the subcontracts must address the following:
   1. Duty to treat and accept referrals
   2. Prior authorization requirements
   3. Access standards and treatment timelines
   4. Relationship with other providers
   5. Reporting requirements and time frames
   6. Quality Assurance/Quality Improvement (QA/QI) Systems
   7. Payment arrangements (including coordination of benefits) and solvency requirements
   8. Financing conditions consistent with this Contract
   9. Compliance with Office of Civil Rights Policy Guidance on Title VI "Language Assistance to Persons with Limited English Proficiency"
   10. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) requirements
   11. Requirement to comply with the "Quality Assessment and Performance Improvement Programs for Specialty Prepaid Health Plans", which can be found on the MDHHS website: https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/practiceguidelines and require the subcontractor to cooperate with the Contractor's quality improvement and utilization review activities
   12. Provisions for the immediate transfer of recipients to a different provider if their health or safety is in jeopardy

13. Subcontractors right to discuss treatment options with a recipient that may not reflect the Contractor's position or may not be covered by the Contractor
14. Subcontractors right to advocate on behalf of the recipient in any grievance or utilization review process, or individual authorization process to obtain necessary health care services
15. Requirement to meet accessibility standards, both as established in Medicaid policy, and this Contract

K. In accordance with 42 CFR 422.216, the Contractor must establish payment rates for plan covered items and services that apply to deemed providers. The Contractor may vary payment rates for providers in accordance with § 422.4(a)(3).
   1. Providers must be reimbursed on a fee-for-service basis.
   2. The Contractor must make information on its payment rates available to providers that furnish services that may be covered under the contractor's private fee-for-service plan.
   3. The Contractor must pay for services of noncontract providers in accordance with 42 CFR 422.100(b)(2)

L. In accordance with 42 CFR 422.208, any physician incentive plan operated by a Contractor, or its subcontractor, must meet the following requirements:
   1. The Contractor makes no specific payment, directly or indirectly, to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to any particular enrollee. Indirect payments may include offerings of monetary value (such as stock options or waivers of debt) measured in the present or future.
   2. If the physician incentive plan places a physician or physician group at substantial financial risk (as determined in this section) for services that the physician or physician group does not furnish itself, the Contractor must assure that all physicians and physician groups at substantial financial risk have either aggregate or per-patient stop-loss protection in accordance with this section.
      a. For all physician incentive plans, the Contractor must provide to CMS, and to any Medicaid beneficiary, the information specified in 42 CFR 422.210.
      b. The Contractor must provide a copy of specific contract language used for incentive, bonus, withhold or sanction provisions (including sub-capitations) to the State at least 30 days prior to the subcontract effective date. The State reserves the right to require an amendment of the subcontract if the provisions appear to jeopardize individuals' access to services. The State will provide notice of approval or disapproval of proposed contract language within 25 days of receipt.

M. In accordance with 42 CFR 447.325, the Contractor may pay the customary charges of the provider but must not pay more than the prevailing charges in the locality for comparable services under comparable circumstances.

N. The Contractor, and its subcontractors, as applicable, must retain, as applicable, beneficiary grievance and appeal records in accordance with 42 CFR 438.416, base data in 42 CFR 438.5(c), MLR reports in 42 CFR 438.8(k), and the data, information, and documentation specified in 42 CFR 438.604, 438.606, 438.608, and 438.610 for a period of no less than 10 years.

O. In accordance with 42 CFR 438.230(c), all subcontracts must allow the State, CMS, the HHS Inspector General, the Comptroller General, or their designees to have the right to audit, evaluate, and inspect any books, records, contracts, computer, or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under this Contract with the State. The subcontractor must make available, for purposes of an audit, evaluation, or inspection under this Contract, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid beneficiaries. The right to audit under this Contract will exist through 10 years from the final date of the Contract period or from the date of completion of any audit, whichever is later.

P. Accreditation of Network Providers
   The Contractor (and its subcontractors, as applicable) may enter into network provider agreements for treatment services provided through outpatient, Methadone, sub-acute detoxification and residential providers only with providers accredited by one of the following accrediting bodies: The

Joint Commission (TJC formerly JCAHO); Commission on Accreditation of Rehabilitation Facilities (CARF); the American Osteopathic Association (AOA); Council on Accreditation of Services for Families and Children (COA); National Committee on Quality Assurance (NCQA), or Accreditation Association for Ambulatory Health Care (AAAHC). The Contractor, or its subcontractor, must determine compliance through review of original correspondence from accreditation bodies to providers. Accreditation is not needed in order to provide access management system (AMS) services, whether these services are operated by a Contractor or through an agreement with the Contractor or for the provision of broker/generalist case management services. Accreditation is required for AMS providers that also provide treatment services and for case management providers that either also provide treatment services or provide therapeutic case management. Accreditation is not required for peer recovery and recovery support services when these are provided through a prevention license.

3. Schedule A, Statement of Work
   Section 3. Project Management, 3.1 Reporting, D. Medical Loss Ratio (MLR) Reporting Requirements is hereby deleted and replaced in its entirety with the following:

   D. Medical Loss Ratio (MLR) Reporting Requirements
      The MLR is a measure of the percentage of premium dollars that each Contractor spends on clinical services and quality improvement activities. For each reporting year, MDHHS will require each Contractor to submit an MLR report that includes at least the total incurred claims, expenditures on quality improving activities, expenditures on fraud prevention activities, non-claims costs, premium revenue, taxes and fees, and expenditure allocation methodologies. MDHHS will ensure Contractors are properly identifying and classifying costs across these categories.
      1. The Contractor must submit a consolidated MLR report to the State for each reporting year as directed by MDHHS and in accordance with 42 CFR 438.8, medical loss ratio standards, and all other regulatory guidance as issued by CMS.
      2. The Contractor must use the reporting tool provided by MDHHS for MLR reporting requirements and follow the state's reporting instructions for completing the requested information.
         a. Technical specifications, including file formats, and explanatory materials are located on the MDHHS website at: https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/reporting
      3. The MLR reporting replaces the Contractor obligation to complete an administrative cost report. The MLR report must provide sufficient administrative cost reporting to meet the actuarial needs. In addition to information required above this will include non-benefit costs in the following categories:
         a. Administrative costs.
         b. Taxes, licensing and regulatory fees, and other assessments and fees.
         c. Contribution to reserves, risk margin, and cost of capital.
         d. Other material non-benefit costs.
      4. In accordance with 42 CFR § 438.8, each PIHP expense must be included under only one type of expense, unless a portion of the expense fits under the definition of, or criteria for, one type of expense and the remainder fits into a different type of expense, in which case the expense must be pro-rated between types of expenses. Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, must be reported on pro rata basis. Expense allocation must be based on a generally accepted accounting method that is expected to yield the most accurate results. Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the contract incurring the expense. Expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to the other entities.
      5. The credibility adjustment is added to the reported MLR calculation before calculating any remittances. The Contractor may not add a credibility adjustment to a calculated MLR if the MLR reporting year experience is fully credible. If the Contractor experience is non-credible, it is presumed to meet or exceed the MLR calculation standards.

6. The Contractor must aggregate data for all Medicaid eligibility groups covered under the Contract with the State unless the State requires separate reporting and a separate MLR calculation for specific populations.
7. MLR must be equal to or higher than 85 percent and the MLR must be calculated and reported for each MLR reporting year by the Contractor.
8. If required by the State, the Contractor must provide a remittance for an MLR reporting year if the MLR for that MLR reporting year does not meet the minimum MLR standard of 85 percent or higher.
9. The Contractor must require any subcontractor providing claims adjudication activities to provide all underlying data associated with MLR reporting to the Contractor within 180 days of the end of the MLR reporting year or within 30 days of being requested by the Contractor, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting.
10. In any instance where the State makes a retroactive change to the capitation payments for a MLR reporting year where the MLR report has already been submitted to the State, the Contractor must re-calculate the MLR for all MLR reporting years affected by the change. In any instance where the State makes a retroactive change to the capitation payments for a MLR reporting year where the MLR report has already been submitted to the State, the Contractor must submit a new MLR report meeting the applicable requirements.
11. The Contractor must attest to the accuracy of the calculation of the MLR in accordance with the MLR standards when submitting required MLR reports.

4. Schedule A, Statement of Work
   Section 3. Project Management, 3.1 Reporting, G. Annual Provider Survey Reporting is hereby added in its entirety with the following:

   G. Annual Provider Survey Reporting
   In compliance with MDHHS policy bulletin MSA 21-39 (and any properly promulgated successor guidance issued) establishing annual cost reporting requirements for behavioral health service providers contracted with the Contractor and/or CMHSPs, the Contractor must support the data collection process by providing to MDHHS the contact information for all of their network providers (regardless of whether such network providers contract directly with the Contractor or directly with a subcontractor, including a CMSHP). This information is due to MDHHS annually upon request. The Contractor must ensure all network providers comply with the MDHHS cost reporting survey process and MDHHS cost reporting policy

5. Schedule C is hereby deleted and replaced with the following:

STATE OF MICHIGAN

Prepaid Inpatient Health Plan (PIHP)

SCHEDULE C
DEFINITIONS / EXPLANATION OF TERMS

The terms used in this Contract will be construed and interpreted as defined below unless the Contract otherwise expressly requires a different construction and interpretation.

Abuse: As defined in 42 CFR 455.2, provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet the professionally recognized standards for health care.

Actuarial Soundness: As defined in 42 CFR, (a) Actuarially sound capitation rates are projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the MCO, PIHP, or PAHP for the time period and the population covered under the terms of the contract, and such capitation rates are developed in accordance with the requirements in paragraph (b) of this section.
(b) *CMS review and approval of actuarially sound capitation rates.* Capitation rates for MCOs, PIHPs, and PAHPs must be reviewed and approved by CMS as actuarially sound. To be approved by CMS, capitation rates must:

(1) Have been developed in accordance with standards specified in § 438.5 and generally accepted actuarial principles and practices. Any proposed differences among capitation rates according to covered populations must be based on valid rate development standards and not based on the rate of Federal financial participation associated with the covered populations.
(2) Be appropriate for the populations to be covered and the services to be furnished under the contract.
(3) Be adequate to meet the requirements on MCOs, PIHPs, and PAHPs in §§ 438.206, 438.207, and 438.208.
(4) Be specific to payments for each rate cell under the contract.
(5) Payments from any rate cell must not cross-subsidize or be cross-subsidized by payments for any other rate cell.
(6) Be certified by an actuary as meeting the applicable requirements of this part, including that the rates have been developed in accordance with the requirements specified in § 438.3(c)(1)(ii) and (e).
(7) Meet any applicable special contract provisions as specified in § 438.6.
(8) Be provided to CMS in a format and within a timeframe that meets requirements in § 438.7.
(9) Be developed in such a way that the MCO, PIHP, or PAHP would reasonably achieve a medical loss ratio standard, as calculated under § 438.8, of at least 85 percent for the rate year. The capitation rates may be developed in such a way that the MCO, PIHP, or PAHP would reasonably achieve a medical loss ratio standard greater than 85 percent, as calculated under § 438.8, as long as the capitation rates are adequate for reasonable, appropriate, and attainable non-benefit costs..

Appropriations Act: An act to make appropriations, to the State, for each fiscal year, and to provide for the expenditure of the appropriation.

Behavioral Health – Healthy Michigan Plan (HMP), Medicaid Health Plan (MHP) Unenrolled (BHHMP): This plan covers Medicaid mental health and substance abuse services managed by the Contractor for Healthy Michigan (HMP) recipients who have a specialty level of need and are not enrolled in a Medicaid Health Plan (Fee For Service-FFS).

Behavioral Health – Healthy Michigan Plan, MHP Enrolled (BHHMP-MHP): This plan covers Medicaid mental health and substance abuse services managed by the Contractor for Healthy Michigan (HMP) recipients who have a specialty level of need and are enrolled in a Medicaid Health Plan for Managed Care (MC).

Behavioral Health – Medicaid, MHP Unenrolled (BHMA): This plan covers Medicaid mental health and substance abuse services managed by the Contractor for MA recipients who have a specialty level of need and are not enrolled in a Medicaid Health Plan (Fee For Service - FFS).

Behavioral Health – Medicaid, MHP Enrolled (BHMA-MHP): This plan covers Medicaid mental health and substance abuse services managed by the Contractor for MA recipients who have a specialty level of need and are enrolled in a Medicaid Health Plan for Managed Care (MC).

Capitated Payments: Is a fixed amount of money per beneficiary per month paid in advance to the Contractor for the delivery of behavioral health care services.

Capitation Rate: The fixed per person monthly rate payable to the Contractor by the State for each Medicaid eligible person covered by the 1115 Demonstration Waiver Program, regardless of whether or not the individual who is eligible for Medicaid receives covered specialty services and supports during the month. There is a separate, fixed per person monthly rate payable for each eligible person covered by the Healthy Michigan Program.

Clean Claim: As defined in 42 CFR 447.45 Timely Claims Payment, b, a clean claim is one that can be processed without obtaining additional information from the provider of the service or a third party. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

Community Mental Health Services Program (CMHSP): A CMHSP is a program that contracts with the State to provide comprehensive behavioral health services in specific geographic service areas, regardless of an individual's ability to pay. (Michigan Mental Health Code 330.1100a, 330.1206). A CMHSP is considered a "Network Provider" under this Contract when directly engaged in the delivery, ordering, or referring of covered services to a beneficiary, and is considered a "Subcontractor" under this Agreement when providing a function or service on behalf of the Contractor related, directly or indirectly, to the performance of Contractor's obligations to the State under this Contract.

CMHSP Contractual Staff: CMHSP contractual staff are not W-2 employees of the CMHSP, but they also do not have a network provider agreement. The following provides guidance regarding whether these contractual staff can be considered "employees" for purposes of reporting, or whether the CMHSP is required to have a network provider agreement with the contractual staff. To determine if a provider without a network provider agreement can be considered an employee of the CMHSP for purposes of the standard cost allocation methodology, EQI reporting, and MLR reporting, the provider must:

1. Use the CMHSP NPI number for billing/encounter submission, and
2. Perform work under the control and direction of the CMHSP, i.e., what will be done and how it will be done.

Relationships where the provider does not use the CMHSP NPI number, or the CMHSP has the right to control and direct only the result of the provider's work (i.e., not what will be done and how it will be done) would be indicative of a network provider relationship.

CMHSP Employee: A CMSHP employee is a person employed by the CMHSP receiving a salary or wage and a W-2 for tax purposes, and where the work performed by the person is under the control of the CMHSP (i.e., how, and where the work is done).

Critical Incident: 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.

Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT): As defined in 42 CFR 440.40(b).

Fraud: As defined in 42 CFR 455.2, the intentional deception or misinterpretation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or another person. It includes any act that constitutes fraud under any applicable federal or State Law.

Flint 1115 Demonstration Waiver: The benefit describes Targeted Case Management (TCM) services provided to pregnant women and children up to age 21 with household income up to and including 400% of the federal poverty level (FPL) who were served by the Flint water system on or between April 1, 2014, and the date the water is deemed safe by the appropriate authorities. Pregnant women will remain eligible throughout their pregnancy and will receive two months of post-partum coverage. Once eligibility has been established for a child, including those children born to pregnant women, the child will remain eligible until age 21 as long as other eligibility requirements are met. TCM services assist individuals in gaining access to appropriate medical, educational, social, and/or other services. TCM services include assessments, planning, linkage, advocacy, coordination, referral, monitoring, and follow-up activities.

Health Care Professional: Includes any of the following: physician, podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse midwife), registered/certified social worker, registered respiratory therapist, and certified respiratory therapy technician (this list is not all inclusive).

Health Insurance Portability and Accountability Act of 1996 (HIPAA): Public Law 104-191 of 1996 to improve the Medicare program under Title XVIII of the Social Security Act, the Medicaid program under Title XIX of the Social Security Act, and the efficiency and effectiveness of the health care system, by encouraging the development of a health information system through the establishment of standards and requirements for the electronic transmission of

certain health information.

Healthy Michigan Plan (HMP): Is a category of eligibility authorized under the Patient Protection and Affordable Care Act and Michigan PA 107 of 2013.

Healthy Michigan Plan Beneficiary: An individual who has met the eligibility requirements for enrollment in HMP and has been issued a Medicaid card.

Intellectual/Developmental Disability: As defined in MCL 330.1100a(25) of the Michigan Mental Health Code.

I**nstitution for Mental Disease (IMD) Services**: Means a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services." (SSA §1905(i).).

Intensive Crisis Stabilization Services (ICSS): Structured treatment and support activities provided by a mobile intensive crisis stabilization team that are designed to promptly address a crisis situation in order to avert a psychiatric admission or other out of home placement or to maintain a child or youth in their home or present living arrangement who has recently returned from a psychiatric hospitalization or other out of home placement. These services must be available to children or youth with serious emotional disturbance (SED) and/or intellectual/developmental disabilities (I/DD), including autism, or co-occurring SED and substance use disorder (SUD).

Limited English Proficiency (LEP): Means being limited in ability or unable to speak, read and/or write the English language well enough to understand and be understood without the aid of an interpreter.

Managed Care Administration: An administrative cost category to which non-encounterable costs of the Contractor or subcontractor must be assigned. Managed care administration are administrative costs to fulfill the obligations of the Contract to organize, arrange, and coordinate clinical service delivery. Non-exhaustive examples include eligibility and coverage verification, utilization management, network development, contracted network provider training, claims processing, activities to improve health care quality, and fraud prevention activities. Costs defined as shared managed care administration must be excluded from the unit cost and the independent rate model.

Maternity Outpatient Medical Services (MOMS): A health coverage program operated by the State.

Medical Loss Ratio (MLR): Is the proportion of premium revenues spent on clinical services and quality improvements. The Affordable Care Act establishes minimum MLR standards and requires issuers to provide rebates when the MLRs are lower than the applicable MLR standard. The Contractor must maintain an MLR of 85% or higher or provide rebates.

Medicaid Managed Specialty Services and Supports Program (MMSSSP): This includes the following: 1115 Behavioral Health Demonstration Waiver and the 1915(c) Habilitation Supports Waiver, Children's Waiver Program (CWP), Serious Emotional Disturbance (SED), the MIChild program, MOMS program, and the 1115 Healthy Michigan Plan.

MIChild: A health care program for low-income, uninsured children under age 19 administered by MDHHS. Beneficiaries receive a comprehensive package of health care benefits including vision, dental, and mental health services.

Network Provider Agreement: An agreement between the Contractor and a provider or between the Contractor's subcontractor and a provider that describes the conditions under which the provider agrees to furnish covered services to the Contractor's enrolled beneficiaries. Agreements with providers that include additional functions or services beyond the provision of covered services to beneficiaries are not network provider agreements and shall be considered subcontracts for the purposes of this Contract.

Network Provider: Any provider, group of providers, or entity that has a provider agreement with the Contractor or the Contractor's subcontractor, including a CMHSP, and receives Medicaid funding directly or indirectly to order, refer or render covered services as a result. A network provider is not a subcontractor by virtue of the network provider agreement, unless the network provider is responsible for services other than those that could be covered in a network provider agreement related to the delivery, ordering, or referring of covered services to a beneficiary.

Per Eligible Per Month (PEPM): A fixed monthly rate per Medicaid eligible person payable to the Contractor by the State for provision of Medicaid services defined within this Contract.

Post-stabilization Care Services: As defined in 42 CFR 438.114(a), covered services related to an emergency medical condition that are provided after a beneficiary is stabilized in order to maintain the stabilized condition, or,

under the circumstances described in 42 CFR 438.114(e) to improve or resolve the beneficiary's condition.

Prepaid Inpatient Health Plan (PIHP): A PIHP is an organization as defined in 42 CFR Part 438 and meets the requirements of MCL 330.1204b.

Provider: An individual or entity engaged in the delivery, ordering, or referring of services.

Regional Entity: An entity established by a combination of community mental health services programs under section 204b of the Michigan Mental Health Code, A 258 of 1974 as amended.

Risk Mitigation Plan: For the purposes of Third-Party Liability, a Risk Mitigation Plan is a document that will be provided by the Medicaid Health Plan outlining the actions the Medicaid Health Plan will take to address risks identified by the State. Risks are issues that will affect a Medicaid Health Plan's ability to meet the minimum TPL requirements required by this Contract, federal, or state law in order to reduce the likelihood of an adverse state or federal TPL audit finding.

Sentinel Event: Is an "unexpected occurrence" involving death (not due to the natural course of a health condition) or serious physical or psychological injury, or risk thereof. Serious injury specifically includes permanent loss of limb or function. The phrase "or risk thereof" includes any process variation for which recurrence would carry a significant chance of a serious adverse outcome (JCAHO, 1998). Any injury or death that occurs from the use of any behavior intervention is considered a sentinel event.

Serious Emotional Disturbance (SED): As defined in Section 330.1100c of the Michigan Mental Health Code

Serious Mental Illness (SMI): As defined in MCL 330.1100d(3) of the Michigan Mental Health Code.

Subcontract: An agreement entered into by the Contractor with any other individual, provider, CMHSP, or other organization who agrees to perform any function or service on behalf of the Contractor related to securing or fulfilling the Contractor's required contract activities and obligations under the terms of this Contract when the intent of such an agreement is to delegate the responsibility for any major service or group of services required by this Contract. Examples of delegated activities include but are not limited to overseeing quality management and assessing performance measurement and improvement, developing or maintaining a compliance program, managing staff qualifications and training, overseeing a utilization management program, assuring compliance with access standards, maintaining information technology systems, overseeing finance system and procedures, providing customer service, upholding enrollee rights and protections, managing the enrollee or provider grievance process, engaging in provider network selection and management, performing credentialing functions, managing the appeals process, making ownership and control disclosures, and other general management functions undertaken on behalf of the Contractor related to fulfilling the Contract requirements. Agreements limited in scope to the provision of covered services to enrollees are not subcontracts and shall be considered network provider agreements for purposes of this Contract.

Subcontractor: An individual, provider, CMHSP, or other organization that provides any function or service on behalf of the Contractor related to securing or fulfilling the Contractor's obligations under this Contract. Subcontractor does not include a network provider, unless the network provider is responsible for services other than those that could be covered in a network provider agreement related only to the provision of covered services to beneficiaries.

Substance Use Disorder (SUD): As defined in MCL 330.1100d(11) of the Michigan Mental Health Code.

6. Schedule E is hereby deleted and replaced with the following:

SCHEDULE E
CONTRACTOR FINANCIAL REPORTING REQUIREMENTS

FINANCIAL PLANNING, REPORTING AND SETTLEMENT

The Contractor must provide the financial reports to the State as listed below. Forms, instructions, and other reporting resources are posted to the MDHHS website address at: https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/reporting

Unless otherwise noted in the Reporting Mailbox column below, submit completed reports electronically (Excel or 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 (Due 9 months after close of fiscal year)	MDHHS-AuditReports@michigan.gov
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

Due Date	Report Title	Report Period	Reporting Mailbox
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

CONTRACTOR NON-FINANCIAL REPORTING REQUIREMENTS SCHEDULE INCLUDING SUD REPORTS

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

Due Date	Report Title	Report Period	Reporting Mailbox
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 22	Managed Care Program Annual Report (MCPAR)	Annually beginning FY2023 January to December prior year	Submit through: DCH-File Transfer Notify Audra Parsons at ParsonsA@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

Due Date	Report Title	Report Period	Reporting Mailbox
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
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
On request	Provider Network Stability Plan Report	October 1 to September 30	WieferichJ@michigan.gov

Due Date	Report Title	Report Period	Reporting Mailbox
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: put c:/4823 4823@dchbull
For discharges: put 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