STATE OF MICHIGAN PROCUREMENT

Department of Health and Human Services
235 South Grand Avenue, Suite 1201, Lansing, MI 48933
Grand Tower Building, Suite 1201, PO Box 30037, Lansing, MI 48909

NOTICE OF CONTRACT

NOTICE OF CONTRACT NO. **MA 230000001246**
between
THE STATE OF MICHIGAN
and

CONTRACTOR	
	Northern Michigan Regional Entity
	1999 Walden Drive
	Gaylord, MI 49735
	Eric Kurtz
	231-487-9144
	ekurtz@nmre.org
	CV0055311

STATE			
	Program Manager	Kristen Jordan	MDHHS
		517-388-7421	
		jordank4@michigan.gov	
	Contract Administrator	Danielle Walsh	MDHHS
		517-241-2110	
		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, 2023	September 30, 2024	N/A	N/A
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			
MISCELLANEOUS INFORMATION			
N/A			
ESTIMATED CONTRACT VALUE AT TIME OF EXECUTION			**$268,904,580.00**

FOR CONTRACTOR:

Northcare Network

Company Name

E-SIGNED by Eric Kurtz
on 2023-09-29 12:28:40 EDT

Authorized Agent Signature

Eric Kurtz

Authorized Agent (Print or Type)

2023-09-29 12:28:40 UTC

Date

FOR THE STATE:

E-SIGNED by Christine H. Sanches
on 2023-09-29 13:16:54 EDT

Signature

Christine H. Sanches, Director,
Bureau of Grants and Purchasing

Name & Title

Michigan Department of Health and Human Services

Agency

2023-09-29 13:16:54 UTC

Date

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STANDARD CONTRACT TERMS

This STANDARD CONTRACT ("**Contract**") is agreed to between the State of Michigan (the "**State**") and Northern Michigan Regional Entity ("**Contractor**"), a Prepaid Inpatient Health Plan (PIHP). This Contract is effective on October 1, 2023 ("**Effective Date**"), and unless terminated, will expire on September 30, 2024 (the "**Term**").

The parties agree as follows:

1. **Duties of Contractor.** Contractor must perform the services and provide the deliverables (the "**Contract Activities**") described in a Statement of Work, the initial Statement of Work is attached as Schedule A Statement of Work. An obligation to provide delivery of any commodity is considered a service and is a Contract Activity.

   Contractor must furnish all labor, equipment, materials, and supplies necessary for the performance of the Contract Activities unless otherwise specified in a Statement of Work.

   Contractor must: (a) perform the Contract Activities in a timely, professional, safe, and workmanlike manner consistent with standards in the trade, profession, or industry; (b) meet or exceed the performance and operational standards, and specifications of the Contract; (c) provide all Contract Activities in good quality, with no material defects; (d) not interfere with the State's operations; (e) obtain and maintain all necessary licenses, permits or other authorizations necessary for the performance of the Contract; (f) cooperate with the State, including the State's quality assurance personnel, and any third party to achieve the objectives of the Contract; (g) return to the State any State-furnished equipment or other resources in the same condition as when provided when no longer required for the Contract; (h) assign to the State any claims resulting from state or federal antitrust violations to the extent that those violations concern materials or services supplied by third parties toward fulfillment of the Contract; (i) comply with all State physical and IT security policies and standards which will be made available upon request; and (j) provide the State priority in performance of the Contract except as mandated by federal disaster response requirements. Any breach under this paragraph is considered a material breach.

   Contractor must also be clearly identifiable while on State property by wearing identification issued by the State, and clearly identify themselves whenever making contact with the State.

2. **Notices.** All notices and other communications required or permitted under this Contract must be in writing and will be considered given and received: (a) when verified by written receipt if sent by courier; (b) when actually received if sent by mail without verification of receipt; or (c) when verified by automated receipt or electronic logs if sent by facsimile or email.

If to State:	If to Contractor:
Danielle Walsh 235 S. Grand Avenue, Suite 1201 Lansing, MI 48933 Walshd4@michigan.gov	Eric Kurtz 1999 Walden Drive Gaylord, MI 49735 ekurtz@nmre.org

If to State:	If to Contractor:
517-241-2110	231-487-9144

3. **Contract Administrator.** The Contract Administrator, or the individual duly authorized for each party, is the only person authorized to modify any terms of this Contract, and approve and execute any change under this Contract (each a "**Contract Administrator**"):

State:	Contractor:
Danielle Walsh 235 S. Grand Avenue, Suite 1201 Lansing, MI 48933 Walshd4@michigan.gov 517-241-2110	Eric Kurtz 1999 Walden Drive Gaylord, MI 49735 ekurtz@nmre.org 231-487-9144

4. **Program Manager.** The Program Manager for each party will monitor and coordinate the day-to-day activities of the Contract (each a "**Program Manager**"):

State:	Contractor:
Kristen Jordan 400 South Pine Street Lansing, MI 48913 jordank4@michigan.gov 517-388-7421	Eric Kurtz 1999 Walden Drive Gaylord, MI 49735 ekurtz@nmre.org 231-487-9144

5. **Performance Guarantee.** Contractor must at all times have sufficient financial resources as objectively determined by the State, to ensure performance of the Contract and must provide proof upon request.

6. **Insurance Requirements.** Contractor, at its sole expense, must maintain the insurance coverage identified below. With respect to Privacy and Security Liability, Contractor may, at the discretion of the DHHS Contract Administrator, defer coverage up to no more than 30 days prior to beginning any work or deliverables under this Contract. All required insurance must: (a) protect the State from claims that may arise out of, are alleged to arise out of, or otherwise result from Contractor's performance.

Required Limits	Additional Requirements
Commercial General Liability Insurance	
Minimum Limits: $1,000,000 Each Occurrence $1,000,000 Personal & Advertising Injury $2,000,000 Products/Completed Operations $2,000,000 General Aggregate	
Automobile Liability Insurance	
If a motor vehicle is used in relation to Contractor's performance, Contractor must have vehicle liability insurance on the motor vehicle for bodily injury and property damage as	

Required Limits	Additional Requirements
required by law.	
Workers' Compensation Insurance	
Minimum Limits: Coverage according to applicable laws governing work activities.	Waiver of subrogation, except where waiver is prohibited by law.
Employers Liability Insurance	
Minimum Limits: $500,000 Each Accident $500,000 Each Employee by Disease $500,000 Aggregate Disease	
Privacy and Security Liability (Cyber Liability) Insurance	
Minimum Limits: $1,000,000 Each Occurrence $1,000,000 Annual Aggregate	Contractor must have their policy cover information security and privacy liability, privacy notification costs, regulatory defense and penalties, and website media content liability.
Professional Liability (Errors and Omissions) Insurance	
Minimum Limits: $3,000,000 Each Occurrence $3,000,000 Annual Aggregate	

If any of the required policies provide **claims-made** coverage, Contractor must: (a) provide coverage with a retroactive date before the Effective Date of the Contract or the beginning of Contract Activities; (b) maintain coverage and provide evidence of coverage for at least three (3) years after completion of the Contract Activities; and (c) if coverage is cancelled or not renewed, and not replaced with another claims-made policy form with a retroactive date prior to the Contract Effective Date, Contractor must purchase extended reporting coverage for a minimum of three (3) years after completion of work.

Contractor must: (a) provide insurance certificates to the Contract Administrator, containing the agreement or delivery order number, at Contract formation and within twenty (20) calendar days of the expiration date of the applicable policies; (b) require that subcontractors maintain the required insurance contained in this Section; (c) notify the Contract Administrator within five (5) business days if any insurance is cancelled; and (d) waive all rights against the State for damages covered by insurance. Failure to maintain the required insurance does not limit this waiver.

This Section is not intended to and is not to be construed in any manner as waiving, restricting or limiting the liability of either party for any obligations under this Contract (including any provisions hereof requiring Contractor to indemnify, defend and hold harmless the State).

7. Reserved.

8. **Reserved.**

9. **Relationship of the Parties.** The relationship between the parties is that of independent contractors, Contractor, its employees, and agents will not be considered employees of the State. No partnership or joint venture relationship is created by virtue of this Contract. Contractor, and not the State, is responsible for the payment of wages, benefits and taxes of Contractor's employees and any subcontractors. Prior performance does not modify Contractor's status as an independent contractor. Neither party has authority to contract for nor bind the other party in any manner whatsoever.

10. **Intellectual Property Rights.** If a Statement of Work requires Contractor to create any intellectual property, Contractor hereby acknowledges that the State is and will be the sole and exclusive owner of all right, title, and interest in the Contract Activities and all associated intellectual property rights, if any. Such Contract Activities are works made for hire as defined in Section 101 of the Copyright Act of 1976. To the extent any Contract Activities and related intellectual property do not qualify as works made for hire under the Copyright Act, Contractor will, and hereby does, immediately on its creation, assign, transfer and otherwise convey to the State, irrevocably and in perpetuity, throughout the universe, all right, title and interest in and to the Contract Activities, including all intellectual property rights therein.

11. **Subcontracting.** Contractor may only delegate managed care functions to a Community Mental Health Service Program with written and express approval from the State. The State will provide an approval or denial of the delegation request within 60 days. Contractor must submit existing delegation arrangements in the form or format determined by the State within 30 days of execution of this Contract. Thereafter, Contractor must submit to the State new or revised delegation agreements at least 90 calendar days before the proposed delegation is to take effect. Contractor will provide any additional information requests from the State to assist in reviewing the delegation for approval. If a delegation request is approved, Contractor must: (a) be the sole point of contact regarding all contractual matters, including payment and charges for all Contract Activities; (b) make all payments to the subcontractor; and (c) incorporate the terms and conditions contained in this Contract in any subcontract with a subcontractor; (d) require the subcontractor to comply with all of Contractor's reporting requirements including but not limited the reporting of administrative costs pursuant to the Medical Loss Ratio and the Standard Cost Allocation methodology Contractor remains responsible for the completion of the Contract Activities and the compliance with the terms of this Contract. The State, in its sole discretion, may require Contractor to revoke the delegation agreement in whole or part and require Contractor to resume delegated managed care functions for deficiencies in the subcontractor's performance of delegated duties or if the State determines the delegation is not in the best interest for the proper administration of the Contract.

12. **Staffing.** The State's Contract Administrator may require Contractor to remove or reassign personnel if the State by providing a notice to Contractor. The State will provide justification for the removal or reassignment and why it is in the best interest of the Medicaid program.

13. **Background Checks.** Contractor must perform background checks on all employees and subcontractors and its employees prior to their assignment. The scope is at the discretion of the State and documentation must be provided as requested. Contractor is responsible for all costs associated with the requested background checks. The State, in its sole discretion, may also perform background checks.

14. **Assignment.** Contractor may not assign this Contract to any other party without the prior approval of the State. Upon notice to Contractor, the State, in its sole discretion, may assign in whole or in part, its rights or responsibilities under this Contract to any other party. If the State determines that a novation of the Contract to a third party is necessary, Contractor will agree to the novation and provide all necessary documentation and signatures.

15. **Change of Control.** Contractor will notify the State, within 30 days of any public announcement or otherwise once legally permitted to do so, of a change in Contractor's organizational structure or ownership. For purposes of this Contract, a change in control means any of the following: (a) a sale of more than 50% of Contractor's stock; (b) a sale of substantially all of Contractor's assets; (c) a change in a majority of Contractor's board members; (d) consummation of a merger or consolidation of Contractor with any other entity; (e) a change in ownership through a transaction or series of transactions; (f) or the board (or the stockholders) approves a plan of complete liquidation. A change of control does not include any consolidation or merger effected exclusively to change the domicile of Contractor, or any transaction or series of transactions principally for bona fide equity financing purposes.

    In the event of a change of control, Contractor must require the successor to assume this Contract and all of its obligations under this Contract.

16. **Reserved.**

17. **Reserved.**

18. **Reserved.**

19. **Reserved.**

20. **Reserved.**

21. **Terms of Payment.** The State is exempt from State sales tax for direct purchases and may be exempt from federal excise tax, if Services purchased under this Agreement are for the State's exclusive use. Notwithstanding the foregoing, all prices are inclusive of taxes, and Contractor is responsible for all sales, use and excise taxes, and any other similar taxes, duties and charges of any kind imposed by any federal, state, or local governmental entity on any amounts payable by the State under this Contract.

    The State has the right to withhold payment of any disputed amounts until the parties agree as to the validity of the disputed amount. The State will notify Contractor of any dispute within a reasonable time. Payment by the State will not constitute a waiver of any rights as to Contractor's continuing obligations, including claims for deficiencies or substandard Contract Activities. Contractor's acceptance of final payment by the

State constitutes a waiver of all claims by Contractor against the State for payment under this Contract, other than those claims previously filed in writing on a timely basis and still disputed.

The State will only disburse payments under this Contract through Electronic Funds Transfer (EFT). Contractor must register with the State at http://www.michigan.gov/SIGMAVSS to receive electronic fund transfer payments. If Contractor does not register, the State is not liable for failure to provide payment.

Without prejudice to any other right or remedy it may have, the State reserves the right to set off at any time any amount then due and owing to it by Contractor against any amount payable by the State to Contractor under this Contract.

22. **Liquidated Damages.** Liquidated damages, if applicable, will be assessed as described in a Statement of Work. The parties understand and agree that any liquidated damages (which includes but is not limited to applicable credits) set forth in this Contract are reasonable estimates of the State's financial loss and damage in accordance with applicable law. The parties acknowledge and agree that Contractor could incur liquidated damages for more than 1 event. The assessment of liquidated damages will not constitute a waiver or release of any other remedy the State may have under this Contract for Contractor's breach of this Contract, including without limitation, the State's right to terminate this Contract for cause under Section 24 and the State will be entitled in its discretion to recover actual damages caused by Contractor's failure to perform its obligations under this Contract. However, the State will reduce such actual damages by the amounts of liquidated damages received for the same events causing the actual damages. Amounts due the State as liquidated damages may be set off against any fees payable to Contractor under this Contract, or the State may bill Contractor as a separate item and Contractor will promptly make payments on such bills.

23. **Stop Work Order.** The State may suspend any or all activities under the Contract at any time. The State will provide Contractor a written stop work order detailing the suspension. Contractor must comply with the stop work order upon receipt. Within 90 calendar days, or any longer period agreed to by Contractor, the State will either: (a) issue a notice authorizing Contractor to resume work, or (b) terminate the Contract or delivery order. The State will not pay for Contract Activities, Contractor's lost profits, or any additional compensation during a stop work period.

24. **Termination for Cause.** (a) The State may terminate this Contract for cause, in whole or in part, if Contractor, as determined by the State: (i) endangers the value, integrity, or security of any facility, data, or personnel; (ii) becomes insolvent, petitions for bankruptcy court proceedings, or has an involuntary bankruptcy proceeding filed against it by any creditor; (iii) engages in any conduct that may expose the State to liability; (iv) breaches any of its material duties or obligations under this Contract; or (v) fails to cure a breach within the time stated by the State in a notice of breach. Any reference to specific breaches being material breaches within this Contract will not be construed to mean that other breaches are not material.

(b) If the State terminates this Contract under this Section, the State will issue a termination notice specifying whether Contractor must: (i) cease performance immediately or (ii) continue to perform for a specified period. If it is later determined that Contractor was not in breach of the Contract, the termination will be deemed to

have been a Termination for Convenience, effective as of the same date, and the rights and obligations of the parties will be limited to those provided in Section 25, Termination for Convenience.

The State will only pay for amounts due to Contractor for Contract Activities accepted by the State on or before the date of termination, subject to the State's right to set off any amounts owed by Contractor for the State's reasonable costs in terminating this Contract for cause, including administrative costs, attorneys' fees, court costs, transition costs. Contractor must promptly reimburse to the State any fees prepaid by the State prorated to the date of such termination, including any prepaid fees. Contractor must pay all reasonable costs incurred by the State in terminating this Contract for cause, including administrative costs, attorney's fees, court costs, transition costs, and any costs the State incurs to procure the Contract Activities from other sources.

25. **Termination for Convenience**. The State may immediately terminate this Contract in whole or in part without penalty and for any reason or no reason, including but not limited to, appropriation or budget shortfalls. The termination notice will specify whether Contractor must: (a) cease performance of the Contract Activities immediately or (b) continue to perform the Contract Activities in accordance with Section 26, Transition Responsibilities. If the State terminates this Contract for convenience, the State will pay all reasonable costs, as determined by the State, for State approved Transition Responsibilities to the extent the funds are available.

26. **Transition Responsibilities**. Upon termination or expiration of this Contract for any reason, Contractor must, for a period of time specified by the State (not to exceed 2 years) provide all reasonable transition assistance requested by the State, to allow for the expired or terminated portion of the Contract Activities to continue without interruption or adverse effect, and to facilitate the orderly transfer of such Contract Activities to the State or its designees. Such transition assistance may include, but is not limited to: (a) continuing to perform the Contract Activities at the established Contract rates and local match requirements; (b) taking all reasonable and necessary measures to transition performance of the work, including all applicable Contract Activities, training, equipment, software, leases, reports and other documentation, to the State or the State's designee; (c) transferring title in and delivering to the State, at the State's discretion, all completed or partially completed deliverables prepared under this Contract as of the Contract termination date; and (d) preparing an accurate accounting from which the State and Contractor may reconcile all outstanding accounts (collectively, "Transition Responsibilities "). This Contract will automatically be extended through the end of the transition period.

27. **Return of State Property.** Upon termination or expiration of this Contract for any reason, Contractor must take all necessary and appropriate steps, or such other action as the State may direct, to preserve, maintain, protect, or return to the State all materials, data, property, and confidential information provided directly or indirectly to Contractor by any entity, agent, vendor, or employee of the State.

28. **Indemnification.** To the extent permitted by law, Contractor must defend, indemnify and hold the State, its departments, divisions, agencies, offices, commissions, officers, and employees harmless, without limitation, from and against any and all actions, claims, losses, liabilities, damages, costs, attorney fees, and expenses

(including those required to establish the right to indemnification), arising out of or relating to: (a) any breach by Contractor (or any of Contractor's employees, agents, subcontractors, or by anyone else for whose acts any of them may be liable) of any of the promises, agreements, representations, warranties, or insurance requirements contained in this Contract; (b) any infringement, misappropriation, or other violation of any intellectual property right or other right of any third party; (c) any bodily injury, death, or damage to real or tangible personal property occurring wholly or in part due to action or inaction by Contractor (or any of Contractor's employees, agents, subcontractors, or by anyone else for whose acts any of them may be liable); and (d) any acts or omissions of Contractor (or any of Contractor's employees, agents, subcontractors, or by anyone else for whose acts any of them may be liable)

The State will notify Contractor in writing if indemnification is sought; however, failure to do so will not relieve Contractor, except to the extent that Contractor is materially prejudiced. Contractor must, to the satisfaction of the State, demonstrate its financial ability to carry out these obligations.

The State is entitled to: (i) regular updates on proceeding status; (ii) participate in the defense of the proceeding; (iii) employ its own counsel; and to (iv) retain control of the defense, at its own cost and expense, if the State deems necessary. Contractor will not, without the State's prior written consent (not to be unreasonably withheld), settle, compromise, or consent to the entry of any judgment in or otherwise seek to terminate any claim, action, or proceeding. To the extent that any State employee, official, or law may be involved or challenged, the State may, at its own expense, control the defense of that portion of the claim.

Any litigation activity on behalf of the State, or any of its subdivisions under this Section, must be coordinated with the Department of Attorney General. An attorney designated to represent the State may not do so until approved by the Michigan Attorney General and appointed as a Special Assistant Attorney General.

The State is constitutionally prohibited from indemnifying Contractor or any third parties. Notwithstanding the foregoing, nothing in this section shall be construed as a waiver of any governmental immunity for Contractor, its directors or employees as provided by statute or modified by court decisions.

29. **Infringement Remedies.** If, in either party's opinion, any piece of equipment, software, commodity, or service supplied by Contractor or its subcontractors, or its operation, use or reproduction, is likely to become the subject of a copyright, patent, trademark, or trade secret infringement claim, Contractor must, at its expense: (a) procure for the State the right to continue using the equipment, software, commodity, or service, or if this option is not reasonably available to Contractor, (b) replace or modify the same so that it becomes non-infringing; or (c) accept its return by the State with appropriate credits to the State against Contractor's charges and reimburse the State for any losses or costs incurred as a consequence of the State ceasing its use and returning it.

30. **Limitation of Liability and Disclaimer of Damages. IN NO EVENT WILL THE STATE'S AGGREGATE LIABILITY TO CONTRACTOR UNDER THIS CONTRACT, REGARDLESS OF THE FORM OF ACTION, WHETHER IN CONTRACT, TORT, NEGLIGENCE, STRICT LIABILITY OR BY STATUTE OR OTHERWISE, FOR ANY CLAIM RELATED TO OR ARISING UNDER THIS CONTRACT, EXCEED THE**

MAXIMUM AMOUNT OF FEES PAYABLE UNDER THIS CONTRACT. The State is not liable for consequential, incidental, indirect, or special damages, regardless of the nature of the action.

31. **Disclosure of Litigation, or Other Proceeding.** Contractor must notify the State within 14 calendar days of receiving notice of any litigation, investigation, arbitration, or other proceeding (collectively, "**Proceeding**") involving Contractor, a subcontractor, or an officer or director of Contractor or subcontractor, that arises during the term of the Contract, including: (a) a criminal Proceeding; (b) a parole or probation Proceeding; (c) a Proceeding under the Sarbanes-Oxley Act; (d) a civil Proceeding involving: (1) a claim that might reasonably be expected to adversely affect Contractor's viability or financial stability; or (2) a governmental or public entity's claim or written allegation of fraud; or 3) any complaint related to the services provided in this Contract filed in a legal or administrative proceeding alleging Contractor or its subcontractors discriminated against its employees, subcontractors, vendors, or suppliers during the performance of Contract activities and during the term of this Contract; or (e) a Proceeding involving any license that Contractor is required to possess in order to perform under this Contract.

32. **Reserved.**

33. **State Data.**

    a. **Ownership**. The State's data ("**State Data**," which will be treated by Contractor as Confidential Information) includes: (a) the State's data, user data, and any other data collected, used, processed, stored, or generated as the result of the Contract Activities; (b) personally identifiable information ("**PII**") collected, used, processed, stored, or generated as the result of the Contract Activities, including, without limitation, any information that identifies an individual, such as an individual's social security number or other government-issued identification number, date of birth, address, telephone number, biometric data, mother's maiden name, email address, credit card information, or an individual's name in combination with any other of the elements here listed; and, (c) protected health information ("**PHI**") collected, used, processed, stored, or generated as the result of the Contract Activities, which is defined under the Health Insurance Portability and Accountability Act (HIPAA) and its related rules and regulations. State Data is and will remain the sole and exclusive property of the State and all right, title, and interest in the same is reserved by the State. This section survives the termination of this contract.

    b. **Contractor Use of State Data**. Contractor is provided a limited license to State Data for the sole and exclusive purpose of providing the Contract Activities, including a license to collect, process, store, generate, and display State Data only to the extent necessary in the provision of the Contract Activities. Contractor must: (a) keep and maintain State Data in strict confidence, using such degree of care as is appropriate and consistent with its obligations as further described in this Contract and applicable law to avoid unauthorized access, use, disclosure, or loss; (b) use and disclose State Data solely and exclusively for the purpose of providing the Contract Activities, such use and disclosure being in accordance with this Contract, any applicable Statement of Work, and applicable law; (c) keep and maintain State Data in the continental United States and (d) not use, sell,

rent, transfer, distribute, commercially exploit, or otherwise disclose or make available State Data for Contractor's own purposes or for the benefit of anyone other than the State without the State's prior written consent. This section survives the termination of this contract.

c. **Extraction of State Data**. Contractor must, within 5 business days of the State's request, provide the State, without charge and without any conditions or contingencies whatsoever (including but not limited to the payment of any fees due to Contractor), an extract of the State Data in the format specified by the State.

d. **Backup and Recovery of State Data**. Unless otherwise specified in a Statement of Work, Contractor is responsible for maintaining a backup of State Data and for an orderly and timely recovery of such data. Unless otherwise described in a Statement of Work, Contractor must maintain a contemporaneous backup of State Data that can be recovered within 24 hours. If backup of State Data cannot be made within 24 hours, Contractor must request approval from the State for additional time.

e. **Loss or Compromise of Data**. In the event of any act, error or omission, negligence, misconduct, or breach on the part of Contractor that compromises or is suspected to compromise the security, confidentiality, or integrity of State Data or the physical, technical, administrative, or organizational safeguards put in place by Contractor that relate to the protection of the security, confidentiality, or integrity of State Data, Contractor must, as applicable: (a) notify the State as soon as practicable but no later than 24 hours of becoming aware of such occurrence; (b) cooperate with the State in investigating the occurrence, including making available all relevant records, logs, files, data reporting, and other materials required to comply with applicable law or as otherwise required by the State; (c) in the case of PII or PHI, at the State's sole election, (i) with approval and assistance from the State, notify the affected individuals who comprise the PII or PHI as soon as practicable but no later than is required to comply with applicable law, or, in the absence of any legally required notification period, within 5 calendar days of the occurrence; or (ii) reimburse the State for any costs in notifying the affected individuals; (d) in the case of PII, provide third-party credit and identity monitoring services to each of the affected individuals who comprise the PII for the period required to comply with applicable law, or, in the absence of any legally required monitoring services, for no less than 24 months following the date of notification to such individuals; (e) perform or take any other actions required to comply with applicable law as a result of the occurrence; (f) pay for any costs associated with the occurrence, including but not limited to any costs incurred by the State in investigating and resolving the occurrence, including reasonable attorney's fees associated with such investigation and resolution; (g) without limiting Contractor's obligations of indemnification as further described in this Contract, indemnify, defend, and hold harmless the State for any and all claims, including reasonable attorneys' fees, costs, and incidental expenses, which may be suffered by, accrued against, charged to, or recoverable from the State in connection with the occurrence; (h) be responsible for recreating lost State Data in the manner and on the schedule set by the State without charge to the State; and (i) provide to the State a detailed plan within 10 calendar days of

the occurrence describing the measures Contractor will undertake to prevent a future occurrence. Notification to affected individuals, as described above, must comply with applicable law, be written in plain language, not be tangentially used for any solicitation purposes, and contain, at a minimum: name and contact information of Contractor's representative; a description of the nature of the loss; a list of the types of data involved; the known or approximate date of the loss; how such loss may affect the affected individual; what steps Contractor has taken to protect the affected individual; what steps the affected individual can take to protect himself or herself; contact information for major credit card reporting agencies; and, information regarding the credit and identity monitoring services to be provided by Contractor. The State will have the option to review and approve any notification sent to affected individuals prior to its delivery. Notification to any other party, including but not limited to public media outlets, must be reviewed and approved by the State in writing prior to its dissemination. The parties agree that any damages relating to a breach of this **Section 33** are to be considered direct damages and not consequential damages.

f. **State's Governance, Risk and Compliance (GRC) platform**. Contractor is required to assist the State with its security accreditation process through the development, completion and ongoing updating of a system security plan using the State's automated GRC platform and implement any required safeguards or remediate any security vulnerabilities as identified by the results of the security accreditation process.

34. Non-Disclosure of Confidential Information. The parties acknowledge that each party may be exposed to or acquire communication or data of the other party that is confidential, privileged communication not intended to be disclosed to third parties.

a. **Meaning of Confidential Information**. For the purposes of this Contract, the term "**Confidential Information**" means all information and documentation of a party that: (a) has been marked "confidential" or with words of similar meaning, at the time of disclosure by such party; (b) if disclosed orally or not marked "confidential" or with words of similar meaning, was subsequently summarized in writing by the disclosing party and marked "confidential" or with words of similar meaning; or, (c) should reasonably be recognized as confidential information of the disclosing party. The term "Confidential Information" does not include any information or documentation that was or is: (a) subject to disclosure under the Michigan Freedom of Information Act (FOIA); (b) already in the possession of the receiving party without an obligation of confidentiality; (c) developed independently by the receiving party, as demonstrated by the receiving party, without violating the disclosing party's proprietary rights; (d) obtained from a source other than the disclosing party without an obligation of confidentiality; or, (e) publicly available when received, or thereafter became publicly available (other than through any unauthorized disclosure by, through, or on behalf of, the receiving party). For purposes of this Contract, in all cases and for all matters, State Data is deemed to be Confidential Information.

b. **Obligation of Confidentiality**. The parties agree to hold all Confidential Information in strict confidence and not to copy, reproduce, sell, transfer, or otherwise dispose of, give or disclose such Confidential Information to third parties other than employees, agents, or subcontractors of a party who have a

need to know in connection with this Contract or to use such Confidential Information for any purposes whatsoever other than the performance of this Contract. The parties agree to advise and require their respective employees, agents, and subcontractors of their obligations to keep all Confidential Information confidential. Disclosure to a subcontractor is permissible where: (a) use of a subcontractor is authorized under this Contract; (b) the disclosure is necessary or otherwise naturally occurs in connection with work that is within the subcontractor's responsibilities; and (c) Contractor obligates the subcontractor in a written contract to maintain the State's Confidential Information in confidence. At the State's request, any employee of Contractor or any subcontractor may be required to execute a separate agreement to be bound by the provisions of this Section.

c. **Cooperation to Prevent Disclosure of Confidential Information**. Each party must use its best efforts to assist the other party in identifying and preventing any unauthorized use or disclosure of any Confidential Information. Without limiting the foregoing, each party must advise the other party immediately in the event either party learns or has reason to believe that any person who has had access to Confidential Information has violated or intends to violate the terms of this Contract and each party will cooperate with the other party in seeking injunctive or other equitable relief against any such person.

d. **Remedies for Breach of Obligation of Confidentiality**. Each party acknowledges that breach of its obligation of confidentiality may give rise to irreparable injury to the other party, which damage may be inadequately compensable in the form of monetary damages. Accordingly, a party may seek and obtain injunctive relief against the breach or threatened breach of the foregoing undertakings, in addition to any other legal remedies which may be available, to include, in the case of the State, at the sole election of the State, the immediate termination, without liability to the State, of this Contract or any Statement of Work corresponding to the breach or threatened breach.

e. **Surrender of Confidential Information upon Termination**. Upon termination of this Contract or a Statement of Work, in whole or in part, each party must, within 5 calendar days from the date of termination, return to the other party any and all Confidential Information received from the other party, or created or received by a party on behalf of the other party, which are in such party’s possession, custody, or control; provided, however, that Contractor must return State Data to the State following the timeframe and procedure described further in this Contract. Should Contractor or the State determine that the return of any Confidential Information is not feasible, such party must destroy the Confidential Information and must certify the same in writing within 5 calendar days from the date of termination to the other party. However, each Party’s legal ability to destroy the other Party’s data may be restricted by its retention and disposal schedule, in which case Confidential Information will be destroyed after the retention period expires.

35. Data Privacy and Information Security.

a. **Undertaking by Contractor**. Without limiting Contractor’s obligation of confidentiality as further described, Contractor is responsible for establishing and maintaining a data privacy and information security program, including physical,

technical, administrative, and organizational safeguards, that is designed to: (a) ensure the security and confidentiality of the State Data; (b) protect against any anticipated threats or hazards to the security or integrity of the State Data; (c) protect against unauthorized disclosure, access to, or use of the State Data; (d) ensure the proper disposal of State Data; and (e) ensure that all employees, agents, and subcontractors of Contractor, if any, comply with all of the foregoing. In no case will the safeguards of Contractor's data privacy and information security program be less stringent than the safeguards used by the State, and Contractor must at all times comply with all applicable State IT policies and standards, which are available to Contractor upon request.

b. **Audit by Contractor**. No less than annually, Contractor must conduct a comprehensive independent third-party audit of its data privacy and information security program and provide such audit findings to the State.

c. **Right of Audit by the State.** Without limiting any other audit rights of the State, the State has the right to review Contractor's data privacy and information security program prior to the commencement of Contract Activities and from time to time during the term of this Contract. During the providing of the Contract Activities, on an ongoing basis from time to time and without notice, the State, at its own expense, is entitled to perform, or to have performed, an on-site audit of Contractor's data privacy and information security program. In lieu of an on-site audit, upon request by the State, Contractor agrees to complete, within 45 calendar days of receipt, an audit questionnaire provided by the State regarding Contractor's data privacy and information security program.

d. **Audit Findings**. Contractor must implement any required safeguards as identified by the State or by any audit of Contractor's data privacy and information security program.

e. **State's Right to Termination for Deficiencies**. The State reserves the right, at its sole election, to immediately terminate this Contract or a Statement of Work without limitation and without liability if the State determines that Contractor fails or has failed to meet its obligations under this Section.

36. **Reserved**.

37. **Reserved.**

38. **Records Maintenance, Inspection, Examination, and Audit.** Pursuant to MCL 18.1470, the State or its designee may audit Contractor to verify compliance with this Contract. Contractor must retain and provide to the State or its designee and the auditor general upon request, all records related to the Contract through the term of the Contract and for 10 years after the latter of termination, expiration, or final payment under this Contract or any extension ("**Audit Period**"). If an audit, litigation, or other action involving the records is initiated before the end of the Audit Period, Contractor must retain the records until all issues are resolved.

    The State, CMS, the Office of the Inspector General, the Comptroller General, and their designees may, at any time, inspect and audit any records or documents of Contractor, or its subcontractors, and may, at any time, inspect the premises,

physical facilities, and equipment where Medicaid-related activities or work is conducted. The right to audit under this section exists for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

Within 10 calendar days of providing notice, the State and its authorized representatives or designees have the right to enter and inspect Contractor's premises or any other places where Contract Activities are being performed, and examine, copy, and audit all records related to this Contract. Contractor must cooperate and provide reasonable assistance. If financial errors are revealed, the amount in error must be reflected as a credit or debit on subsequent invoices until the amount is paid or refunded. Any remaining balance at the end of the Contract must be paid or refunded within 45 calendar days.

This Section applies to Contractor, any parent, affiliate, or subsidiary organization of Contractor, and any subcontractor that performs Contract Activities in connection with this Contract.

39. **Representations and Warranties.** Contractor represents and warrants: (a) Contractor is the owner or licensee of any Contract Activities that it licenses, sells, or develops and Contractor has the rights necessary to convey title, ownership rights, or licensed use; (b) all Contract Activities are delivered free from any security interest, lien, or encumbrance and will continue in that respect; (c) the Contract Activities will not infringe the patent, trademark, copyright, trade secret, or other proprietary rights of any third party; (d) Contractor must assign or otherwise transfer to the State or its designee any manufacturer's warranty for the Contract Activities; (e) the Contract Activities are merchantable and fit for the specific purposes identified in the Contract; (f) the Contract signatory has the authority to enter into this Contract; (g) all information furnished by Contractor in connection with the Contract fairly and accurately represents Contractor's business, properties, finances, and operations as of the dates covered by the information, and Contractor will inform the State of any material adverse changes;(h) all information furnished and representations made in connection with the award of this Contract is true, accurate, and complete, and contains no false statements or omits any fact that would make the information misleading; and that (i) Contractor is neither currently engaged in nor will engage in the boycott of a person based in or doing business with a strategic partner as described in 22 USC 8601 to 8606. A breach of this Section is considered a material breach of this Contract, which entitles the State to terminate this Contract under Section 24, Termination for Cause.

40. **Conflicts and Ethics.** Contractor will uphold high ethical standards and is prohibited from: (a) holding or acquiring an interest that would conflict with this Contract; (b) doing anything that creates an appearance of impropriety with respect to the award or performance of the Contract; (c) attempting to influence or appearing to influence any State employee by the direct or indirect offer of anything of value; or (d) paying or agreeing to pay any person, other than employees and consultants working for Contractor, any consideration contingent upon the award of the Contract. Contractor must immediately notify the State of any violation or potential violation of these standards. This Section applies to Contractor, any parent, affiliate, or subsidiary organization of Contractor, and any subcontractor that performs Contract Activities in connection with this Contract.

41. **Compliance with Laws.** Contractor must comply with all federal, state and local laws, rules and regulations.

42. **Reserved.**

43. **Reserved.**

44. **Nondiscrimination.** Under the Elliott-Larsen Civil Rights Act, 1976 PA 453, MCL 37.2101, *et seq*., the Persons with Disabilities Civil Rights Act, 1976 PA 220, MCL 37.1101, *et seq*., and Executive Directive 2019-09. Contractor and its subcontractors agree not to discriminate against an employee or applicant for employment with respect to hire, tenure, terms, conditions, or privileges of employment, or a matter directly or indirectly related to employment, because of race, color, religion, national origin, age, sex (as defined in Executive Directive 2019-09), height, weight, marital status, partisan considerations, any mental or physical disability, or genetic information that is unrelated to the person's ability to perform the duties of a particular job or position. Breach of this covenant is a material breach of this Contract.

45. **Unfair Labor Practice.** Under MCL 423.324, the State may void any Contract with a Contractor or subcontractor who appears on the Unfair Labor Practice register compiled under MCL 423.322.

46. **Governing Law.** This Contract is governed, construed, and enforced in accordance with Michigan law, excluding choice-of-law principles, and all claims relating to or arising out of this Contract are governed by Michigan law, excluding choice-of-law principles. Any dispute arising from this Contract must be resolved in the Michigan Court of Claims. Complaints against the State must be initiated in Ingham County, Michigan. Contractor waives any objections, such as lack of personal jurisdiction or *forum non conveniens*. Contractor must appoint an agent in Michigan to receive service of process.

47. **Non-Exclusivity.** Nothing contained in this Contract is intended nor is to be construed as creating any requirements contract with Contractor, nor does it provide Contractor with a right of first refusal for any future work. This Contract does not restrict the State or its agencies from acquiring similar, equal, or like Contract Activities from other sources.

48. **Force Majeure.** Neither party will be in breach of this Contract because of any failure arising from any disaster or acts of god that are beyond their control and without their fault or negligence. Each party will use commercially reasonable efforts to resume performance. Contractor will not be relieved of a breach or delay caused by its subcontractors. If immediate performance is necessary to ensure public health and safety, the State may immediately contract with a third party.

49. **Dispute Resolution.** The parties will endeavor to resolve any Contract dispute in accordance with this provision. The dispute will be referred to the parties' respective Contract Administrators or Program Managers. Such referral must include a description of the issues and all supporting documentation. The parties must submit the dispute to a senior executive if unable to resolve the dispute within 15 business days. The parties will continue performing while a dispute is being resolved, unless the dispute precludes performance. A dispute involving payment does not preclude performance.

Litigation to resolve the dispute will not be instituted until after the dispute has been elevated to the parties' senior executive and either concludes that resolution is unlikely or fails to respond within 15 business days. The parties are not prohibited from instituting formal proceedings: (a) to avoid the expiration of statute of limitations period; (b) to preserve a superior position with respect to creditors; or (c) where a party makes a determination that a temporary restraining order or other injunctive relief is the only adequate remedy. This Section does not limit the State's right to terminate the Contract.

50. **Media Releases.** Any news releases (including promotional literature and commercial advertisements) which contain specific reference to MDHHS and pertain to the Contract or project to which it relates must not be made without the prior written approval of the State, and then only in accordance with the explicit written instructions of the State.

51. **Schedules**. All Schedules and Exhibits that are referenced herein and attached hereto are hereby incorporated by reference. The following Schedules are attached hereto and incorporated herein:

Document Title	Document Description
Schedule A	Statement of Work
Schedule B	HIPAA Business Associate Agreement
Schedule C	Definitions/Explanation of Terms
Schedule D	Reserved
Schedule E	Reporting Requirements
Schedule F	Medicaid Mental Health Substance Use Disorder Authorization Payment Responsibility Grid
Schedule G	Local Funding Obligation Schedule
Schedule H	Behavioral Health Capitation Rate Certification

52. **Entire Agreement and Order of Precedence.** This Contract, which includes Statement of Work, and schedules and exhibits, is the entire agreement of the parties related to the Contract Activities. This Contract supersedes and replaces all previous understandings and agreements between the parties for the Contract Activities. If there is a conflict between documents, the order of precedence is: (a) first, this Contract, excluding its schedules, exhibits, and Statement of Work; (b) second, Statement of Work as of the Effective Date; and (c) third, schedules expressly incorporated into this Contract as of the Effective Date. NO TERMS ON CONTRACTOR'S INVOICES, ORDERING DOCUMENTS, WEBSITE, BROWSE-WRAP, SHRINK-WRAP, CLICK-WRAP, CLICK-THROUGH OR OTHER NON-NEGOTIATED TERMS AND CONDITIONS PROVIDED WITH ANY OF THE CONTRACT ACTIVITIES, OR DOCUMENTATION HEREUNDER, EVEN IF ATTACHED TO THE STATE'S DELIVERY OR PURCHASE ORDER, WILL CONSTITUTE A PART OR AMENDMENT OF THIS CONTRACT OR IS BINDING

ON THE STATE OR ANY AUTHORIZED USER FOR ANY PURPOSE. ALL SUCH OTHER TERMS AND CONDITIONS HAVE NO FORCE AND EFFECT AND ARE DEEMED REJECTED BY THE STATE AND THE AUTHORIZED USER, EVEN IF ACCESS TO OR USE OF THE CONTRACT ACTIVITIES REQUIRES AFFIRMATIVE ACCEPTANCE OF SUCH TERMS AND CONDITIONS.

53. **Severability.** If any part of this Contract is held invalid or unenforceable, by any court of competent jurisdiction, that part will be deemed deleted from this Contract and the severed part will be replaced by agreed upon language that achieves the same or similar objectives. The remaining Contract will continue in full force and effect.

54. **Waiver.** Failure to enforce any provision of this Contract will not constitute a waiver.

55. **Survival.** Any right, obligation or condition that, by its express terms or nature and context is intended to survive, will survive the termination or expiration of this Contract; such rights, obligations, or conditions include, but are not limited to, those related to transition responsibilities; indemnification; disclaimer of damages and limitations of liability; State Data; non-disclosure of Confidential Information; representations and warranties; insurance and bankruptcy.

56. **Contract Modification.** This Contract may not be amended except by signed agreement between the parties (a "**Contract Change Notice**"). Notwithstanding the foregoing, no subsequent Statement of Work or Contract Change Notice executed after the Effective Date will be construed to amend this Contract unless it specifically states its intent to do so and cites the section or sections amended.

FEDERAL PROVISIONS ADDENDUM

This addendum applies to purchases that will be paid for in whole or in part with funds obtained from the federal government. If any provision below is not required by federal law for this Contract, then it does not apply and must be disregarded. If any provision below is required to be included in this Contract by federal law, then the applicable provision applies, and the language is not negotiable. If any provision below conflicts with the State's terms and conditions, including any attachments, schedules, or exhibits to this Contract, the provisions below take priority to the extent a provision is required by federal law; otherwise, the order of precedence set forth in the Contract applies. Further, Contractor agrees to, through a Contract Change Notice, append or modify specific federal provisions to this Contract, if reasonably necessary to keep the State and Contractor in compliance with federal funding requirements, and comply with the terms set forth therein. Hyperlinks are provided for convenience only; broken hyperlinks will not relieve Contractor from compliance with the law.

A. Equal Employment Opportunity

This Contract is not a "**federally assisted construction contract**" as defined in 41 CFR Part 60-1.3.

B. Davis-Bacon Act (Prevailing Wage)

This Contract is not a "**federally assisted construction contract**" as defined in 41 CFR Part 60-1.3, nor is it a prime construction contract in excess of $2,000.

C. Copeland "Anti-Kickback" Act

This Contract is not a "**federally assisted construction contract**" as defined in 41 CFR Part 60-1.3, nor is it a prime construction contract in excess of $2,000 where the Davis-Bacon Act applies.

D. Contract Work Hours and Safety Standards Act

The Contract does not involve the employment of mechanics or laborers.

E. Rights to Inventions Made Under a Contract or Agreement

If this Contract is funded by a federal "funding agreement" as defined under 37 CFR §401.2 (a) and the recipient or subrecipient wishes to enter into a contract with a small business firm or nonprofit organization regarding the substitution of parties, assignment or performance of experimental, developmental, or research work under that "funding agreement," the recipient or subrecipient must comply with 37 CFR Part 401, "Rights to Inventions Made by Nonprofit Organizations and Small Business Firms Under Government Grants, Contracts and Cooperative Agreements," and any implementing regulations issued by the awarding agency.

F. Clean Air Act and the Federal Water Pollution Control Act

If this Contract is **in excess of $150,000,** Contractor must comply with all applicable standards, orders, and regulations issued under the Clean Air Act (42 USC 7401-7671q) and the Federal Water Pollution Control Act (33 USC 1251-1387), and during performance of this Contract Contractor agrees as follows:

(1) Clean Air Act

(i) Contractor agrees to comply with all applicable standards, orders or regulations issued pursuant to the Clean Air Act, as amended, 42 U.S.C. § 7401 et seq.

(ii) Contractor agrees to report each violation to the State and understands and agrees that the State will, in turn, report each violation as required to assure notification to the Federal Emergency Management Agency or the applicable federal awarding agency, and the appropriate Environmental Protection Agency Regional Office.

(iii) Contractor agrees to include these requirements in each subcontract exceeding $150,000 financed in whole or in part with Federal assistance provided by FEMA or the applicable federal awarding agency.

(2) Federal Water Pollution Control Act

(i) Contractor agrees to comply with all applicable standards, orders, or regulations issued pursuant to the Federal Water Pollution Control Act, as amended, 33 U.S.C. 1251 et seq.

(ii) Contractor agrees to report each violation to the State and understands and agrees that the State will, in turn, report each violation as required to assure notification to the Federal Emergency Management Agency or the applicable federal awarding agency, and the appropriate Environmental Protection Agency Regional Office.

(iii) Contractor agrees to include these requirements in each subcontract exceeding $150,000 financed in whole or in part with Federal assistance provided by FEMA or the applicable federal awarding agency.

G. Debarment and Suspension

A "contract award" (see 2 CFR 180.220) must not be made to parties listed on the government-wide exclusions in the System for Award Management (SAM), in accordance with the OMB guidelines at 2 CFR 180 that implement Executive Orders 12549 (51 FR 6370; February 21, 1986) and 12689 (54 FR 34131; August 18, 1989), "Debarment and Suspension." SAM Exclusions contains the names of parties debarred, suspended, or otherwise excluded by agencies, as well as parties declared ineligible under statutory or regulatory authority other than Executive Order 12549.

(1) This Contract is a covered transaction for purposes of 2 CFR. Part 180 and 2 CFR. Part 3000. As such, Contractor is required to verify that none of Contractor's principals (defined at 2 CFR. § 180.995) or its affiliates (defined at 2 CFR. § 180.905) are excluded (defined at 2 CFR. § 180.940) or disqualified (defined at 2 CFR. § 180.935).

(2) Contractor must comply with 2 CFR. Part 180, subpart C and 2 CFR. Part 3000, subpart C, and must include a requirement to comply with these regulations in any lower tier covered transaction it enters into.

(3) This certification is a material representation of fact relied upon by the State. If it is later determined that Contractor did not comply with 2 CFR. Part. 180, subpart C and 2 CFR. Part. 3000, subpart C, in addition to remedies available to the State, the Federal Government may pursue available remedies, including but not limited to suspension and/or debarment.

(4) The bidder or proposer agrees to comply with the requirements of 2 CFR. Part 180, subpart C and 2 CFR. Part 3000, subpart C while this offer is valid and throughout the period of any contract that may arise from this offer. The bidder or proposer further agrees to include a provision requiring such compliance in its lower tier covered transactions.

H. Byrd Anti-Lobbying Amendment, 31 U.S.C. § 1352 (as amended)

Contractor has applied or bid for an award of **$100,000 or more** and shall file the required certification in *Exhibit 1 – Byrd Anti-Lobbying Certification* attached to the end of this Addendum. Each tier certifies to the tier above that it will not and has not used federally appropriated funds to pay any person or organization for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, officer or employee of Congress, or an employee of a Member of Congress in connection with obtaining any federal contract, grant, or any other award covered by 31 U.S.C. § 1352. Each tier shall also disclose any lobbying with non-federal funds that takes place in connection with obtaining any federal award. Such disclosures are forwarded from tier to tier up to the recipient who in turn will forward the certification(s) to the federal awarding agency.

I. Procurement of Recovered Materials

If this Contract is a procurement to purchase products or items designated by the EPA under 40 CFR. part 247 during the course of a fiscal year, then under 2 CFR 200.323, Contractors must comply with section 6002 of the Solid Waste Disposal Act, as amended by the Resource Conservation and Recovery Act.

(1) In the performance of this contract, Contractor shall make maximum use of products containing recovered materials that are EPA-designated items unless the product cannot be acquired:

(i) Competitively within a timeframe providing for compliance with the contract performance schedule;

(ii) Meeting contract performance requirements; or

(iii) At a reasonable price.

(2) Information about this requirement, along with the list of EPA- designated items, is available at EPA's Comprehensive Procurement Guidelines web site, https://www.epa.gov/smm/comprehensive- procurement-guideline-cpg-program.

(3) Contractor also agrees to comply with all other applicable requirements of Section 6002 of the Solid Waste Disposal Act.

J. Prohibition on Contracting for Covered Telecommunications Equipment or Services

Contractor acknowledges and agrees that Section 889(b) of the John S. McCain National Defense Authorization Act for Fiscal Year 2019, Pub. L. No. 115-232 (the "McCain Act"), and 2 CFR. §200.216, prohibit the obligation or expending of federal award funds on certain telecommunication products or with certain entities for national security reasons on or after August 13, 2020.

During performance of this Contract, Contractor agrees as follows:

(a) *Definitions.* As used in this Section J. Prohibition on Contracting for Covered Telecommunications Equipment or Services ("Section J"):

(1) the terms "backhaul," "critical technology," "interconnection arrangements," "reasonable inquiry," "roaming," and "substantial or essential component" have the meanings defined in 48 CFR § 4.2101;

(2) the term "covered foreign country" has the meanings defined in § 889(f)(2) of the McCain Act; and

(3) the term "covered telecommunications equipment or services" has the meaning defined in § 889(f)(3) of the McCain Act.

(b) *Prohibitions*.

(1) Unless an exception in paragraph (c) of this Section J applies, neither Contractor nor any of its subcontractors may use funds received under this Contract to:

(i) Procure or obtain any equipment, system, or service that uses covered telecommunications equipment or services as a substantial or essential component of any system, or as critical technology of any system;

(ii) Enter into, extend, or renew a contract to procure or obtain any equipment, system, or service that uses covered telecommunications equipment or services as a substantial or essential component of any system, or as critical technology of any system;

(iii) Enter into, extend, or renew a contract with an entity that uses any covered telecommunications equipment or services as a substantial or essential component of any system, or as critical technology as part of any system; or

(iv) Provide, as part of its performance of this contract, subcontract, or other contractual instrument, any equipment, system, or service that uses covered telecommunications equipment or services as a substantial or essential component of any system, or as critical technology as part of any system.

(c) *Exceptions*.

(1) This Section J does not prohibit Contractor from providing—

(i) A service that connects to the facilities of a third-party, such as backhaul, roaming, or interconnection arrangements; or

(ii) Telecommunications equipment that cannot route or redirect user data traffic or permit visibility into any user data or packets that such equipment transmits or otherwise handles.

(d) *Reporting requirement*.

(1) In the event Contractor identifies covered telecommunications equipment or services used as a substantial or essential component of any system, or as critical technology as part of any system, during contract performance, or Contractor is notified of such by a subcontractor at any tier or by any other source, Contractor shall report the information in paragraph (d)(2) of this Section J to the recipient or subrecipient, unless elsewhere in this contract are established procedures for reporting the information. In the event of this occurrence, reports should be submitted to the contract administrator.

(2) Contractor shall report the following information pursuant to paragraph (d)(1) of this Section J:

(i) Within one business day from the date of such identification or notification: The contract number; the order number(s), if applicable; supplier name; supplier unique entity identifier (if known); supplier Commercial and Government Entity (CAGE) code (if known); brand; model number (original equipment manufacturer number, manufacturer part number, or wholesaler number); item description; and any readily available information about mitigation actions undertaken or recommended.

(ii) Within 10 business days of submitting the information in paragraph (d)(2)(i) of this Section J: Any further available information about mitigation actions undertaken or recommended. In addition, Contractor shall describe the efforts it undertook to prevent use or submission of covered telecommunications equipment or services, and any additional efforts that will be incorporated to prevent future use or submission of covered telecommunications equipment or services.

(e) *Subcontracts.* Contractor shall insert the substance of this Section J, including this paragraph (e), in all subcontracts and other contractual instruments.

K. Domestic Preferences for Procurements

As appropriate, and to the extent consistent with law, Contractor should, to the greatest extent practicable, provide a preference for the purchase, acquisition, or use of goods, products, or materials produced in the United States. This includes, but is not limited to iron, aluminum, steel, cement, and other manufactured products.

For purposes of this Section K – **Domestic Preferences for Procurements**:

"Produced in the United States" means, for iron and steel products, that all manufacturing processes, from the initial melting stage through the application of coatings, occurred in the United States.

"Manufactured products" mean items and construction materials composed in whole or in part of non-ferrous metals such as aluminum; plastics and polymer-based products such as polyvinyl chloride pipe; aggregates such as concrete; glass, including optical fiber; and lumber.

L. Affirmative Socioeconomic Steps

For all contracts utilizing federal funding sources subject to Title 2 of the Code of Federal Regulations (CFR) Part 200 issued on or after November 12, 2020, if subcontracts are to be let, the prime contractor is required to take all necessary steps identified in 2 CFR. § 200.321(b)(1)-(5) to ensure that small and minority businesses, women's business enterprises, and labor surplus area firms are used when possible.

M. Copyright and Data Rights

Pursuant to 2 CFR § 200.315(b), the State may copyright any work which is subject to copyright and was developed, or for which ownership was acquired, under a Federal award. The Federal awarding agency reserves a royalty-free, nonexclusive and

irrevocable right to reproduce, publish, or otherwise use the work for Federal purposes, and to authorize others to do so.

N. Additional FEMA Contract Provisions

This Contract does not involve purchases that will be paid for in whole or in part with funds obtained from the Federal Emergency Management Agency (FEMA).

O. Other Federal Contract Provisions

The following provisions also apply to purchases that will be paid for in whole or in part with funds obtained from the federal government: Contractor must comply with federal requirements in Title XIX of the Social Security Act, 42 CFR Part 438 and other applicable laws, including requirements incorporated into the Medicaid and Children's Health Insurance Program Managed Care Final Rule published November 13, 2020 and effective on December 14, 2020, and requirements in effect prior to the release of the 2020 Final Rule (i.e., in effect in 42 CFR Part 438 contained in 42 CFR Parts 430 to 481, edition revised as of May 6, 2016) and did not materially change within the 2020 Final Rule.

EXHIBIT 1 BYRD ANTI-LOBBYING CERTIFICATION

Contractor must complete this certification if the purchase will be paid for in whole or in part with funds obtained from the federal government and the purchase is greater than $100,000.

APPENDIX A, 44 CFR. PART 18 – CERTIFICATION REGARDING LOBBYING

Certification for Contracts, Grants, Loans, and Cooperative Agreements

The undersigned certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, “Disclosure Form to Report Lobbying,” in accordance with its instructions.
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

   This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, Title 31, U.S.C. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Contractor, Northern Michigan Regional Entity, certifies or affirms the truthfulness and accuracy of each statement of its certification and disclosure, if any. In addition, Contractor understands and agrees that the provisions of 31 U.S.C. Chap. 38, Administrative Remedies for False Claims and Statements, apply to this certification and disclosure, if any.

E-SIGNED by Eric Kurtz
on 2023-09-29 12:28:45 EDT

Signature of Contractor's Authorized Official

Eric Kurtz Authorized Official

Name and Title of Contractor's Authorized Official

2023-09-29 12:28:45 UTC

Date

SCHEDULE A- STATEMENT OF WORK CONTRACT ACTIVITIES

Contract No. MA 230000001246
Prepaid Inpatient Health Plan (PIHP)

The State hereby enters into a Contract with the specialty Prepaid Inpatient Health Plan (PIHP) Contractor identified on the signature page of this Contract.

BACKGROUND

Under approval granted by the Centers for Medicare and Medicaid Services (CMS), the Michigan Department of Health and Human Services (MDHHS) operates a 1115 Behavioral Health Demonstration Waiver. Under this waiver, selected Medicaid State plan specialty services related to mental health and developmental disability services, as well as certain covered substance abuse services, have been "carved out" (removed) from Medicaid primary physical health care plans and arrangements.

CMS has also approved a 1115 Demonstration Waiver titled the Healthy Michigan Plan (HMP) which provides health care coverage for adults who become eligible for Medicaid under Section 1902(2)(10)(A)(i)(VIII) of the Social Security Act. In Michigan, the 1115 Behavioral Health Demonstration Waiver and the Healthy Michigan Plan are managed on a shared risk basis by specialty PIHP contractors, selected through the Application for Participation (AFP) process which can be found on the MDHHS website: https://www.michigan.gov/-/media/Project/Websites/mdhhs/Folder2/Folder64/Folder1/Folder164/2_6_2013_AFP.pdf?rev=d6864822812b4c5fb1ace235562cbc71.

Services provided under the behavioral health managed care program include treatment for people with Serious Mental Illness(SMI), Serious Emotional Disturbance (SED), Substance Use Disorder (SUD) and Intellectual and Developmental Disabilities (I/DD). Behavioral Health Services include State plan and Early Periodic Screening, Diagnosis and Treatment (EPSDT) services, 1915(i) Waiver services and 1915(c) Waiver services:

- Children's Waiver Program (CWP)
- Habilitation Supports Waiver (HSW)
- Serious Emotional Disturbance (SED) Waiver

All the substance abuse services are covered under the State plan (or alternative benefit plan (ABP)) for the HMP population.

SCOPE

The purpose of this Contract is to obtain the services of Contractor to manage the 1115 Behavioral Health Demonstration Waiver Program, the Healthy Michigan Plan and relevant approved Waivers in a designated service area and to provide a comprehensive array of specialty mental health and substance abuse services and supports as indicated in this Contract. Contractor must manage its responsibilities in a manner that promotes maximum value, efficiency, and effectiveness consistent with State and federal statute and applicable waiver standards. This includes limiting managed care administrative duplication thereby reducing avoidable costs while maximizing the Medical Loss Ratio (MLR). Contractor must actively manage behavioral health services for its geographical service area using standardized methods and measures for determination of need and appropriate deliveryof service. Contractor must ensure that cost variances in services are supported by

quantifiable measures of need to ensure accountability, value and efficiency. Contractor must minimize duplication of contracts and reviews for providers contracting with multiple Community Mental Health Services Programs (CMHSPs) in the service area.

RESPONSIBILITIES OF THE STATE

The State will administer this Contract with Contractor, monitor Contract performance, and perform the following activities:

1. Notify Contractor of the name, address, and telephone number, if available, of all Medicaid, MI Child and Healthy Michigan eligibles in the service area. Contractor will be notified of changes, as they are known to the State.
2. The State has the authority to take whatever action is necessary to address repeated health and welfare issues or emergencies or Contractor's failure to provide medically necessary services timely.

REQUIREMENTS

Contractor must provide Deliverables/Services and staff, and otherwise do all things necessary or incidental to the performance requirements and performance of work, pursuant to the requirements set forth in this Contract. Contractor must comply with all provisions of Medicaid policy applicable to Contractors unless provisions of this Contract stipulate otherwise. All policies, procedures, operational plans and clinical guidelines followed by Contractor must be in writing and available to the State and CMS upon request. All medical records, report formats, information systems, liability policies, provider network information and other details specific to performing the Contracted Services must be available to the State and CMS upon request.

Contractor must have sufficient administrative staff and organizational components to comply with the responsibilities reflected in this Contract. Contractor must ensure that all personnel has training, education, experience, licensing, or certification appropriate to their position and responsibilities.

1. General Requirements

The following sections provide an explanation of the specifications and expectations that Contractor must meet and the services that must be provided under the Contract. Contractor and its provider network are not, however, constrained from supplementing this with additional services or elements deemed necessary to fulfill the intent of the Medicaid Managed Specialty Services and Supports Program (MMSSSP) and the Flint 1115 Waiver.

A. Service Area

1. Targeted Geographical Area for Implementation
   a. Contractor must manage the 1115 Behavioral Health Demonstration Waiver Program and the HealthyMichigan Plan under the terms of this Contract for its geographic service area. Counties included in each service area can be found at the following website: https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/cmhsp.
2. Target Population
   a. Contractor must serve Medicaid beneficiaries in the service area described in Section 1.A.1.a. above who require the Medicaid services included under the 1115 Behavioral Health Demonstration Waiver; who are eligible for the Healthy Michigan Plan, the 1915(i) State Plan Benefit the Flint 1115 Waiver; who are enrolled in the 1915(c) waivers (HSW, CWP, SED); who are enrolled in the MIChild program; who are enrolled in the Maternity Outpatient Medical Services (MOMS) program, or for

whom Contractor has assumed or been assigned County of Financial Responsibility (COFR) status under Chapter 3 of the Mental Health Code.

3. Home and Community Character
   a. Contractor must assure that the residential (adult foster care, specialized residential, provider owned/controlled) and non-residential services (skill building, supported employment, community living supports, pre-vocational, out of home non-vocational) where individuals are supported by funds from the Medicaid 1915(c) waiver programs (Habilitation Supports Waiver, Children's Waiver, and Children's SED Waiver) maintain a home and community character setting as required by federal regulation and the resultant, Michigan-specific, Home and Community Based Services State Transition Plan.

B. Customer Services Standards

1. Introduction
   Contractor must establish a Customer Services Unit. Contactor must convey an atmosphere that is welcoming, helpful and informative. As per 42 CFR 438.66, these standards apply to Contractor and to any entity to which Contractor has delegated the customer service function in accordance with 42 CFR 438.230.
2. Functions
   a. Welcome and orient individuals to services and benefits available, and the provider network.
   b. Provide information about how to access behavioral health, primary health, and other community services.
   c. Provide information about how to access the various rights processes.
   d. Provide the "Your Rights When Receiving Mental Health Services in Michigan" booklet. Reference the followingwebsite for more information: https://cmham.org/services/bookstore/.
   e. Help individuals with problems and inquiries regarding benefits.
   f. Assist people with and oversee local complaint and grievance processes.
   g. Track and report patterns of problem areas for the organization.
3. Requirements
   Contractor must:
   a. Establish a Customer Services Unit with a minimum of one full-time equivalent (FTE).
   b. Establish a toll-free customer service telephone line with access to alternative telephonic communication methods (such as teletypewriter (TTY)).
   c. Publish customer service numbers in agency brochures and public information material.
   d. Ensure initial calls are answered by a live voice during normal business hours, a minimum of eight hours daily, Monday through Friday, excluding observed holidays.
   e. Publish how to access Customer Services information outside of normal business hours in the Customer Services Handbook and on Contractor website.
   f. Provide each beneficiary a Customer Services Handbook within a reasonable time.
   g. Post the customer handbook on Contractor website.
   h. Provide the Customer Services Handbook to the beneficiary by one of the following methods:
      i. Mailing a printed copy to the beneficiary's mailing address.
      ii. Emailing an electronic version after obtaining the beneficiary's written approval.
      iii. Notifying the beneficiary by providing a written statement that identifies where the handbook can be foundon the website.
      iv. Other alternate distribution method based on the request of the beneficiary.
   i. Provide, upon request, each affiliate CMHSP's current organizational chart, list of

Board members, board meeting schedule and minutes and annual report.

j. Upon request, assist beneficiaries with filing grievances and appeals, accessing local dispute resolution processes, and coordinating with Fair Hearing Officers and the local Office of Recipient Rights (ORR). See Section L. Grievance and Appeals Process for Beneficiaries.
k. Ensure staff are trained and possess current, working knowledge in the following areas:
    i. The populations served (serious mental illness, serious emotional disturbance, developmental disability and substance use disorder) and eligibility criteria for various benefits plans (e.g., Medicaid, Healthy Michigan Plan, MIChild).
    ii. Service array, medical necessity requirements and eligibility for and referral to specialty services.
    iii. Person-centered planning.
    iv. Self-determination.
    v. Recovery and Resiliency.
    vi. Peer Specialists.
    vii. Grievance and appeals, Fair Hearings, local dispute resolution processes, and Recipient Rights. Contractor must ensure that newly hired staff be trained in Recipient Rights within 30 days of hire.
    viii. Limited English Proficiency (LEP) and cultural competency.
    ix. Information on covered items and services and benefits not covered under this Contract.
    x. The Public Behavioral Health System.
    xi. Customer services functions and beneficiary rights and protections in accordance with federal regulations.
    xii. Community resources (e.g., advocacy organizations, housing options, schools, public health agencies).
    xiii. Public Health Code, Mental Health Code and Medicaid Provider Manual.

4. Customer Services Handbook Requirements

Contractor must comply with 42 CFR 438.10, including the following:

a. Include the date of publication/revision and version number in each Customer Services Handbook.
b. Provide a current version of the Customer Services Handbook to the beneficiary upon first request of service and annually thereafter, or sooner if substantial revisions have been made.
c. To the extent possible, provide each beneficiary with at least 30 days' notice before the intended effective date of any change that the State defines as significant in the information specified in 42 CFR 438.10(g)(2). Significant is defined as any change that affects a beneficiary's Medicaid benefits, including but not limited to: Contractor contract information, authorization for services, covered benefits and copays.
d. The topics with asterisks (*) below must use the standard language templates (which can be found on https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/customer-services.)
e. Ensure all information contained in the Customer Services Handbook is easily understood.
f. The information must be available in the prevalent non-English language(s) spoken in Contractor's service area.
g. Obtain State approval, in writing, prior to publishing original and revised editions of the Customer Services Handbook.
h. Produce supplemental materials to the Customer Services Handbook, as needed, to ensure compliance with Contractual Requirements (e.g., inserts/stickers).

i. Use the State's description for each Medicaid covered service.
j. Include the following contact information for Medicaid Health Plans (MHP) or Medicaid fee-for-service programs:
    i. Plan/program name
    ii. Locations
    iii. Telephone numbers
k. Include the following topics in the Customer Services Handbook:
    i. Topics Requiring use of MDHHS Template Language, which can be found on the https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/customer-services, include:
        1) *Template #1: Confidentiality and Family Access to Information
        2) *Template #2: Coordination of Care
        3) *Template #3: Emergency and After-Hours Access to Services
        4) *Template #4: Glossary or Definition of Terms
        5) *Template #5: Grievance and Appeals Processes
        6) *Template #6: Language Assistance and Accommodations
        7) *Template #7: Payment for Services
        8) *Template #8: Person-Centered Planning
        9) *Template #9: Recipient Rights
        10) *Template #10: Recovery and Resiliency
        11) *Template #11: Service Array
        12) *Template #12: Service Authorization
        13) *Template #13: Tag Lines
        14) *Template #14: Fraud, Waste and Abuse
    ii. Other Required Topics (not necessarily in this order), include:
        1) Benefits Provided by Contractor.
        2) How and where to access any benefits provided.
        3) Access to out-of-network services.
        4) Affiliate the names, addresses and phone numbers of the following personnel:
            a) Executive director.
            b) Medical director.
            c) Recipient rights officer.
            d) Customer services.
            e) Emergency (911) and after-hours contact numbers.
        5) Community resource list (and advocacy organizations) .
        6) Index.
        7) Right to information about Contractor operations (e.g., organizational chart, annual report).
        8) Services not covered under contract.
        9) Welcome to the PIHP.
        10) What are customer services and what it can do for the individual; hours of operation and process for obtaining customer assistance after hours?
    iii. Other Suggested Topics
        1) Customer services phone number in the footer of each page
        2) Safety information
        3) Web Address

C. Payment Reform

1. Behavioral Health Integration
    a. Contractor recognizes the importance of integrating both physical health and behavioral health services in order to effectively address beneficiary needs and

improve health status.

b. Contractor agrees to work with the State to develop initiatives to better integrate services covered by Contractor and the MHP(s) serving Contractor's beneficiaries and to provide incentives to support behavioral health integration.
c. Contractor agrees to collaborate with MHPs and the State to develop shared metrics to measure the quality of care provided to beneficiaries jointly served by Contractor and MHPs.

2. Data Reporting
   a. In order to continually improve the performance of its contracted providers, Contractor must collect and report data in a consistent and coordinated manner in collaboration with the State.
   b. Contractor agrees to work collaboratively with the State and with other Contractors to develop standard measure specifications, data collection processes, baseline data, and reports that will be provided to contracted providers and the State.
3. Responsibility for Payment of Authorized Services
   a. Contractor will be responsible for payment for services that Contractor authorizes, including Medicaid substance use disorder services. This provision presumes Contractor, and its network providers/subcontractors are fulfilling their responsibility to individuals according to terms specified in the Contract.
   b. Services must not be delayed or denied as a result of a dispute of payment responsibility between two or more network providers/subcontractors. In the event there is an unresolved dispute between Contractor and network providers/subcontractor(s), either one may request the State's involvement to resolve the dispute and make a determination. Likewise, services must not be delayed or denied as a result of a dispute of payment responsibility between Contractor and the network provider/subcontractor.
   c. Contractor, or their designee, must be contacted for authorization for post-stabilization care. Contractor is financially responsible for post-stabilization specialty care services obtained which are pre-approved by Contractor, or their designee, if authorization is delegated to it by Contractor in accordance with 42 CFR 438.230.
   d. Contractor is also responsible for post-stabilization care services when they are administered to maintain, improve or resolve the beneficiary's stabilized condition when:
      i. Contractor does not respond to a request for pre-approval within one hour.
      ii. Contractor cannot be contacted.
      iii. Contractor's representative and the treating physician cannot reach an agreement concerning the beneficiary's care and a Contractor physician is not available for consultation. In this situation, Contractor must give the treating physician the opportunity to consult with a Contractor physician and the treating physician may continue with care of the patient until a Contractor physician is reached or one of the criteria of 42 CFR 422.133(c)(3) is met.
   e. Financial responsibility for enrollees who are children is the county where the child and parents have primary residence. For temporary and permanent wards of the State or court (including tribal), financial responsibility is the county where the child current resides in the community (i.e., licensed foster care home, relative placement, or independent living) as long as the foster care case remains open. Residential treatment facilities licensed as a Child Caring Institution (CCI) including shelter placements contracted by MDHHS child welfare are not considered "residing in the community." If a temporary or permanent court ward is residing in the community with a foster family, the county where the child is residing is responsible for authorizing inpatient psychiatric hospitalization when medically necessary. If the child

is not residing in the community and placed by child welfare in a residential treatment facility or a DHHS emergency shelter licensed as a CCI, the county of court record would be responsible for assessing and authorizing the inpatient psychiatric hospitalization and providing transition services (assessment for community-based services, wraparound, case management or supports coordination) for up to 180 days prior to discharge.

f. In accordance with 42 CFR 438.114(c)(1)(ii)(B), Contractor is prohibited from denying payment for treatment obtained by a beneficiary when a representative of Contractor instructs the beneficiary to seek emergency services. The attending emergency physician, or the provider actually treating the beneficiary, is responsible for determining when the beneficiary is sufficiently stabilized for transfer or discharge in accordance with 42 CFR 438.114(d)(3).

g. In accordance with 42 CFR 438.114(d)(2), Contractor may not hold an enrollee who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specificcondition or stabilize the patient.

4. Medicaid Services Verification
   a. Contractor must perform annual verification of Medicaid claims in accordance with Medicaid Services Verification: https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/practiceguidelines and must be finalized no later than December 31.
5. Liability for Payment
   a. Contractor must provide that its Medicaid beneficiaries are not held liable for Covered services provided to thebeneficiary, for which the State does not pay Contractor, or Contractor does not pay the individual or health care provider that furnished the services under a contractual, referral, or other arrangement.

D. Contract Remedies and Sanctions

1. The State will utilize a variety of means to assure compliance with Contract requirements and with the provisions of Section 330.1232b of Michigan's Mental Health Code. The State will pursue remedial actions and possibly sanctions as needed to resolve outstanding contract violations and performance concerns. The application of remedies and sanctions shall be a matter of public record. If action is taken under the provisions of Section 330.1232b of the Mental Health Code, an opportunity for a hearing will be afforded Contractor, consistent with the provisions of Section 330.1232b.(6) and/or the Administrative Procedures Act 306 of 1969.
2. The pursuance of any of remedial actions does not require a Contract amendment. The Contract Compliance notice to Contractor is sufficient authority. The use of remedies and sanctions will typically follow a progressive approach, but the State reserves the right to deviate from the progression as needed to seek correction of serious, or repeated patterns of substantial non-compliance or performance problems. Contractor can utilize the dispute resolution provision of the Contract to dispute a Contract compliance notice issued by the State or pursue other available legal remedies.
3. Before imposing a sanction on a Contractor, the State will provide Contractor with timely written Contract compliancenotice that explains both of the following:
   a. The compliance issue along with its statutory/regulatory/contractual basis and the objective evidence upon which the finding of fault is based.
   b. The opportunity for a hearing to contest or dispute the State's findings and intended sanction, prior to the imposition of the sanction. A hearing under this Section is subject to the provisions governing a contested case under the Administrative Procedures Act of 1969, 1969 Public Act (PA) 306, MCL 24.201 to 24.328, unless otherwise agreed to in the specialty PIHP contract.
4. The State may do any of the following:

a. Require a plan of correction and specified status reports that becomes a Contract performance objective.
b. Retain a portion of the .002% contract withhold to be earned through timely and accurate completion and resolution of corrective action plans associated with the MDHHS conducted 1915(c) Waivers (CWP, HSW, and SEDW) site reviews of PIHP operations as specified in the CAP Incentive Scoring Metric, which is located on the MDHHS Reporting Requirements website at https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/reporting
c. Impose a direct dollar penalty and make it a non-matchable Contractor administrative expense and reduce earned savings from that fiscal year by the same dollar amount.
d. Delay up to 25% of scheduled payment amount to Contractor until compliance is achieved.
    i. The State may apply this sanction in a subsequent payment cycle and will give prior written notice to Contractor.
e. Initiate Contract termination.

E. Access and Availability

1. Provider Network Services

   Contractor is responsible for maintaining and continually evaluating an effective provider network adequate to fulfill the obligations of this contract. Contractor remains the accountable party for the Medicaid beneficiaries in its service area, regardless of the functions it has delegated to its provider networks as specified in 42 CFR 438.230. In this regard and in compliance with 42 CFR Parts 438.414; 438.10(g)(2)(xi)(C)(D)(E) and 457.1260, Contractor must:

   a. Maintain a regular means of communicating and providing information on changes in policies and procedures to its providers. This may include guidelines for answering written correspondence to providers, offering provider- dedicated phone lines, and a regular provider newsletter.
   b. Have clearly written mechanisms to address provider grievances and complaints, and an appeal system to resolve disputes.
   c. Provide a copy of Contractor's prior authorization policies to the provider when the provider joins Contractor's provider network. Contractor must notify providers of any changes to prior authorization policies.
   d. Provide a copy of Contractor's grievance, appeal and fair hearing procedures and timeframes to the provider when the provider joins Contractor's provider network. Contractor must notify providers of any changes to those procedures or timeframes.
   e. Provide to the State, in the format specified by the State, provider agency information profiles that contain a complete listing and description of the provider network available to recipients in the service area.
   f. Assure that services are accessible, taking into account travel time, availability of public transportation, and other factors that may determine accessibility.
   g. Assure that network providers do not segregate beneficiaries in any way from other individuals receiving their services.

2. Network Requirements

   a. Contractor must maintain a network of qualified providers in sufficient numbers, mix, and geographic locations throughout their respective service area for the provision of all covered services. Contractor may also utilize qualified providers from outside Contractor’s service area for the provision of covered services.
   b. Contractor must consider anticipated enrollment and expected utilization of services.
   c. Contractor must provide documentation on which the State bases its certification that Contractor complied with the State’s requirements for availability and accessibility of services, including the adequacy of the provider network as referenced in 42 CFR

Parts 438.604(a)(5); 438.606; 438.207(b) and 438.206.

d. Contractor must submit any other data, documentation, or information relating to the performance of the entity's obligations as required by the State as referenced in 42 CFR Parts 438.604(b) and 438.606.
e. In accordance with 42 CFR 438.14, Contractor must demonstrate that there are sufficient Indian Health Care Providers (IHCP) participating in the provider network to ensure timely access to services available under the Contract from such providers for Indian beneficiaries who are eligible to receive services.
    i. If timely access to covered services cannot be ensured due to few or no IHCPs, Contractor must:
        1) Allow Indian beneficiaries to access out-of-State IHCPs; or
        2) Show good cause for disenrollment from both Contractor and the State's managed care program in accordance with 42 CFR § 438.56(c).
    ii. Contractor must permit Indian beneficiaries to obtain services covered under the Contract from out-of- network IHCPs from whom the beneficiary is otherwise eligible to receive such services.
    iii. Contractor must permit an out-of-network IHCP to refer an Indian beneficiary to a network provider.

3. Changes in Provider Network
    a. Contractor must notify the State within seven days of any changes to the composition of the provider network organizations that negatively affect access to care. Contractor must have procedures to address changes in its network that negatively affect access to care. Changes in provider network composition that MDHHS determines to negatively affect recipient access to covered services may be grounds for sanctions.
    b. The State may apply sanctions to Contractor if a network change that negatively affects beneficiaries' access to care is not reported timely, or Contractor is not willing or able to correct the issue.
4. Out of Network Providers
    a. Contractor must provide adequate and timely access to, and authorize and reimburse Out-of-Network providers and cover Medically Necessary services for beneficiaries if such services could not reasonably be obtained by a Network Provider on a timely basis inside or outside the State of Michigan. Contractor must cover such out-of-Network services for as long as Contractor's Provider Network is unable to provide adequate access to covered Medically Necessary services for the identified beneficiary(s).
    b. If Contractor cannot reasonably provide access to non-emergent Covered Services by a Network Provider within access requirements of this Contract, Contractor must include in its service authorization decision, the provision of Covered Services Out-of-Network.
    c. Contractor must coordinate with Out-of-Network providers with respect to payment and follow all applicable MDHHS policies to ensure the beneficiary is not liable for costs greater than would be expected for in network services including a prohibition on balance billing in compliance with 42 CFR 438.106, 42 CFR 438.116 and the Medicaid Provider Manual.
    d. Contractor must comply with all related Medicaid Policies regarding authorization and reimbursement for Out-of-Network providers.
        i. Contractor must pay Out-of-Network Medicaid providers' claims at established Medicaid fees in effect on the date of service.
        ii. If Michigan Medicaid has not established a specific rate for the Covered Service, Contractor must follow Medicaid Policy to determine the correct

payment amount.

5. 1115 Behavioral Health Demonstration Waiver and Healthy Michigan Programs
   a. Services may be provided at or through Contractor service sites or contractual provider locations. Unless otherwise noted in the Michigan Medicaid Provider Manual, mental health and intellectual/developmental disabilities services may also be provided in other locations in the community, including the beneficiary's home, according to individual need and clinical appropriateness.
6. Provider Procurement
   a. Contractor is responsible for the development of the service delivery system and the establishment of sufficient administrative capabilities to carry out the requirements and obligations of this Contract. Where Contractor and its provider network fulfill these responsibilities through subcontracts, they must adhere to applicable provisions of federal procurement requirements as specified in 2 CFR 200. In complying with theserequirements and in accordance with 42 CFR 438.12, Contractor:
      i. May not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law,solely on the basis of that license or certification.
      ii. Must give those providers not selected for inclusion in the network written notice of the reason for its decision.
      iii. Is not required to contract with providers beyond the number necessary to meet the needs of itsbeneficiaries and is not precluded from using different practitioners in the same specialty. Nor isContractor prohibited from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to its beneficiaries. In addition, Contractor's selection policies and procedures cannot discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatments. Also, Contractor must ensure that it does not employ or contract with providers excluded from participation in federal health care programs under either Section 1128or Section 1128A of the Social Security Act.
7. Access Standards
   a. Contractor must ensure timely access to supports and services in the preferred language of the person served based on their language skills and in accordance with the Access Standards (https://www.michigan.gov/documents/mdhhs/Access_Standards_702741_7.pdf) which can be found on the MDHHS website: https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/practiceguidelines and the following timeliness standards and report its performance on the standards in accordance with Schedule E of this Contract.
   b. Have written policies guaranteeing each beneficiary's right to request and receive a copy of their medicalrecords, and to request that they be amended or corrected.
8. Person Centered Planning
   a. The Michigan Mental Health Code, MCL 330.1712, establishes the right for all individuals to have an Individual Plan of Service (IPOS) developed through a person-centered planning process. Contractor must implement person-centered planning in accordance with the MDHHS Person-Centered Planning Policy which can be found on the MDHHS website: https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/practiceguidelines. In accordance with 42 CFR 438.208(b)(2)(i), the person-centered planning process must include coordination of

services between settings of care which includes appropriate discharge planning for short and long-term hospitalizations. This provision is not a requirement of Substance Use Disorder Services.

b. Contractor must ensure that its provider network uses a specially-constituted committee, such as a behavior treatment plan review committee, to review and approve or disapprove any plans that propose to use restrictive or intrusive interventions with individuals served by the public mental health system who exhibit seriously aggressive, self-injurious or other behaviors that place the individual or others at risk of physical harm. The Committee must substantially incorporate the standards in the Standards for Behavior Treatment Plan Review Committees, https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Folder4/Folder13/Folder3/Folder113/Folder2/Folder213/Folder1/Folder313/Technical_Requirement_for_Behavior_Treatment_Plans.pdf?rev=92e7d3739bf64c97991657af19362634&hash=E6D047EBF35C585C715665FF2ACD9BCD which can be found on the MDHHS website: https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/practiceguidelines

9. Cultural Competence
   a. The supports and services provided by Contractor (both directly and through contracted providers) must demonstrate an ongoing commitment to linguistic and cultural competence that ensures access and meaningful participation for all people in the service area. Such commitment includes acceptance and respect for the cultural values, beliefs and practices of the community, as well as the ability to apply an understanding of the relationships of language and culture to the delivery of supports and services.
   b. To effectively demonstrate such commitment, it is expected that Contractor has five components in place: (1) a method of community assessment; (2) sufficient policy and procedure to reflect Contractor's value and practice expectations; (3) a method of service assessment and monitoring; (4) ongoing training to assure that staff are aware of, and able to effectively implement, policy; and (5) the provision of supports and services within the cultural context of the recipient.
   c. Contractor must participate in the State's efforts to promote the delivery of services in a culturally competent manner to all beneficiaries, including those with limited English proficiency and diverse cultural and ethnic backgrounds, and those who are Deaf, Hard of Hearing, and Deaf and Blind. Treatment will be modifiedto effectively serve individuals who are deaf, hard of hearing, and deaf and blind as determined by their language skills and preferences.
10. Self-Direction
    a. It is the expectation that Contractor will assure compliance among their network of service providers all elements of Participant-Directed Services outlined in the 1915(i)(1)(G)(iii), 1915(c) Appendix E HCBS waiverauthorities and the Self-Directing Services Policy which can be found on the MDHHS website: https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/practiceguidelines. This provision is not a requirement of Substance Use Disorder Services.
11. Choice
    a. In accordance with 42 CFR 438.6, Contractor must assure that the beneficiary is allowed to choose his orher health care professional, i.e., physician, therapist, etc. to the extent possible and appropriate.
12. Second Opinion
    a. If the beneficiary requests, Contractor must provide for a second opinion from a

qualified health care professional within the network or arrange for the ability of the beneficiary to obtain one outside the network, atno cost to the beneficiary.

13. Denials by a Qualified Professional
    a. Contractor must assure that any decision to deny a service authorization request or to authorize a servicein an amount, duration, or scope that is less than requested, must be made by a health care professional whohas appropriate clinical expertise in treating the beneficiary's condition.
14. Recovery Policy
    a. All Supports and Services provided to individuals with mental illness, including those with co-occurring conditions, must be based in the principles and practices of recovery outlined in the Michigan Recovery Council document, Recovery Policy and Practice Advisory which can be found on the MDHHS website: https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/drugcontrol/reportstats/reportcontent/policies-and-advisories
15. Nursing Home Placements
    a. Contractor agrees to provide medically necessary Medicaid specialty services to facilitate placement from,or divert admissions to, a nursing home for eligible beneficiaries determined by the Omnibus Budget Reconciliation Act (OBRA) screening assessment to have a mental illness and/or developmental disability and in need of placement and/or services.
16. Nursing Home Mental Health Services
    a. Residents of nursing homes with mental health needs must be given the same opportunity for access toContractor services as other individuals covered by this Contract.
17. Payments to Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)
    a. When Contractor pays FQHCs and RHCs for specialty services included in the specialty services waivers,Contractor must ensure that payments are no less than amounts paid to non-FQHC and non-RHCs for similar services.
18. Indian Health Service/Tribally Operated Facility or program/Urban Indian Clinic (I/T/U)
    a. Contractor is required to pay any Indian Health Service, Tribal Operated Facility Organization/Program/Urban Indian Clinic (I/T/U), or I/T/U contractor, whether participating in Contractor provider network or not, for Contractor authorized medically necessary covered Medicaid managed care services provided to Medicaid beneficiary/Indian beneficiaries who are eligible to receive services from the I/T/U provider either (1) at a rate negotiated between Contractor and the I/T/U provider, or (2) if there is no negotiated rate, at a rate not less than the level and amount of payment that would be made if the provider were not an I/T/U provider.
    b. In accordance with 42 CFR 438.14, when an Indian Health Care Provider is not enrolled in Medicaid as a FQHC, regardless of whether it participates in the network of Contractor, it has the right to receive its applicable encounter rate published annually in the Federal Register by the Indian Health Service, or in theabsence of a published encounter rate, the amount it would receive if the services were provided under the state plan's FFS payment methodology.
19. Persons Associated with the Corrections System
    a. Under an arrangement between the Michigan Department of Corrections (MDOC) and the Michigan Department of Health and Human Services (MDHHS), the PIHP must be responsible for medically necessary community-based substance use disorder treatment services for individuals under the supervision of the Michigan Department of Corrections once those individuals are no longer incarcerated. These individuals are typically under parole or probation orders. Individuals referred by court and services through local

community corrections (PA 511) systems must not be excluded from these Medicaid/Healthy Michigan program funded medically necessary community-based substance use disorder treatment services.

b. Referrals, Screening and Assessment
    i. Individuals under MDOC supervision are considered a priority population for assessment and admission for substance use disorder treatment services due to the public safety needs related to their MDOC involvement. Contractor must ensure timely access to supports and services in accordance with this Contract. The Code of Federal Regulations and the Michigan Public Health Code define the first four (4) priority population enrollees. The fifth population is established by MDHHS due to its high-risk nature. The priority populations are identified as follows and in the order ofimportance:
        1) Pregnant injecting drug user.
        2) Pregnant.
        3) Injecting drug user
        4) Parent at risk of losing their child(ren) due to substance use.
        5) Individual under supervision of MDOC AND referred by MDOC OR individual being released directly from an MDOC facility without supervision AND referred by MDOC. Excludes individuals referred by court and services through local community corrections (PA 511 funded) systems.
        6) All others.
    ii. Contractor must designate a point of contact within each Contractor catchment area for referral, screening and assessment problem identification and resolution. The position title and contact information will be provided to the State, which will provide the information to the MDOC Central OfficePersonnel. Contractor must provide this contact information to MDOC Supervising Agents in their regions.
    iii. The MDOC Supervising Agent will refer individuals in need of substance use disorder treatment through the established referral process at Contractor. The Supervising Agent will make best efforts to obtain from the individual a signed Michigan Behavioral Health Standard Consent Form, MDHHS-5515, and provide it to Contractor and/or designated access point along with any pertinentbackground information and the most recent MDOC Risk Assessment summary.
    iv. The Supervising Agent will assist the individual in calling Contractor or designated access point fora substance abuse telephonic screening for services. Individuals that are subsequently referred for substance use disorder treatment as a result of a positive screening must receive an in-person assessment. If the individual referred is incarcerated, the Supervising Agent will make best efforts to facilitate service initiation and appropriate contact with Contractor/Designated Access Point. Provided that it is possible to do so, Contractor must make best efforts to ensure the individual receives a telephonic, video or in-person screening for services at the designated location as arrangedby MDOC Supervising Agent. Contractor/designated access point may not deny an individual an in-person assessment via phone screening.
    v. Assessments must be conducted in accordance with MDHHS-approved assessment instruments (if any) and admissions decisions based on MDHHS-approved medical necessity criteria included in this Contract. In the case of MDOC supervised individuals, these assessments should include consideration of the individual's presenting symptoms and substance use/abuse history prior to and during incarceration and consideration of their

SUD treatment history while incarcerated. To the extentconsistent with HIPAA, the Michigan Mental Health Code and 42 CFR Part 2, and with the written consent of the individual, Contractor/designated provider will provide notice of an admission decision to the Supervising Agent within one business day, and if accepted, the name and contact information of the individual's treatment provider. If the individual is not referred for treatment services, Contractor/designated access point will provide information regarding community resources such as AA/NA or other support groups to the individual.

vi. Contractor must not honor Supervising Agent requests or proscriptions for level or duration of care, services or supports and must base admission and treatment decisionsonly on medical necessity criteria and professional assessment factors.

c. Plan of Service
   i. The individualized master treatment plan must be developed in a manner consistent with the principles of person-centered planning as applicable to individuals receiving treatment for substance use disorders as defined in this Contract and applicable portions of Person-Centered Planning Policy (which can be found at: https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/practiceguidelines .
   ii. Contractor/designated provider agrees to inform the Supervising Agent when Medication AssistedTreatment (MAT) is being used, including medication type. If the medication type changes, Contractor/designated provider must inform the Supervising Agent. Contractor/designated provider must obtain a release of information from the beneficiary.

d. Residential Services
   i. If an individual referred for residential treatment does not appear for, or is determined not to meet, medical necessity criteria for that level of care, the Supervising Agent must be notified with one business day. If an individual is participating in residential treatment, the individual may not be given unsupervised day passes, furloughs, etc. without consultation with the Supervising Agent. Leaves for any non-emergent medical procedure should be reviewed/coordinated with the Supervising Agent. If an individual is absent from an off-site supervised therapeutic activity without proper authorization, Contractor/designated provider must notify the Supervising Agent by the end of the day on which the absence occurred.
   ii. Contractor/designated provider may require individuals participating in residential treatment to submit to drug testing when returning from off property activities and any other time there is a suspicion of use. Positive drug test results and drug test refusals must be reported to the Supervising Agent. Contractor/designated provider must obtain a release of information from the beneficiary.
   iii. Additional reporting notifications for individuals receiving residential care include:
      1) Death of an individual under supervision.
      2) Relocation of an individual's placement for more than 24 hours.
      3) Contractor/designated provider must immediately, and no more than one hour from awareness of the occurrence, notify the MDOC Supervising Agent any serious sentinel event by or upon an individual under MDOC supervision while on the treatment premises or while on authorized leaves.
      4) Contractor/designated provider must notify the MDOC Supervising Agent of any criminalactivity involving an MDOC supervised individual within one hour

of learning of the activity.

e. Service Participation
   i. Contractor must ensure the designated provider completes a monthly progress report on each individual on a template supplied by the MDOC and must ensure it is sent via encrypted email to the Supervising Agent by the fifth day of the following month.
   ii. Contractor/designated provider must not terminate any referred individual from treatment for violation of the program rules and regulations without prior notification to the individual's Supervising Agent, except in extreme circumstances. Contractor/designated provider must collaborate with the MDOC for any non-emergency removal of the referred individual and allow the MDOC time to develop a transportation plan and a supervision plan prior to removal.
   iii. Contractor must ensure a recovery plan is completed and sent to the Supervising Agent within five business days of discharge. Recovery planning must include an offender's acknowledgment of the plan and Contractor's referral of the offender to the prescribed aftercare services.

f. Testimony
   With a properly executed release inclusive of the court with jurisdiction, Contractor and/or its designated provider, must provide testimony to the extent consistent with applicable law, including HIPAA and 42 CFR Part2.

g. Training
   i. In support of the needs of programs providing services to individuals under MDOC supervision, the MDHHS will make available training on criminogenic risk factors and special therapy concerns regarding the needs of this population.
   ii. Contractor must ensure its provider network delivers services to individuals served consistent with professional standards of practice, licensing standards, and professional ethics.

h. Compliance Monitoring
   Contractor is not accountable to the MDOC under this Contract. Contractor must permit the MDHHS, or its designee, to visit Contractor to monitor Contractor provider network oversight activities for the individuals served under this Section.

i. Provider Network Oversight
   Contractor is solely responsible for the composition, compensation and performance of its contracted provider network. To the extent necessary, Contractor must include performance requirements/standards based on existing regulatory or contractual requirements applicable to the MDOC-supervised population. Provider network oversight must be in compliance with applicable sections of this Contract.

20. Network Adequacy Standards.
    Information regarding Network Adequacy Standards can be found at the following MDDHS website:
    https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/reporting
    a. Pursuant to 42 CFR Parts 438.68 and 457.1218, MDHHS created a Network Adequacy Standard policy (MSA 18-49) and corresponding procedural document to effectuate network adequacy standards for Michigan's specialty behavioral health delivery system. Contractor must comply with the network adequacy standards set forth in the policy and procedure documents.
    b. Contractor must comply with the standards set forth in this Contract requirement. The State will provide 90 days' advance written notice to Contractor prior to the effective date of any changes to the network adequacy procedure.

c. Contractor must submit a plan on how the standards will be effectuated. Contractor must consider atleast the following parameters for their plans:
    i. Maximum time and distance
    ii. Timely appointments
    iii. Language, Cultural competence, and Physical accessibility

21. Intensive Crisis Stabilization Services (ICSS)
    Contractor must report its performance on the standards specific to ICSS for children on behalf of the enrolledprograms in their geographic service area in accordance with Schedule E of this Contract.
22. Transition of Care
    Contractor must develop and implement a transition of care policy consistent with 42 CFR 438.62 and the MDHHStransition of care technical requirement to ensure continuity of care for its beneficiaries.
    a. Contractor's transition of care policy must ensure continued access to services during a transition from FFS to a managed care entity, or transition from one managed care entity to another when a beneficiary, in the absence of continued services, would suffer serious detriment to their health or be at risk of hospitalization or institutionalism.
    b. The transition of care policy must include at a minimum:
        i. Transitioning Beneficiaries have access to services consistent with the access they previously had.
        ii. Transitioning Beneficiaries must be permitted to retain their current provider for the time period required in MDHHS' transition of care technical requirement if that provider is not in Contractor's network.
        iii. Transitioning Beneficiaries are referred to appropriate providers within Contractor's network.
        iv. Contractor, if previously serving a beneficiary must fully and timely comply with requests for historicalutilization, data from the beneficiary's new contractor or MDHHS.
    c. Contractor must include instructions to beneficiaries and potential beneficiaries on how to access continuedservices upon transition.

F. Covered Services

1. General
    a. Contractor must conform to professionally accepted standards of care and may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition of a beneficiary.
    b. Contractor must operate consistent with all applicable Medicaid policies and publications for coverages and limitations. If new Medicaid services are added, expanded, eliminated, or otherwise changed, Contractor must implement the changes consistent with State direction and the terms of this Contract.
    c. Contractor will be responsible for the operation of the 1115 Behavioral Health Demonstration Waiver, the Healthy Michigan Plan, the 1915(i) State Plan Benefit, those who are enrolled in one of the three 1915(c) waivers (Habilitation Supports Waiver, Children's Waiver Program, or the Waiver for Children with Serious Emotional Disturbances) and other public funding within its designated service area. Operation of the 1115 Behavioral Health Demonstration Waiver Program must conform to regulations applicable to the concurrent program and toeach (i.e., 1115 Behavioral Health Demonstration Waiver and 1915 (c)) Waiver. Contractor will also be responsible for development of the service delivery system and the establishment of sufficient administrative capabilities to carry out the requirements and obligations of this Contract. If Contractor elects to subcontract,Contractor must comply with

applicable provisions of federal procurement requirements as specified in 2 CFR 200, except as waived for CMHSPs in the 1115 Behavioral Health Demonstration Waiver.

d. 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. 1115 Demonstration Waiver
   a. State Plan Services: Under the 1115 Demonstration Waiver, Contractor is responsible for providing thecovered services as described in the Michigan Medicaid Provider Manual.
3. 1915(c) Services
   a. Contractor is responsible for provision of certain enhanced community support services for those beneficiaries in the service area who are enrolled in one of the three Michigan's 1915(c) Home and CommunityBased Services Waivers. Covered services are described in the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter of the Michigan Medicaid Provider Manual.
4. Healthy Michigan Plan
   a. Contractor is responsible for providing the covered services described in the Behavioral Health and Intellectual and Developmental Disability Supports and Services Mental Health/Substance Abuse Chapter ofthe Michigan Medicaid Provider Manual as well as the additional Substance Use Disorder services and supports described in the Medicaid Provider Manual for individuals who are eligible for the Healthy MichiganPlan.
5. MIChild
   a. Contractor must provide medically necessary defined mental health benefits to children enrolled in theMIChild program.
6. Flint 1115 Waiver
   a. The demonstration waiver expands coverage to children up to age 21 years and to pregnant women with incomes up to and including 400 percent of the federal poverty level (FPL) who were served by the Flint water system from April 2014 through a State-specified date. This demonstration is approved in accordance with Section 1115(a) of the Social Security Act, and is effective as of March 3, 2016, the date of the signed approval through September 30, 2026.
   b. Medicaid-eligible children and pregnant women who were served by the Flint water system during the specified period will be eligible for all services covered under the State plan. All such persons will have access to Targeted Case Management services under a fee for service contract between the State and Genesee Health Systems (GHS). The fee for service contract will provide the targeted case management services in accordancewith the requirements outlined in the Special Terms and Conditions for the Flint Section 1115 Demonstration, the Michigan Medicaid State Plan and Medicaid Policy.
7. Institution for Mental Disease (IMD) Services
   a. Contractor is responsible for providing the covered services in an IMD up to 15 days per month perindividual if the following conditions are met:
      i. The IMD stay is a medically appropriate substitute for the covered setting under the State plan.
      ii. The IMD stay is a cost-effective substitute for the setting under the State plan.
      iii. The beneficiary is not required to use the alternative setting.
8. Early Periodic Screening, Diagnosis and Treatment (EPSDT)
   a. Under Michigan's 1115 Behavioral Health Demonstration Waiver, Contractor is

responsible for the provision of specialty services Medicaid benefits and must make these benefits available to beneficiaries referred by a primary EPSDT screener, to correct or ameliorate a qualifying condition discovered through the screening process.

b. While transportation to EPSDT corrective or ameliorative specialty services is not a covered service under this waiver, Contractor must assist beneficiaries in obtaining necessary transportation either through the State or through the beneficiary's Medicaid health plan.

9. Special Health Care Needs
   a. Beneficiaries with special health care needs must have direct access to a specialist, as appropriate for theindividual's health care condition, as specified in 42 CFR 438.208(c) (4).
10. Opioid Health Home (OHH) (Optional Benefit to be provided by approved Contactors)
    a. The OHH will provide comprehensive care management and coordination services to Medicaid beneficiaries with opioid use disorder who also have or are at risk of developing another chronic condition. For enrolled beneficiaries, the OHH will function as the central point of contact for directing patient-centered care across the broader health care system. Beneficiaries will work with an interdisciplinary team of providers to develop an individualized recovery care plan to best manage their care. The model will also elevate the role and importance of peer recovery coaches and community health workers to foster direct empathy and connection to improve overall health and wellness. In doing so, this will attend to a beneficiary's complete health and social needs. Participation is voluntary, and enrolled beneficiaries may opt out at any time.
    b. OHH receives reimbursement for providing the following federally mandated core services:
       i. Comprehensive care management
       ii. Care coordination and health promotion
       iii. Comprehensive transitional care
       iv. Patient and family support
       v. Referral to community and support services
    c. Contractor, serving as the Lead Entity (LE), must meet all requirements indicated in the Opioid Health Home State Plan Amendment, Medical Services Administration (MSA) Policy 18-27, Opioid Health Home Handbook, and all other Medicaid laws, regulations, policies, and procedures (reference the following MDHHS website: www.michigan.gov/ohh)Contractor must utilize State Plan qualified Opioid Treatment Programs(OTPs) and Office Based Opioid Treatment providers (OBOTs) to execute the OHH via a "Hub and Spoke" system of care. Participation is voluntary and enrolled beneficiaries may opt-out at any time. The OHH will provide comprehensive care management and coordination services to Medicaid beneficiaries with an opioid use disorder diagnosis.
    d. Contractor, serving as the LE, will be responsible for the administrative oversight, coordination, and provision of OHH services.
    e. Contractor is responsible for the selection and paneling of designated Opioid Health Home Partners (OHHPs), coordination of enrollment through the Waiver Support Application, payment, health information technology, coordination of services, and other requirements cited in the approved State Plan, Policy, and the OHH Handbook.
    f. OHH providers will be required to enroll in Contractor's provider panel.
    g. Contractor must execute a contract with OHHPs to ensure an adequate network of providers to meet the state plan defined requirements.
    h. Contractor must provide technical assistance and training to current and prospective

OHHPs to successfully operationalize the OHH program.

i. Provider Types
    i. Eligible provider types for the OHH include OTPs and OBOT providers.

11. Behavioral Health Home (BHH) (Optional Benefit to be provided by approved Contactors)
    a. BHH will provide comprehensive care management and coordination services to Medicaid beneficiaries with a serious mental illness or serious emotional disturbance. For enrolled beneficiaries, the BHH will function as the central point of contact for directing patient-centered care across the broader health care system. Beneficiaries will work with an interdisciplinary team of providers to develop a person-centered health action plan to best manage their care. The model will also elevate the role and importance of Peer Support Specialists and Community Health Workers to foster direct empathy and raise overall health and wellness. In doing so, this will attend to a beneficiary's complete health and social needs. Participation is voluntary and enrolled beneficiaries may opt-out at any time.
    b. BHH receives reimbursement for providing the following federally mandated core services:
        i. Comprehensive care management
        ii. Care coordination and health promotion
        iii. Comprehensive transitional care
        iv. Patient and family support
        v. Referral to community and support services
    c. Contractor, serving as the LE, will be responsible for the administrative oversight, coordination, and provision of BHH services.
    d. Contractor must meet all requirements indicated in the BHH Handbook, and all other Medicaid laws, regulations, policies, and procedures (reference the following MDHHS website: www.michigan.gov/bhh)
    e. Contractor is responsible for the selection and paneling of designated Behavioral Health Home Partners (BHHPs), coordination of enrollment through the Waiver Support Application, payment, health information technology, coordination of services, and other requirements cited in the approved State Plan, Policy, and the BHH Handbook.
    f. Contractor must execute a contract with BHHPs to ensure an adequate network of providers to meet the state plan defined requirements.
    g. Contractor must provide technical assistance and training to current and prospective BHHPs to successfully operationalize the BHH program.
12. Long-Term Support Services
    a. Long Term Services and Supports (LTSS) provided under this Contract must be provided in a setting which complies with the 42 CFR 441.301(c)(4) requirements for home and community-based settings. Contractor must establish and maintain a member advisory committee. The member advisory committee must include a reasonably representative sample of the LTSS population, or other individuals representing those beneficiaries, covered under this Contract.
13. Maternity Outpatient Medical Services (MOMS)
    a. Contractor must provide medically necessary defined mental health benefits to women enrolled in the MOMS program.
14. CMS Certified Community Behavioral Health Clinic (CCBHC) Demonstration

    Contractors with certified CCBHC Demonstration Sites in their regions will execute the PIHP duties and responsibilities as cited and required by the MDHHS CCBHC Policy and the MDHHS MI CCBHC Demonstration Handbook to implement the CMH CCBHC Demonstration in accordance with Section 223 of the Protecting Access to Medicare Act

of 2014.

a. Per the CCBHC Policy and MI CCBHC Demonstration Handbook, key PIHP responsibilities and duties include, but are not limited to, the following:
    i. CCBHC Oversight and Support
    ii. CCBHC Enrollment and Assignment
    iii. CCBHC Coordination and Outreach
    iv. CCBHC Payment
    v. CCBHC Reporting
    vi. CCBHC Grievance Monitoring
b. PIHPs must comply with the CCBHC Demonstration Policy and the most current version of the corresponding MI CCBHC Demonstration Handbook, as authorized by the policy. MDHHS may modify the MI CCBHC Demonstration Handbook as needed in accordance with the following parameters:
    i. For minor changes (e.g., formatting, style, organization, grammar, etc.) or technical modifications that do not substantively alter CCBHC operations, MDHHS will draft and send an updated draft version of the MI CCBHC Demonstration Handbook with proposed changes to the PIHPs for notice and review. Upon receiving the proposed changes, the PIHPs will have up to 15 days to provide feedback. PIHPs will, as part of its review, notify and seek feedback from its contracted CCBHCs on the proposed Handbook updates. A majority of the PIHPs may waive the 15-day feedback period to allow the new version of the MI CCBHC Demonstration Handbook to take effect sooner.
    ii. For all other changes, MDHHS will draft and send an updated draft version of the MI CCBHC Demonstration Handbook with proposed changes to the PIHPs for notice and review. Upon receiving the proposed changes, the PIHPs will have up to 30 days to provide feedback. PIHPs will, as part of its review, notify and seek feedback from its contracted CCBHCs on the proposed Handbook updates. A two-thirds majority of the PIHPs may waive the 30-day feedback period to allow the new version of the MI CCBHC Demonstration Handbook to take effect sooner.

G. Contractor Governance and Board Requirements

1. For the purposes of this Contract, the designation as a Contractor applies to single county Community Mental Health Service Program or regional entities (organized under Section 1204b of the Mental Health Code or Urban Cooperation Act) serving Contractor's service areas as defined by the State. Contractor must either be a single county CMHSP, or a regional entity jointly and representatively governed by all CMHSPs in the service area pursuant to Section 204 or 205 of PA 258 of 1974, as amended in the Mental Health Code.
2. Contractor Substance Use Disorder Oversight Policy Board
3. Contractor must establish a SUD Oversight Policy Board pursuant to Section 287 of PA 258 of 1974, as amended in the Mental Health Code.
4. Contractor must Provide timely notification to the Department, in writing, of any action by its governing board or any other funding source that would require or result in significant modification in the provision of services, funding or compliance with operational procedures.

H. Behavioral/Physical Health Integration

1. Medicaid Health Plan (MHP) Agreements
    a. Many Medicaid beneficiaries receiving services from Contractor will be enrolled in an MHP for their healthcare services. The MHP is responsible for non-specialty level mental health services. It is therefore essential that Contractor have a written, functioning Coordinating Agreement with each MHP serving any part of Contractor's

service area. The written Coordinating Agreement must describe the coordination arrangements, inclusive of but not limited to, the exchange of information, referral procedures, care coordination and dispute resolution. At a minimum, these arrangements must address the integration of physical and mental health services provided by the MHP and Contractor for the shared consumer base plans. A model Coordination Agreement is provided on the MDHHS Policies and Practice Guidelines website: https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/practiceguidelines. Contractors must, in collaboration with coordinating MHPs, update the Coordination Agreement to incorporate any necessary remedies to improve continuity of care, care management, and the provision of health care services, at least annually.

2. Integrated Physical and Mental Health Care
    a. Contractor must initiate affirmative efforts to ensure the integration of primary and specialty behavioral health services for Medicaid beneficiaries. These efforts must focus on persons that have a chronic condition such as a serious mental health illness, co-occurring substance use disorder, children with serious emotional disorders or a developmental disability and have been determined by Contractor to be eligible for Medicaid Specialty Mental Health Services and Supports.
        i. Contractor must implement practices to encourage all consumers eligible for specialty mental health services to receive a physical health assessment including identification of the primary health care home/provider, medication history, identification of current and past physical health care and referrals for appropriate services. The physical health assessment will be coordinated through the consumer's MHP as defined in H.1.
        ii. As authorized by the consumer, Contractor must include the results of any physical health care findings that relate to the delivery of specialty mental health services and supports in the PCP process.
        iii. Contractor must make its best effort to conduct an initial screening of each enrollee's needs, within 90 days of the effective date of enrollment for all new enrollees. Contractor must make subsequent attempts to conduct an initial screening of each enrollee's needs if the initial attempt to contact the enrollee is unsuccessful. Since Contractor is not an enrollment model, screening once an individual presents for services would meet this agreement.
3. Primary Care Coordination
    a. In accordance with 42 CFR Part 2 Contractor must take all appropriate steps to assure that substance use disorder treatment services are coordinated with primary health care. Care Coordinating Agreements or joint referral agreements, by themselves, are not sufficient to show that Contractor has taken all appropriate steps related to coordination of care. Client treatment case file documentation is also necessary. Client treatment case files must include, at minimum, the primary care physician’s name and address, a signed release of information for purposes of coordination, or a statement that the client has refused to sign a release.
    b. Contractor must coordinate the services furnished to the beneficiary with the services the beneficiary receives with Fee For Service (FFS) Medicaid.

I. Eligibility

1. Medicaid Eligibility
    a. The MDHHS MSA administers the Medicaid program in Michigan. Eligibility is determined by the State with the sole authority to determine whether individuals or families meet eligibility requirements.
2. 1915(c) Habilitation Supports Waiver
    a. Contractor must identify Medicaid Beneficiaries who are eligible for and meet criteria for

the HSW per the approved 1915(c) HSW application and submit eligible enrollees to the State for review and approval.

b. The 1915(c) HSW and 1915(i) uses an “attrition management” model that allows PIHPs to “fill in behind” attrition with new beneficiaries up to the limits established in the CMS- approved waiver. MDHHS has allocated slots to each of the PIHPs. The process for filling a slot involves the following steps: 1) the PIHPs submit applications for Medicaid beneficiaries for enrollment based on vacant slots within the PIHP and includes required documentation that supports the eligibility for HSW; 2) MDHHS personnel reviews the PIHP enrollmentapplications; and 3) MDHHS personnel approves (within the constraint of the total yearly number of available waiver certificates and priority populations described in the CMS-approved waiver) those beneficiaries who meet the requirements described above.
c. The State may reallocate an existing HSW slot from one Contractor to another if:
    i. Contractor has presented no suitable candidate for enrollment in the HSW within 60 days of the certificate being vacated and
    ii. there is a high priority candidate (person exiting the ICF/ IID or at highest risk of needing ICF/ IID placement, or young adult aging off CWP) in another service area where no certificate is available.
d. The State will review all disenrollments from the HSW.
e. Contractor is responsible for the administration of the HSW and therefore must adhere to the requirements outlined in CMS approved 1915 (c) HSW application.

3. 1915(c) Children’s Waiver Program
    a. Contractor must identify children who meet the eligibility criteria for the Children’s Waiver Program Benefit Plan and submit to, the State, prescreens for those children. For children determined ineligible for the CWP, Contractor, on behalf of the State, informs the family of its right to request a Medicaid fair hearing by providing written adequate notice of denial of the CWP to the family.
    b. Contractor must carry out administrative and operational functions delegated by State to Contractor as specified in the CMS approved (c) waiver application. These delegated functions include level of care determination; review of participant service plans; prior authorization of waiver services; utilization management; qualified provider enrollment; quality assurance and quality improvement activities.
    c. Contractor must determine the appropriate Category of Care/Intensity of Care and the amount of publicly funded hourly care for each Children’s Waiver Program recipient per the Medicaid Provider Manual.
    d. Contractor must assure that services are provided in amount, scope, and duration as specified in the approved plan.
    e. Contractor must comply with policy covering credentialing, temporary/provisional credentialing and re- credentialing processes for those individuals and organizational providers directly or contractually employed by Contractor, as it pertains to the rendering of services within the Children’s Waiver Program.
    f. Contractor is responsible for ensuring that each provider, directly or contractually employed, credentialed or non-credentialed, meets all applicable licensing, scope of practice, contractual and Medicaid Provider Manual qualifications, and requirements.
4. 1915(c) Serious Emotional Disability Waiver (SEDW)
    a. The intent of this program is to provide Home and Community Based Waiver Services, as approved by Centersfor Medicare and Medicaid Services (CMS) for children with Serious Emotional Disturbances Benefit Plan, along with state plan services in accordance with the Medicaid Provider Manual.
        i. Contractor must assess eligibility for the SEDW and submit applications to the State for those children Contractor determines are eligible. For children

determined ineligible for the SEDW, Contractor, on behalf of the State, informs the family of its right to request a Medicaid fair hearing by providing written adequate notice of denial of the SEDW to the family.

ii. Contractor must carry out administrative and operational functions delegated by the State to Contractor as specified in the CMS approved (c) waiver application. These delegated functions include level of care determination; review of participant service plans; prior authorization of waiver services; utilization management; qualified provider enrollment; quality assurance and quality improvement activities.

iii. Contractor must assure that services are provided in amount, scope and duration as specified in the approved plan of service. Wraparound is a required service for all participants in the SEDW and Contractor must assure sufficient service capacity to meet the needs of SEDW recipients.

iv. Contractor must comply with credentialing, temporary/provisional credentialing and re- credentialing processes for those individuals and organizational providers directly or contractually employed by Contractor, as it pertains to the rendering of services within the SEDW. Contractor is responsible for ensuring that each provider, directly or contractually employed, credentialed or non-credentialed, meets all applicable licensing, scope of practice, contractual and Medicaid Provider Manual qualifications and requirements.

b. SEDW Child Welfare Project Procedural Requirements
Contractor must:

i. Develop local agreements with County local MDHHS offices outlining roles and responsibilities regarding the MDHHS SEDW Child Welfare Project.

ii. Identify a specific referral process for children identified as potentially eligible for the SEDW, with the assistance of local MDHHS workers, Contractor SEDW Coordinator, CMHSP SEDW Leads and Wraparound Supervisors.

iii. Participate in required SEDW Child Welfare Project State/Local technical assistance meetings and trainings.

iv. Collect and report, to the State, all data as requested by the State.

J. Parity and Benefits

1. Contractor must ensure compliance with 42 CFR part 438, subpart K, Parity in Mental Health and Substance Use Disorder Benefits. Contractor must comply with all applicable federal regulations, including the information requirements in the parity regulations, specifically 42 CFR 438.915 Availability of Information. The State will work with the Contractor to ensure the necessary changes to achieve full compliance are successfully implemented. The State will analyze parity compliance as part of routine monitoring of Contractor.
2. Contractor must use processes, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for mental health or substance use disorder benefits that are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for medical/surgical benefits as identified by the State, in the same classification.
3. Contractor must not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits as identified by the State, in the same classification furnished to beneficiaries (whether or not the benefits are furnished by the same Managed Care Plan (MCP).
4. Contractor may not apply any cumulative financial requirements for mental health or

substance use disorder benefits in a classification (inpatient, outpatient, emergency care, prescription drugs) that accumulates separately from any established for medical/surgical benefits as identified by the State, in the same classification.

5. Contractor may not impose Non-Quantitative Treatment Limitation (NQTLs) for mental health or substance use disorder benefits in any classification unless, under the policies and procedures of Contractor as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical as identified by MDHHS, benefits in the classification.

K. Quality Improvement and Program Development

1. Utilization Management Incentives
   a. Contractor must assure that compensation to individuals or entities that conduct utilization management activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medicallynecessary services to any beneficiary.
2. Quality Assessment/Performance Improvement Program (QAPIP) and Standards
   a. Contractor must have a fully operational QAPIP in place that meets the conditions specified in the Quality Assessment and Performance Improvement Program Technical Requirement (https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Folder4/Folder13/Folder3/Folder113/Folder2/Folder213/Folder1/Folder313/QA_and_PIP__for_Specialty_Prepaid_Inpatient_Health_Plans.pdf?rev=d4dc2f2bff104f199c2c38c5d460185c&hash=7D31840A589904614DDE39B83B790A8C.) which can be found on the MDHHS website: https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/practiceguidelines
   b. External Quality Review
      i. The State will arrange for an annual, external independent review of the quality and outcomes, timeliness of, and access to covered services provided by Contractor. Contractor must address the findings of the external review through its QAPIP. Contractor must develop and implement performance improvement goals, objectives and activities in response to the external review findings as part of Contractor's QAPIP. A description of the performance improvement goals, objectives and activities developed and implemented in response to the external review findings will be included in Contractor's QAPIP and provided to the State, annually, by February 28. The State may also require separate submission of an improvement plan specific to the findings of the external review.
      ii. If Contractor has received accreditation by a private independent accrediting entity, it must authorize the private independent accrediting entity to provide the State a copy of its most recent accreditation review, including the following:
         1) Accreditation status, survey type, and level (as applicable).
         2) Recommended actions or improvements, corrective action plans, and summaries of findings.
         3) Expiration date of the accreditation.
   c. LTSS Assessment
      The comprehensive QAPIP program must include mechanisms to assess the quality and appropriateness of care furnished to beneficiaries using LTSS, including an assessment of care between care settings and a comparison of services and supports received with those set forth in the beneficiary's treatment/service plan.

Contractor is required to implement mechanisms to comprehensively assess each Medicaid beneficiary identified as needing LTSS to identify any ongoing special conditions of the beneficiary that require a course oftreatment or regular care monitoring. The assessment mechanisms must use appropriate providers or individuals meeting LTSS service coordination requirements of the State or Contractor as appropriate.

3. Annual Effectiveness Review
    a. Contractor must annually conduct an effectiveness review of its QAPIP. The effectiveness review must include analysis of whether there have been improvements in the quality of health care and services for beneficiary as a result of quality assessment and improvement activities and interventions carried out by Contractor. The analysis should take into consideration trends in service delivery and health outcomes over time and include monitoring of progress on performance goals and objectives. Information on the effectiveness of Contractor's QAPIP must be provided annually to network providers and to recipients upon request. Information on the effectiveness of Contractor's QAPIP must be provided to the State annually, no later than February 28.
4. Service and Utilization Management
    a. Contractor must perform utilization management functions sufficient to control costs and minimize riskwhile assuring quality care.
5. Other Quality Requirements
    a. Contractor must disseminate all practice guidelines it uses to all affected providers and, upon request, to beneficiaries. Contractor must ensure decisions for utilization management, beneficiary education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. Contractor must assure services are planned and delivered in a manner that reflects the values and expectations contained in the following guidelines (which can be found on the MDHHS website: https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/practiceguidelines) :
        i. Inclusion Practice Guideline
        ii. Housing Practice Guideline
        iii. Consumerism Practice Guideline
        iv. Personal Care in Non-Specialized Residential Settings
        v. Family-Driven and Youth-Guided Policy and Practice Guideline
        vi. Employment Works! Policy

L. Grievance and Appeals Process for Beneficiaries.

1. Grievance and Appeals Policies and Procedures
    a. Contractor must establish and maintain an internal process for the resolution of Grievances and Appeals from beneficiaries. The Appeal and Grievance Resolution Processes Technical Requirement (https://www.michigan.gov/documents/mdhhs/Appeal-and-Grievance-Resolution-Processes-Technical-Requirement_704451_7.pdf) which can be found on the MDHHS website: https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/practiceguidelines
    b. Contractor must comply with 42 CFR 438.100, Enrollee Rights.
    c. Contractor must establish and maintain an internal process for the resolution of Grievances and Appeals from beneficiaries.
    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.

e. Contractor must seek the State's approval of Contractor's Grievance and Appeal policies prior to implementation. These written policies and procedures must meet the following requirements:
    i. Except as specifically exempted in this Section, Contractor must administer an internal Grievance and Appeal procedure according to the requirements of MCL 500.2213 and 42 CFR 438.400 – 438.424 (Subpart F).
    ii. Contractor must cooperate with the Michigan Department of Insurance and Financial Services (DIFS) in the implementation of MCL 550.1901-1929, "Patient's Rights to Independent Review Act".
    iii. Contractor must have only one level of Appeal for beneficiaries. A beneficiary may file a Grievance and request an Appeal with Contractor.
    iv. Contractor must make a determination on non-expedited Appeals not later than 30 Days after an Appeal is submitted in writing by the beneficiary. The 30-Day period may be tolled; however, for any period of time the beneficiary is permitted to take under the Medicaid Appeals procedure and for a period of time that must not exceed 14 Days if (1) the beneficiary requests the extension or (2) Contractor shows that there is need for additional information and how the delay is in the beneficiary's interest. Contractor may not toll (suspend) the time frame for Appeal decisions other than as described in this Section.
    v. Contractor must make a determination on Grievances within 90 Days of the submission of a Grievance.
    vi. If Contractor extends the timeframes not at the request of the beneficiary, it must:
        1) Make reasonable efforts to give the beneficiary prompt oral notice of the delay.
        2) Within two Days, provide the beneficiary written notice of the reason for the decision to extend the timeframe and inform the beneficiary of the right to file an Appeal if he or she disagrees with that decision.
        3) Resolve the Grievance as expeditiously as the beneficiary's health condition requires and not later than the date the extension expires.
    vii. If an Appeal is submitted by a third party but does not include a signed document authorizing the third party to act as an authorized representative for the Beneficiary, the 30-Day time frame begins on the date an authorized representative document is received by Contractor. Contractor must notify the Beneficiary that an authorized representative form or document is required. For purposes of this Section, "third party" includes, but is not limited to, health care Providers.
    viii. Contractor must provide written notice of resolution in a format and language that, at a minimum, meets the standard described in accordance with 42 CFR 438.10.
    ix. Contractor may extend the timeframe for processing a grievance by up to 14 calendar days if:
        1) The beneficiary requests the extension.
        2) Contractor shows there is need for additional information and that the delay is in the beneficiary's interest (upon the State's request).

2. Grievance and Appeal Procedure Requirements

Contractor's internal Grievance and Appeal procedure must include the following components:

a. Contractor must give beneficiaries timely and adequate notice of an Adverse Benefit determination in writing consistent with the requirements in 42 CFR 438.02, 438.10,

438.404 and this Contract. The notice must explain thefollowing:

i. The Adverse Benefit determination Contractor has made or intends to make.
ii. The reasons for the Adverse Benefit Determination, including the right of the beneficiary to be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the beneficiary's Adverse Benefit Determination. Such information includes Medical Necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits.
iii. The beneficiary's right to request an Appeal of the Adverse Benefit Determination, including information on exhausting Contractor's one level of Appeal and the right to request a State Fair Hearing.
iv. The procedures for exercising their Appeal rights, the circumstances under which an Appeal process can be expedited and how to request it.
v. The beneficiary's right to have benefits continue pending resolution of the Appeal, how to request that benefits be continued, and, if allowed under State policy, the circumstances under which thebeneficiary may be required to pay the costs of these services.

b. Contractor must mail the Adverse Benefit Determination notice within the timeframes specified in 42 CFR 438.404(c).
c. Contractor must allow beneficiaries 60 Days from the date of the Adverse Benefit notice in which to file an Appeal.
d. Contractor must provide beneficiaries reasonable assistance in completing forms and taking other procedural steps. This includes but is not limited to interpreter services and toll-free numbers that have adequate TTY/TDD and interpreter capability.
e. Contractor must acknowledge receipt of each Grievance and Appeal
f. Contractor must ensure that the individuals who make decisions on Grievances and Appeals are individuals who:
    i. Are not involved in any previous level of review or decision-making, nor a subordinate of any such individual; and
    ii. Are health care professionals who have the appropriate clinical expertise in treating the beneficiary's condition when the Grievance or Appeal involves a clinical issue.
    iii. Must take into account all comments, documents, records and other information submitted by thebeneficiary or their representative without regard to whether such information was submitted orconsidered in the initial Adverse Benefit determination.
g. Contractor must provide that oral inquires seeking to Appeal an Adverse Benefit determination are treated as Appeals to establish the earliest possible filing date for the Appeal and must be confirmed in writing, unless the beneficiary or the Provider requests expedited resolution.
h. Contractor must provide the beneficiary a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. Contractor must inform the beneficiary of the limited time available for this sufficiency in advance of the resolution timeframe for Appeals in the case of Expedited Appeal resolution.
i. Contractor must provide the beneficiary and his or her representative the beneficiary's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by Contractor in connection with the Appeal of the Adverse Benefit Determination. This information must be provided free of charge and sufficiently in advance of the resolution

timeframe for Appeals.

j. Contractor must consider the beneficiary, his or her representative, or estate representative of a deceased beneficiary as parties to the Appeal.
k. Contractor must notify the beneficiary, in writing, of Contractor's decision on the Grievance or Appeal.

3. Notice to Beneficiaries of Grievance Procedure
   a. Contractor must inform beneficiaries about Contractor's internal Grievance procedures at the time of Initial Enrollment and any other time a beneficiary expresses dissatisfaction by filing a Grievance with Contractor.
   b. The internal Grievance procedures information must be included in the member handbook and must explain:
      i. How to file a Grievance with Contractor
      ii. The internal Grievance resolution process
4. Notice to beneficiaries of Appeal Procedure
   a. Contractor must inform beneficiaries of Contractor's Appeal procedure at the time of Initial Enrollment, each time a service is denied, reduced, or terminated, and any other time a Contractor makes a decision that is subject to Appeal under the definition of Appeal in this Contract.
   b. The Appeal procedure information must be included in the member handbook and must explain:
      i. How to file an Appeal with Contractor.
      ii. The internal Appeal process.
      iii. The member's right to a Fair Hearing with the State after Contractor's one level Appeal processhas been exhausted.
5. Contractor Decisions Subject to Appeal
   a. When Contractor makes a decision subject to Appeal, as defined in this Contract, Contractor must provide a written Adverse Benefit determination notice to the beneficiary and the requesting Provider, if applicable. Contractor must mail the notice within the following timeframes:
   b. For termination, suspension, or reduction of previously authorized Medicaid Services, within the timeframes specified in 42 CFR 431.211,431.213, and 431.214.
   c. For denial of payment, at the time of any action affecting the claim.
   d. For standard service authorization decisions that deny or limit services, within the timeframe specified in 42 CFR438.210(d)(1).
   e. If Contractor meets the criteria set forth for extending the timeframe for standard service authorization decisions consistent with 42 CFR438.210(d)(1)(ii), Contractor must:
      i. Give the beneficiary written notice of the reason for the decision to extend the timeframe and inform the beneficiary of the right to file a Grievance if he or she disagrees with that decision; and
      ii. Issue and carry out its determination as expeditiously as the beneficiary's health condition requires and no later than the date the extension expires.
   f. For service authorization decisions not reached within the timeframes specified in 42 CFR 438.210(d) (which constitutes a denial and is thus an adverse benefit determination), on the date that the timeframes expire.
   g. For expedited service authorization decisions, within the timeframes specified in 42 CFR 438.210(d)(2).
   h. Contractor must continue the beneficiary's benefits if all the following conditions apply:
      i. The beneficiary files the request for an Appeal timely in accordance with 42 CFR 438.402(c)(1)(ii) and (c)(2)(ii).

ii. The Appeal involves the termination, suspension, or reduction of a previously authorized services.
iii. The services were ordered by an authorized Provider.
iv. The period covered by the original authorization has not expired; and the beneficiary timely files for continuation of benefits, meaning on or before the later of the following:
a) Within 10 days of Contractor's mailing the Adverse Benefit determination notice.
b) The intended effective date of Contractor's proposed Adverse Benefit determination notice.

i. If Contractor continues or reinstates the beneficiary's benefits while the Appeal or State Fair Hearing is pending, the benefits must be continued until one of the following occurs:
i. The beneficiary withdraws the Appeal or request for State Fair Hearing.
ii. The beneficiary fails to request a State Fair Hearing and continuation of benefits withing 10 days after Contractor mails an adverse resolution to the beneficiary's Appeal.
iii. A State Fair Hearing decision adverse to the beneficiary is made.
iv. The authorization expires or authorization service limits are met.

j. If Contractor or State Fair Hearing Officer reverses a decision to deny, limit or delay services, that were not furnished while the Appeal was pending, Contractor must authorize or provide the disputed services promptly, and as expeditiously as the beneficiary's health condition requires but no later than 72 hours from the date it receives notice reversing the determination.

k. If Contractor or State Fair Hearing Officer reverses a decision to deny authorization of services, and the beneficiary received the disputed services while the Appeal was pending, Contractor must pay for those services.

6. Adverse Benefit Determination Notice

a. Adverse Benefit determination notices involving Service Authorization Request decisions that deny or limitservices must be made within the time frames described in this Contract. Adverse Benefit Determination Notices pursuant to claim denials must be sent on the date of claim denial for termination, suspension, or reduction of previously authorized Medicaid-Covered Services. Contractor must mail Adverse Benefit Determination Notices within the following timeframes:
i. At least 10 Days before the date of action, except as permitted under 42 CFR 431.213 and 431.214.
ii. Contractor may send an Adverse Benefit Determination Notice not later than the date of actionif (less than 10 Days before as required above):
1) Contractor has factual information confirming the death of a beneficiary.
2) The beneficiary submits a signed written statement that:
a) He/she no longer requests the services or;
b) The beneficiary gives information that requires termination or reduction of services and indicates that he/she understands that service termination or reduction will result.
3) The beneficiary has been admitted into an institution where he/she is ineligible under theplan for further services.
4) The beneficiary's whereabouts are unknown, and the post office returns Contractor's maildirected to the beneficiary indicating no forwarding address.
5) Contractor verified, with MDHHS, that the beneficiary has been accepted for Medicaidservices by another local jurisdiction, state, territory or

commonwealth.
6) A Change in the level of health care is prescribed by the beneficiary's Provider.
7) The notice involves an Adverse Benefit Determination with regard to preadmissionrequirements.

iii. Contractor may shorten the period of advance notice to five Days before the date of action if:
1) Contractor has facts indicating that action should be taken because of probable Fraudby the beneficiary; and
2) The facts have been verified, if possible, through secondary sources.

b. The notice must include the following components:
i. The Adverse Benefit Determination Contractor has taken or intends to take and the reasons for that action.
ii. The reasons for the Adverse Benefit Determination, including the right of the beneficiary to be provided, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the beneficiary's Adverse Benefit Determination. Such information included medical criteria, behavioral health and any processes, strategies or evidentiary standards used in setting coverage limits. The beneficiary's right to request an Appeal, including information on exhausting Contractor's one level of Appeal and the right to request a State Fair Hearing.
iii. An explanation of Contractor's Appeal process.
iv. The beneficiary's right to request a Fair Hearing.
v. The circumstances under which expedited resolution is available and how to request it.
vi. The beneficiary's right to have benefits continue pending resolution of the Appeal and how to request that benefits be continued.
vii. Must be mailed in a timely manner in accordance with 42 CFR 438.404(c).

c. Written adverse action notices must also meet the following criteria:
i. Be translated for the individuals who speak prevalent non-English languages as defined by the Contract.
ii. Include language clarifying that oral interpretation is available for all languages and how the beneficiary can access oral interpretation services.
iii. Use easily understood language written below the 6.9 reading level.
iv. Use an easily understood format.
v. Be available in Alternative Formats, and in an appropriate manner that takes into consideration thosewith special needs.

d. In accordance with 42 CFR 438.420(d), if the final resolution of the appeal or State Fair Hearing is adverse to the beneficiary, that is, upholds Contractor's adverse benefit determination, Contractor may, consistent with the State's usual policy on recoveries under 42 CFR 431.230(b) and as specified in this Contract, recover the cost of services furnished to the beneficiary while the appeal and State Fair Hearing was pending, to the extent that they were furnished solely because of the requirements of this Grievance and Appeals Section.

7. State Medicaid Appeal Process
a. The State must maintain a Fair Hearing process to ensure beneficiaries have the opportunity to Appeal decisions directly to the State. Any beneficiary dissatisfied with a State agency determination denying a beneficiary's request to transfer Contractors/disenroll has access to a State Fair Hearing.
b. Contractor must include the Fair Hearing process as part of the written internal process for resolution of Appeals and must describe the Fair Hearing process in the

member handbook. The parties to the State Fair Hearing may include Contractor as well as the beneficiary and her or his representative or the representative of a deceased beneficiary's estate.

c. A beneficiary may request a State Fair Hearing only after receiving notice that Contractor has upheld itsAdverse Benefit Determination.
    i. If Contractor fails to adhere to the required Appeals notice and timing requirements in 42 CFR 438.408,the beneficiary is deemed to have exhausted Contractor's Appeals process.
d. Contractor must allow the beneficiary 120 Days from date of Contractor's Appeal resolution notice torequest a State Fair Hearing.

8. Expedited Appeal Process
    a. Contractor must establish and maintain an expeditated review process for appeals when Contractor or provider, acting on behalf of the beneficiary, indicates that taking the time for a standard resolution could seriously jeopardize the beneficiary's life, physical or mental health, or ability to attain, maintain, or regain maximum function. 42 CFR 438.410(a)
    b. Contractor's written policies and procedures governing the resolution of Appeals must include provisions forthe resolution of Expedited Appeals as defined in the Contract. These provisions must include, at a minimum, the following requirements:
        i. The beneficiary or Provider may file an Expedited Appeal either orally or in writing.
        ii. The beneficiary or Provider must file an Expedited Appeal within 60 calendar days of the Adverse Benefit Determination.
        iii. Contractor must make a decision on the Expedited Appeal within 72 hours of receipt of the Expedited Appeal.
        iv. Contractor must provide written notice of resolution in a format and language that, at a minimum, meets the standard described in accordance with 42 CFR 438.10.
            1) For notice of an expedited resolution, Contractor must also make reasonable efforts toprovide oral notice.
        v. If Contractor denies the request for an Expedited Appeal, Contractor must transfer the Appeal to the standard Appeal resolution timeframe and give the beneficiary written notice of the denial within two Days of the Expedited Appeal request.
        vi. Contractor must not take any punitive actions toward a Provider who requests or supports anExpedited Appeal on behalf of a beneficiary.

9. Grievance and Appeals Records
    Contractor and its network providers/subcontractors as applicable, must maintain record of all Grievance and Appeals
    a. The record of each Grievance and Appeal must contain, at a minimum all the following:
        i. A general description of the reason for the Appeal or Grievance.
        ii. The date received.
        iii. The date of each review or, if applicable, review meeting.
        iv. Resolution at each level of the Appeal and/or Grievance.
        v. Date of resolution for each Appeal and/or Grievance.
        vi. Name of covered person for whom the Appeal or Grievance was filed.
    b. The record must be accurately maintained in a manner accessible to the State and available upon request to CMS.
    c. Grievance and appeal records must be retained for 10 years from the final date of the contract period orfrom the date of completion of any audit, whichever is later.

M. Beneficiary Services

1. Provider Directory
    a. Contractor must maintain and publish a complete provider directory, including pharmacies, medical suppliers, ancillary health providers, independent facilitators and fiscal intermediaries, in hard copy and web-based formats.
    b. Information included in a paper provider directory must be updated at least monthly and electronic provider directories must be updated no later than 30 calendar days after Contractor receives updated provider information.
    c. Directory must be made available in a prominent, readily accessible location in a machine-readable format, which can be electronically retained and printed.
    d. Paper form requests must be fulfilled within five business days, without charge to the beneficiary.
    e. Contractor provider directory must be organized by county.
    f. Contractor's provider directory must contain, at a minimum, the following information:
        i. provider name
        ii. address
        iii. telephone number
        iv. website URL
        v. services provided
        vi. whether the provider is accepting new patients
        vii. languages spoken, including American Sign Language (ASL)
        viii. cultural and linguistic capabilities
        ix. whether the providers' office/facility has accommodations for people with physical disabilities
2. Written Materials
    a. All Informative materials, including the provider directory, intended to be distributed through written or other media (e.g., Electronic) to beneficiaries or the broader community that describe the availability of covered services and supports and how to access those supports and services, including but not limitedto provider directories, beneficiary handbooks, appeal and grievance notices, and denial and termination notices, must meet the following standards:
        i. All such materials must be written at or below the 6.9 grade reading level when possible (i.e., in some situations it is necessary to include medications, diagnosis and conditions that do not meet the 6.9 grade level criteria).
        ii. All materials must be in an easily understood language and format and use a font size no smaller than 12 point.
        iii. All informative materials, including the provider directory, must be made available in paper form upon request and in an electronic form that can be electronically retained and printed. It must also be made available in a prominent and readily accessible location on Contractor's website, in a machine-readable file and format. Information included in a paper provider directory must be updated at least monthly and electronic provider directories must be updated no later than 30 calendar days after Contractor receives updated provider information.
        iv. All materials shall be available in the languages appropriate to the people served within Contractor's area for specific Non-English Language that is spoken as the primary language by more than 5% of the population in Contractor's Region. Such materials must be available in any language alternative to English as required by the Limited English Proficiency Policy Guidance (Executive Order 13166 of August 11, 2000, Federal Register Vol. 65, August 16, 2000). All such materials must be available in alternative

formats in accordance with the Americans with Disabilities Act (ADA), at no cost to the beneficiary. Beneficiaries must be informed of how to access the alternative formats.

v. If Contractor provides information electronically, it must inform the customer that the information is available in paper form without charge and upon request and provides it upon request within five business days.
vi. Material must not contain false, confusing, and/or misleading information.
vii. For consistency in the information provided to beneficiaries, Contractor must use State developed definitions for managed care terminology, including: appeal, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services and devices, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, physician services, prescription drug coverage, prescription drugs, primary care provider, rehabilitation services and devices, skilled nursing care, specialist, co-payment excluded services, health insurance, medically necessary, network, non-participating, plan preauthorization, participating provider, premium, provider and urgent care, as defined in the this Contract and/or Medicaid provider manual.

b. Additional Information Requirements
   i. To take into consideration the special needs of beneficiaries with disabilities or LEP, Contractor must ensure that beneficiaries are notified that oral interpretation is available for any language, written information is available in prevalent languages, and auxiliary aids, such as and Teletypewriter/Text Telephone (TTY/TDY) and American Sign Language (ASL), and services are available upon request at no cost, and how to access those services as referenced in 42 CFR Parts 438.10(d)(3) and 438.10(d)(4). Contractor must also ensure that beneficiaries are notified how to access alternative formats as defined in 42 CFR 438.10(d)(6)(iv). In mental health settings, Video Remote Interpreting (VRI) is to be used only in emergency situations, extenuating circumstances, or during a state or national emergency as a temporary solution until they can secure a qualified interpreter and in accordance with R 393.5055 VRI standards, usage, limitations, educational, legal, medical, mental health standards.
   ii. All written materials for potential beneficiaries must include taglines in the prevalent non-English languages in Contractor's region, as well as large print, explaining the availability of written translations or oral interpretation to understand the information provided and the toll-free telephone number of the entity providing choice counseling services as required by 42 CFR 438.71(a) and as defined in 42 CFR Parts 438.10 (d)(3) and 431.10(d)(4). In accordance with 42 CFR Parts 438.10(d)(3) 438.10(d)(6) and 438.10(d)(6)(iv), Large print means printed in a font size no smaller than 18 point.
      1) Contractor must provide the following information to all beneficiaries who receivespecialty supports and services:
         a) A listing of contracted providers that identifies provider name as well as any groupaffiliation, locations, telephone numbers, web site URL (as appropriate), specialty (as appropriate), the provider's cultural capability, any non-English languages spoken, if the provider's office/facility has accommodations for people with physical disabilities, and whether they are accepting new beneficiaries. This includes any restrictions on the

beneficiary's freedom of choice among network providers. The listing would be available in the format that is preferable to the beneficiary: written paper copy or on-line. The listing must be kept current and offered to each beneficiary annually.

b) Their rights and protections, as specified in Section L. Grievance and Appeals Process for Beneficiaries.
c) The amount, duration, and scope of benefits available under the Contract in sufficient detail to ensure that beneficiaries understand the benefits to which they are entitled.
d) Procedures for obtaining benefits, including authorization requirements.
e) The extent to which, and how, beneficiaries may obtain benefits and the extent to which, and how, after-hours crisis services are provided.
f) Annually (e.g., at the time of person-centered planning) provide to the beneficiary the estimated annual cost to Contractor of each covered support and service he/she is receiving. Cost of Services provides principles and guidance for transmission of this information, this can be found at: https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/practiceguidelines.
g) Contractor is required to provide Explanation of Benefits (EOBs) to 5% of theconsumers receiving services. The EOB distribution must comply with all State and Federal regulations regarding release of information as directed by MDHHS. MDHHS will monitor EOB distribution annually. A model Explanation of Benefits which can found at: https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/practiceguidelines. Contractor may, but is not required to, utilize the model template.

2) Contractor must give each beneficiary written notice of a significant change in its applicable provider network including the addition of new providers and planned termination of existing providers.
3) Contractor must make a good faith effort to give written notice of termination of a contracted provider, within 15 days after receipt or issuance of the termination notice, to each beneficiary who received his or her primary care from or was seen on a regular basis by the terminated provider as defined in 42 CFR 438.10(f)(1).
4) Contractor must provide information to beneficiaries about managed care and carecoordination responsibilities of Contractor, including:
    a) Information on the structure and operation of the Managed Care Organization (MCO) or Contractor.
    b) Upon request, physician incentive plans in use by Contractor or networkproviders as set forth in 42 CFR 438.3(i).
    c) Contractor must provide information on how to contact their designated personor entity for coordination of services as referenced in 42 CFR 438.208(b)(1).

N. Provider Services

1. Provider Credentialing
    a. Contractor must have written credentialing policies and procedures for ensuring that

all providers rendering services to individuals are appropriately credentialed within the State and are qualified to perform their services. Credentialing must take place every two years. Contractor must ensure that network providers residing and providing services in bordering states meet all applicable licensing and certification requirements within their state. Contractor also must have written policies and procedures for monitoring its providers and for sanctioning providers who are out of compliance with Contractor's standards. Reference the MDHHS website: https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/practiceguidelines.

2. Health Care Practitioner Discretions
    a. Contractor may not prohibit, or otherwise restrict a health care professional acting within their lawful scope of practice from advising or advocating in the following areas on behalf of a beneficiary who is receiving services under this Contract:
        i. Beneficiary's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
        ii. Any information the beneficiary needs in order to decide among all relevant treatment options.
        iii. Risks, benefits, and consequences of treatment or non-treatment
        iv. Beneficiary's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.
3. Reserved
4. Level of Care Utilization System (LOCUS) Contractor must:
    a. Ensure that the LOCUS is incorporated into the initial assessment process for all individuals 18 and older seeking supports and services for a severe mental illness using MDHHS approved methods for scoring the tool listed below:
        i. Use of the online scoring system through State approved vendor with costs covered by the State.
        ii. Use of software purchased through State approved vendor with costs covered the State.
    b. Ensure that each individual 18 years and older with a severe mental illness has a LOCUS completed as part of any assessment and re-assessment process if they are not receiving Early Periodic Screening Diagnosis and Treatment Services (EPSDT). If the child / youth aged 18-21 years is receiving EPSDT in the CMHSP system, the CAFAS needs to be completed at intake, quarterly, and exit up to age 21.
    c. Collaborate with the State for ongoing fidelity monitoring on the use of the tool.
    d. Provide to the State the composite score for each LOCUS that is completed in accordance with the established reporting guidelines.
5. National Core Indicator (NCI) Surveys
    a. Contractor must provide, to the State, the mailing addresses, pre-survey and background information, and demographics needed for the State or its designee to schedule and conduct the face-to-face surveys for the identified survey participants in their service area.
    b. Contractor must coordinate appointments and, if required, obtain consent from beneficiaries.
    c. Contractor must disseminate the survey results to the stakeholders in their service area(s) and utilize the results in their quality improvement activities.
    d. Contractor must identify a specific individual to be the primary point of contact between Contractor, its designees, and the State.
6. Standardized SUD Assessment Process
    a. The State requires the use of SUD assessment tools that utilize the American

Society of Addiction Medicine (ASAM) criteria. The selected assessment tool must:
    i. collect all necessary information to provide a Diagnostic and Statistical Manual based diagnosis.
    ii. recommend ASAM placement needs.
    iii. be appropriate for the age of the individual.
    iv. comply with State-specified reporting requirements at the data element level identified within the 1115 Behavioral Health Waiver's standard terms and conditions (STCs).
b. Contractor is responsible for ensuring the State approved assessment tool is implemented and fidelity is maintained.
c. Contractor must honor network reciprocity requirements including valid SUD assessment tool results performed by a qualified provider under agreement with an alternate PIHP.
    i. Contractor must ensure appropriate release of information authorizations are executed.
d. Contractor must work with the State and its independent evaluators for data collection and reporting as detailed in the approved 1115 Behavioral Health Demonstration Waiver evaluation plan.
    i. Contractor must monitor the use of the approved assessment tool by sampling case files on review.
    ii. An auditing tool will be provided by the State. This tool can be used to validate the level of care determination and to monitor compliance with the STCs. Cases where deviations from the assessment recommended level of care must be justified by the clinician with clinical notes attached to the assessment.

7. Claims Management System
    a. A valid claim is a claim for supports and services that Contractor is responsible for under this Contract. It includes services authorized by Contractor, and those like Medicare co-pays and deductibles that Contractor may be responsible for regardless of their authorization.
    b. Contractor must assure the timely payments to all providers for clean claims. This includes payment at 90% or higher of all clean claims from network providers within 30 days of receipt, and at least 99% of all clean claims within 90 days of receipt, except services rendered under a subcontract in which other timeliness standards have been specified and agreed to by both parties.
    c. Contractor must have an effective provider appeal process to promptly and fairly resolve provider-billing disputes.
    d. Post-Payment Review
    Contractor may utilize a post-payment review methodology to assure claims have been paid appropriately. Regardless of method, Contractor must have a process in place to verify that services were provided.
    e. Total Payment
    Contractor or its network providers/subcontractors must not require any co-payments, recipient pay amounts, or other cost sharing arrangements unless specifically authorized by the State. Network providers/subcontractors must not seek, nor accept, additional supplemental payment for services authorized by Contractor.
    f. Electronic Billing Capacity
    Contractor must be capable of accepting HIPAA compliant electronic billing for services billed to Contractor, or Contractor claims management agent, as stipulated in the Michigan Medicaid Provider Manual. Contractor may require its providers to meet the same standard as a condition for payment.
    g. Vouchers

i. Vouchers issued to individuals for the purchase of services provided by professionals may be utilized in non- contract agencies that have a written referral network agreement with Contractor that specifies credentialing and utilization review requirements. Voucher rates for such services must be predetermined by Contractor using the actual cost history for each service category and average local provider rates for like services. These rates represent total payment for services rendered. Those accepting vouchers may not require any additional payment from the individual. Voucher arrangements for purchase of individual-directed supports delivered by non-professional practitioners may be through a fee-for-service arrangement. The use of vouchers is not subject to the provisions of Section E.6 (Provider Procurement) and Section 2.7 (Use of Subcontractors) of this Contract.

h. Programs with Community Inpatient Hospitals

i. Upon request from the State, Contractor must develop programs for improving access, quality, and performance with providers. Such programs must include the State in the design methodology, data collection, and evaluation. The State and Contractor will develop revised methods for the programs with community inpatient hospitals to ensure they comply with 42 CFR 438.6(c).

1) Hospital Eligibility

Hospital eligibility is determined by the State. Community hospitals, including Institutes for Mental Disease, are eligible for Hospital Rate Adjustor (HRA) directed payments based on Contractor inpatient encounters. Out of State hospitals are not eligible. The hospital billing provider NPI on the original invoice must be enrolled in the state Medicaid management information system (CHAMPS).

2) Determination of the Hospital Payment Amount

Contractor reported community inpatient psychiatric encounters will be used by the State as the basis for determining an annual add-on rate. Directed payment allocations are based on room and board encounters, identified by billing provider NPI. Encounters accepted in CHAMPS during the prior quarter will be included in the directed payment for that quarter. Medicaid and Healthy Michigan Plan encounters will be included in allocation pool.

3) State Payment Process

Contractor will receive a quarterly gross adjustment from the State. The amount of a quarterly payment to Contractor will be equal to the total amount shown on the HRA directed payment instructions for the prior quarter.

4) Directed Payment Instructions

The State will provide directed payment instructions indicating the payment amount per hospital, at the PIHP level. Instructions will be provided to Contractor prior to the end of the 1st month in each quarter.

5) Contractor Payment Obligations and Payment Process

Payment is made by Contractor to each hospital identified in the HRA directed payment instructions at the amount specified. Payments are quarterly with no minimum payment threshold. Payments are due to hospitals every three months within 10 State business days of Contractor receiving the quarterly HRA gross adjustment from the State. The State acknowledges that payments can be made without a current contractual arrangement between

Contractor/affiliate CMHSPs and the hospital receiving an HRA payment. Contractor delegation to affiliate CMHSPs is not recommended.

6) Contractor Reporting Requirements
Financial status reports will continue to include HRA payment revenue and payment information requirements.

8. MDHHS Standard Consent Form
Michigan PA 129 of 2014 was enacted to promote the use and acceptance of a standard consent form. Contractor must implement a written policy that requires the provider network to use, accept, and honor the standard consent form created as a result of the Public Act (Form MDHHS-5515). Per PA 559 of 2016, the policy must recognize written consent is not always required.
9. Trauma Policy
Contractor must develop a trauma-informed system in accordance with the MDHHS/BPHASA Trauma Policy, which can be found on the MDHHS website: https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/practiceguidelines
10. Substance Use Disorder (SUD) Services
    a. Contractor must comply with the SUD Services Policy and Advisory Manual, which can be found on the MDHHS website: https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/drugcontrol/reportstats/reportcontent/policies-and-advisories.
    b. Contractor must:
        i. Develop comprehensive plans for substance use disorder treatment and rehabilitation services consistent with guidelines established by the State.
        ii. Review and comment to the Department of Licensing and Regulatory Affairs (LARA) on applications for licenses submitted by local treatment, rehabilitation, and prevention organizations (SUD Rules can be found at the following website: https://ars.apps.lara.state.mi.us/AdminCode/DeptBureauAdminCode?Department=Licensing%20and%20Regulatory%20Affairs&Bureau=Bureau%20of%20Community%20and%20Health%20Systems (under the Substance Use Disorder Programs titled document)).
        iii. Provide technical assistance for local substance use disorder service programs.
        iv. On request from MDHHS or LARA, subject to applicable regulations, collect and transfer data and financial information from local programs to the LARA.
        v. Annually evaluate and assess substance use disorder services in the State-designated community mental health entity in accordance with guidelines established by the State. (SUD Rules can be found at the following website: https://ars.apps.lara.state.mi.us/AdminCode/DeptBureauAdminCode?Department=Licensing%20and%20Regulatory%20Affairs&Bureau=Bureau%20of%20Community%20and%20Health%20Systems (under the Substance Use Disorder Programs titled document))
        vi. Follow financial requirements as described in this Contract and Schedule E.
        vii. Follow progress reporting requirements as described in Schedule E.
        viii. Enter into subcontracts with providers for SUD services.
        ix. Ensure network providers are appropriately licensed for the service(s) provided in accordance with Michigan Public Health Code, PA 368 of 1978.
    c. Provider Network Oversight Management
        i. The provision of SUD treatment services must be based on the ASAM Level of Care (LOC) criteria.
            1) If Contractor plans to purchase case management services or peer

recovery and recovery support services, and only these services, from an agency that is not accredited per this Contract, Contractor may request a waiver of the accreditation requirement.

ii. To ensure compliance with contractual and administrative rule requirements, fidelity to assessment process and ASAM LOC Criteria:
    1) Conducting an annual review of each network provider's program, policies, practices and clinical records.
    2) Documenting compliance with the purported LOC for each provider.
        a) Include any corrective action that may have been taken and documentation that indicates all LOCs are available in the service area.
    3) Ensuring review documentation is available for the State during biennial Contractor site visits for comparison with State provider reviews.

d. Reimbursement for Services to Persons with Co-Occurring Disorders
    i. SUD funds may be used to reimburse providers for integrated mental health and substance use disorder treatment services to persons with co-occurring substance use and mental health disorders.
    ii. Contractor may reimburse a Community Mental Health Services Program (CMHSP) or network provider for substance use disorders treatment services for such persons who are receiving mental health treatment services through the CMHSP or network provider.
    iii. Contractor may also reimburse a provider, other than a CMHSP or network provider for substance use disorders treatment provided to persons with co-occurring substance use and mental health disorders.

e. American Society of Addiction Medicine (ASAM) Level of Care (LOC) for Network Providers
    i. Contractor must enter into network provider agreements for SUD treatment with organizations that provide services based on the ASAM LOC only.
    ii. The State Approved ASAM SUD treatment providers can be found in the Customer Relationship Management (CRM) system. Contractor must ensure that to the extent licensing allows all the following LOCs are available for adult and adolescent populations:

Level of Care	ASAM Title
0.5	Early Intervention
1	Outpatient Services
2.1	Intensive Outpatient Services
2.5	Partial Hospitalization Services
3.1	Clinically Managed Low Intensity Residential Services
3.3*	Clinically Managed Population Specific High Intensity Residential Services
3.5	Clinically Managed High Intensity Residential Services
3.7	Medically Monitored Intensive Inpatient Services
OTP Level 1**	Opioid Treatment Program
1-WM	Ambulatory Withdrawal Management without Extended On-Site Monitoring
2-WM	Ambulatory Withdrawal Management with Extended On-Site Monitoring
3.2-WM	Clinically Managed Residential Withdrawal Management
3.7-WM	Medically Monitored Inpatient Withdrawal Management

* Not designated for adolescent populations **Adolescent treatment per federal guidelines

iii. It is further required that all SUD treatment providers complete the MDHHS LOC Designation Questionnaire every two years and receive a formal designation for the LOC that is being offered.

11. Electronic Visit Verification (EVV)
    a. Contractor must ensure its network providers, and subcontractors comply with 42 USC 1396b (or sec. 1903(l) of the Social Security Act and the State's implementation timeline.
        i. Contractor must provide evidence of compliance upon request. Compliance must be in the form ofeither:
            1) An existing EVV system that meets State requirements as confirmed by Contractor's on-site review.
            2) Participation in the State sponsored Statewide EVV system.
        ii. Personal Care Services (PCS) includes community living support and respite services in a person's home, in a non-licensed setting.
        iii. Contractor must ensure its subcontracts, or those of their CMHSP participants, stipulates the EVVsystem supports self-directed arrangements and is minimally burdensome or disruptive to care.
12. Critical Incidents
    a. Contractor must require all its residential treatment providers to prepare and file critical incidentreports that include the following components:
        i. Provider determination whether critical incidents are sentinel events.
        ii. Following identification as a sentinel event, the provider must ensure that a root cause analysis or investigation takes place.
        iii. Based on the outcome of the analysis or investigation, the provider must ensure that a plan of action is developed and implemented to prevent further occurrence of the sentinel event. The plan must identify who is responsible for implementing the plan, and how implementation will be monitored. Alternatively, the provider may prepare a rationale for notpursuing a preventive plan.
    b. Contractor must report the following incidents for beneficiaries enrolled in the CWP, SEDW, HSW and the1115/1915(i) State Plan: 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 injuryrelated to the use of physical management. Type of injury will include a subcategory for reporting injuries that resulted from the use of physical management.
    c. Contractor must comply with the reporting requirements and guidelines identified in the Critical Incident Reporting and Event Notification Requirements which can be found on the MDHHS website: https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/practiceguidelines

O. Health Information Systems

1. A Contractor organized as a regional entity must ensure that health plan information technology functions are clearlydefined and separately contracted from any other function provided by a subcontractor CMHSP. A Contractor organized as a regional entity may have a single subcontractor CMHSP perform Contractor health plan information technology functions on behalfof the regional entity if each of the following requirements are met:
    a. The contract between Contractor and the CMHSP clearly describes the CMHSP's contractual responsibility to Contractor for the health plan information technology

related functions.

b. The contract between Contractor and the CMHSP for Contractor health plan information technology functions must be separate from other EHR functions performed as a CMHSP.

2. Contractor must ensure that all Health Information Systems used by Contractor and/or its subcontractors have the capacity to fulfill the obligations of this Contract. Contractor must maintain a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of this part. The system must provide information on areas including, but not limited to, utilization, claims, grievance and appeals, and disenrollment for other than loss of Medicaid eligibility. Contractor must develop, implement and maintain policies and procedures that describe how Contractor will comply with the requirements of this Section.
   a. Contractor must comply with the following:
      i. Section 6504(a) of the Affordable Care Act, which requires that State claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the State to meet the requirements of Section 1903(r)(1)(F) of the Act and as defined in 42 CFR 438.242(b)(1).
      ii. Collect data on beneficiary and provider characteristics as specified by the State, and on all services furnished to beneficiaries through an encounter data system or other methods as may be specified by the State.
      iii. Ensure that data received from providers is accurate and complete by:
         1) Verifying the accuracy and timeliness of reported data, including data from network providers is compensating on the basis of capitation payments.
         2) Screening the data for completeness, logic, and consistency.
         3) Collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for State Medicaid quality improvement and care coordination efforts.
      iv. Make all collected data available to the State and, upon request, to CMS.
   b. Contractor must ensure all encounter data is complete and accurate for the purposes of rate calculations and quality and utilization management and must provide for:
      i. Collection and maintenance of sufficient beneficiary encounter data to identify the provider who delivers any item(s) or service(s) to beneficiaries.
      ii. Submission of beneficiary encounter data to the State at a frequency and level of detail to be specified by CMS and the State, based on program administration, oversight, and program integrity needs.
      iii. Submission of all beneficiary encounter data that the State is required to report to CMS under 42 CFR 438.818. Specifications for submitting encounter data to the State in standardized ASC X12N 837 and NCPDP formats.
3. Capabilities
   a. Health Information Systems capabilities are required for the following:
      i. Monthly downloads of Medicaid eligible information.
      ii. Individual registration and demographic information.
      iii. Provider enrollment.
      iv. Third party liability activity.
      v. Claims payment system and tracking.
      vi. Grievance and complaint tracking.
      vii. Tracking and analyzing services and costs by population group, and special

needs categories as specified by the State.

viii. Encounter and demographic data reporting.
ix. Quality indicator reporting.
x. HIPAA compliance.
xi. Uniform Business Practices (UBP) compliance.
xii. Individual access and satisfaction.
xiii. Utilization of Benefit Enrollment and Maintenance (834) and Payment Order Remittance Advice (820) reconciliation files as the primary source for eligibility determination for Contractor functions. Eligibility Inquiry and Response file (270/271) is intended as the primary tool for the CMHSP and provider system to determine eligibility.

4. Beneficiary Service Records
Contractor must ensure that providers establish and maintain a comprehensive individual service record system consistent with the provisions of MSA Policy Bulletins, and appropriate State and federal statutes. Contractor must ensure that providers maintain in a legible manner, via hard copy or electronic storage/imaging, recipient service records necessary to fully disclose and document the quantity, quality, appropriateness, and timeliness of services provided. The records must be retained according to the retention schedules in place by the Department of Technology, Management and Budget (DTMB) General Schedule #20 at: https://www.michigan.gov/dtmb/services/recordsmanagement/schedules/GSLocal .This requirement must be extended to all of Contractor's provider agencies.
5. Contractor must analyze claims and encounter data to create utilization reports. The utilization data must be detailed for each CMHSP and consolidated for the entire geographic service area. Contractor must utilize thisinformation to develop and update their risk management strategies and other health plan functions.
6. Contractor must actively participate with the State to develop metrics the State will use to provide reports to Contractor (i.e., benchmarking Contractor's data against Statewide data).
7. Contractor must participate with the State and CMHSPs in activities to standardize and consistently submitencounter data when the CMHSP identified as the County of Financial Responsibility (COFR) is not part of Contractor's geographic service area.

P. Legal Expenses

1. Sufficient documentation must be maintained to support the allowability of legal expenses. Invoices must contain sufficient detail to evidence allowability. The following legal expenses are allowed:
   a. Legal expenses required in the administration of the program on behalf of the State of Michigan or Federal Government.
   b. Legal expenses relating to employer activities, labor negotiation, or in response to employment related issues or allegations, per 2 CFR 200.
   c. Legal expenses incurred in the course of providing consumer care.
   d. Legal expenses in response to enforcement action or audit findings issued by the State or CMS under the followingcircumstances:
      i. Contractor prevails and the action is reversed, or any contested adjustment is reduced by 50 percent or more; or
      ii. Contractor enters into a settlement agreement with the State or CMS prior to any Hearing.The following legal expenses are not allowed:
   e. Legal expenses of responding to an action against Contractor by MDHHS or CMS from initiating an enforcement action or issuing an audit finding, except those legal costs described above as allowable.

f. Legal expenses for the prosecution of claims against the State of Michigan or the Federal Government.
g. Legal expenses contingent upon recovery of costs from the State of Michigan or the Federal Government.

Q. Observance of State and Federal Laws and Regulations

1. General
   a. Contractor must comply with all State and federal laws, statutes, regulations, and administrative procedures and implement any necessary changes in policies and procedures as required by the State.
   b. Federal regulations governing contracts with risk-based managed care plans are specified in Section 1903(m) of the Social Security Act and 42 CFR Part 434 and will govern this Contract.
2. Compliance with False Claims Acts
   If the Contactor makes or receives annual payments under this Contract of at least $5,000,000, it must make provisions for written policies for all employees of the entity, and of any network provider/subcontractor or agent, that provides 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.
3. Third Party Liability Requirements
   Third Party Liability (TPL) refers to health insurers, self-insured plans, group health plans, service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service to pay for care and services available under the approved Medicaid state plan. Contractors are payers of last resort and will be required to identify and seek recovery from all other liable third parties in order to be made whole, including recoveries from any related court judgment or settlement if Contractor has been notified of the legal action. Contractor must follow the "Guidelines Used to Determine Cost Effectiveness and Time/Dollar Thresholds for Billing" as described in the Michigan State Medicaid Plan (which can be found at the following link: https://www.michigan.gov/mdhhs/assistance-programs/medicaid/michigan-medicaid-state-plan). Contractor may pursue cases below the thresholds at their discretion.
      i. Contractor must seek to identify and recover all sources of third-party funds based on industry standards and those outlined by MDHHS TPL Division.
      ii. Contractor may retain all such collections as provided for in Section 226a of the Michigan Mental Health Code as applicable. If third party resources are available and liability has been established, Contractor is required to follow Medicaid policy, guidance, and all applicable State and federal statutes, the Medicaid Provider Manual, the State Plan, and the TPL Guidelines and Best Practices Guidance for cost avoiding Medicaid covered services.
      iii. Contractor must follow Medicaid Policy, guidance and all applicable State and federal statutes regarding TPL. MDHHS TPL policy information can be found in federal regulations, Michigan Compiled Law, MDHHS Medicaid Provider Manual, Medicaid State Plan, and TPL Guidelines, and are available upon request. Contractor use of best practices is strongly encouraged by the State and are available in the TPL Guidelines and Best Practices Guidance. Contractor must develop and implement written policies describing its procedures for TPL recovery. The State will review Contractor's policies and procedures for compliance with this Contract and for consistency with TPL

recovery requirements in 42 USC 1396(a) (25), 42 CFR 433 Subpart D.

iv. Contractor must submit a Risk Mitigation Plan in a format required by the State, to address any risk identified in the MDHHS TPL Dashboard within 30 days of a State request. This requirement does not become effective until Contractor has received two quarterly MDHHS TPL dashboards.

v. Contractor must report third party collections through encounter data submissions, and in aggregate, as required by the State.

vi. Contractor must provide third party recovery data to MDHHS in the electronic format prescribed by the State.

vii. Contractor must collect any payments available from other health insurers including Medicare and private health insurance for services provided to its members in accordance with Section 1902(a)(25) of the Social Security Act and 42 CFR 433 Subpart D and the Michigan Mental Health Code and Public Health Code as applicable.

viii. The State will provide Contractor with all known third party resources for its beneficiaries. This information is available real-time within CHAMPS or through Eligibility Inquiry and Response file 270 requests. The State will provide the most recent data to Contractor on the daily Enrollment/Eligibility 834 HIPAA file. The State will provide Contractor with a full history of known third party resources for beneficiaries through a secure file transfer process.

ix. If Contractor denies a claim due to third party resources (other insurance), Contractor must provide the other insurance carrier ID, if known, to the billing provider.

x. When a beneficiary is also enrolled in Medicare, Medicare will be the primary payer. Contractor must make the beneficiary whole by paying or otherwise covering all Medicare cost-sharing amounts incurred by the beneficiary such as coinsurance, co-pays and deductible whether Contractor authorized the service or not.

xi. If the State enters into a Coordination of Benefits Agreement (CBA) with Medicare for FFS, and if Contractor is responsible for coordination of benefits for individuals dually eligible for Medicaid and Medicare, the State requires Contractor to enter into a CBA with Medicare and participate in the automated claims crossover process.

xii. Contractor must respond within 30 days of subrogation notification pursuant to MCL 400.106(10).

xiii. Contractor must cooperate with TPL subrogation best practices including, but not limited to:

1) Providing the State with most recent contact information of Contractor's assigned TPL staff including staffname(s), fax and telephone numbers.
2) Informing the State, in writing, within 14 Days of vacancy or staffing change of assigned TPL staff.
3) Reporting TPL quarterly subrogation activities to the State on a template developed by the State.

xiv. Contractor is prohibited from recovering loss directly from the beneficiary.

4. Confidentiality

a. Contractor must maintain the confidentiality, security and integrity of beneficiary information that is used in connection with the performance of this Contract to the extent and under the conditions specifiedin HIPAA, the Michigan Mental Health Code (PA 258 of 1974, as amended), the Michigan Public Health Code (PA 368 of 1978 as amended), and 42 CFR Part 2.

b. All beneficiary information, medical records, data and data elements collected, maintained, or used in the administration of this Contract must be protected by Contractor from unauthorized disclosure.
c. Contractor must provide safeguards that restrict the use or disclosure of information concerning beneficiaries to purposes directly connected with its administration of the Contract.
d. Contractor must have written policies and procedures for maintaining the confidentiality of data, including medical records, client information, and appointment records.

5. Advance Directives Compliance
In accordance with 42 CFR 422.128 and 42 CFR 438.3(j), Contractor must maintain written policies and procedures for advance directives. Contractor must provide adult beneficiaries with written information on advance directive policies and a description of applicable State law and their rights under applicable laws. This information must be continuously updated to reflect any changes in State law as soon as possible but no later than 90 days after it becomes effective. Contractor must inform individuals that grievances concerning noncompliance with the advance directive requirements may be filed with Customer Service. This must include prohibiting Contractor from conditioning the provision of care based on whether or not the individual has executed an advance directive.
6. Pro-Children Act
Contractor must comply with Public Law 103-227, also known as the Pro-Children Act of 1994, 20 USC 6081 et seq, which requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted by and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through State or local governments, by federal grant, contract, loan or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where Women, Infants, and Children (WIC) coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity. Contractor must assure that this language will be included in any sub-awards that contain provisions for children's services. Contractor must assure, in addition to compliance with Public Law 103-227, any service or activity funded in whole or in part through this Contract will be delivered in a smoke-free facility or environment. Smoking will not be permitted anywhere in the facility, or those parts of the facility under the control of Contractor. If activities or services are delivered in residential facilities or in facilities or areas that are not under the control of Contractor (e.g., a mall, residential facilities or private residence, restaurant or private work site), the activities or services must be smoke free.
7. Hatch Political Activity Act and Intergovernmental Personnel Act
Contractor must comply with the Hatch Political Activity Act, 5 USC 1501-1509, and 7324-7328, and the Intergovernmental Personnel Act of 1970, as amended by Title VI of the Civil Service Reform Act, Public Law 95-454, 42 USC 4728 - 4763. Federal funds cannot be used for partisan political purposes of any kind by any person or organization involved in the administration of federally assisted programs.
8. Limited English Proficiency

a. Contractor must comply with the Office of Civil Rights Policy Guidance on the Title VI Prohibition Against Discrimination as it affects persons with Limited English Proficiency, 45 CFR 92.201 and Section 1557 of the Patient Protection and Affordable Care Act. Contractor is expected to take reasonable steps to provide meaningful access to each individual beneficiary with limited English Proficiency, such as language assistance services, including but not limited to, services oral and written translation. This includes interpretation services for deaf, hard of hearing and deaf/blind populations in accordance with The MICHIGAN DEPARTMENT OF CIVIL RIGHTS DIVISION ON DEAF, DEAF BLIND AND HARD OF HEARING QUALIFIED INTERPRETER – GENERAL RULES (By authority conferred on the division on deaf and hard of hearing by Section 8a of the deaf persons' interpreters act, 1982 PA 204, MCL 393.508a, Section 9 of the division on deafness act, 1937 PA 72, MCL 408.209, and ERO 1996-2, MCL 445.2001, ERO 2003-1, MCL 445.2011, and ERO 2008-4, MCL 445.2025.)
b. Contractor must comply with all applicable federal requirements in Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities, as amended); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973, as amended; the Americans with Disabilities Actof 1990, as amended; and Section 1557 of the Patient Protection and Affordable Care Act.

9. Health Insurance Portability and Accountability Act (HIPAA) and 42 CFR PART 2
To the extent that State and Contractor are HIPAA Covered Entities and/or Programs under 42 CFR Part 2, each agrees that it will comply with HIPAA's Privacy Rule, Security Rule, Transaction and Code Set Rule and Breach Notification Rule and 42 CFR Part 2 (as now existing and as may be later amended) with respect to all Protected Health Information and substance use disorder treatment information that it generates, receives, maintains, uses, discloses or transmits in the performance of its functions pursuant to this Agreement. To the extent that Contractordetermines that it is a HIPAA Business Associate of the State and/or a Qualified Service Organization of the State, then the State and Contractor will enter into a HIPAA Business Associate Agreement and a Qualified Service Organization Agreement that complies with applicable laws and is in a form acceptable to both the State and Contractor.
    a. Contractor must not share any protected health data and information provided by the State that falls within HIPAA requirements except as permitted or required by applicable law or to a network provider/subcontractor as appropriate under this agreement.
    b. Contractor must ensure that any network provider/subcontractor will have the same obligations as Contractor not to share any protected health data and information from the State that falls under HIPAA requirements in the terms and conditions of the subcontract.
    c. Contractor must only use the protected health data and information for the purposes of this Contract.
    d. Contractor must have written policies and procedures addressing the use of protected health data and information that falls under the HIPAA requirements. The policies and procedures must meet all applicable federal and State requirements including the HIPAA regulations. These policies and procedures must include restricting access to the protected health data and information by Contractor's employees.
    e. Contractor must have a policy and procedure to immediately report to the State any suspected or confirmed unauthorized use or disclosure of protected health

data and information that falls under the HIPAA requirements of which Contractor becomes aware. Contractor must work with the State to mitigate the breach and will provide assurances to the State of corrective actions to prevent further unauthorized uses or disclosures.

f. Failure to comply with any of these Contractual requirements may result in the termination of this Contract in accordance with Section 24 Termination for Cause in the Standard Contract Terms. In accordance with HIPAA requirements, Contractor is liable for any claim, loss or damage relating to unauthorized use or disclosure of protected health data and information by Contractor received from the State or any other source.
g. Contractor must enter into a business associate agreement .
h. All recipient information, medical records, data and data elements collected, maintained, or used in the administration of this Contract must be protected by Contractor from unauthorized disclosure as required by State and federal regulations. Contractor must provide safeguards that restrict the use or disclosure of information concerning recipients to purposes directly connected with its administration of the contract.
i. Contractor must have written policies and procedures for maintaining the confidentiality of all protectedinformation.

10. Ethical Conduct
    State administration of this Contract is subject to the State of Michigan State Ethics Act: Act 196 of 1973, “Standards of Conduct for Public Officers and Employees. Act 196 of 1973 prescribes standards of conduct for public officers andemployees.” The State administration of this Contract is subject to the State of Michigan Governor’s Executive Order No: 2001-03, “Procurement of Goods and Services from Vendors.”
11. Conflict of Interest
    Contractor and the State are subject to the federal and State conflict of interest statutes and regulations that apply to Contractor under this Contract, including Section 1902(a)(4)(C) and (D) of the Social Security Act: 41 U.S.C. Chapter 21 (formerly Section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423): 18 U.S.C. 207)): 18 U.S.C. 208: 42 CFR 438.58: 45 CFR Part 92: 45 CFR Part 74: 1978 PA 566: and MCL 330.1222.
12. Human Subject Research
    Contractor must comply with Protection of Human Subjects Act, 45 CFR, Part 46, subpart A, Sections 46.101-124 and HIPAA. Contractor must, prior to the initiation of the research, submit Institutional Review Board (IRB) application material for all research involving human subjects, which is conducted in programs sponsored by the State or in programs which receive funding from or through the State of Michigan, to the State’s IRB for review and approval, or the IRB application and approval materials for acceptance of the review of another IRB. All such research must be approved by a federally assured IRB, but the State’s IRB can only accept the review and approval of another institution’s IRB under a formally approved interdepartmental agreement. The manner of the review will be agreed upon between the State’s IRB Chairperson and Contractor’s IRB Chairperson or Executive Officer(s).
13. Fiscal Soundness of the Risk-Based Contractor
    Federal regulations require that the risk-based Contractor maintain a fiscally solvent operation and the State has the right to evaluate the ability of Contractor to bear the risk of potential financial losses, or to perform services based on determinations of payable amounts under the Contract.
14. Medicaid Policy
    Contractor must comply with provisions of Medicaid policy developed under the formal

policy consultation process, as established by the Medical Assistance Program.

15. Service Requirements
    a. Contractor must limit Medicaid and MIChild services to those that are medically necessary and appropriate, and that conform to accepted standards of care.
    b. Contractor must operate the provision of their Medicaid services consistent with the applicable sections of the Social Security Act, the Code of Federal Regulations (CFR), the CMS/HCFA State Medicaid & State Operations Manuals, Michigan's Medicaid State Plan, and the Michigan Medicaid Provider Manual: Mental Health-Substance Abuse Section.
    c. Contractor must provide covered State plan or 1915(c) services (for beneficiaries enrolled in the Michigan Medicaid Managed Specialty Services and Supports Program) in sufficient amount, duration and scope to reasonably achieve the purpose of the service.
    d. Consistent with 42 CFR 440.210 and 42 CFR 440.220, services to recipients must not be reduced arbitrarily.
    e. Criteria for medical necessity and utilization control procedures that are consistent with the medical necessity criteria/service selection guidelines specified by the State and based on practice standards may be used to place appropriate limits on a service (42 CFR 440.230).
16. Home and Community Based Setting (HCBS) Transition Implementation
    a. In order to ensure compliance with the HCBS rule Contractor must complete the following: administer the assessment process for new and existing providers, review and analyze data collected from the assessment, notify providers of a need for corrective action (if required), develop a corrective action plan, ensure corrective action is implemented and monitor ongoing compliance. Contractor will develop a process to ensure settings are surveyed with a frequency identified by the State. Contractor will provide the State with its proposal to address those settings that do not comply with the required HCBS assessment process, including timelines. Contractor will provide updated reports to the State specifying assessment activities taken and required remediation or validation activities as identified by the State.
    b. Contractor must ensure that all new providers of HCBS services complete the HCBS Comprehensive Assessment. Contractor may provide provisional approval to the new provider as long as the setting does not qualify for heightened scrutiny. When a setting qualifies for heightened scrutiny, Contractor must communicate this to the HCBS Transition team, who will determine the required next steps, that must include an individualized consultation.
        i. Contractor must ensure that provisionally approved providers and beneficiaries receive the comprehensive HCBS assessment within 90 days of the beneficiaries' IPOS. Contractors must ensure providers complete this assessment and subsequent remediation/validation processes in order to be eligible for HCBS funding.
    c. Contractor must ensure that all HCBS final rule requirements are met, as described in the Michigan Medicaid Provider Manual.
    d. Contractor must not enter into new contracts with new providers of services covered by the Federal HCBS Rule (42 CFR Parts 430,431, 435, 436, 440, 441 and 447) unless the provider has obtained provisional approval status through completion of the HCBS New Provider Application, demonstrating that the provider does not require heightened scrutiny. Provisional approval allows a new provider or an existing provider with a new setting, service, or licensee to provide services to HCBS participants pending the full assessment process. Providers and participants will

receive the comprehensive HCBS assessment during the first assessment cycle occurring 90 days post provisional approval. Providers will complete the HCBS assessment and cooperate with Contractor to demonstrate 100% compliance with the Federal HCBS rule and State requirements as promulgated by the MDHHS and documented in the Michigan Statewide Transition Plan. Failure to complete the provisional approval process and the ongoing compliance assessments will result in the exclusion from participating in Medicaid or Healthy Michigan Plan funded HCBS services. Contractor must monitor their provider panel annually for ongoing compliance with the HCBS rule and implement a system to remove providers from the regions network due to failure to meet requirements of the rule. Contractor must maintain documentation of this annual review and/or removal from its provider network. Contractor must make all HCBS provider network status collected data available to the State and, upon request, to CMS.

e. Contractor shall conduct a physical assessment of the setting annually and the comprehensive assessments at least once every two years to ensure that the setting remains home and community based.

f. Please reference the HCBS Technical Advisory which is located on the MDHHS Policy and Practice Guidelines website, https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/practiceguidelines for further detail on these requirements.

17. Electronic Visit Verification (EVV)
In accordance with Section 12006(a) of the 21st Century Cures Act, Contractor must implement EVV for all Medicaid Personal Care Services (PCS) that requires an in home visit by a provider. This applies to PCS provided under Sections 1905(a)(24), 1915(c), 1915(i), 1915(j), 1915(k), and Section 1115; and HHCS provided under 1905(a)(7) of the Social Security Act or a waiver.

18. Programs or Activities No Longer Authorized by Law
Should any part of the scope of work under this Contract relate to a State program that is no longer authorized by law(e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), Contractor must do no work on that part after the effective date of the loss of program authority. The State will adjust capitation rates to remove costs that are specific to any program or activity that is no longer authorized by law. If Contractor works on a program or activity no longer authorized by law after the date the legal authority for the work ends, Contractor will not be paid for that work. If the state paid Contractor in advance to work on a no-longer-authorized program or activity and under the terms of this Contract the work was to be performedafter the date the legal authority ended, the payment for that work should be returned to the State. However, if Contractor worked on a program or activity prior to the date legal authority ended for that program or activity, and the State included the cost of performing that work in its payments to Contractor, Contractor may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

R. Program Integrity

1. The State, MDHHS-Office of Inspector General (OIG) is responsible for overseeing the program integrity activities of Contractor and all subcontracted entities.
2. 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, 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. 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 Contractor will monitor those activities.
c. 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. 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. 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. 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 Contractor 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 Contractor's employees.
    iii. A system for training and education for the Compliance Officer, Contractor's senior management, and 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's 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:
        1) Record review, including statistically valid random sampling and extrapolation to identify and recover overpayments made to providers
        2) Beneficiary interviews to confirm services rendered.
        3) Provider self-audit protocols.
        4) 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 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 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 network provider/subcontractors of Contractor

to both Contractor and the MDHHS-OIG. Dissemination of this information must be made to all Contractors network providers/subcontractors and members annually. Contractor must indicate that reporting of fraud, waste or abuse may be made anonymously.

3. Biannual meetings will be held between MDHHS-OIG and all Contractor Compliance Officers to train and discuss fraud, waste, and abuse.
4. Subcontracted Entities/Network Providers
   a. Contractor must include program integrity compliance provisions and guidelines in all contracts with subcontracted entities/network providers.
   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 Contractor of quarterly reports detailing program integrity compliance activities.
      iii. Assistance and guidance by 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 Contractor
      vii. Implementation of training procedures regarding fraud, waste, and abuse for the subcontracted entities' employees at all levels.
   c. Annually, Contractor must submit a list of subcontracted entities and network providers using the template created by MDHHS-OIG.
      i. 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 contracted to provide, and Provider email address(es).
5. Investigations
   a. 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, 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, 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.
6. Reporting Fraud, Waste, or Abuse
   a. Upon receipt of allegations involving fraud, waste, or abuse regardless of entity (i.e., Contractor, employee, subcontracted entity, network provider, or member), Contractor

must perform a preliminary investigation. Upon completion of the preliminary investigation, if 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), Contractor must promptly refer the matter to MDHHS-OIG. These referrals must be made using Contractor fraud referral template and be shared with MDHHS-OIG via secure File Transfer Process (sFTP) using Contractor's applicable MDHHS-OIG sFTP area. After reporting a potential credible allegation of fraud, 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 Contractor has sustained a documented loss, the State shall not be obligated to repay any monies recovered to Contractor.

b. Contractor must report all suspicion of waste or abuse on the Quarterly Submission described in Section R.8. 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.

7. Overpayments
   a. Contractor must report overpayments due to fraud, waste, or abuse to MDHHS-OIG.
      i. If Contractor identifies an overpayment involving potential fraud prior to identification by MDHHS-OIG, Contractor refers the findings to MDHHS-OIG and waits for further instruction from MDHHS-OIG prior to recovering the overpayment.
      ii. If Contractor identifies an overpayment involving waste or abuse prior to identification by MDHHS- OIG, Contractor must void or correct applicable encounters, should recover the overpayment, and must report the overpayment on its quarterly submission (see Section R.8. Quarterly Submissions below).
      iii. If a Network Provider identifies an overpayment, they must agree to:
         1) Notify Contractor, in writing, of the reason for the overpayment and the date the overpayment was identified.
         2) Return the overpayment to Contractor within 60 calendar days of the date the overpayment was identified.
   b. These overpayment provisions do not apply to any amount of a recovery to be retained under False Claims Act cases or through other investigations.
8. Quarterly Submissions
   a. 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. Contact terminations.

b. All program integrity activities performed each quarter must be reported to OIG according to Schedule E- Reporting Requirements.
c. 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. Contractor must include any improper payments identified and amounts adjusted in encounter data and/or overpayments recovered by 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.
        1) These encounters must be identified by Contractor and reported to MDHHS-OIG. MDHHS-OIG will record a gross adjustment to be taken out of Contractor’s next capitation payment.
    v. Report only corrected encounters associated with post payment evaluations that resulted in a determined overpayment amount.

9. 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, Contractor must, at minimum, apply the same sanction to the provider upon receipt of written notification of the sanction from MDHHS-OIG. Contractor may pursue additional measures/remedies independent of the State. If MDHHS OIG lifts a sanction, Contractor may elect to do the same.
10. 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, Contractor is required to comply with MDHHS-OIG’s requests for documentation and information related to program integrity and compliance.
11. Contractor Ownership and Control Interest
    a. Prohibited Relationships: In order to comply with 42 CFR 438.610, a Contractor may not knowingly have a relationship of the type described in paragraph (b) 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.
iii. An individual or entity that is excluded from participation in any Federal health care program under Section 1128 or 1128A of the Act.

b. The relationships described in paragraph (a) of this Section, are as follows:
i. A director, officer, or partner of Contractor.
ii. A subcontractor of Contractor, as governed by 42 CFR 438.230.
iii. A person with beneficial ownership of five percent (5%) or more of Contractor's equity.
iv. A network provider or person with an employment, consulting, or other arrangement with Contractor for the provision of items and/or services that are significant and material to Contractor's obligations under its Contract with the State.

c. “Excluded” individuals or entities that have been excluded from participating in the Medicare, Medicaid, or any other Federal health care programs. Bases for exclusion include convictions for program-related fraud, patient abuse, licensing board actions, and/or default on Health Education Assistance loans.

d. Ownership & Control Disclosures:
i. 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. Contractor must require provider entity disclosure of ownership and control information at the following intervals:
1) Provider enrollment.
2) Provider re-enrollment.
3) Whenever there is a change in ownership or control of the provider entity.
ii. Pursuant to 42 CFR 455.104: the State will review ownership and control disclosures submitted by Contractor and any of Contractor’s Subcontractors. Contractor is required to identify and report whether an individual or entity with an ownership or control interest in the disclosing entity is related to another individual with an ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling and/or whether the individual or entity with an ownership or control interest in any Subcontractor in which the disclosing entity has a five percent (5%) or more interest is related to another individual with ownership or control interest as a spouse, parent, child, or sibling. Contractor is also required to identify the name of any other disclosing entity in which an owner of the disclosing entity has an ownership or control interest.

e. Exclusions Monitoring:
i. At the time of provider enrollment or re-enrollment in Contractor’s provider network, Contractor must search the following databases to ensure that the provider entity, and any individuals with ownership or control interests in the provider entity (direct or indirect ownership of five percent (5%) or more or a managing employee), have not been excluded from participating in federal

health care programs.

1) Office of Inspector General's (OIG) exclusions database, which can be found at https://exclusions.oig.hhs.gov/. This list includes parties excluded from federal programs and may also be referenced as the "excluded parties lists" (EPLS).
2) The State of Michigan Sanctioned Provider list, which can be found at the following internet address: https://www.michigan.gov/mdhhs/doing-business/providers/providers/billingreimbursement/list-of-sanctioned-providers .
3) System for Award Management (SAM) information can be found in this contract under the Federal Provisions Addendum.

ii. Contractor must search the OIG exclusions database and the State of Michigan Sanctioned Provider list monthly to capture exclusions and reinstatements that have occurred since the last search, or at any time providers submit new disclosure information.

iii. Contractor must notify the MDHHS OIG immediately using the approved OIG reporting form and process if search results indicate that any of their network's provider entities, or individuals or entities with ownership or control interests in a provider entity are on the OIG exclusions database. Contractor must also provide notification to MDHHS OIG if it has taken any administrative action that limits a provider's participation in the Medicaid program.

S. Fiscal Audits and Compliance Examinations

1. Required Audit and Compliance Examination`
   Contractor must submit to the State, a Financial Statement Audit and a Compliance Examination as described below. Contractor must also submit a Corrective Action Plan for any audit or examination findings that impact State-funded programs, and the management letter (if issued) with a response.
2. Financial Statement Audit
   Contractor must submit to the State a Financial Statement Audit prepared in accordance with generally accepted auditing standards (GAAS).
3. Compliance Examination
   Contractor must submit a contract end date (September 30) Compliance Examination conducted in accordance with the American Institute of CPA's (AICPA's) Statements on Standards for Attestation Engagements (SSAE) 18 Attestation Standards – Clarification and Recodification AT-C Section 205, and the Compliance Examination Guidelines which can be found on the MDHHS website: https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/practiceguidelines.
4. Due Date and Where to Send
   The required Financial Statement Audit, Compliance Examination, and any other required submissions (i.e. Corrective Action Plan and management letter with a response) must be submitted to the State within 30 days after receipt of the practitioner's reports, but no later than June 30 following the Contract year end by e-mail to MDHHS-AuditReports@michigan.gov. The required materials must be assembled as one document in a PDF file compatible with Adobe Acrobat (read only). The subject line must state Contractor name and fiscal year end. The State reserves the right to request a hard copy of the materials if for any reason the electronic submission process is not successful.
5. Penalty
   If Contractor does not submit the required Financial Statement Audit, Compliance Examination, and applicable Corrective Action Plans by the due date and an extension has not been approved by the State, the State may withhold from the current funding an amount equal to 5% of the audit year's grant funding (not to exceed $200,000) until the required

filing is received by the State. The State may retain the amount withheld if Contractor is more than 120 days delinquent in meeting the filing requirements and an extension has not been approved by the State. This is a contract enforcement mechanism and not a sanction per Sec 232b of the Mental Health Code.

6. Management Decisions
   The State will issue a management decision on findings, comments, and questioned costs contained in Contractor Financial Statement Audit and Compliance Examination Report. The management decision relating to the Financial Statement Audit will be issued within six months after the receipt of a complete and final reporting package. The management decision relating to the Compliance Examination will be issued within eight months after the receipt of a complete and final reporting package. The management decision will include whether or not the finding or comment is sustained; the reasons for the decision, and the expected Contractor action to repay disallowed costs, make financial adjustments, or take other action. Prior to issuing the management decision, the State may request additional information or documentation from Contractor, including a request for practitioner verification or documentation, as a way of mitigating disallowed costs. The appeal process available to Contractor relating to the State management decisions on Compliance Examination findings, comments, and disallowed costs can be found on the MDHHS website: https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/practiceguidelines.
7. Other Audits
   The State or federal agencies may also conduct or arrange for additional audits to meet their needs.
8. Reviews and Audits
   a. The State and federal agencies may conduct reviews and audits of Contractor regarding performance under this Contract. The State will make good faith efforts to coordinate reviews and audits to minimize duplication of effort by Contractor and independent auditors conducting audits and compliance examinations.
   b. These reviews and audits will focus on Contractor compliance with State and federal laws, rules, regulations, policies, and waiver provisions, in addition to Contract provisions and Contractor policy and procedure.
   c. The State reviews and audits will be conducted according to the following protocols, except when conditions appear to be severe and warrant deviation or when State or federal laws supersede these protocols.
      i. State Reviews
         1) As used in this Section, a review is an examination or inspection by the State or its agent, of policies and practices, in an effort to verify compliance with requirements of this Contract.
         2) The State will schedule onsite reviews at mutually acceptable start dates to the extent possible, with the exception of those reviews for which advance announcement is prohibited by rule or federal regulation, or when the deputy director for the Health Care Administration determines that there is demonstrated threat to consumer health and welfare or substantial threats to access to care.
         3) Except as precluded in Standard Contract Terms 31. Disclosure of Litigation, or Other Proceeding above, the protocol and/or instrument to be used to review Contractor, or a detailed agenda if no protocol exists, will be provided to Contractor at least 30 days prior to the review.
         4) At the conclusion of the review, the State will conduct an exit conference with Contractor. The purpose of the exit conference is to allow the State to present the preliminary findings and recommendations.

5) Following the exit conference, the State will generate a report within 45 days identifying thefindings and recommendations that require a response by Contractor.
    a) Contractor will have 30 days to provide a Correction Action Plan (CAP) for achieving compliance. Contractor may also present new information to the Statethat demonstrates it was in compliance with the questioned provisions at the time of the review. (New information can be provided anytime between the exit conference and the CAP). When access or care to individuals is a serious issue, Contractor may be given a much shorter period to initiate corrective actions, and this condition may be established, in writing, as part of the exit conference identified in (d) above. If,during a State on-site visit, the site review team member identified an issue that placesa participant in imminent risk to health or welfare, the site review team would invoke animmediate review and response by Contractor, which must be completed in seven calendar days.
    b) The State will review the CAP, seek clarifying or additional information from Contractor as needed, and issue an approval of the CAP within 30 days of havingrequired information from Contractor. The State will take steps to monitor Contractor's implementation of the CAP as part of performance monitoring.
    c) The State will protect the confidentiality of the records, data and knowledge collectedfor or by individuals or committees assigned a peer review function in planning the process of review and in preparing the review or audit report for public release.
6) State follow-up will be conducted to ensure that remediation of out-of-compliance issues occur within 90 days after the CAP is approved by the State.

ii. State Audits
1) The State and/or federal agencies may inspect and audit any financial records of the entity or its network provider/subcontractors. As used in this Section, an audit is an examination of Contractor's and its contract service providers' financial records, policies, contracts, and financial management practices, conducted by the MDHHS Bureau of Audit, or its agent, or by a federal agency or its agent, to verify Contractor's compliance with legal and contractual requirements.
2) The State will schedule State audits at mutually acceptable start dates to the extent possible. The State will provide Contractor with a list of documents to be audited at least 30 days prior to the date of the audit. An entrance meeting will be conducted with Contractor to review the nature and scope of the audit.
3) State audits of Contractor will generally supplement the independent auditor’s Compliance Examination and may include one or more of the following objectives (the State may, however, modify its audit objectives as deemed necessary):
    a) to assess Contractor’s effectiveness and efficiency in complying with the Contract and establishing and implementing specific policies and procedures as required by the Contract; and
    b) to assess Contractor’s effectiveness and efficiency in reporting their financial activity to the State in accordance with Contractual requirements: applicable federal, State, and local statutory requirements;

Medicaid regulations; and applicable accounting standards; and

c) to determine the State's share of costs in accordance with applicable State requirements and agreements, and any balance due to/from Contractor.

4) To accomplish the above listed audit objectives, State auditors will review Contractor's documentation,interview Contractor staff members, and perform other audit procedures as deemed necessary. The audit report and appeal process can be found on the MDHHS website: https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/practiceguidelines.

9. Financial Management System
   a. 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. Contractor must comply with generally accepted accounting principles (GAAP) for government units when preparing financial statements. Contractor and their network providers/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 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 Contractor must ensure consistent treatment of costs across different funding sources and assure proper allocation to costs to the appropriate source. Contractor must comply with the Standard Cost Allocation (SCA) methodology established by MDHHS when assigning the fund source and ensure subcontractors comply with SCA methodology.
   c. 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.

1.1 Transition

A. See Section 26 Transition Responsibilities of the Standard Contract Terms.
B. If this Contract is canceled or expires and is not renewed, the following will take effect:
   1. Within 45 days following the end date of this Contract, Contractor must provide interim financial, performance, and other reports as required.
   2. Within two years following the end date of this Contract, Contractor must provide final financial, performance, and other reports as required.
   3. Payment for any and all valid claims for services rendered to covered beneficiaries prior to the effective end date are the responsibility of Contractor.
   4. The portion of all Medicaid Internal Service Fund (ISF), Medicaid Savings, and any other reserves, and related interest, held by Contractor that were funded with the State's funds are owed to the State within 90 days, less amounts needed to cover outstanding claims or liabilities, unless otherwise directed in writing by the State.
   5. Reconciliation of equipment with a value exceeding $5,000, purchased by Contractor or its provider network with funds provided under this Contract, since January 1, 2015, will occur as part of settlement of this Contract. Contractor must submit, to the State, an inventory of equipment meeting the above specifications within 45 days of the end date. The inventory listing must identify the current value and proportion of Medicaid funds used to purchase each item, and whether or not the equipment is required by

Contractor as part of continued service provision to the continuing service population. The State will provide written notice within 90 days or less of any needed settlements concerning the portion of funds ending. If Contractor disposes of the equipment, the appropriate portion of the value must be returned to the State (or used to offset costs in the final financial report).

6. All financial, administrative, and clinical records under Contractor's responsibility must be retained according to the retention schedules in place by the Department of Technology, Management and Budget's (DTMB) General Schedule #20 at: https://www.michigan.gov/dtmb/-/media/Project/Websites/dtmb/Services/Records-Management/RMS_GS20.pdf?rev=9df833feb31e40c9a7438d5c4ef711f1&hash=DC32AC21A9F07F49855DB2B2550D7E10 unless these records are transferred to a successor organization or Contractor is directed otherwise in writing by the State.

1.2 Specific Standards

A. IT Policies, Standards and Procedures (PSP)

All services and products provided as a result of this contract must comply with all applicable State IT policies and standards. Contractor is required to review all applicable links provided below and ensure compliance.

Public IT Policies, Standards and Procedures (PSP):
DTMB - IT Policies, Standards & Procedures (michigan.gov)

B. Acceptable Use Policy

To the extent that Contractor has access to the State's computer system, Contractor must comply with the State's Acceptable Use Policy, see 1340.00.130.02 Acceptable Use of Information Technology (michigan.gov). All Contractor Personnel will be required, in writing, to agree to the State's Acceptable Use Policy before accessing the State's system. The State reserves the right to terminate Contractor's access to the State's system if a violation occurs.

C. SOM Digital Standards

All software items provided by Contractor must adhere to the State of Michigan Application/Site Standards which can be found at www.michigan.gov/standards.

D. ADA Compliance

The State is required to comply with the Americans with Disabilities Act of 1990 (ADA) and has adopted standards and procedures regarding accessibility requirements for websites and software applications. All websites, applications, software, and associated content and documentation provided by Contractor as part of the Solution must comply with Level AA of the World Wide Web Consortium (W3C) Web Content Accessibility Guidelines (WCAG) 2.0.

1.3 Hosting

Contractor must maintain and operate a backup and disaster recovery plan to achieve a Recovery Point Objective (RPO) (maximum amount of potential data loss in the event of a disaster) of 24 hours, and a Recovery Time Objective (RTO) (maximum period of time to fully restore the Hosted Services in the case of a disaster) of 24 hours.

2. Staffing, Organizational Structure, Governing Body, and Subcontractors

2.1. Contractor Representative

Contractor must appoint individuals, specifically assigned to State of Michigan accounts, that will respond to State inquiries regarding the Contract Activities, answering questions related to ordering and delivery, etc. (the "Contractor Representative").

2.2. Customer Service Toll-Free Number

Contractor must specify its toll-free number for the State to make contact with Contractor Representative. Contractor Representative must be available for calls during the hours of 8:00 a.m. to 5:00 p.m. EST.

2.3. Work Hours

Contractor must provide Contract Activities during the State's normal working hours Monday – Friday, 8:00 a.m. to 5:00 p.m. EST, and possible night and weekend hours depending on the requirements of the project.

2.4. Key Personnel

A. Contractor must appoint individuals who will be directly responsible for the day-to-day operations of the Contract ("Key Personnel"). Key Personnel must be specifically assigned to the State account, be knowledgeable on the contractual requirements, and respond to State inquires within 48 hours.
B. Administrative Personnel Requirements
    1. Contractor must employ or contract with sufficient administrative staff to comply with all program standards and applicable Mental Health Code requirements. At a minimum, Contractor must specifically staff positions listed below:
        a. Executive director/chief executive officer.
        b. Medical director.
        c. Quality improvement director.
        d. Chief financial officer.
        e. Chief information officer.
        f. Compliance officer.
        g. Grievance and appeals coordinator.
    2. Contractor must ensure all staff have appropriate training, education, experience, appropriate licensure and liability insurance coverage to fulfill the requirements of the position.
        a. Contractor must assure that all Contract employees receive annual training in recipient rights protection. Contractor must forward any recipient rights complaints filed against a Contract employee to MDHHS-ORR for review and possible investigation.
    3. Resumes for all staff listed above must be provided to the State upon request. Resumes must include detailed, chronological work experience.
C. Executive Personnel
    1. Contractor must inform the State, in writing, within seven days of vacancies or staffing changes for the staff listed above.
    2. Contractor must fill vacancies for the staff listed above with qualified persons within six months of the vacancy unless an extension is granted by the State.

2.5. Criminal Background Checks

A. Contractor (or network provider/subcontractor), in accordance with the general purposes and objectives of this Contract, must ensure that each direct-hire or contractually employed individual health care staff and/or practitioner meets all background checks, applicable licensing, scope of practice, contractual, and Medicaid Provider Manual (MPM) requirements.
B. Contractor must:
    1. Conduct a search that reveals information substantially similar to information found on an Internet Criminal History Access Tool (ICHAT) check and a national and state sex offender registry check for each new employee, subcontractor, subcontractor employee, or volunteer (including students and interns) who works under this Contract.
        a. ICHAT: https://apps.michigan.gov/
        b. Michigan Public Sex Offender Registry: https://mspsor.com/

c. National Sex Offender Registry: https://www.nsopw.gov/

2. Conduct a Central Registry (CR) check for each new employee, subcontractor, subcontractor employee, or volunteer (including students and interns) who under this Contract works directly with children.
   a. Central Registry: https://www.michigan.gov/mdhhs/0,5885,7-339-73971_7119_50648_48330-180331--,00.html
3. Require each new employee, subcontractor, subcontractor employee, or volunteer (including students and interns) who works under this Contract, works directly with enrollees, or who has access to enrollee information to notify Contractor in writing of criminal convictions (felony or misdemeanor), pending felony charges, or placement on the CR as a perpetrator, at hire or within ten (10) days of the event after hiring.
4. Use information from the Medicaid Provider Manual (General Information for Providers; Section 6 – Denial of Enrollment, Termination and Suspension; Item 6.1 – Termination or Denial of Enrollment) and the Social Security Act (Subsection 1128(a)(b)), to determine whether to prohibit any employee, subcontractor, subcontractor employee, or volunteer (including students and interns) from performing work directly with enrollees or accessing enrollee information related to enrollees under this Contract, based on the results of a positive ICHAT response, reported criminal felony conviction, or perpetrator identification.
5. Use information from the Medicaid Provider Manual (General Information for Providers; Section 6 – Denial of Enrollment, Termination and Suspension; Item 6.1 – Termination or Denial of Enrollment) and the Social Security Act (Subsection 1128(a)(b)), to determine whether to prohibit any employee, subcontractor, subcontractor employee or volunteer (including students and interns)from performing work directly with children under this Contract, based on the results of a positive CR response or reported perpetrator identification.

2.6. Organizational Chart/Contractor Organizational Structure

Contractor must provide annually a current organizational chart that lists staff members and subcontractors, by name and title. (see Schedule E for submission information). Contractor must maintain an administrative and organizational structure that supports a high quality, comprehensive managed care program inclusive of all behavioral health specialty services. Contractor's management approach and organizational structure must ensure effective linkages between administrative areas including provider network service, customer service, service area network development, quality improvement and utilization review, grievance/complaint review, financial management and health information systems. Effective linkages are determined by outcomes that reflect coordinatedmanagement.

2.7. Use of Subcontractors

A. 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 as specified in 42 CFR 438.230.
B. In accordance with 42 CFR 434.6 and 42 CFR 438.230 the term “subcontract(s)” includes contractual agreements between Contractor and any other entity, including a provider, that performs any function or service for Contractor related to securing or fulfilling 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. Engaging in provider network development
   2. Health Benefit Managers (HBMs) – entities that arrange for the provision of health

services covered under this Contract.

3. 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. 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. Contractor shall be held fully liable and retain full responsibility for the performance and completion of all Contract requirements regardless of whether Contractor performs the work or subcontracts for services. 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 Contractor and subcontractor must take corrective action on any identified deficiencies or areas of improvement.

F. 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. Contractor must fulfill the requirements of 42 CFR 438.230 by ensuring 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/practiceguidelinesfor 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, 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, 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 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. 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. Contractor must incorporate all subcontractors' data into 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, 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 Contractor delegates network development responsibilities to a subcontractor including a CMHSP, the subcontracts must address the following, in accordance with 42 CFR 438.230:
   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 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. Network Providers right to discuss treatment options with a recipient that may not reflect Contractor's position or may not be covered by Contractor.
   14. Network Providers 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, Contractor must establish payment rates for plan covered items and services that apply to deemed providers. Contractor may vary payment rates for providers in accordance with 42 CFR422.4(a)(3).
   1. Providers must be reimbursed on a fee-for-service basis.
   2. Contractor must make information on its payment rates available to providers that furnish services that may be covered under Contractor’s private fee-for-service plan.
   3. 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. 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, 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, Contractor must provide to CMS, and to any Medicaid beneficiary, the information specified in 42 CFR 422.210.
b. 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, 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. 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
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). 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 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. Project Management

3.1. Reporting

A. Release of Report Data
    1. Written Approval

Contractor must obtain the State's written approval prior to publishing or making formal public presentations ofstatistical or analytical material based on its beneficiaries other than as required by this Contract, statute or regulations. The State is the owner of all data made available by the State to Contractor or its agents, network providers/subcontractors or representatives under the Contract.

2. Acceptable Use of State Data
   Contractor must not use the State's data for any purpose other than providing the Services to beneficiaries covered by Contractor under any Contract or Program, nor will any part of the State's data be disclosed, sold, assigned, leased or otherwise disposed of to the general public or to specific third parties or commerciallyexploited by or on behalf of Contractor. No employees of Contractor, other than those on a strictly need-to-know basis, have access to the State's data, except as provided by law.
3. Acceptable Use of Personally Identifiable Data
   a. Contractor must not possess or assert any lien or other right against the State's data. Without limiting the generality of this Section, Contractor must only use personally identifiable information as strictly necessary to provide the Services to beneficiaries covered by Contractor under any Contract or Program and must disclose the information only to its employees on a strict need-to-know basis.
   b. Contractor must always comply with all laws and regulations applicable to the personally identifiable information.
4. Acceptable Use of Contractor Data
   The State is the owner of all State-specific data under the Contract. The State may use the data provided by Contractor for any purpose. The State will not possess or assert any lien or other right against Contractor's data.Without limiting the generality of this Section, the State may use personally identifiable information only as strictly necessary to utilize the Services and must disclose the information only to its employees on a strict need-to-know basis, except as provided by law. Other material developed and provided to the State remains the State's sole and exclusive property.

B. Uniform Data and Reporting
   1. To measure Contractor's accomplishments in the areas of access to care, utilization, service outcomes, recipient satisfaction, and to provide sufficient information to track expenditures and calculate future capitation rates, Contractor must provide the State with uniform data and information as specified by the State as previously agreed, and such additional or different reporting requirements (with the exemption of those changes required by federal or state law and/or regulations) as the parties may agree upon from time to time. Any changes in the reporting requirements, required by state and federal law, will be communicated to Contractor at least 90 days before they are effective unless state or federal law requires otherwise. Both parties must agree to other changes, beyond routine modifications, to the data reporting requirements.
   2. Contractor's timeliness in submitting required reports and their accuracy will be monitored by the State and will be considered by the State in measuring the performance of Contractor. Regulations promulgated pursuant to the Balance Budget Act of 1997 (BBA) require that the CEO or designee certify the accuracy of the data.
   3. Contractor must cooperate with the State in carrying out validation of data provided by Contractor by making available recipient records and a sample of its data and data collection protocols. Contractor must certify that the data they submit are accurate, complete and truthful. An annual certification from, and signed by, the chief executive officer or the chief financial officer, or a designee who reports directly to either must be submitted annually. The certification must attest to the accuracy, completeness, and truthfulness of the information in each of the sets of data in this Section.

4. The State and Contractor agree to use the Encounter Data Integrity Group (EDIT) for the development of instructions with costing related to procedure codes, and the assignment of Medicaid and non-Medicaid costs. The recommendations from the EDIT group have been incorporated into Schedule E (see Mental Health and Substance Use Disorder Reporting Requirements website at: https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/reporting .
5. Encounter Data Reporting
   In order to assess quality of care, determine utilization patterns and access to care for various health care services, affirm capitation rate calculations and estimates, Contractor must submit encounter data containing detail for eachrecipient encounter reflecting all services provided by Contractor. Encounter records must be submitted monthly via electronic media in the HIPAA-compliant format specified by the State. Encounter level records must have a common identifier that will allow linkage between the State's and Contractor's health information systems.
6. Encounter Data Reporting Requirements
   a. Due dates: Encounter data are due within 30 days following adjudication of the claim for the service provided, or in the case of a Contractor whose business practices do not include claims payment, within 30 days following the end of the month in which services were delivered. It is expected that encounter data reported will reflect services for which providers were paid (paid claims), third party reimbursed, and/or any services provided directly by Contractor. Submit the encounter data for an individual on any claims adjudicated, regardless of whether there are still other claims outstanding for the individual for the month in which service was provided. In order that the State can use the encounter data for its federal and State reporting, it must have the count of units of service provided to each consumer during the fiscal year. Therefore, the encounter data for the fiscal year must be reconciled within 90 days of the end of the fiscal year. Claims for the fiscal year that are not yet adjudicated by the end of that period, should be reported as encounters with a monetary amount of "0." Once claims have been adjudicated, a replacement encounter must be submitted.
   b. Who to Report: Contractor must report the encounter data for all mental health and developmental disabilities (MH/DD) Medicaid beneficiaries in its entire service area for all services provided under the State's benefit plans. Contractor must report the encounter data for all substance use disorder Medicaid beneficiaries in its service area. Encounter data is collected and reported for every beneficiary for which a claim was adjudicated, or service rendered during the month by Contractor (directly or via contract) regardless of payment source or funding stream. Contractor's and CMHSPs that contract with another Contractor or CMHSP to provide mental health services should include that consumer in the encounter data set. In those cases, Contractor or CMHSP that provides the service via a contract should not report the consumer in this data set. Likewise, Contractor or CMHSPs that contract directly with a Medicaid Health Plan, or subcontract via another entity that contracts with a Medicaid Health Plan to provide the Medicaid mental health outpatient benefit, should not report the consumer in this data set.
   c. The Health Insurance Portability and Accountability Act (HIPAA) mandates that all consumer level data reported after October 16, 2002, must be compliant with the transaction standards.
      i. A summary of the relevant requirements is:
         1. Encounter data (service use) is to be submitted electronically on a Health Care Claim form 837,version 5010.

2. The encounter requires a small set of specific demographic data: gender, diagnosis, Medicaid number, race, and social security number, and name of the consumer.
3. Information about the encounter such as provider name and identification number, place of service, and amount paid for the service is required.
4. The 837 includes a “header” and “trailer” that allows it to be uploaded to the CHAMPS system.
5. Every behavioral health encounter record must have a corresponding Behavioral Health Registry record reported prior to the submission of the Encounter. Failure to report a registry record prior to submitting an encounter for a consumer receiving services will result in the encounter being rejected by the CHAMPS system.

d. The information on HIPAA contained in this Contract relates only to the data that the State is requiring for its own monitoring and/or reporting purposes and does not address all aspects of the HIPAA transaction standards with which Contractor must comply for other business partners (e.g., providers submitting claims, or third-party payers). Further information is available at: https://www.michigan.gov/mdhhs/doing-business/providers/hipaa.
e. Data that is uploaded to CHAMPS must follow the HIPAA-prescribed formats for encounter data. The 837/5010 includes header and trailer information that identifies the sender and receiver and the type of information being submitted. If data does not follow the formats, entire files could be rejected by the electronic system.
f. HIPAA also requires that procedure codes, revenue codes and modifiers approved by the CMS be used for reporting encounters. Those codes are found in the most recent edition of the Current Procedural Terminology (CPT) Manual, published by the American Medical Association, the Health Care Financing Administration Common Procedure Coding System (HCPCS), the National Drug Codes (NDC), the Code on Dental Procedures and Nomenclature (CDPN), the International Classification of Diseases, Tenth Revision, Clinical Modification (IICD-10-CM), ICD-10 and the Michigan Uniform Billing Manual. The procedure codes in these coding systems require standard units that must be used in reporting on the 837/5010.
g. The State has produced a code list of covered Medicaid specialty and HSW, CWP and SEDW supports and services names (as found in the Medicaid Provider Manual) and the CPT or HCPCS codes/service definition/units as soon as the majority of mental health services have been assigned CPT or HCPCS codes. This code list is available on the MDHHS web site: https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/reporting
h. Stored encounter data will be subject to regular and ongoing quality checks as developed by the State. The State will give Contractor a minimum of 60 days’ notice prior to the implementation of new quality data edits; however, the State may implement informational edits without 60 days’ notice. When encounter corrections are needed, the encounters are to be voided and replaced. The original encounter record number (Claim Number) is to be included when encounter records are voided and resubmitted.
i. The following elements reported on the 837/5010 encounter format will be used by the State for Federal and State reporting, Contract Management, and Actuarial Services. The items with an ** are required by HIPAA, and when they are absent will result in rejection of a file. Items with an ** must have 100% of values recorded within the acceptable range of values. Failure to meet accuracy standards on

these items may result in Contract action. Refer to HIPAA 837 transaction implementation guides for exact location of the elements. Contractor must consult the HIPAA implementation guides, and clarification documents (on MDHHS's web site) for additional elements required of all 837/5010 encounter formats. The Supplemental Instructions contain field formats and specific instructions on how to submit encounter level data.

ii. **1.a. PIHP Plan Identification Number (PIHPID or PIHP CA Function ID)
The State-assigned 7-digit payer identification number must be used to identify Contractor with all data transactions.

iii. 1.b. CMHSP Plan Identification Number (CMHID)
The State-assigned 7-digit payer identification number must be used to identify the CMHSP with all mental health and/or developmental disabilities transactions.

iv. **2. Identification Code/Subscriber Primary Identifier (see the details in the submitter's manual)
Ten-digit Medicaid number must be entered for a Medicaid or MIChild beneficiary. If the consumer is not a beneficiary, enter the nine-digit Social Security number. If consumer has neither a Medicaid number nor a Social Security number, enter the unique identification number assigned by the CMHSPor CONID.

v. **3. *Identification Code/Other Subscriber Primary Identifier* (please see the details in the submitter'smanual)
Enter the consumer's unique identification number (CONID) assigned by the CMHSP regardless ofwhether it has been used above.

vi. **4. *Date of birth*
Enter the date of birth of the beneficiary/consumer.

vii. ***5. Diagnosis*
Enter the ICD-10 primary diagnosis of the consumer.

viii. ***6. EPSDT*
Enter the specified code indicating the child was referred for specialty services by the EPSDTscreening.

ix. ***7. Encounter Data Identifier*
Enter specified code indicating this file is an encounter file.

x. ***8. Line Counter Assigned Number*
A number that uniquely identifies each of up to 50 service lines per claim.

xi. ***9. Procedure Code*
Enter procedure code from code list for service/support provided. The code list is located on theMDHHS web site. Do not use procedure codes that are not on the code list.

xii. **10. Procedure Modifier Code*
Enter modifier as required for Habilitation Supports Waiver services provided to beneficiaries; for Autism Benefit services under EPSDT; for Community Living Supports and Personal Care levels ofneed; for Nursing Home Monitoring; and for evidence-based practices. See Costing per Code List.

xiii. **11. Monetary Amount* :
Enter the charge amount, paid amount, adjustment amount (if applicable), and adjustment code inclaim information and service lines. (See https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/reporting).
Click on Instructions for Reporting Financial Information – 837 Encounters; then click Instructions for Reporting Financial Information)

xiv. ***12. Quantity of Service*

Enter the number of units of service provided according to the unit code type. Only whole numbersshould be reported.

xxiv. *Place of Service Code*
Enter the specified code for where the service was provided, such as an office, inpatient hospital, etc.(See PIHP/CMHSP Encounter Reporting Costing Per Code and Code Chart at https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/reporting.)

xxv. *Diagnosis Code Pointer*
Points to the diagnosis code at the claim level that is relevant to the service.

xxvi. ***15. Date Time Period*
Enter date of service provided (how this is reported depends on whether the Professional, or theInstitutional format is used).

xxvii. ***16. Billing Provider Name*
Enter the name of the Billing Provider for all encounters. (See Instructions for Reporting Financial Information – 837 Encounters; Instructions for Reporting Financial Information at https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/reporting.)If the Billing Provideris a specialized licensed residential facility, also report the LARA license facility number (See Instructions for Reporting Specialized Residential Facility Details at https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/reporting Click on Instructions for Reporting Financial Information – 837 Encounters; LARA License Reporting).

xxviii. ***17. Rendering Provider Name*
Enter the name of the Rendering Provider when different from the Billing Provider (See Instructions forReporting Financial Information – 837 Encounters; Instructions for Reporting Financial Information at https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/reporting.)

xxix. 18. *Facility Location of the Specialized Residential Facility*
In instances in which the specialized licensed residential facility is not the Billing Provider, report thename, address, NPI (if applicable) and LARA license of the facility in the Facility Location (2310C loop). (See Instructions for Reporting Financial Information – 837 Encounters; LARA Licensing Reporting at https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/reporting.)

xxx. ***19. Provider National Provider Identifier (NPI), Employer Identification Number (EIN) or Social Security Number (SSN)* Enter the appropriate identification number for the Billing Provider, and asapplicable, the Rendering Provider. (See Instructions for Reporting Financial Information – 837 Encounters; Instructions for Reporting Financial Information at https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/reporting.)

7. Reporting Requirements for Behavioral Health Treatment Episode Data Set (BH-TEDS)
   a. Technical specifications, including file formats, error descriptions, edit/error criteria, and explanatory materialson record submission are located on MDHHS's website at: https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/reporting.)
   b. Reporting covered by these specifications includes the following:
      i. BH-TEDS Start Records (due monthly)
      ii. BH-TEDS Discharge/Update/End Records (due monthly)
      iii. BH-TEDS Crisis Event Q record (due monthly)
   c. Basis of Data Reporting

The basis for data reporting policies for Michigan behavioral health includes:

i. Federal funding awarded to Michigan through the Combined SABG/MHBG Behavioral Health federal block grant.
ii. SAMHSA's Behavioral Health Services Information Systems (BHSIS) award agreement administered through Eagle Technologies, Inc that awards the State a contracted amount of funding if the data meet minimum timeliness, completeness and accuracy standards.
iii. Legislative boilerplate annual reporting and semi-annual updates

d. Policies and Requirements Regarding Data

BH TEDS Data reporting will encompass Behavioral Health services provided to persons supported in whole or in part with MDHHS-administered funds.

i. Policy:
Reporting is required for all persons whose services are paid in whole or in part with State administered funds regardless of the type of co-pay or shared funding arrangement made for the services.
ii. For purposes of State reporting, an admission, or start, is defined as the formal acceptance of a client into behavioral health services. An admission or start has occurred if and only if the person begins receiving behavioral health services.
    1) Data definitions, coding and instructions issued by the State apply as written. Where a conflict or difference exists between the State definitions and information developed by Contractor or locally contracted data system consultants, the State definitions are to be used.
    2) All SUD data collected and recorded on BH-TEDS must be reported using the proper Michigan Department of Licensing and Regulatory Affairs (LARA) substance use disorder services site license number. LARA license numbers are the primary basis for recording and reporting data to the State at the program level.
    3) There must be a unique person identifier number assigned to each individual. It must be 11 characters in length, and alphanumeric. This same number must be used to report data for BH-TEDS and encounters for the individual within Contractor's service region. It is recommended that a method be established by Contractor and funded programs to ensure that each individual is assigned the same identification number regardless of how many times he/she enters services in any program in the service area, and that the client number be assigned to only one individual.
    4) Any changes or corrections made on Contractor on forms or records submitted by the program must be made on the corresponding forms and appropriate records maintained by the program. Each Contractor and its programs must establish a process for making necessary edits and corrections to ensure identical records. Contractor is responsible for making sure records at the State level are also corrected via submission of change records in data uploads.
    5) Contractor must make corrections to all records that are submitted but fail to pass the error checking routine. All records that receive an error code are placed in an error master file and are not included in the analytical database. Unless acted upon, they remain in the error file and are not removed by the State.
    6) Contractor is responsible for generating each month's data upload to the State consistent with established protocols and procedures. Monthly data

uploads must be received by the State via the DEG no later than the last day of the following month.

7) Contractor must communicate data collection, recording and reporting requirements to local providers as part of the contractual documentation. Contractor may not add to or modify any of the above to conflict with or substantively affect State policy and expectations as contained herein.
8) Statements of the State's policy, clarifications, modifications, or additional requirements may be necessary and warranted. Documentation will be forwarded accordingly.

e. Method for submission
BH-TEDS data are to be submitted in a fixed length format, per the file specifications.

f. Due dates
BH TEDS data are due monthly. Contractor is responsible for generating each month's data upload to the State consistent with established protocols and procedures. Monthly data uploads must be received by the State via the DEG no later than the last day of the following month.

g. Who to report
Contractor must report BH-TEDS data for all individuals with mental health, intellectual/developmental disabilities, and substance use disorders who receive services funded in whole or in part with the State's administered funding. If Contractor is participating in the Medicare/Medicaid integration project, Contractor must not report BH-TEDS records for beneficiaries for whom Contractor's financial responsibility is to a non-contracted provider during the 180-day continuity of care.

8. Coordination of Benefits information is required based on current CMS managed care rules and MDHHS encounter reporting specifications.

C. Ad Hoc Reporting
Notwithstanding the provisions of 3.1.B.1., the State may request from Contractor, on an ad hoc basis, reporting to ascertain compliance with provisions of this agreement. These requests will allow a minimum of 30 days for preparation and submission unless a different time frame is agreed to by all parties.

D. Reports and Annual Appropriation Boilerplate Requirements
Contractor must submit timely reports on annual appropriation boilerplate requirements.

E. 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. 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. 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 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. Contractor may not add a credibility adjustment to a calculated MLR if the MLR reporting year experience is fully credible. If Contractor experience is non-credible, it is presumed to meet or exceed the MLR calculation standards.
6. 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 Contractor.
8. Contractor is not required to make a remittance if it does not meet the minimum MLR standard of 85 percent or higher.
9. Contractor must require any subcontractor providing claims adjudication activities to provide all underlying data associated with MLR reporting to Contractor within 180 days of the end of the MLR reporting year or within 30 days of being requested by 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, 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, Contractor must submit a new MLR report meeting the applicable requirements.
11. Contractor must attest to the accuracy of the calculation of the MLR in accordance with the MLR standards when submitting required MLR reports.

F. Finance Planning, Reporting and Settlement
1. The final expenditure report must reflect incurred, but not paid claims. Contractor must provide financial reportson forms and formats specified by the State. Forms and instructions are posted to the State website at: https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/reporting (See Financial Planning, Reporting and Settlement Section of Schedule E).
2. Contractor must comply with:

a. Governmental Accounting Standards Board (GASB) standards for Generally Accepted Accounting Principles
b. Audit and Accounting Guide: State and Local Governments, current edition, by AICPA
c. 2 CFR 200 Subpart E

G. Public Health Reporting
PA 368 of 1978 requires that health professionals comply with specified reporting requirements for communicable diseaseand other health indicators. Contractor must ensure compliance with all such reporting requirements through its provider contracts.

H. 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 Contractor and/or CMHSPs, 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 Contractor or directly with a subcontractor, including a CMSHP). This information is due to MDHHS annually upon request. Contractor must ensure all network providers comply with the MDHHS cost reporting survey process and MDHHS cost reporting policy.

4. Internal Service Fund (ISF)

The establishment of an ISF is one method for securing funds as part of the overall strategy for covering risk exposure. The ISF fund balance should be kept at a minimum to assure that the overall level of Contractor funds is directed toward consumer services. Requirements for an ISF are below:

A. Contractor must establish an ISF.

B. The purpose of the ISF is to ensure that Contractor has a reserve of funds to pay any liabilities that Contractor may incur in a future year that are in excess of 100% of the risk corridor-related operating budget for which Contractor is financial responsible, as described in Section 7, Risk Corridor. For example, as specified in Subsection 7(C), a Contractor is financially responsible for liabilities incurred between 100% and 105% of the risk corridor-related operating budget, and Contractor may use funds in the ISF to pay those liabilities in future years. Contractor may use funds in the ISF only for this defined purpose of paying for liabilities in excess of the 100% of the risk corridor-related operating budget. Contractor may not use funds in the ISF to pay liabilities incurred in previous years.

C. Contractor may transfer Medicaid Capitation funds up to 7.5% of the Medicaid/Healthy Michigan Plan pre-payment authorization to the ISF in any given year. Contractor may not transfer any funds in excess of that percentage to the ISF in any year.

D. The ISF must only be used for the defined purpose and not be used to finance any activities or costs other than ISF eligible expenses.

E. All programs exposed to the risk corridor must be charged their proper share of the ISF charges to the extent that those programs are covered for the risk of financial loss. Such charges must be allocated to the various programs/cost categories based on the relative proportion of the total contractual obligation, actual historical cost experience, or reasonable historical cost assumptions. If actual historical cost experiences or reasonable historical cost assumptions are used, they must cover, at a minimum, the most recent two years in which the books are closed.

F. A set of self-balancing accounts must be maintained for the ISF in compliance with generally accepted accounting principles (GAAP).

G. The amount of funds paid to the ISF will be determined in compliance with reserve requirements as defined by GAAP and applicable federal and State financing provisions contained in the State/Contractor Contract.

H. To establish an adequate funding level to cover risk corridor requirements (e.g., to pay

liabilities incurred between 100% and 105% of the risk corridor-related operating budget in a future year), Contractor may make payments up to the lesser of: (1) the total potential liability relative to the risk corridor and the overall risk management strategy of Contractor's operating budget; or (2) the risk reserve requirements and the applicable financing provisions contained in the State/Contractor Contract.

I. Contractor must establish a policy and procedure for increasing payments to the ISF in the event that it becomes inadequate to cover future losses and related expenses.
J. Payments to the ISF must be based on either actuarial principles, actual historical cost experiences, or reasonable historical cost assumptions, pursuant to the provisions of 2 CFR 200 sub part E. If actual historical cost experiences or reasonable historical cost assumptions are utilized, they must cover, at a minimum, the most recent two years in which the books have been closed.
K. If the ISF becomes over-funded, it must be reduced within one fiscal year through the abatement of current charges or, if such abatements are inadequate to reduce the ISF to the appropriate level, it must be reduced through refunds in accordance with 2 CFR 200 Subpart E Cost Principles.
L. Upon Contract cancelation or expiration, any funds remaining in the ISF and all of the related claims and liabilities must be transferred to the new contractor that encompasses the existing Contractor's service area. When existing Contractor's geographic service area overlaps more than one new contractor service area, the State will provide the percentage allocation to each new contractor.

5. Authorizing Document

The appropriate authorizing document for services will be this Contract.

6. Contractor Risk Management Strategy

A. Risk Management Strategy
Each Contractor must define the components of its risk management strategy that is consistent with general accounting principles as well as federal and State regulations.
B. Contractor Assurance of Financial Risk Protection
1. Contractor must provide, to the State, upon request, documentation that demonstrates financial risk protections sufficient to cover Contractor's determination of risk. Contractor must update this documentation any time there is a change in the information.
2. Contractor may use one or a combination of measures to assure financial risk protection, including pledged assets, reinsurance, and creation of an ISF. The use of an ISF must be consistent with the requirements of Section 4 of the State/Contractor Contract with the State.
3. Contractor must submit a specific written Risk Management Strategy to the Department (see Schedule E). The Risk Management strategy will identify the amount of reserves, insurance and other revenues to be used by Contractor to assure that its risk commitment is met. Whenever General Funds are included as one of the listed revenue sources, the State may disapprove the list of revenue sources, in whole or in part, after review of the information provided and a meeting with Contractor. Such a meeting will be convened within 45 days after submission of the risk management strategy. If disapproval is not provided within 60 days following this meeting, the use of General Funds will be considered to be allowed. Such disapproval will be provided in writing to Contractor within 60 days of the first meeting between the State and Contractor. Should circumstances change, Contractor may submit a revision to its Risk Management Strategy at any time. The State will provide a response to this revision,

when it changes Contractor's intent to utilize General Funds to meet its risk commitment, within 30 days of submission.

7. Risk Corridor

The shared risk arrangements must cover all MMSSSP Programs. The risk corridor is administered across all services, with noseparation for mental health and substance abuse funding.

A. Contractor must retain unexpended risk-corridor-related funds between 95% and 100% of said funds. Contractor must retain 50% of unexpended risk-corridor related funds between 90% and 95% of said funds. Contractor must return unexpended risk-corridor-related funds to the MDHHS between 0% and 90% of said funds and 50% of the amount between 90% and 95%.
B. Contractor may retain funds as noted above, except as specified in Section 1.1.D. Transition.
C. Contractor must be financially responsible for liabilities incurred above the risk corridor-related operating budget between 100% and 105% of said funds contracted.
D. Contractor will be responsible for 50% of the financial liabilities above the risk corridor-related operating budget between 105% and 110% of said funds contracted.
E. Contractor will not be financially responsible for liabilities incurred above the risk corridor-related operating budget over 110% of said funds contracted.
F. The risk corridor is calculated on an annual basis. The only expenditures counted in calculating the risk corridor are those incurred for services delivered in, or other allowable activities performed attributable to, the applicable year for which the risk corridor is being calculated. The only revenue counted in calculating the risk corridor is revenue paid to Contractor for the applicable year for which the risk corridor is being calculated.
G. Contractor's transfer of funds to the ISF shall be treated as an expenditure by Contractor for purposes of calculating unexpended risk-corridor-related funds.
H. The assumption of a shared-risk arrangement between Contractor and the State will not permit Contractor to overspend its total operating budget for any fiscal year.
I. Contractor must not pass on, charge, or in any manner shift financial liabilities to Medicaid beneficiaries resulting from Contractor financial debt, loss and/or insolvency.
J. Contractor's financial responsibility for liabilities for costs between 100% and 110% must first be paid from Contractor's Internal Service Fund (ISF) for risk funding or insurance for cost over-runs. The ISF balance must be tracked by Medicaid and Healthy Michigan funds contributed. Each portion of the ISF must retain its character as Medicaid and Healthy Michigan Funds but may be used for risk financing across the Medicaid and Healthy Michigan programs. Medicaid ISF amounts may be used for Medicaid or Healthy Michigan cost over runs into the risk corridor and Healthy Michigan ISF amounts may be used for Medicaid or Healthy Michigan cost over runs into the risk corridor.
K. If Contractor's liability exceeds the amount available from ISF and insurance, then other funding available to Contractor may be utilized in accordance with the terms of Contractor's Risk Management Strategy.
L. General Restrictions

   Use of funds held in the ISF must be restricted to the following:

   1. Contractor must restrict the use of the ISF to the defined purpose specified in Section 4, Internal Service Fund. No expenses from this fund will be match able-only the payments to the ISF will be match able. No other expenses may be paid from the ISF.
   2. Contractor may invest ISF funds in accordance with statutes regarding investments (e.g., Mental Health Code 330.1205, Sec. 205(g)), provided that Contractor does not use ISF funds in a manner inconsistent with the purpose of the ISF set out in Section 4 of the State/Contractor Contract with the State.)The earnings from the investment of ISF funds must be used to fund the risk reserve requirements of the ISF in accordance with Section 4 of the contract.

3. The ISF may not loan or advance funds to any departments, agencies, governmental funds, or other entities in accordance with 2 CFR 200 Subpart E.
4. Funds paid to the ISF must not be used to meet federal cost sharing or used to match federal or State funds pursuant to 2 CFR 200 Subpart E.
5. State funds paid to the ISF must retain its character as State funds in accordance with the Mental Health Code and must not be used as local funds.

M. General Accounting Standards

The ISF must be established and accounted for in compliance with the following standards:

1. Generally accepted accounting principles (GAAP).
2. GASB Statement No. 10, Accounting and Financial Reporting for Risk Financing and Related Insurance Issues, or other current standards.
3. 2 CFR 200 Subpart E, Cost Principles, or other current standards.
4. Other financing provisions contained in the State/Contractor Contract.
5. The financial requirements set forth in the 1115 and 1915 (i) Waiver.

N. Financing

The State will immediately notify Contractor of modifications in funding commitments in this Contract under the following conditions:

1. Action by the Michigan State Legislature or by the Center for Medicare and Medicaid Services that removes any State funding for, or authority to provide for, specified services.
2. Action by the Governor pursuant to the Constitution 1963, Article 5, Section 20 that removes the State's funding for specified services or that reduces the State's funding level below that required to maintain services on a statewide basis.
3. A formal directive by the Governor, or the Michigan Department of Technology, Management and Budget (DTMB) on behalf of the Governor, requiring a reduction in expenditures.

8. Payment Terms

A. Contract Financing

1. Contractor must accept transfers of all reserve accounts and related liabilities accumulated by Contractor that formerly operated within the current Contractor's geographic service area. Contractor must accept transfer of all liabilities accumulated by Contractor that formerly operated within Contractor's geographic service area that were incurred and paid on behalf of the new Contractor as start-up costs.
2. Local Obligation
    a. Contractor must provide to the State, for deposit into a separate contingency account, local funds as authorized in the State Appropriations Act. These funds must not include either State funds received by a CMHSP for services provided to non-Medicaid recipients or the State matching portion of the Medicaid capitation payments made to a CMHSP or an affiliation of CMHSPs. The amount of local funds and payment schedule is included in Schedule G. In the event Contractor is unable to provide the required local obligation, Contractor must notify the State's Program Manager immediately.
    b. Local financial obligations exclude grants or gifts received by the county, Contractor, or subcontractors, from an individual or agency contracting to provide services to Contractor.
        i. An exception may be made, where Contractor can demonstrate that such funds constitute a transfer of grants or gifts made for the purposes of financing mental health services and are not made possible by Contractor payments to the network provider/subcontractor that are claimed as matchable expenses for the purpose of state financing.
    c. The following are potential revenue sources for the local obligation:

i. Appropriations of general county funds to Contractor by the County Board of Commissioners.
ii. Appropriations of funds to Contractor or its network provider/subcontractor by cities or townships.
iii. Funds raised by fee-for-service subcontractors and/or network providers as part of the network provider's/subcontractor's contractual obligation, the intent of which is to satisfy and meet the local match obligation of Contractor, as reflected in this Contract.
iv. Grants, bequests, donations, gifts from local non-governmental sources, charitable institutions or individuals.
    1) gifts that specify the use of the funds for any particular individual identified by name or relationship may not be used as local match funds.
v. Funds of participating CMHSPs from the Community Mental Health Special Fund Account, consistent with Section 226a of the Michigan Mental Health Code.
    1) Federal Supplemental Security Income (SSI) does not qualify for use under Section 226a of the Michigan Mental Health Code.
vi. Interest earned on funds deposited or invested by or on behalf of Contractor, except as otherwise restricted by 2 CFR 200 Subpart E.
    1) Interest earned on the State's funds by subcontractors and/or network providers as specified in its contracts with Contractor may not be used as local obligation.
vii. Other Revenues for Mental Health Services - As long as the source of revenue is not federal or State funds, revenues from other county departments/funds (such as childcare funds) or revenues from public or private school districts for Contractor mental health services.

B. State Funding

The State's funding includes MMSSSP and the Flint 1115 Waiver. The financing in this Contract is always contingent on the annual Appropriation Act. CMHSPs within a PIHP may, but are not required to, use General Funds to provide services not covered under MMSSSP or underwrite a portion of the cost of covered services to these beneficiaries. The State reserves the right to disallow such use of General Funds if it believes that the CMHSP was not appropriately assigning costs in order to maximize the savings allowed within the risk corridors. Specific financial detail regarding the State funding is provided in Schedules G and H.

1. Medicaid Payments

The State will provide to Contractor both the State and federal share of Medicaid funds as a capitated payment based upon a per eligible per month (PEPM) methodology. The State will provide access to an electronic copy of the names of the Medicaid eligible people for whom a capitation payment is made. A PEPM payment is determined for each of the populations covered by this Contract, which includes services for people with a developmental disability, a mental illness or emotional disturbance, and people with a substance use disorder as reflected in this Contract. PEPM payment is made to Contractor for all beneficiaries in its service area, not just those with the above-named diagnoses. The actual number of Medicaid beneficiaries will be determined monthly, and Contractor will be notified of the beneficiaries in their service area when the payment is made.

a. Medicaid Rate Calculation

The Medicaid Rate Calculation is based on the actuarial documentation letter from

the State's contracted Medicaid Actuarial Services Vendor. The State's contracted Medicaid Actuarial Services Vendor letter documents the calculation rate methodology and provides the required certification regarding actuarial soundness as required by the Balanced Budget Act Rules effective August 13, 2002. The chart of rates and factors contained in the actuarial documentation is included in Schedule H.

b. Medicaid Payments
The State will provide Contractor with managed care payments each month for the Medicaid covered specialty services listed under the Benefit Plan (BP). When applicable, additional payments may be scheduled (e.g., retro-rate implementation and up to six months retro eligibility). HIPAA compliant 834 and 820 transactions will provide eligibility and remittance information. Monthly payment will include:
    i. Base Rates for each Benefit Plan (BHMA, BHMA-MHP, BHHMP, BHHMP-MHP, HSW-MC**, SED-MC, CWP-MC)
    **For HSW beneficiaries of a PIHP that includes the county of financial responsibility (COFR), referred to as the "responsible PIHP", but whose county of residence is in another PIHP, referred to as the "residential PIHP", the HSW capitation payment will be paid to the COFR within the "responsible PIHP" based on the multiplicative factor for the "residential PIHP".
    ii. Recovery of payments previously made for beneficiaries prior to MDHHS notification of death.
    iii. Recovery of payments previously made for beneficiaries, who upon retrospective review, did not meet all the Benefit Plan enrollment requirements.

Contractor must be able to receive and transmit HIPAA compliant files, such as:
    i. 834 – Eligibility
    ii. 820 – Payment/Remittance Advice
    iii. 837 – Encounter

c. Medicaid State Plan Payments
The capitation payment excludes individuals enrolled in a Program for All Inclusive Care (PACE) organization, individuals incarcerated, and individuals with a Medicaid deductible.

d. Savings and Reinvestment
Provisions regarding the Medicaid, Healthy Michigan Plan, and the Flint 1115 Waiver savings and Contractor reinvestment strategy are included in the following Section e. It should be noted that only a PIHP may earn and retain Medicaid/Healthy Michigan Plan savings. CMHSPs may not earn or retain Medicaid/Healthy Michigan Plan savings. Note that these provisions may be limited or canceled per Schedule A, Statement of Work, Section 1.1 Transition and may be modified by actions stemming from Schedule A, General Requirements, Section 1.D Contract Remedies and Sanctions.

e. Medicaid Savings
Consistent with Section 7("Risk Corridor") of the contract, Contractor may retain unexpended Medicaid Capitation funds up to 7.5% of the Medicaid/Healthy Michigan Plan pre-payment authorization. The Contractor may not retain any unexpended Medicaid Capitation funds in excess of that 7.5%. The unexpended and retained funds described in this paragraph are hereafter referred to as "Medicaid Savings funds." These Medicaid saving funds may only be used on Medicaid service expenditures made within one (1) year of the end of the Contract

year in which the Medicaid savings fund were realized. Any Medicaid savings funds not spent consistent with the previous sentence must be returned to the state within 60 days of the end of the contract year settlement process.

2. Habilitation Supports Waiver (HSW) Payments
    a. The 1915(c) HSW capitation payment will be made to Contractor based on HSW beneficiaries who have enrolled through the State enrollment process and have met the following requirements:
        i. Has a developmental disability as defined by Michigan law.
        ii. Is Medicaid eligible as defined in the CMS approved waiver.
        iii. Is residing in a community setting.
        iv. Otherwise eligible for Intermediate Care Facilities for individuals with Intellectual Disability (ICF/IID) level of care services.
    b. Beneficiaries enrolled in the HSW Program may not be enrolled simultaneously in any other 1915(c) waiver programs, such as the Children's Waiver Program (CWP) and Serious Emotional Disturbance Waiver (SEDW). The capitation payment excludes individuals who reside, for an entire month, in any of the following: ICF/IID, Nursing Home, Child Caring Institution (CCI), or who are incarcerated. HSW capitation payments exclude individuals who are enrolled in a PACE organization. The HSW capitation payment will be scheduled and/or adjusted to occur monthly. When applicable, additional payments may be scheduled.
    c. Encounters for provision of services authorized in the CMS approved waiver must contain the appropriate modifier to be recognized as valid HSW encounters. Encounters must be processed and submitted on time, as defined in Section N. Provider Services, 7. Claims Management System and the Reporting Requirements (see Schedule E), in order to assure timely HSW service verification.
3. The Children's Waiver Program (CWP) Payments
    a. The 1915(c) CWP capitation payment will be made to Contractor based on CWP beneficiaries who have enrolled through the State's enrollment process and have met the following requirements:
        i. Has a developmental disability as defined by Michigan law.
        ii. Is Medicaid eligible as defined in the CMS approved waiver.
        iii. Is residing in a community setting.
        iv. eligible for Intermediate Care Facilities for individuals with Intellectual Disability (ICF/IID) level of care services
    b. Beneficiaries enrolled in the CWP may not be enrolled simultaneously in any other 1915(c) waiver programs, such as the Habilitation Supports Waiver (HSW) and Serious Emotional Disturbance Waiver (SEDW). The capitation payment excludes individuals who reside, for an entire month, in any of the following: ICF/IID, Nursing Home, Child Caring Institution (CCI), or who are incarcerated. CWP capitation payments exclude individuals who are enrolled in a PACE organization. The CWP capitation payment will be scheduled and/or adjusted to occur monthly. When applicable, additional payments may be scheduled.
    c. Encounters must be processed and submitted on time, as defined in Section N. Provider Services, 7. Claims Management System and the Reporting Requirements in order to assure timely CWP service verification.
4. Serious Emotional Disturbance Waiver Payments
    a. The SEDW capitation payment will be made to Contractor based on SEDW beneficiaries who have enrolled through the MDHHS enrollment process.

Beneficiaries enrolled in the SEDW may not be enrolled simultaneously in any other 1915(c) waiver programs, such as the Children's Waiver Program (CWP) and HSW. The capitation payment excludes individuals who reside, for an entire month, in any of the following: ICF/IID, Nursing Home, Child Caring Institution (CCI), or who are incarcerated. The SEDW capitation payment will be scheduled and/or adjusted to occur monthly. When applicable, additional payments may be scheduled.

b. Encounters must be processed and submitted on time, as defined in Section N. Provider Services, 7. Claims Management System and the Reporting Requirements in order to assure timely CWP service verification.

5. Expenditures for MMSSSP and the Flint 1115 Waiver.
   a. Contractor may expend any funds received for MMSSSP. All funds must be spent on Medicaid beneficiaries for Medicaid services. Surplus funding in either Medicaid or Healthy Michigan may be utilized to cover a funding deficit in either program. If a deficit still exists, the Medicaid or Healthy Michigan Plan risk reserve may be utilized. Medicaid or HMP risk reserve can fund a deficit in either program. The surplus funds must be used before the ISF can be utilized.
   b. While there is flexibility in month-to-month expenditures and service utilization related to the different funding sources in MMSSSP, Contractor must submit encounter data on service utilization - with transaction code modifiers that identify the service for each specific MMSSSP program. The encounter data (including cost information) will serve as the basis for future MMSSSP capitated rate development.
6. Capitated Payments and Other Pooled Funding Arrangements
   Medicaid funds may be utilized for the implementation of, or continuing participation in, locally established multi- agency pooled funding arrangements developed to address the needs of beneficiaries served through multiple public systems. Medicaid funds supplied or expensed to such pooled funding arrangements must reflect the expected cost ofcovered Medicaid services for Medicaid beneficiaries participating in or referred to the multi-agency arrangement or project. Medicaid funds cannot be used to supplant or replace the service or funding obligation of other public programs.
7. OHH Payments
   The State will provide a monthly case rate to Contractor based on the number of OHH beneficiaries with at leastone OHH service during a calendar month. Contractor will reimburse the OHHP for delivering health home services. Depending on the current services provided by the OHH Contractor can negotiate a rate with the OHHP while following the guidelines below, requirements in the approved SPA, MDHHS OHH Bulletin MSA 20-31 and the OHH Handbook.
8. BHH Payments
   The State will provide a monthly case rate to Contractor based on the number of BHH beneficiaries with at least one BHH service during a calendar month. Contractor will reimburse the HHP for delivering health home services.Depending on the current services provided by the HHP, Contractor can negotiate a rate with the HHP for value-based payment (VBP) while following the requirements in the approved SPA, policy, and the BHH Handbook.
9. Premium Pay Hourly Wage Increase for Direct Care Workers (DCW)
   a. Based on current year appropriations, MDHHS has implemented a wage increase for direct care workers, to be included on an ongoing basis. This applies to MDHHS programs and service codes as identified in MSA L Letters. The L Letters can be found on the MDHHS website : https://www.michigan.gov/mdhhs/doing-business/providers/providers/medicaid/communicationtraining/173142 Contractor

must implement the hourly wage increase, with MDHHS providing increased capitation rates to cover the actual cost of these mandatory pay increases. Contractor must disperse these funds to eligible contracted providers employing individuals that qualify for the increase.

b. As this is a base wage increase, Contractor must ensure that the full amount of funds appropriated for a direct care worker wage increase is provided to direct care workers through sustained increased wages. Agencies will be provided with a per-hour amount to cover additional costs related to implementing the increase.
c. DCW wage increase funding will be a component of monthly capitation payments made to Contractor. 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.
d. All wage increase payments are subject to audit and potential recoupment. Providers must retain documentation that demonstrates the distribution of payments to eligible staff.

10. MDHHS Incentive Payment
    a. For the PIHPs to be eligible for an incentive payment, the child must meet the following requirements:
        i. To receive the MDHHS Incentive Payment, the child must meet the following eligibility criteria:
            1) Have a Serious Emotional Disturbance as defined by Michigan Law.
            2) Eligible for Medicaid.
            3) Between the ages of 0 to 18.
            4) Be served in the MDHHS Foster Care System or Child Protective Services (Risk Categories I and II)
            5) Meet one of the following criteria:
                a) Service Criteria 1: At least one of the following services was provided in the eligible month:
                    1. H2021 – Wraparound Services
                    2. H0036 – Home Based Services
                    3. H2033 - Multi-Systemic Therapy (MST) for juveniles
                b) Service Criteria 2: Two or more state plan behavioral health services covered under the 1115 Demonstration Waiver, excluding one-time assessments, were provided in the eligible month.
        ii. Incentive Payments: The incentive payment will occur quarterly. Each incentive payment will be determined by comparing the PIHP's identified eligible children with the encounter data submitted. Valid encounters must be submitted within 90 days of the provision of the service regardless of the claim adjudication status in order to assure timely incentive payment verification. Once the incentive payment has taken place there will not be any opportunities for submission of eligible children for a quarterly payment already completed.
        iii. Quarterly incentive payments will occur as follows:
            1) April: Based on eligible children and the supporting encounter data submitted for October 1 – December 31.
            2) July: Based on eligible children and the supporting encounter data submitted for January 1 – March 31.
            3) October: Based on eligible children and the supporting encounter data submitted for April 1 – June 30.
            4) January: Based on eligible children and the supporting encounter

data submitted for July 1 –September 30.

iv. The State will provide access to an electronic copy of the names of those individuals eligible for incentive payments, which incentive payment amount they are to receive, and the COFR.

v. PIHPS are expected to provide a one-page annual narrative report by each CMHSP in their Region summarizing how the MDHHS incentive payment is directly supporting mental health services for children involved in child welfare. This report will be due at the same time as the CAFAS/PECFAS annual reporting for the MDHHS Incentive. The PIHP shall also include the total amount of annual MDHHS DHIP incentive funding they received and total amount and percentage that they passed down to CMHSPs. If the amount was less than 85% of the total amount received, please provide an explanation.

11. CCBHC Payments

Per the requirements of the CMS CCBHC Demonstration, Contractor will receive from the State the equivalent of the CMS-approved PPS-1 rate for each Medicaid CCBHC-eligible service day. A portion of this PPS rate is included in the overall capitation rate, and the remainder provided in a supplemental payment. The CCBHC supplemental payment will be made to Contractor based on CCBHC beneficiaries who have been enrolled through the MDHHS WSA/CHAMPS enrollment process. One component of this supplemental payment reflects that estimated difference between the PPS rate and the amount included in the capitation rates based on anticipated utilization of CCBHC services for Medicaid beneficiaries. The State will also incorporate an amount for CCBHC administration in this supplemental payment based on projected total CCBHC demonstration costs. The State and Contractor will reconcile to the number of daily visits delivered by the CCBHC to ensure the full PPS payment can be provided to the CCBHC. Contingent on the availability of State General Funds or other grant funding, the State will provide Contractor with an annual payment and/or prospective payments based on anticipated utilization to offset the costs of non-Medicaid CCBHC services. Contractor's liability to the CCBHC's non-Medicaid individuals served is limited to the State General Funds and/or other grant funds earmarked for services to a CCBHC eligible population. To the extent that modifications to the CCBHC Handbook conflict with this contract, the contract language shall govern.

C. MIChild

The State will provide the federal and matching share of MIChild funds as a capitated payment based upon actuariallysound Per Enrolled Child Per Month (PECPM) methodology for MIChild-covered mental health services. The MIChild capitation payment will be scheduled and/or adjusted to occur monthly. When applicable, additional payments may bescheduled.

D. Contractor Performance Bonus

Contract withholds and the Performance Bonus Incentive Program have been established to support program initiatives as specified in the MDHHS Medicaid Quality Strategy. Awards will be made to Contractors according to criteria established by the State. Criteria for Performance Bonus awards will include, but is not limited to, assessment of performance in quality of care, access to care and administrative functions. Each year, the State will establish and communicate to Contractor the criteria and standards to be used for the performance bonus awards.

1. Withhold Arrangements

a. The State will withhold 0.2% of BHMA, BHMA-MHP, capitation payments to Contractor. The withheld funds will be issued to Contractor in the following amounts within 60 days of when the required report is received by the State:

i. 0.03% for timely submission of the Projection Financial Status Report – Medicaid
ii. 0.03% for timely submission of the Interim Financial Status Report – Medicaid
iii. 0.04% for timely submission of the Final Medicaid Contract Reconciliation and Cash Settlement
iv. 0.04% for timely submission of the Encounter Quality Initiative
v. 0.03% for timely submission of encounters (defined in Schedule E)
vi. 0.03% for timely resolution of corrective action plans. Scoring metric will be available on the MDHHS reporting requirements website located at https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/reporting.

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 Contractor's results from the joint metrics, the narrative report, and 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 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:
      1) Contractor-only Pay for Performance Measure(s): 45%
      2) Contractor Narrative Reports: 25%
      3) MHP/Contractor Joint Metrics: 30%
      4) The State will distribute earned funds by April 30 of each year.

c. Opioid Health Home (OHH) Benefit
   The State will withhold 5% of monthly case rate payments to Contractor for potential pay for performance (P4P) award payments for OHHPs meeting or exceeding performance benchmarks. This withhold is outside of the actuarial equivalent monthly case rate. The methodology for determining P4P payment, including the metrics, specifications, and distribution is cited in the OHH Handbook, which can be found at the following website: https://www.michigan.gov/mdhhs/assistance-programs/medicaid/opioid-health-home. If awarded, the State will distribute P4P payments to Contractor within one (1) year of the end of the performance year. Contractor must distribute P4P monies to OHHPs that meet the quality improvement benchmarks in accordance with the distribution methodology cited in the OHH Handbook. OHH P4P funding awarded to Contractor will be treated as restricted local funding. Restricted local funding must be utilized for the benefit of the public behavioral health system.

d. Behavioral Health Home (BHH) Benefit
   The State will withhold 5% of monthly case rate payments to Contractor for potential pay for performance (P4P) award payments for BHHPs meeting or exceeding performance benchmarks. This withhold is outside of the actuarial equivalent monthly case rate. The methodology for determining P4P payment, including the metrics, specifications, and distribution is cited in the BHH Handbook, which can be found at the following website:

https://www.michigan.gov/mdhhs/assistance-programs/medicaid/behavioral-health-home. If awarded, the State will distribute P4P payments to Contractor within one (1) year of the end of the performance year. Contractor must distribute pay for performance monies to BHHPs that meet the quality improvement benchmarks in accordance with the distribution methodology cited in the BHH Handbook. BHH P4P funding awarded to Contractor will be treated as restricted local funding. Restricted local funding must be utilized for the benefit of the public behavioral health system.

e. Certified Community Behavioral Health Center (CCBHC) Demonstration Quality Bonus Payment (QBP)
The State will withhold 5% of the CCBHC benefit plan capitation payments for potential CCBHC QBP award payments for CCBHCs that meet or exceed federally defined QBP measures and benchmarks. This withhold is outside of the actuarial equivalent PPS-1 rate payment. The methodology for determining QBP payment, including the metrics, specifications, and distribution is cited in the CCBHC Handbook, which can be found at the following website: https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/ccbhc. QBP funding awarded to Contractor will be treated as restricted local funding. Restricted local funding must be utilized for the benefit of the public behavioral health system.

SCHEDULE B- HIPAA BUSINESS ASSOCIATE AGREEMENT

Contract No. MA 230000001246
Prepaid Inpatient Health Plan (PIHP)

HIPAA BUSINESS ASSOCIATE AGREEMENT

The parties to this Business Associate Agreement ("Agreement") are the Michigan Department of Health and Human Services and Northern Michigan Regional Entity.

RECITALS

A. Under this Agreement, the Business Associate will collect or receive certain information on the Covered Entity's behalf, some of which may constitute Protected Health Information ("PHI"). In consideration of the receipt of PHI, the Business Associate agrees to protect the privacy and security of the information as set forth in this Agreement.

B. Covered Entity and the Business Associate intend to protect the privacy and provide for the security of PHI collected or received by the Business Associate under the Agreement in compliance with the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA") and the HIPAA Rules, as amended.

C. The HIPAA Rules require the Covered Entity to enter into an agreement containing specific requirements with the Business Associate before the Business Associate's receipt of PHI.

AGREEMENT

1. Definitions.

a. The following terms used in this Agreement have the same meaning as those terms in the HIPAA Rules: Breach; Data Aggregation; Designated Record Set; Disclosure; Health Care Obligations; Individual; Minimum Necessary; Notice of Privacy Practices; Protected Health Information; Required by Law; Secretary; Security Incident; Security Measures, Subcontractor; Unsecured Protected Health Information, and Use.

b. "Business Associate" has the same meaning as the term "business associate" at 45 CFR 160.103 and regarding this Agreement means Northern Michigan Regional Entity.

c. "Covered Entity" has the same meaning as the term "covered entity" at 45 CFR 160.103 and regarding this Agreement means the Michigan Department of Health and Human Services.

d. “HIPAA Rules” means the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

2. Obligations of Business Associate.

Business Associate agrees to:

a. use and disclose PHI only as permitted or required by this Agreement or as required by law.

b. implement and use appropriate safeguards, and comply with Subpart C of 45 CFR 164 regarding electronic protected health information, to prevent use or disclosure of PHI other than as provided in this Agreement. Business Associate must maintain, and provide a copy to the Covered Entity within 10 days of a request from the Covered Entity, a comprehensive written information privacy and security program that includes security measures that reasonably and appropriately protect the confidentiality, integrity, and availability of PHI relative to the size and complexity of the Business Associate’s operations and the nature and the scope of its activities.

c. report to the Covered Entity within 24 hours of any use or disclosure of PHI not provided for by the Agreement of which it becomes aware, including breaches of Unsecured Protected Health Information as required by 45 CFR 164.410, and any Security Incident of which it becomes aware. If the Business Associate is responsible for any unauthorized use or disclosure of PHI, it must promptly act as required by applicable federal and State laws and regulations. Covered Entity and the Business Associate will cooperate in investigating whether a breach has occurred, to decide how to provide breach notifications to individuals, the federal Health and Human Services’ Office for Civil Rights, and potentially the media.

d. ensure, according to 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, that any subcontractors that create, receive, maintain, or transmit PHI on behalf of the Business Associate agree to the same restrictions, conditions, and requirements that apply to the Business Associate regarding such information. Each subcontractor must sign an agreement with the Business Associate containing substantially the same provisions as this Agreement and further identifying the Covered Entity as a third party beneficiary of the agreement with the subcontractor. Business Associate must implement and maintain sanctions against subcontractors that violate such restrictions and conditions and must mitigate the effects of any such violation.

e. make available PHI in a Designated Record Set to the Covered Entity within 10 days of a request from the Covered Entity to satisfy the Covered Entity’s obligations under 45 CFR 164.524.

f. within ten days of a request from the Covered Entity, amend PHI in a Designated Record Set under, 45 § 164.526. If any individual requests an amendment of PHI directly from the Business Associate or its agents or subcontractors, the Business Associate must notify the Covered Entity in writing within ten days of the request and amend the information within twenty days of the request. Any denial of amendment of PHI maintained by the Business Associate or its agents or subcontractors is the responsibility of the Business Associate. § 164.526.

g. maintain, and within ten days of a request from the Covered Entity make available, the

information required to provide an accounting of disclosures to enable the Covered Entity to fulfill its obligations under 45 CFR § 164.528. Business Associate is not required to provide an accounting to the Covered Entity of disclosures: (i) to carry out treatment, payment or health care operations, as set forth in 45 CFR § 164.506; (ii) to individuals of PHI about them as set forth in 45 CFR § 164.502; (iii) under an authorization as provided in 45 CFR § 164.508; (iv) to persons involved in the individual's care or other notification purposes as set forth in 45 CFR § 164.510; (v) for national security or intelligence purposes as set forth in 45 CFR § 164.512(k)(2); (vi) to correctional institutions or law enforcement officials as set forth in 45 CFR § 164.512(k)(5); (vii) as part of a limited data set according to 45 CFR 164.514(e); or (viii) that occurred before the compliance date for the Covered Entity. Business Associate agrees to implement a process that allows for an accounting to be collected and maintained by the Business Associate and its agents or subcontractors for at least six years before the request, but not before the compliance date of the Privacy Rule. At a minimum, such information must include: (i) the date of disclosure; (ii) the name of the entity or person who received PHI and, if known, the address of the entity or person; (iii) a brief description of PHI disclosed; and (iv) a brief statement of purpose of the disclosure that reasonably informs the individual of the basis for the disclosure or a copy of the written request for disclosure. If the request for an accounting is delivered directly to the Business Associate or its agents or subcontractors, the Business Associate must, within ten days of the receipt of the request, forward it to the Covered Entity in writing.

h. to the extent the Business Associate is to carry out one or more of the Covered Entity's obligations under Subpart E of 45 CFR Part 164, comply with the requirements of Subpart E that apply to the Covered Entity when performing those obligations.

i. make its internal practices, books, and records relating to the Business Associate's use and disclosure of PHI available to the Secretary for purposes of determining compliance with the HIPAA Rules. Business Associate must concurrently provide to the Covered Entity a copy of any PHI that the Business Associate provides to the Secretary.

j. retain all PHI throughout the term of the Agreement and for a period of six years from the date of creation or the date when it last was in effect, whichever is later, or as required by law. This obligation survives the termination of the Agreement.

k. implement policies and procedures for the final disposition of PHI and the hardware and equipment on which it is stored, including but not limited to, removal of PHI before re-use.

l. within ten days of a written request by the Covered Entity, the Business Associate and its agents or subcontractors must allow the Covered Entity to conduct a reasonable inspection of the facilities, systems, books, records, agreements, policies and procedures relating to the use or disclosure of PHI under this Agreement. Business Associate and the Covered Entity will mutually agree in advance upon the scope, timing and location of such an inspection. Covered Entity must protect the confidentiality of all confidential and proprietary information of the Business Associate to which the Covered Entity has access during the course of such inspection. Covered Entity and the Business Associate will execute a nondisclosure agreement, if requested by the other party. The fact that the Covered Entity inspects, or fails to inspect, or has the right to inspect, the Business Associate's facilities, systems, books, records, agreements, policies and procedures does not relieve the Business Associate of its responsibility to comply with this Agreement. Covered Entity's (i) failure to detect or (ii) detection, but failure to notify Associate or require Associate's remediation of any

unsatisfactory practices, does not constitute acceptance of such practice or a waiver of the Covered Entity's enforcement rights under this Agreement.

3. Permitted Uses and Disclosures by the Business Associate.

a. Business Associate may use or disclose PHI:

(1) for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate; provided, however, either (A) the disclosures are required by law, or (B) the Business Associate obtains reasonable assurances from the person to whom the information is disclosed that the information will remain confidential and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached;

(2) as required by law.

(3) for Data Aggregation services relating to the health care operations of the Covered Entity;

(4) to de-identify, consistent with 45 CFR 164.514(a) – (c), PHI it receives from the Covered Entity. If the Business Associates de-identifies the PHI it receives from the Covered Entity, the Business Associate may use the de-identified information for any purpose not prohibited by the HIPAA Rules; and

b. Business Associate agrees to make uses and disclosures and requests for PHI consistent with the Covered Entity's minimum necessary policies and procedures.

c. Business Associate may not use or disclose PHI in a manner that would violate Subpart E of 45 CFR Part 164 if done by the Covered Entity except for the specific uses and disclosures described above in 3(a)(i) and (iii).

4. Covered Entity's Obligations

Covered entity agrees to:

a. use its Security Measures to reasonably and appropriately maintain and ensure the confidentiality, integrity, and availability of PHI transmitted to the Business Associate under this Agreement until the PHI is received by the Business Associate.
b. provide the Business Associate with a copy of its Notice of Privacy Practices and must notify the Business Associate of any limitations in the Notice of Privacy Practices of the Covered Entity under 45 CFR 164.520 to the extent that such limitation may affect the Business Associate's use or disclosure of PHI.
c. notify the Business Associate of any changes in, or revocation of, the permission by an individual to use or disclose the individual's PHI to the extent that such changes may affect the Business Associate's use or disclosure of PHI.
d. notify the Business Associate of any restriction on the use or disclosure of PHI that the Covered Entity has agreed to or is required to abide by under 45 CFR 164.522 to the extent that such restriction may affect the Business Associate's use or disclosure of PHI.

5. Term. This Agreement continues in effect until terminated or is replaced with a new agreement between the parties containing provisions meeting the requirements of the HIPAA Rules, whichever first occurs.

6. Termination.

a. Material Breach. In addition to any other provisions in the Agreement regarding breach, a breach by the Business Associate of any provision of this Agreement, as determined by the Covered Entity, constitutes a material breach of the Agreement and provides grounds for the Covered Entity to terminate this Agreement for cause. Termination for cause is subject to 6.b.:

(1) Default. If the Business Associate refuses or fails to timely perform any of the provisions of this Agreement, the Covered Entity may notify the Business Associate in writing of the non-performance, and if not corrected within thirty days, the Covered Entity may immediately terminate the Agreement. The Business Associate must continue performance of the Agreement to the extent it is not terminated.

(2) Business Associate's Duties. Notwithstanding termination of the Agreement, and subject to any directions from the Covered Entity, the Business Associate must protect and preserve property in the possession of the Business Associate in which the Covered Entity has an interest.

(3) Erroneous Termination for Default. If the Covered Entity terminates this Agreement under Section 6(a) and after such termination it is determined, for any reason, that the Business Associate was not in default, then such termination will be treated as a termination for convenience, and the rights and obligations of the parties will be the same as if the Agreement had been terminated for convenience.

b. Reasonable Steps to Cure Breach. If the Covered Entity knows of a pattern of activity or practice of the Business Associate that constitutes a material breach or violation of the Business Associate's obligations under the provisions of this Agreement or another arrangement and does not terminate this Agreement under Section 6(a), then the Covered Entity must notify the Business Associate of the pattern of activity or practice. The Business Associate must then take reasonable steps to cure such breach or end such violation, as applicable. If the Business Associate's efforts to cure such breach or end such violation are unsuccessful, the Covered Entity may either (i) terminate this Agreement, if feasible or (ii) report the Business Associate's breach or violation to the Secretary.

c. Effect of Termination. After termination of this Agreement for any reason, the Business Associate, with respect to PHI it received from the Covered Entity, or created, maintained, or received by the Business Associate on behalf of the Covered Entity, must:

(1) retain only that PHI which is necessary for the Business Associate to continue its proper management and administration or to carry out its legal responsibilities;
(2) return to the Covered Entity (or, if agreed to by the Covered Entity in writing, destroy) the remaining PHI that the Business Associate still maintains in any form;
(3) continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to electronic protected health information to prevent use or disclosure of the PHI, other than as provided for in this Section, for as long as the Business Associate retains the PHI;

(4) not use or disclose the PHI retained by the Business Associate other than for the purposes for which such PHI was retained and subject to the same conditions set out at Section 3(a)(1) which applied before termination; and

(5) return to the Covered Entity (or, if agreed to by the Covered Entity in writing, destroy) the PHI retained by the Business Associate when it is no longer needed by the Business Associate for its proper management and administration or to carry out its legal responsibilities.

7. No Waiver of Immunity. The parties do not intend to waive any of the immunities, rights, benefits, protection, or other provisions of the Michigan Governmental Immunity Act, MCL 691.1401, *et seq*., the Federal Tort Claims Act, 28 U.S.C. 2671 *et seq.*, or the common law.

8. Data Ownership. The Business Associate has no ownership rights in the PHI. The covered entity retains all ownership rights of the PHI.

9. Disclaimer. The Covered Entity makes no warranty or representation that compliance by the Business Associate with this Agreement, HIPAA, or the HIPAA Rules will be adequate or satisfactory for the Business Associate's own purposes. The Business Associate is solely responsible for all decisions made by the Business Associate regarding the safeguarding of PHI.

10. Certification. If the Covered Entity determines an examination is necessary to comply with the Covered Entity's legal obligations under HIPAA relating to certification of its security practices, the Covered Entity or its authorized agents or contractors, may, at the Covered Entity's expense, examine the Business Associate's facilities, systems, procedures and records as may be necessary for such agents or contractors to certify to the Covered Entity the extent to which the Business Associate's security safeguards comply with HIPAA, the HIPAA Rules or this Agreement.

11. Amendment. The parties acknowledge that state and federal laws relating to data security and privacy are rapidly evolving and that amendment of this Agreement may be required to provide for procedures to ensure compliance with such developments. The parties specifically agree to take such action as is necessary to implement the standards and requirements of HIPAA and the HIPAA Rules. Upon the request of either party, the other party agrees to promptly enter into negotiations concerning the terms of an amendment to this Agreement embodying written assurances consistent with the standards and requirements of HIPAA and the HIPAA Rules. Either party may terminate the Agreement upon thirty days written notice if (i) one party does not promptly enter into negotiations to amend this Agreement when requested by the other party or (ii) the Business Associate does not enter into an amendment to this Agreement providing assurances regarding the safeguarding of PHI that the Covered Entity, in its sole discretion, deems sufficient to satisfy the standards and requirements of HIPAA or the HIPAA Rules.

12. Assistance in Litigation or Administrative Proceedings. Business Associate must make itself, and any subcontractors, employees or agents assisting the Business Associate in the performance of its obligations under this Agreement, available to the Covered Entity, at no cost to the Covered Entity, to testify as witnesses, or otherwise, if litigation or administrative proceedings are commenced against the Covered Entity, its directors, officers or employees, departments, agencies, or divisions based upon a claimed violation of HIPAA or the HIPAA Rules or other laws relating to the Business Associate's or its subcontractors use or disclosure of PHI under this Agreement, except where the Business Associate or its subcontractor, employee or agent is a named adverse party.

13. No Third Party Beneficiaries. Nothing express or implied in this Agreement is intended to confer upon any person other than the Covered Entity, the Business Associate and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

14. Interpretation and Order of Precedence. Any ambiguity in this Agreement must be interpreted to permit compliance with the HIPAA Rules. Where the provisions of this Agreement differ from those mandated by the HIPAA Rules, but are nonetheless permitted by the HIPAA Rules, the provisions of this Agreement control.

15. Effective Date. This Agreement is effective upon receipt of the last approval necessary and the affixing of the last signature required.

16. Survival of Certain Agreement Terms. Notwithstanding any contrary provision in this Agreement, the Business Associate's obligations under Section 6(d) and record retention laws ("Effect of Termination") and Section 12 ("No Third Party Beneficiaries") survive termination of this Agreement and are enforceable by the Covered Entity.

17. Representatives and Notice.

a. Representatives. The individuals listed below are designated as the parties' respective representatives for purposes of this Agreement. Either party may from time to time designate in writing new or substitute representatives.

b. Notices. All required notices must be in writing and must be hand delivered or given by certified or registered mail to the representatives at the addresses set forth below or sent via email to the Privacy Security Mailbox at MDHHSPrivacySecurity@michigan.gov.

Covered Entity Representative:

James Bowen
Privacy and Security Manager
MDHHS Compliance Office
333 South Grand Ave, 4th Floor
Lansing, MI 48933
(517) 284-1018

Business Associate Representative:

Name: Eric Kurtz
Title: CEO
Department: NMRE
Address: 1999 Walden Drive Gaylord mi
Phone: 231-330-2119
Email: ekurtz@nmre.org

Name: Eric Kurtz
Title:
Department:
Address:
Phone:
Email:

Any notice given to a party under this Agreement shall be deemed effective, if addressed to such party, upon: (i) delivery, if hand delivered; or (ii) the third Business Day after being sent by certified or registered mail.

Business Associate

[INSERT NAME]

By: E-SIGNED by Eric Kurtz on 2023-09-29 12:31:19 EDT

Date: 2023-09-29 12:31:19 UTC

Print Name: Eric Kurtz

Title: Authorized Official

Covered Entity

[INSERT NAME]

By: E-SIGNED by Kristen Jordan on 2023-09-29 12:39:10 EDT

Date: 2023-09-29 12:39:10 UTC

Print Name: Kristen Jordan

Title: Director, Bureau of Specialty Behavioral Health Services

Covered Entity

[INSERT NAME]

By: E-SIGNED by Tony Weber on 2023-09-29 13:13:19 EDT

Date: 2023-09-29 13:13:19 UTC

Print Name: Tony Weber

Title: Chief Compliance Officer

SCHEDULE C- DEFINITIONS / EXPLANATION OF TERMS

Contract No. MA 230000001246
Prepaid Inpatient Health Plan (PIHP)

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 42 CFR 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 42 CFR 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 42 CFR438.3(c)(1)(ii) and (e).
(7) Meet any applicable special contract provisions as specified in 42 CFR 438.6.
(8) Be provided to CMS in a format and within a timeframe that meets requirements in 42 CFR 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 42 CFR438.8, 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 42 CFR 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

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 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 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 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 Contractor for the delivery of behavioral health care services.

Capitation Rate: The fixed per person monthly rate payable to 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 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.

Delegation: an agreement between Contractor and an individual, provider, CMHSP or other organization to perform certain functions that otherwise would be the responsibility of Contractor to perform. Contractor oversees and is accountable for any functions or responsibilities that are delegated to other entities whether the functions are provided by Contractor or other entities.

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 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. 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 Contractor and a provider or between Contractor's subcontractor and a provider that describes the conditions under which the provider agrees to furnish covered services to 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

Contractor or 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 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 Contractor with any other individual, provider, CMHSP, or other organization who agrees to perform any function or service on behalf of Contractor related to securing or fulfilling 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 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 Contractor related to securing or fulfilling 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.

SCHEDULE D- RESERVED

SCHEDULE E- CONTRACTOR FINANCIAL REPORTING REQUIREMENTS

Contract No. MA 230000001246
Prepaid Inpatient Health Plan (PIHP)

FINANCIAL PLANNING, REPORTING AND SETTLEMENT

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	Final (Use tab in FSR Bundle) October 1 to September 30	MDHHS-BHDDA-Contracts-MGMT@michigan.gov
February 28	Encounter Quality Initiative Report (EQI) including Attestation to accuracy, completeness, and truthfulness of claims and payment data	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
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-BCCHPS-Reporting@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	Projection (Use tab in FSR Bundle)	MDHHS-BHDDA-Contracts-MGMT@michigan.gov

Due Date	Report Title	Report Period	Reporting Mailbox
		October 1 to September 30	
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
November 1	PIHP Medicaid FSR Bundle MA, HMP	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 receipt	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 receipt	Compliance exam and plan of correction	Annually October 1 to September 30	MDHHS-AuditReports@michigan.gov

SCHEDULE E- CONTRACTOR NON-FINANCIAL REPORTING REQUIREMENTS

Contract No. MA 230000001246
Prepaid Inpatient Health Plan (PIHP)

NON-FINANCIAL REPORTING REQUIREMENTS SCHEDULE

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

Mental Health and Substance Use Disorder (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
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 Report	October 1 to September 30	MDHHS-BHDDA-Contracts-MGMT@michigan.gov
March 31	Performance Indicators	October 1 to December 31	QMPMeasures@michigan.gov
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

Due Date	Report Title	Report Period	Reporting Mailbox
June 30	Performance Indicators	January 1 to March 31	QMPMeasures@michigan.gov
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
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 Fiscal Year	Contractor's MDHHS OIG sFTP Area
November 15	PIHP Current Organizational Chart	Annually Current Fiscal Year	MDHHS-BHDDA-Contracts-MGMT@michigan.gov
December 31	Performance Indicators	July 1 to September 30	QMPMeasures@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	October 1 to September 30 Due last day of each month.	Submit via DEG at: https://milogintp.michigan.gov

Due Date	Report Title	Report Period	Reporting Mailbox
	(BH- TEDS)	See resources at: https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/reporting	
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 through the Customer Relationship Management (CRM) System

*Reports required if 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

SCHEDULE F- MEDICAID MENTAL HEALTH SUBSTANCE USE DISORDER AUTHORIZATION AND PAYMENT RESPONSIBILITY GRID

Contract No. MA 230000001246
Prepaid Inpatient Health Plan (PIHP)

The attached grid is designed to be utilized as a general guideline to assist Medicaid Health Plans, Prepaid Inpatient Health Plans, Community Mental Health Service Programs, and providers in determining the responsible entity for authorization and payment. These are general guidelines and all entities should follow Medicaid policy as described in the Medicaid Provider Manual and in the agency's contract with the State.

Acronyms:

- BHM - Behavioral Health Manager
- CMHSP - Community Mental Health Services Program
- DRG – Diagnosis Related Group
- ED – Emergency Department
- FFS – Fee for Service
- I/DD – Intellectual/Developmental Disability
- MHA – Mental Health Assessment
- MHP - Medicaid Health Plan
- MAT – Medication Assisted Treatment
- NF – Nursing Facility
- OBAT – Office Based Alcohol Treatment
- OBOT – Office Based Opioid Treatment
- OTP – Opioid Treatment Provider
- PAR – Pre-Admission Review
- PIHP - Prepaid Inpatient Health Plan
- SBIRT – Screening, Brief Intervention, and Referral to Treatment Services
- SED – Serious Emotional Disturbance
- SMI - Serious Mental Illness
- SUD - Substance Use Disorder

Notes:

- Diagnosis may be ***one*** of the factors considered in determining responsible payor but **is not** the only factor.
- Unless otherwise indicated by the most current ICD-10-CM coding guidelines, list first the ICD-10 code for the diagnosis, condition, problem, or other reason for the encounter/visit that is shown in the medical record to be chiefly responsible for the services provided followed by additional ICD-10 codes that describe any coexisting conditions.
- Specialty supports and services provided to individuals with an I/DD outlined in the Medicaid Provider Manual are the responsibility of the PIHP; mental health, physical health and substance use disorder services for these individuals are handled by the appropriate agency as designated below.
- When the grid below indicates that authorization and payment is the responsibility of the PIHP, refer to the contracted entity for specialty behavioral health services (CMHSP or other).
- When the grid below indicates that payment is the responsibility of the MHP, provider network requirements apply.
- Post-psychiatric hospitalization crisis intervention is the responsibility of the PIHP.
- Refer to the Medicaid Provider Manual for additional coverage and reimbursement information including information for those beneficiaries enrolled with an Integrated Care Organization.

Setting in Which Service is Provided							
Outpatient Office (FQHCs/RHCs/THCs, Physician Office, Psychiatrist, Psychologist, Social Worker)	**Medical Emergency Department**	**Mental Health Crisis Center - Access and Screening Center**	**Outpatient Behavioral Health (Crisis) Residential Services**	**Outpatient Substance Abuse Office, Residential Substance Abuse Center or Sub-Acute Detox Center Including OTPs.**	**Inpatient Acute Care Hospital (Medically Managed)**	**Inpatient Psychiatric Hospital (Excluding State Psychiatric Hospital Services)**	**Nursing Facility**
Mental Health Services to Individuals Who Have "Mild to Moderate" Mental Illness or whose severity has not yet been diagnosed. NOTE: The authorization and payment responsibilities delineated hold true regardless if the individual has concurrent I/DD or SUD.							
The MHP is responsible for outpatient mental health services including screening; this service may or may not require authorization from MHP. MHP must coordinate care as appropriate. Payer responsible: MHP or FFS based upon beneficiary enrollment.	After medical screening and stabilization, if a medical health professional believes that pre-screening for inpatient psychiatric hospital services is indicated, or if the need for specialty supports is identified, the ED should contact the PIHP for a PAR. Authorization and payment for PAR are the responsibility of the PIHP. The PAR may be conducted telephonically or face-to- face in the ED by the PIHP. The MHP/FFS is responsible for mild to moderate mental illness treatment services, as determined by the discharge diagnosis, provided by practitioners in the ED who are not associated to a PIHP. Payer Responsible: mixed	Crisis intervention is the responsibility of the PIHP even if individual is currently categorized as "mild to moderate" mental illness. Payer responsible: PIHP	Mental health and SUD services should be coordinated with the MHP—this is especially true if the individual has co-occurring disorders (mental health and SUD). Payer responsible: PIHP	The PIHP is responsible for payment for services provided by PIHP contracted providers. Payer responsible: FFS or PIHP depending upon contract arrangements.	Mental health assessment while the individual is in an inpatient medical acute care hospital is the responsibility of the MHP (or FFS if applicable); the MHP may require prior authorization for the assessment. If the mental health assessment finds that admission for inpatient psychiatric hospital services is indicated, the PIHP must be contacted for PAR. Authorization and payment of the PAR is the responsibility of the PIHP. Payer responsible: mixed - Inpatient medical acute care MHP/FFS, payment for inpatient psychiatric admission PIHP	The PIHP's designated screening unit determines the need for inpatient mental health services. The PIHP provides the authorization for mental health inpatient admission and is responsible for mental health inpatient admission costs including psychiatrists' fees. Payer responsible: PIHP	Nursing facilities complete the Pre- admission Screening and Annual Resident Review (PASARR) Mental health services provided by the nursing facility staff, as specified in the resident's plan of care, are included in the facility's per diem rate. Nursing facilities must provide mental health, intellectual/developmental disability or related condition services that are of lesser intensity than specialized services to all residents who need such services. Payer responsible: MHP or FFS based upon beneficiary enrollment.

Setting in Which Service is Provided							
Outpatient Office (FQHCs/RHCs/THCs, Physician Office, Psychiatrist, Psychologist, Social Worker)	**Medical Emergency Department**	**Mental Health Crisis Center - Access and Screening Center**	**Outpatient Behavioral Health (Crisis) Residential Services**	**Outpatient Substance Abuse Office, Residential Substance Abuse Center or Sub-Acute Detox Center Including OTPs.**	**Inpatient Acute Care Hospital (Medically Managed)**	**Inpatient Psychiatric Hospital (Excluding State Psychiatric Hospital Services)**	**Nursing Facility**
Mental Health Services to Individuals Who Have "Serious" Mental Illness. NOTE: The authorization and payment responsibilities delineated in this row hold true regardless if the individual has concurrent I/DD or SUD.							
The PIHP is responsible for services provided by qualified providers contracted with the PIHP. The MHP must provide information to the Enrollee regarding the availability of specialty behavioral health services and coordinate care as appropriate. Payer responsible: PIHP	After medical screening and stabilization, if a medical health professional believes that pre-screening for inpatient psychiatric hospital services is indicated, or if the need for specialty supports is identified, the ED should contact the PIHP for a PAR. Authorization and payment for PAR are the responsibility of the PIHP. The PAR may be conducted telephonically or face-to- face in the ED by the PIHP. The MHP/FFS is responsible for medical stabilization treatment services for individuals with serious mental illness, as determined by the discharge diagnosis, provided by practitioners who are not associated to a PIHP. Payer responsible: mixed.	The PIHP is responsible for treating the individual until the individual is stabilized and no longer meets the criteria for serious mental illness treatment as outlined in Medicaid policy. Payer responsible: PIHP	The PIHP is responsible for clinically managed low-intensity outpatient and residential services including but not limited to clinically managed high intensity residential services and medically monitored high intensity inpatient services. Mental health and SUD services should be coordinated with the MHP—this is especially true if the individual has co-occurring disorders (mental health and SUD). Payer responsible: PIHP	The PIHP is responsible for payment for services provided by PIHP contracted providers. Payer responsible: FFS or PIHP depending upon contract arrangements.	Mental health assessment while the individual is in an inpatient medical acute care hospital is the responsibility of the MHP (or FFS if applicable); the MHP may require prior authorization for the assessment. If the mental health assessment finds that admission for inpatient psychiatric hospital services is indicated, the PIHP must be contacted for PAR. Authorization and payment of the PAR is the responsibility of the PIHP. Payer responsible: mixed - Inpatient medical acute care MHP/FFS, payment for inpatient psychiatric admission PIHP	The PIHP determines the need for inpatient mental health services. The PIHP provides the authorization for mental health inpatient admission and is responsible for mental health inpatient admission costs including psychiatrists' fees. Payer responsible: PIHP	Specialized services are those identified by the PASARR Level II and are provided or arranged by the PIHP. These services must be available to nursing facility individuals regardless of whether they are identified and required by the PASARR process, or whether the individual is determined to require additional services to be provided or arranged for by the State as specialized services. Individuals with a primary diagnosis of dementia are also covered by this requirement, even though the PASARR process exempts individuals with a primary diagnosis of dementia. Specialized services are defined as those mental health services for residents who have a mental illness, I/DD or related condition which are 1) of greater intensity than those normally required from a NF, 2) provided in conjunction with usual NF services, 3) determined through the PASARR process, 4) provided or arranged for by the local CMHSP, OR 5) Result in the continuous and aggressive implementation of an individualized plan of care. Payer responsible: MHP or FFS based upon beneficiary enrollment.

Setting in Which Service is Provided							
Outpatient Office (FQHCs/RHCs/THCs, Physician Office, Psychiatrist, Psychologist, Social Worker)	**Medical Emergency Department**	**Mental Health Crisis Center - Access and Screening Center**	**Outpatient Behavioral Health (Crisis) Residential Services**	**Outpatient Substance Abuse Office, Residential Substance Abuse Center or Sub-Acute Detox Center Including OTPs.**	**Inpatient Acute Care Hospital (Medically Managed)**	**Inpatient Psychiatric Hospital (Excluding State Psychiatric Hospital Services)**	**Nursing Facility**
Substance Use Disorder Treatment Services							
MAT services provided by practitioners enrolled with or associated to a PIHP are reimbursed by the PIHP. OBOT and OBAT services provided by practitioners not enrolled with or associated to a PIHP are reimbursed FFS. SUD services provided in the office setting (e.g., SBIRT) by a practitioner not enrolled with or associated to a PIHP are reimbursed by the MHP or FFS based upon beneficiary enrollment.	FFS/MHP is responsible for ambulatory withdrawal management. If the patient is admitted for acute medical detoxification, the ED costs are rolled into the inpatient DRG. MAT services provided by practitioners enrolled with or associated to a PIHP are reimbursed by the PIHP. MAT services provided by practitioners not enrolled with or associated to a PIHP are reimbursed by FFS.	Payer responsible: PIHP	Payer responsible: PIHP	The PIHP is responsible for clinically managed and medically monitored withdrawal management in the residential or licensed outpatient program.	FFS/MHP is responsible for medically managed intensive inpatient acute detox and associated potentially life-threatening substance-induced toxic conditions requiring acute medical monitoring or intervention and detoxification services in the acute care setting. Services include primary medical and nursing care services including intensive care services. Payer Responsible: MHP or FFS based upon beneficiary enrollment.	Payer responsible: PIHP	Services rendered for the treatment of alcohol and drug abuse are an ancillary service and are not included in the facility's per diem rate. Payer Responsible: MHP or FFS based upon beneficiary enrollment.

Setting in Which Service is Provided							
Outpatient Office (FQHCs/RHCs/THCs, Physician Office, Psychiatrist, Psychologist, Social Worker)	**Medical Emergency Department**	**Mental Health Crisis Center - Access and Screening Center**	**Outpatient Behavioral Health (Crisis) Residential Services**	**Outpatient Substance Abuse Office, Residential Substance Abuse Center or Sub-Acute Detox Center Including OTPs.**	**Inpatient Acute Care Hospital (Medically Managed)**	**Inpatient Psychiatric Hospital (Excluding State Psychiatric Hospital Services)**	**Nursing Facility**
Medical Services – Professional and Facility Services Including Diagnostic Tests (e.g., Radiology and Laboratory Services Including Toxicology Screening)							
Payer Responsible: MHP or FFS based upon beneficiary enrollment and current OBOT/OBAT policy (MHP may require authorization for non-emergent care).	Payer Responsible: MHP or FFS based upon beneficiary enrollment and current OBOT/OBAT policy (MHP may require authorization for post-stabilization treatment).	Payer responsible: PIHP	Payer responsible: PIHP	Payer responsible: PIHP	Payer Responsible: MHP or FFS based upon beneficiary enrollment (MHP may require authorization for non-emergent care).	PIHPs are responsible for costs related to providing a psychiatric admission, history and physical. MHPs or FFS are responsible for medical services.	Ancillary services (defined in the Nursing Facility Chapter of the Medicaid Provider Manual) should be billed to the MHP or FFS based upon beneficiary enrollment.

SCHEDULE G- LOCAL FUNDING OBLIGATION SCHEDULE

Contract No. MA 230000001246
Prepaid Inpatient Health Plan (PIHP)

Attachments to Schedule G: Local Funding Obligation Schedule include:

a. The schedule will be added via an amendment once available.

SCHEDULE H- BEHAVIORAL HEALTH CAPITATION RATE CERTIFICATION

Contract No. MA 230000001246
Prepaid Inpatient Health Plan (PIHP)

The Medicaid PEPM rates effective October 1 is included as follows. The actual number of Medicaid beneficiaries will be determined monthly, and Contractor will be notified of the beneficiaries in their service area via the pre-payment process.

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

a. The schedule will be added via an amendment once available.