STATE OF MICHIGAN
PROCUREMENT
Michigan.gov/MiProcurement

TABLE OF CONTENTS

SCHEDULE A - STATEMENT OF WORK

Request for Proposal No. 250000002670
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.

IMPORTANT NOTE TO CONTRACTORS/BIDDERS: In addition to responses to the Schedule J Narrative Submission Questions document, there are specific requirements for which acceptance must be simply acknowledged through a checkbox(es), and others that require further explanation. Click the appropriate checkbox and complete the entries as appropriate.

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. Through this authority, the Medicaid Managed Care system delivers selected Medicaid State plan specialty services related to mental health and developmental disability services, as well as certain covered Substance Use Disorder (SUD) services. These services have been "carved out" (removed) from Medicaid primary physical health care plans and arrangements.

CMS has also approved a 1115 Demonstration 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 and the Healthy Michigan Plan are managed on a shared risk basis by specialty PIHP contractors, selected through a competitive procurement process, the details of which can be found on the Specialty Behavioral Health Services website: https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/specialty-behavioral-health-services.

The 2025 public survey issued as part of the competitive procurement process led to the development of four strategic pillars for PIHPs:

1. Provide high quality, timely services:
   a. Ensure timely access to services through network adequacy and provider availability.
   b. Deliver high-quality services that address the full continuum of care.
2. Improve choice & consistency across regions:
   a. Improve choice in access to services.
   b. Promote consistency across regions to ensure access to services regardless of where members reside.
3. Ensure accountability & transparency:
   a. Increase accountability & transparency through enhanced oversight and outcomes-centered performance management.
   b. Remove structural conflict of dual payor/ provider responsibilities.
4. Simplify the system with reduced bureaucracy:
   a. Decrease bureaucracy and administrative burden, improving efficiency for providers as well as members accessing care.

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) State Plan Amendment (SPA), services, and 1915(c) State Plan Amendment (SPA) Waiver services:

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

All the SUD 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 SUD services and supports as indicated in this Contract. This is a Capitated Rate Contract paid on a price-per eligible per month (PEPM) basis. 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 portion of funds to be directed to beneficiary services. Contractor must actively manage behavioral health services for its awarded region 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 is required to hold contracts with each Community Mental Health Services Program (CMHSP) in its region(s) and must minimize duplication of contracts and reviews for providers contracting with multiple CMHSPs in the service area.

Remedies, Sanctions, or liquidated damages described in Schedule A are in addition to, and not in lieu of, the State's ability to terminate this Contract pursuant to the Contract terms. Requirements outlined in Schedule A are in addition to, and not in lieu of, any requirements set forth elsewhere in this Contract.

RESPONSIBILITIES OF THE STATE

The State will administer this Contract with Contractor, monitor Contract performance, and perform oversight. In addition, 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. MDHHS is the single-state agency with final responsibility to administer and supervise Michigan's Medicaid program. Entities contracting with the State to fulfill the State's obligations are required under the terms of their contracts and state and federal Medicaid law to follow MDHHS' policies, rules, and regulations and adhere to its obligations.

1. **Requirements**
   Contractor must provide deliverables/services and staff to do all things necessary to ensure the performance requirements and performance of work as required by this Contract. The requirements set forth in Schedule A and elsewhere in the Contract may collectively be referred to as "Contract Activities." Contractor must comply with all provisions of Medicaid policy and Medicaid Waivers 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, applicable policies, 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 have training, education, experience, licensing, or certification appropriate to their position and responsibilities.

1.1 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 Specialty Behavioral Health Program. Contractors are expected to provide managed care functions to beneficiaries. Those functions cannot be delegated to contracted network providers with the exception of Preadmission screening for emergency intervention services per Mental Health Code MCL 330.1409 which shall be performed by the CMHSP with Contractor authorization of inpatient admissions as indicated by the preadmission screening unit. Managed care functions include, but are not limited to, eligibility and coverage verification, utilization management, network development, contracted network provider training, claims processing, activities to improve health care quality, and fraud prevention activities. (See Schedule G, Definitions of Terms, for a complete list of managed care functions). Contractor may not directly provide or deliver health care services beyond these managed care functions. Contractor must be considered a nonprofit organization, Public body/Governmental entity, or a Public University.

☐	I have reviewed the above requirement and affirm that I meet the mandatory minimum.
Bidder must provide documentation that their organizational structure meets one of the requirements stated in the Proposal Instructions, Section 7. Mandatory Minimum Requirements labeled as, "Documentation for Mandatory Minimum Requirement".	

A. Service Area

1. Targeted Geographical Area for Implementation
    a. Contractor must manage the Specialty Behavior Health Services population under the terms of this Contract for its awarded region(s). Counties included in each service area can be found at the following website: https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/specialty-behavioral-health-services. Contractor must operate in one or more of three (3) regions throughout the State for the provision of Covered Services.
2. Region Expansion during Contract Term
    a. The Contractor's region includes all areas identified by MDHHS in which beneficiaries may be enrolled. Expansion of, or changes to, the Contractor's region will be at the sole discretion of MDHHS.
3. Target Population
    a. Contractor is responsible for serving beneficiaries eligible for Medicaid Specialty Behavioral Health Services:
        i. In the service area described in Section 1.A.1.a. above, pursuant to the terms of this Contract.

4. Home and Community Character
    a. Contractor must ensure that the residential (adult foster care, specialized residential, provider owned/controlled) and non-residential services (skill building, community living supports, and out of home non-vocational) where individuals are supported by funds from the Medicaid Home and Community Based Services (HCBS) 1915(i) State Plan Amendment (SPA) and HCBS 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 outlined in the HCBS Section of the Medicaid Provider Manual.

☐	I have reviewed the above requirement and agree.

B. Customer Services Standards

1. Introduction
    a. 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 the Contractor. These Customer Service Standards can be found on the MDHHS website: https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/practiceguidelines. Contractor must abide by all requirements within the PIHP Customer Service Standards.
2. Functions 42 CFR 438.71(d)
    a. Welcome and orient individuals to the managed care system including services and benefits available, and the provider network.
    b. Provide information regarding covered services to assist the beneficiary in making decisions about care options, including how to access behavioral health, primary care and other community services.
    c. Provide an access point for complaints, concerns about access to covered services, enrollment and other related matters.
    d. Provide outreach to beneficiaries and authorized representatives through various means when requested, including information about how to access the various rights processes.
    e. Provide education on grievance and appeal rights, the State Fair Hearing process, and beneficiary rights and responsibilities, including the "Your Rights When Receiving Mental Health Services in Michigan" booklet. Reference the following website for more information: https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/recipientrights/information/rights-information-handbooks-and-podcast.
    f. Help individuals with problems and inquiries regarding benefits.
    g. Assist with navigating the appeals and grievance process, including the appeal of an Adverse Benefit Determination or State Fair Hearing and, upon request, provide sources for legal representation. See Section L. Grievance and Appeals Process for Beneficiaries.
    h. Review data to identify, remediate and participate in the resolution of systemic issues for the organization. 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. 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.

d. Publish customer service numbers in agency brochures and public information material.
e. Publish how to access Customer Services information outside of normal business hours in the Customer Services Handbook and on Contractor website.
f. Develop a Customer Services Handbook in accordance with the MDHHS Customer Services Standards and 42 CFR 438.10(g)(2).
g. 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 found on the website.
    iv. Other alternate distribution method based on the request of the beneficiary.
h. Include the date of publication/revision and/or version number in each Customer Services Handbook.
i. 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.
j. Utilize model handbook and notices templates in accordance with the MDHHS Customer Service Standards and Appeals and Grievance Policy.
k. 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, how to access afterhours emergency coverage.
l. Ensure all information contained in the Customer Services Handbook follows the guidelines for written materials as indicated in N. Beneficiary Services 2. Written materials.
m. Obtain State approval, in writing, prior to publishing original and revised editions of the Customer Services Handbook.
n. Produce supplemental materials to the Customer Services Handbook, as needed, to ensure compliance with Contractual Requirements (e.g., inserts/stickers).

☐	I have reviewed the above requirement and agree.

C. Payment Reform

1. Data Reporting
    a. In order to oversee and continually improve the performance of its network providers, Contractor must collect and report data in a consistent and coordinated manner, as directed by 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 network providers/subcontractors and the State.
2. Responsibility for Payment of Covered Services
    a. Contractor will be responsible for payment for services that Contractor authorizes, including Medicaid SUD services. This provision presumes Contractor, and its network providers and subcontractors are fulfilling their responsibility to individuals according to

the terms specified in the Contract.

b. Services must not be delayed or denied as a result of a dispute of payment responsibility with or among two or more network providers/subcontractors. In the event there is an unresolved dispute between Contractor and network providers/subcontractor(s), either entity may request the State's involvement to resolve the dispute and make a determination. However, services must not be delayed or denied as a result of or during any such dispute.
c. Contractor, or designee, must be contacted for authorization for post-stabilization care. Contractor is financially responsible for post-stabilization care services that are pre-approved by Contractor.
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) is met.
e. Financial responsibility for beneficiaries 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 currently 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, Intensive Care Coordination with 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 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.

3. Liability for Payment
    a. Contractor must ensure that its Medicaid beneficiaries are not held liable for Covered services provided to the beneficiary, 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.

☐	I have reviewed the above requirement and agree.

D. Contract Enforcement Methods (Civil Monetary Contract Remedies, Credits and Liquidated Damages

1. MDHHS will utilize a variety of means to assure compliance with Contract requirements and any applicable laws. MDHHS may impose late fees, performance credits ("civil monetary sanctions"), enrollment adjustments (including suspension of all new enrollments, suspension of auto-assigned enrollment, and redistribution of existing enrollment to other Contractors), and other contract remedies, credits and liquidated damages on Contractor. Civil monetary sanctions, contract remedies credits and liquidated damages shall collectively be referenced as ("contract enforcement methods"). MDHHS will utilize contract enforcement methods to require the Contractor to implement corrective action plans and to resolve outstanding requirements as appropriate.
2. The provisions governing a contested case under the Administrative Procedures Act of 1969, 1969 Public Act (PA) 306, MCL 24.201 to 24.328, do not apply to contract enforcement mechanisms under this section because they are not issued pursuant to the authority provided in MCL 330.1232b.
3. MDHHS may employ contract enforcement methods to address any Contractor violations and performance concerns. The use of contract enforcement methods will typically follow a progressive approach, but MDHHS reserves the right to deviate from the progression as needed, and at MDHHS's sole discretion. The application of remedies shall be a matter of public record.
4. Contract enforcement methods include but are not limited to:
   a. Requiring the Contractor to submit a plan of correction and specified status reports that become a Contract performance objective.
   b. Imposing a direct dollar credit and making it a non-matchable Contractor administrative expense and reducing earned savings from that fiscal year by the same dollar amount.
   c. Delaying up to 25% of scheduled payment amount to Contractor until Contractor comes into compliance as determined by MDHHS. MDHHS may apply this credit in a subsequent payment cycle and will provide prior written notice to Contractor.
5. The pursuit of any contract enforcement method does not require a Contract amendment. The Contract Compliance notice to Contractor is sufficient authority.
6. Contract enforcement methods imposed pursuant to this Contract may be collected by deducting the amount of the monetary sanction from any payments due to Contractor or by demanding immediate payment by Contractor. MDHHS, at its sole discretion, may establish an installment payment plan for payment of any civil monetary sanction. The determination of the amount of any civil monetary sanction is at the sole discretion of MDHHS, within the ranges set by MDHHS. Self-reporting by Contractor will be taken into consideration in determining the amount of any monetary sanction.
7. For instances where the specific contract compliance concerns prompting MDHHS' outreach to the Contractor are also the subject of a Medicaid Fair Hearing, the concurrent Medicaid Fair Hearing does not preclude the Contractor from also cooperating fully with the Department's contract compliance investigation/outreach.
8. Any contractual financial Sanctions, Credits, or Withholds may be imposed upon the Contractor and carried out by MDHHS, regardless of whether or not the contractual dispute item causing the financial Sanction, Credit, or Withhold has been, or is in the process of being, adjudicated through

the dispute resolution or administrative hearings processes.

9. The Contractor will not pass-through liquidated damages imposed under this Contract to a provider and/or subcontractor, unless the provider and/or subcontractor caused the damage through its own action or inaction. Nothing described herein will prohibit a provider and/or a subcontractor from seeking judgment before an appropriate court in situations where it is unclear that the provider and/or the subcontractor caused the damage by an action or inaction. All liquidated damages imposed pursuant to this Contract, whether paid or due, will be paid by the Contractor out of administrative costs and profits.
10. Areas of noncompliance for which MDHHS may utilize contract enforcement methods include, but are not limited to noncompliance in the following areas:
    a. Administration and management.
    b. Standards promulgated by MDHHS.
    c. Provision of medically necessary covered services.
    d. Misrepresentation or falsification of information to state or federal government.
    e. Appeal and grievance systems.
    f. CMS 1915(c)Waivers and 1915(i)SPA reporting requirements (including as outlined in the CAP scoring metric).
    g. Claims management.
    h. Enrollee materials and customer services.
    i. Finance, including medical loss ratio reporting.
    j. Information systems, including encounter data reporting.
    k. Marketing.
    l. Medical management, including utilization management and case management.
    m. Program integrity.
    n. Provider network management, including provider directory standards.
    o. Availability and accessibility of services, including network adequacy standards.
    p. Quality improvement.
    q. Financial statement reporting, audits, compliance examination reporting.
    r. Settlement reporting.
    s. Capital reserve requirements.
11. Areas related to the delivery of Long Term Services and Supports (LTSS) not otherwise included in paragraphs (10)(a) through (r) of this Section as applicable to the managed care program.
    a. Administrative Subcontractor oversight.
    b. All other provisions of the Contract, as appropriate.

☐	I have reviewed the above requirement and agree.

E. Access and Availability

1. Provider Network Services
   Contractor is responsible for maintaining and continually evaluating an effective provider network that is adequate to fulfill the obligations of this Contract. Contractor remains the accountable party for the Medicaid beneficiaries in its service area. 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 provide 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, in the format specified by the State, a complete listing and description of the provider network available to recipients in the service area.
f. Assure that services are accessible, considering 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. Indian Health Care Providers (IHCP) Network Requirements
   a. 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. Network Adequacy Standards
   Information regarding Network Adequacy Standards can be found at the following MDHHS 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 Standards policy (MSA 18-49) and corresponding procedural document to effectuate network adequacy standards for Michigan's specialty behavioral health delivery system. Contractor's Provider Network must be supported by Provider Contracts and sufficient to provide adequate access to all Covered Services for the maximum number of beneficiaries specified under this Contract. Contractor must ensure its Provider Network can deliver Covered Services to all beneficiaries, including but not limited to beneficiaries with limited English Proficiency, Beneficiaries who are deaf or hard of hearing, beneficiaries with diverse cultural and ethnic backgrounds, and beneficiaries with physical and mental disabilities. 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 Schedule I-Network Adequacy Procedure. MDHHS reserves the right to revise the network adequacy standards, as needed.
   c. Contractor must submit the Network Adequacy Profile File (NAP File) quarterly to MDHHS according to the Schedule E.
   d. Contractor must submit the Network Access Plan on how the standards will be effectuated. The Network Access Plan must be submitted at least annually according to

Schedule E and updated anytime a provider network change occurs (as described below), or a Network Exception Request Form is submitted. The Network Access Plan must include all MDHHS requested elements (outlined in Network Access Plan Document) including but not limited to the following:

i. Maximum time and distance.
ii. Provider to enrollee ratios.
iii. Timely appointments and access to services.
iv. Language, Cultural competence, and Physical accessibility.
v. Contractor offers appropriate range of specialty behavioral health and SUD services, in accordance with this Contract, that is adequate for anticipated number of beneficiaries for the Service Area.
vi. Maintenance of a network of Providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of beneficiaries in the Service Area.
vii. Contractor must make Covered Services available 24 hours a day, seven days a week, when Clinically Necessary.

e. If Contractor's Provider Network changes such that it no longer meets network adequacy standards, the Contractor must:
    i. Update and submit to MDHHS within ten business days its Network Access Plan to describe the Network non-compliance and how the Contractor is addressing it.
    ii. Immediately update its assessment of capacity, as reported to MDHHS.

    Failure to do (i) and (ii), above, may result in MDHHS imposing monetary Sanctions and/or other Sanctions according to Section D. Contract Enforcement Methods

f. Contractor may request Provider Network Exceptions to the time, distance and Provider-to-enrollee ratio standards identified in Schedule I Network Adequacy Procedure. Approval of any requested Provider Network Exceptions will be at the sole discretion of MDHHS. Requests must be submitted via the Provider Network Exception Request Form accompanied by an updated Network Access Plan within ten business days of identified network gap, noncompliance, or change in provider network negatively impacting network adequacy. The request must include, but is not limited to:
    i. A plan for how Contractor will reasonably deliver Covered Services to beneficiaries who may be affected by the exception and how Contractor will work to increase access to the applicable provider type in the designated county or counties.
    ii. How Contractor will monitor, track and report to MDHHS the delivery of Covered Services to beneficiaries potentially affected by the exception.

g. If a Provider Network Exception to a time, distance or Provider-to-enrollee ratio standard is granted by MDHHS, the exception is limited to the identified provider type and county or counties and is granted for a period of up to one year, unless otherwise specified. If the Contractor seeks to extend the network exception needs beyond the first year, Contractor must submit a revised Network Exception Request Form for approval and review.
    i. 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.
    ii. Contractor must consider anticipated enrollment and expected utilization of services.
    iii. The availability of Covered Services through telehealth may not be considered in

the Contractor's demonstration of network adequacy or its compliance with the network adequacy standards identified in the procedure document.

iv. 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. Submission of documentation will take place as specified by the State but no less frequently than the following:

v. At the time Contractor enters into a contract with the State.

vi. On an annual basis.

vii. Anytime there has been significant change (as defined by the State) in Contractor operations that would affect adequacy of capacity and services, including changes in services, benefits, geographic service area, composition of or payments to its provider networks, or at the enrollment of a new population.

h. 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.

4. Changes in Provider Network
   a. Contractor must notify the State within seven days of any changes to the composition of the provider network organizations through the MDHHS Behavioral Health Customer Relationship Management (CRM). In addition, notification must be provided anytime there has been a significant change. A significant change could include, but is not limited to, contract non-renewal for network provider, provider and/or consumer relocation, warranties and representation, etc.
   b. Contractor must have procedures to assess the impact of changes in its network to ensure an adequate network of providers is maintained.
   c. The inability to maintain an adequate provider network may be grounds for sanctions and/or corrective action planning.
5. 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(ies) as referenced in 42 CFR 438.206(b)(4).
   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 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.

☐	I have reviewed the above requirements E.1 through E.5 and agree.

6. 1115 Behavioral Health Demonstration Waiver and Healthy Michigan Programs
    a. Unless otherwise noted in the Michigan Medicaid Provider Manual, mental health and intellectual/developmental disabilities services may be provided in other locations in the community, including the beneficiary's home, according to individual need and clinical appropriateness.
7. 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 these requirements 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 its beneficiaries and is not precluded from using different practitioners in the same specialty. Nor is Contractor 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 1128 or Section 1128A of the Social Security Act.
        iv. Contractor may not include non-compete clauses in its contract with providers.
8. Access Standards
    a. Contractor must ensure timely access to covered supports and services taking into account the urgency of the need for services, as well as appointment wait time in accordance with the MDHHS Access Standards, which can be found on the MDHHS website: https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/practiceguidelines.
    b. Contractor must ensure that services included in the contract are available 24 hours a day, seven (7) days a week, when medically necessary.
    c. Contractor must ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid beneficiaries with physical or mental disabilities.
    d. 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, disabilities, and regardless of sex which includes sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity and sex stereotypes.
    e. Contractor must Establish mechanisms to ensure compliance by network providers. 42 CFR 438.206(c)(1)(iv)
    f. Contractor must monitor network providers regularly to determine compliance. 42 CFR 438.206(c)(1)(v)

g. Contractor must take corrective action if there is a failure to comply by a network provider. 42 CFR 438.206(c)(1)(vi)
h. Contractor must have written policies guaranteeing each beneficiary's right to request and receive a copy of their medical records, and to request that they be amended or corrected.

9. Person Centered Planning
   a. In accordance with 42 CFR 441.725 Person-centered service plan and 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 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(c), the person-centered planning process must include considerations for additional services for enrollees with special health care needs or who need LTSS.
   b. As part of the person-centered planning process, Contractor must engage in family-driven and youth-guided approaches to services with children and families and engage family members and youth at the program, evaluation, and governance levels. This must be done in accordance with the Family-Driven and Youth-Guided Policy and Practice Guidelines, which can be found on the MDHHS website: https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/practiceguidelines.
   c. Contractor must offer new and existing recipients (other than those previously terminated from self-directed service arrangements) the choice to self-direct their services.
   d. 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 Technical Requirement for Behavior Treatment Plans, 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.

10. 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, the Contractor must have 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 ensure 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 must be modified to effectively serve individuals who are deaf, hard of hearing, and deaf and blind as determined by their language skills and preferences.

11. Self-Direction
    a. Contractor must ensure compliance among their network of service providers with all elements of Participant-Directed Services outlined in the 1915(i)(1)(G)(iii), 1915(c) Appendix E HCBS waiver authorities, the Self-Direction Technical Requirement Implementation Guide, and the Self-Directed Services Technical Requirements 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 SUD Services.

☐	I have reviewed the above requirements E.6 through E.11 and agree.

12. Choice
    a. In accordance with 42 CFR 438.3(l), Contractor must ensure that the beneficiary is allowed to choose his or her health care professional, e.g., physician, therapist, etc. to the extent possible and appropriate.
13. 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 beneficiary to obtain one outside the network, at no cost to the beneficiary.
14. Denials by a Qualified Professional
    a. Contractor must ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a health care professional who has appropriate clinical expertise in treating the beneficiary's condition.
15. Recovery Policy
    a. All Supports and Services provided to individuals with mental illness, including individuals 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.
16. Nursing Home Placements
    a. Contractor must 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.
17. Nursing Home Mental Health Services
    a. Residents of nursing homes with mental health needs must be given the same opportunity for access to Contractor services as other individuals covered by this Contract.
18. 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. (For additional detail regarding the

coverage responsibilities under the Mental Health Framework, see section F.8, Covered Services and/or the Schedule H, Payment Responsibility Grid.)

19. Indian Health Service/Tribally Operated Facility or program/Urban Indian Clinic (I/T/U)
    a. Contractor must 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's 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 the absence of a published encounter rate, the amount it would receive if the services were provided under thestate plan's Fee for Service (FFS) payment methodology.

☐	I have reviewed the above requirements E.12 through E.19 and agree.

20. Persons Associated with the Corrections System
    a. Under an arrangement between the Michigan Department of Corrections (MDOC) and MDHHS, the Contractor must be responsible for medically necessary community-based SUD treatment services for individuals under the supervision of the MDOC. 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 behavioral health and SUD treatment services.
    b. Referrals, Screening and Assessment
        i. Individuals under MDOC supervision are considered a priority population for assessment and admission for SUD 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 beneficiaries. 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.
            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, and to the MDOC Substance Use Treatment Services Manager. Contractor must provide this contact information to MDOC Supervising Agents in their regions

iii. The MDOC Supervising Agent will make best efforts to refer individuals in need of SUD treatment through the established referral process. 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 pertinent background information related to individual risk, need, and responsivity factors. An individual on MDOC supervision who self refers to the Contractor and/or designated access point shall be asked to sign a Michigan Behavioral Health Standard Consent Form, MDHHS-5515, to include MDOC Supervising Agent.

iv. The MDOC Supervising Agent will direct the individual to contact the Contractor or designated access point for a SUD telephonic or in person screening for services. Individuals that are subsequently referred for SUD treatment as a result of a positive screening must receive an in-person assessment. If the individual referred is incarcerated, the MDOC 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 telephone, video or in-person screening for services at the designated location as arranged by the MDOC Supervising Agent. Contractor/designated access point may not deny an individual an in-person assessment via phone screening.

v. Contractor must conduct assessments in accordance with MDHHS-approved assessment instruments and admissions decisions based on MDHHS-approved medical necessity criteria included in this Contract. In the case of MDOC supervised individuals, these assessments must 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 extent consistent with HIPAA, the Michigan Mental Health Code and 42 CFR Part 2, and with the written consent of the individual, Contractor/designated provider must provide notice of an admission decision to the MDOC 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 must provide information regarding community resources to address individual risk, need, and responsivity factors.

vi. Contractor must base admission and treatment decisions only on medical necessity criteria and professional assessment factors independent of supervising agent requests or prescriptions for level or duration of care, services or supports.

c. Plan of Service

i. The individualized treatment plan must be developed in a manner consistent with the principles of person-centered planning as applicable to individuals receiving treatment for SUDs 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 and/or designated access point must attempt to obtain a release

of information from the beneficiary, to include MDOC Supervising Agent.

iii. Contractor/designated provider must inform the MDOC Supervising Agent when Medication Assisted Treatment (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 MDOC Supervising Agent must be notified within 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 MDOC 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 MDOC 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. Provided a release of information is obtained, positive drug test results and drug test refusals must be reported to the Supervising Agent.

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 of 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 criminal activity 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 MDOC 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 MDOC 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 MDOC 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
    i. 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, MDHHS will require annual training for all designated access points and providers 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 through defined performance metrics and reports made available to MDOC.
h. Compliance Monitoring
    i. 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
    i. Contractor is solely responsible for the composition, compensation and performance of its contracted provider network. As set forth by MDHHS, Contractor must include performance requirements/standardsbased 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.
    ii. Contractor must be prepared to engage in any requested Managed Care Case Review meetings with MDHHS and MDOC upon request.

21. Intensive Crisis Stabilization Services (ICSS)
    a. Contractor must report its performance on the standards specific to ICSS for children on behalf of the enrolled programs in their geographic service area in accordance with Schedule E of this Contract.
22. Transition of Care
    a. Contractor must develop and implement a transition of care policy consistent with 42 CFR 438.62 and the MDHHS Transition of Care Technical Requirement to ensure continuity of care for its beneficiaries.
    b. MDHHS reserves the right to modify the Transition of Care Technical Requirement, including but not limited to specifying that Medicaid Health Plan (MHP) beneficiaries transitioning between PIHP and MHP mental health coverage must have continued access to their mental health providers for a period no less than 12 months, even if those providers are not in the PIHP (or MHP) provider network, and that payment to those Out-of-Network providers must comply with MDHHS Out-of-Network requirements.
    c. The Contractor's transition of care policy must be included in the beneficiary handbook and submitted to MDHHS for review.
    d. 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.
    e. The transition of care policy must include at a minimum:
        i. Transitioning beneficiaries have access to services consistent with the access

they previously had and in compliance with State and federal access requirements.

ii. Transitioning beneficiaries must be permitted to retain their current provider for the time period required in the MDHHS' transition of care technical requirement, even 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 historical utilization, data from the beneficiary's new contractor or MDHHS.

f. Contractor must include instructions to beneficiaries and potential beneficiaries on how to access continued services upon transition and assist them in accessing continued services, as needed.

☐	I have reviewed the above requirements E.20 through E.22 and agree.

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 consistently 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, the Michigan Medicaid State Plan, and the terms of this Contract.
   c. Contractor will be responsible for the operation of the 1115 Behavioral Health Demonstration Waiver, the specialty behavioral Health services covered under Healthy Michigan Plan, the 1915(i) State Plan Benefit, those who are enrolled in one of the three 1915(c) waivers (HSW, CWP, or the SEDW for Children) 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 to each (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.
   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
   a. State Plan Services: Under the 1115 Demonstration, Contractor must provide the covered services as described in the Michigan Medicaid Provider Manual. The 1115 Demonstration established the PIHP managed care delivery system and includes services not otherwise authorized through the state plan or 1915(c) waivers.
3. 1915(c) Services
   a. Contractor must provide certain enhanced community support services for those beneficiaries in the service area who are enrolled in one of the three Michigan's

1915(c) HCBS 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. 1915(i) State Plan Amendment (SPA) Services
    a. Contractor must provide the covered services, as described in the Behavioral Health and I/DD Supports and Services chapter of the Michigan Medicaid Provider Manual, for beneficiaries enrolled in the 1915(i)SPA.
5. Healthy Michigan Plan
    a. Contractor must provide the covered services described in the Behavioral Health and I/DD Supports and Services Mental Health/SUD Chapter of the Michigan Medicaid Provider Manual as well as the additional SUD services and supports described in the Medicaid Provider Manual for individuals who are eligible for the Healthy Michigan Plan.
6. MIChild
    a. Contractor must provide medically necessary defined mental health benefits to children enrolled in the MIChild program.
7. 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 FFS contract between the State and Genesee Health Systems (GHS). The FFS contract will provide the targeted case management services in accordance with the requirements outlined in the Special Terms and Conditions for the Flint Section 1115 Demonstration, the Michigan Medicaid State Plan and Medicaid Policy.

☐	I have reviewed the above requirements F.1 through F.7 and agree.

8. Mental Health Framework
    a. Overview
        i. MDHHS is advancing a more person-centered approach to mental health coverage responsibility for Medicaid beneficiaries enrolled in an MHP. These changes are being made under the banner of the "Mental Health Framework," a MIHealthyLife initiative. Beginning October 1, 2026, PIHP Contractors must cover all State Plan mental health services for MHP beneficiaries who have been identified as having a higher level of mental health need or who are enrolled in a 1915(c) HCBS waiver (CWP, HSW, SEDW) or 1915(i) State Plan Behavioral Health benefit. For these MHP beneficiaries, PIHPs will have full mental health coverage responsibility, including responsibility for their outpatient mental health care.
    b. Responsibility and Assessment
        i. For MHP beneficiaries who are not enrolled in a 1915(c) HCBS waiver (CWP, HSW, SEDW) or 1915(i)SPA Behavioral Health benefit and who have been identified as having a lower level of mental health need or whose level of mental

health need has not yet been assessed, the MHP will be primarily responsible for their mental health coverage, with the exception of a subset of services that the PIHP will continue to cover.

ii. For MHP beneficiaries in Contractor's service area, Contractor is responsible for covering mental health services as follows: Contractor must cover all State Plan mental health services for MHP beneficiaries who meet the criteria as described in the Mental Health Framework. These include (but may not be limited to):
   1) Beneficiaries who have been identified as having a higher level of mental health needs through a State-specified standardized assessment process.
   2) Beneficiaries in a 1915(c) HCBS waiver (CWP, HSW, SEDW) or the 1915(i)SPA Behavioral Health benefit.

iii. Beneficiary's level of mental health needs will be determined through a standardized assessment process, described in this Contract.. Mental health coverage responsibility for MHP beneficiaries will be reflected in an updated version of the Medicaid Mental Health and SUD Payment Responsibility Grid and in Medicaid policy, including the Mental Health Framework and the Medicaid Provider Manual.

iv. MDHHS reserves the right to further modify Mental Health Framework coverage responsibility criteria and policies.

c. Readiness, Training and Transition
   i. Contractor must partner with MDHHS in readiness and transition activities associated with changes in mental health coverage, at MDHHS direction.
   ii. Contractor must ensure staff are trained on criteria for MHP and PIHP coverage of mental health services, consistent with Mental Health Framework policy.

9. Institution for Mental Disease (IMD) Services
   a. As per 42 CFR 438.3(e)(2)(iii), the covered services in an IMD will be offered to beneficiaries at the option of the Contractor and with agreement from the beneficiary up to 15 days per month per individual 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.
10. Early Periodic Screening, Diagnosis and Treatment (EPSDT)
   a. Under Michigan's 1115 Behavioral Health Demonstration Waiver, Contractor is responsible for the provision of certain Medicaid services for specified populations, pursuant to the 1115 Demonstration Waiver. To the extent that beneficiaries under 21 years of age are referred for services by a primary EPSDT screener and the services are deemed medically necessary to correct or ameliorate a qualifying condition discovered through the screening process, Contractor must make such services available to the beneficiary, in compliance with EPSDT requirements in the Medicaid Provider Manual.
   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 MHP.
11. Special Health Care Needs
   a. Beneficiaries with special health care needs must have direct access to a specialist, as appropriate for the individual's health care condition, as specified in 42 CFR 438.208(c)(4).

☐	I have reviewed the above requirements F.8 through F.11 and agree.

12. Substance Use Disorder Health Home (SUDHH) (Optional Benefit to be provided by approved Contactors)
    a. The SUDHH will provide comprehensive care management and coordination services to Medicaid beneficiaries with opioid use disorder, alcohol use disorder and/or stimulant use disorder who also have or are at risk of developing another chronic condition. For enrolled beneficiaries, the SUDHH 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 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 address beneficiary's complete health and social needs. Participation is voluntary, and enrolled beneficiaries may opt out at any time.
    b. SUDHH 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 SUDHH State Plan Amendment, Medical Services Administration (MSA) Policy, SUDHH Handbook, and all other Medicaid laws, regulations, policies, and procedures (reference the following MDHHS website:www.michigan.gov/SUDHH).Contractor must utilize State Plan qualified Opioid Treatment Programs (OTPs) and Office Based Opioid Treatment providers (OBOTs) to execute the SUDHH via a “Hub and Spoke” system of care. Participation is voluntary and enrolled beneficiaries may opt-out at any time. The SUDHH will provide comprehensive care management and coordination services to Medicaid beneficiaries with a qualifying SUD diagnosis.
    d. Contractor, serving as the LE, will be responsible for the administrative oversight, coordination, and provision of SUDHH services.
    e. Contractor, serving as the LE is responsible for the selection and paneling of designated Health Home Partners (HHPs), 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 SUDHH Handbook.
    f. Contractor, serving as the LE, must execute a contract with HHPs to ensure an adequate network of providers to meet the state plan defined requirements.
    g. Contractor, serving as the LE, must provide technical assistance and training to current and prospective HHPs to successfully operationalize the SUDHH program.
13. 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 SMI or SED. 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 address 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 contracts 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.

14. Long-Term Support Services (LTSS)
    a. 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.
15. Maternity Outpatient Medical Services (MOMS)
    a. Contractor must provide medically necessary defined mental health benefits to women enrolled in the MOMS program.
16. Certified Community Behavioral Health Clinic (CCBHC) Demonstration
    a. Contractor must engage in care planning activities in coordination with CCBHCs for shared beneficiaries, either directly or through its provider network. Care planning and coordination activities should utilize the Transition of Care Technical Requirement.
    b. Contractor must allow CCBHCs to develop a Designated Collaborating Organization (DCO) agreement with an SUD provider in the Contractor's Provider Network.
    c. Contractor must honor MDHHS approved screening and assessments from CCBHCs, consistent with requirements in F. Covered Services. 8. Mental Health Framework and facilitate a warm handoff during instances when a CCBHC is required to refer individuals to the Contractor's access center, including referrals made using the MDHHS-specified referrals process in F. Covered Services. 8. Mental Health Framework. CCBHCs must refer individuals with the following needs to the Contractor's access center:
        i. Individuals who require a service that is at a higher level of care than the nine core CCBHC services offered at the CCBHC or their contracted DCO.

ii. Individuals seeking access to services a CCBHC does not provide.
iii. Individuals seeking access to services offered through the 1915(c) waivers (HSW, CWP, SEDW for Children) or 1915(i)SPA services.

☐	I have reviewed the above requirements F.12 through F.16 and agree.

G. Contractor Governance and Board Requirements

1. **Contractor Governing Body:** Contractor must have a governing body to ensure adoption and implementation of written policies governing the operation of the Contractor. Contractor must have a separate and distinct board structure that is not shared with any contracted provider entity. This governance responsibility includes, but is **not** limited to, hearing and addressing public comment, overseeing daily operations, implementing quality protocols, and managing consumer complaints, in accordance with the conflict-of-interest safeguards and ownership disclosure requirements under 42 CFR § 455 Subpart B.
2. **SUD Oversight Policy Board:** Contractor must establish a SUD Oversight Policy Board pursuant to Section 330.1287 of PA 258 of 1974, as amended in the Mental Health Code.
3. **Governing Body Chair:** The chief executive officer that oversees the day-to-day conduct and operations of the Contractor must be responsible to the governing body.
4. **Governing Body Meetings:** The governing body must meet at least quarterly and must keep a timely permanent and public record of all proceedings available to MDHHS and/or CMS upon request.
5. **Governing Body composition:**
    a. The Board must be comprised of no more than 15 voting members.
    b. A minimum of one-third (1/3) of its Governing Body must be individuals with lived experience in Michigan's specialty behavioral health system.
        i. One of the individuals must include a family member of a youth receiving services through Michigan's public specialty BH system.
    c. Network Providers may hold no more than one-third (1/3) of the seats of the governing body, and board must:
        i. Exclude any Network Providers that have ownership in the Contractor entity.
        ii. Ensure members do not have any control, influence, or decision-making authority in establishment of the regional PIHP Provider Networks.
6. **Governing Body Conflict of Interest**:
    a. Members of the governing body must be selected in a way that minimizes any potential or perceived conflicts of interest.
    b. Governance for the payor entity must be fully independent of and distinct from any providers with which they contract for Medicaid-covered services, as well as from any owners holding direct or indirect interests in those providers.
    c. Board members must not be compensated officers, key personnel, or employees employed by or responsible for the conduct of the Contractor.
    d. Board members must not be members of multiple PIHP boards.
7. **Governing Body Procedures: Contractor must have written and publicly posted policies and procedures for the governing body detailing, at a minimum, the following:**
    a. Board accountability statement.
    b. Board goals and priorities.
    c. Conflict of interest and independence requirements for board membership.
    d. The length of the term for board members.
    e. Filling of vacancies.
    f. Information accessibility.

8. **Governing Board Notifications:** Contractor must provide timely notification to MDHHS, 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.

☐	I have reviewed the above requirement and agree.

H. Behavioral/Physical Health Integration

1. Behavioral Health Integration
    a. Contractor recognizes the importance of integrating both physical health and behavioral health services to effectively serve the whole person, address beneficiary needs and improve health status.
    b. Contractor must work with MDHHS to develop and implement initiatives to integrate services covered by Contractor and the Medicaid Health Plans (MHPs) serving Contractor's beneficiaries and to provide incentives to support behavioral health integration. These initiatives will include, but are not limited to, the following:
        i. Improve coordination of physical health and behavioral health services covered by Contractor.
        ii. Improve coordination of services covered by Contractor and MHPs for shared beneficiaries.
        iii. Provide incentives that advance the integration and coordination of physical health and mental health care at the clinical level.
        iv. Facilitate information sharing between MHPs and PIHPs.
        v. Support network providers in understanding and complying with MDHHS' requirements relating to mental health referrals across MHP and PIHP delivery systems.
    c. Contractor must work with MHPs and MDHHS to report on MDHHS defined shared metrics that seek to measure the quality of care provided to beneficiaries jointly served by Contractor and MHPs. These shared metrics are available on the MDHHS reporting requirements website located at https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/reporting.
    d. Contractor must initiate affirmative efforts to ensure the integration of primary care and 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 SUD, children with SED or a I/DD 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.
        ii. As authorized by the beneficiary, 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 Person-Centered Planning (PCP) process.
        iii. Contractor must make its best effort to conduct an initial screening of each beneficiary's needs within 90 days of the effective date of enrollment for all new beneficiaries. Contractor must make subsequent attempts to conduct an initial

screening of each beneficiary's needs if the initial attempt to contact the beneficiary is unsuccessful.

2. Medicaid Health Plan (MHP) Coordinating Agreements
    a. Many Medicaid beneficiaries receiving services from Contractor will be enrolled in an MHP. The MHP is responsible for Medicaid-covered physical health services for all MHP beneficiaries as well as certain State Plan mental health services for beneficiaries who are not in a 1915(c) HCBS waiver (CWP, HSW, SEDW) or 1915(i)SPA Behavioral Health Benefit and who have been identified as having a lower level of mental health need or whose level of mental health need has not yet been assessed.
    b. Contractor must establish and maintain Coordinating Agreements 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, processes for beneficiary referrals, access to and coordination of care to ensure continuity of care for beneficiaries served by both Contractor and the MHP 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 beneficiaries. The PIHP-MHP model agreement can be found on the MDHHS Policies and Practice Guidelines website at https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/practiceguidelines. All Coordinating Agreements must be submitted to and approved by MDHHS. Contractors must, in collaboration with coordinating MHPs, update the Coordinating Agreements to incorporate any necessary remedies to improve continuity of care, care management, and the provision of health care services, at least annually.
    c. MDHHS will provide Contractor with a separate model Coordinating Agreement for MHPs serving as Highly Integrated Dual Special Needs Plans (HIDE SNPs). 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. Contractors must, in collaboration with coordinating MHPs, update the Coordinating Agreements to incorporate any necessary remedies to improve continuity of care, care management, and the provision of health care services, at least annually. For Coordinating Agreements with HIDE SNPs, MDHHS reserves the right to specify, approve or reject Coordinating Agreement updates.
    d. Contractor must respond within five business days to inquiries from the MDHHS MI Coordinated Health contract management team when issues arise with serving HIDE SNP members.
3. Certified Community Behavioral Health Clinics (CCBHCs)
    a. In addition, Medicaid beneficiaries receiving services from Contractor may also participate with a CCBHC. CCBHCs provide outpatient behavioral health services to anyone with a behavioral health diagnosis regardless of insurance type, geographic location, or ability to pay. CCBHCs are required to coordinate with the Contractor when an individual's level of need exceeds the level of care provided by a CCBHC (see F. Covered Services 16. CCBHC Demonstration for more details). For further information on CCBHCs, please refer to the most recent version of the Michigan CCBHC Handbook.
4. Contractor Referrals to/from MHPs, MHP Network Providers and CCBHCs
    a. Contractor must establish a designated point of contact to coordinate referrals for services with its network providers, CCBHCs, MHPs and MHP network providers. Contractor's designated point of contact must:

i. Have the experience necessary to facilitate and oversee referrals for mental health care services both within and outside of Contractor's provider network.
ii. Be available during normal business hours.
iii. Facilitate referrals to and from MHPs or MHP network providers CCBHCs for mental health care.
iv. Be identified with up-to-date contact information to each MHP and CCBHC serving any part of Contractor's service area.

b. For all MHPs in the Contractor's service area, Contractor must maintain record of the MHP and CCBHC designated point(s) of contact for mental health referrals and share that information with providers in the Contractor's Provider Network at least annually, whenever updates are made, and upon request from the Provider.
c. To further facilitate referrals for mental health care, Contractor must maintain up-to-date contact information for CMHSP and Emergency Intervention Service network providers as well as CCBHCs in its service area and share this information with each MHP serving any part of Contractor's service area.
d. Contractor must compile and share with its network providers up-to-date information for MHPs' designated mental health points of contact, as communicated by each MHP to Contractor.
e. When referring a MHP beneficiary to MHP network provider or CCBHC for mental health services, Contractor must utilize the format, process and timeline specified by MDHHS.
f. Contractor must act on all referrals received from MHPs, MHP network providers and CCBHCs in accordance with MDHHS-specified process and timelines.
g. Contractor must ensure its network providers:
i. Utilize the MDHHS-specified format, process and timeline when referring MHP beneficiaries to MHP network providers and CCBHCs for mental health services.
ii. Conduct a warm handoff to support referrals for mental health care when the other provider can be identified by the referring provider.
iii. Act on referrals they receive from MHPs, MHP network providers and CCBHCs in accordance with MDHHS-specified process and timelines.
h. Contractor must verify whether members who qualify for 1915(i)SPA services are enrolled in a HIDE SNP, to support care coordination and avoid duplication of services. In scenarios where the 1915(i)SPA and the HIDE SNP waiver offer duplicative services, these should be covered by the HIDE SNP.

5. Care Management
a. Contractor must arrange for and provide a robust care management program to all Medicaid beneficiaries with behavioral health needs who require intensive care management, including but not limited to child and adult beneficiaries who have significant behavioral health issues and complex physical comorbidities.
b. Adult beneficiaries (ages 21 and older) who have significant behavioral health issues and complex physical comorbidities are, at a minimum, Medicaid beneficiaries who meet the following criteria:
i. Have received one or more PIHP service in the prior six (6) months;
ii. Have four or more Emergency Department (ED) visits within the prior six (6) months; and
iii. Have diagnoses of two or more of any of the following physical health chronic conditions:
1) Asthma.
2) Atrial fibrillation.
3) Cancer (breast, colorectal, lung, prostate or blood cancers).

4) Chronic kidney disease.
5) Chronic Obstructive Pulmonary Disease (COPD).
6) Congestive heart failure.
7) Diabetes.
8) Hyperlipidemia.
9) Hypertension.
10) Ischemic heart disease.
11) Obesity.
12) Osteoporosis.
13) Rheumatoid arthritis, osteoarthritis, psoriatic arthritis.
14) Stroke.

i. Child and adolescent beneficiaries (aged 20 and younger) who have significant behavioral health issues and complex physical comorbidities shall be defined as beneficiaries who meet criteria approved by MDHHS.
ii. Contractor must work with MDHHS and MHPs to produce, at intervals designated by MDHHS, a list of child and adult MHP beneficiaries who have significant behavioral health issues and complex physical comorbidities, as defined above.

c. Contractor must maintain an electronic bidirectional exchange of information with each MHP as described in Section O. Management Information Systems.
d. Contractor must work collaboratively with MHPs to regularly identify and coordinate the provision of services to shared beneficiaries who have significant behavioral health issues and complex physical comorbidities.
e. Contractor must work with MHPs to provide care management services, including joint care planning, to shared beneficiaries who have significant behavioral health issues and complex physical comorbidities, that are based on as defined by the beneficiary and, for child and adolescent beneficiaries, their caregiver(s). Contractor must engage in care planning activities in coordination with HIDE SNP plans for shared HIDE SNP members, either directly or through its provider network.
f. Contractor must meaningfully utilize the MDHHS-supported web-based care management system, CareConnect360 (CC360) to document a jointly created care plan and to track contacts, issues, and services regarding shared beneficiaries who have significant behavioral health issues and complex physical comorbidities.
g. Contractor must designate personnel to oversee the appropriate use of CC360. Contractor CC360 personnel must include:
i. One Super Managing Employee (SuME) with the authority to assign Managing Employees. MDHHS approval of the SuME is required.
ii. Managing Employees (not limited in number) with the authority to approve CC360 users, also approved by MDHHS through the Database Security Application (DSA).
h. Contractor and MHP care managers must hold case reviews at least monthly, during which staff must discuss shared beneficiaries who have significant behavioral health issues and complex physical comorbidities and develop shared care management interventions.
i. For children in foster care where an MHP is involved in providing services to the beneficiary, the Contractor and MHP must jointly collaborate on the development and implementation of the beneficiary's care plan(s).

6. Primary Care Coordination
a. In accordance with 42 CFR Part 2, Contractor must take all appropriate steps to

ensure that SUD treatment services are coordinated with primary health care services. 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. Beneficiary treatment case file documentation is also necessary. Beneficiary treatment case files must include, at minimum, the beneficiary's Primary Care Physician's name and address, a signed release of information for purposes of coordination, or a statement that the beneficiary has refused to sign a release.

b. Contractor must coordinate the services furnished to the beneficiary with the services the beneficiary receives with FFS Medicaid.

1. Emergency Intervention Services
   a. Contractor must ensure the delivery of coordinated and responsive care to beneficiaries who experience a crisis.
   b. For beneficiaries enrolled in an MHP, Contractor must notify the beneficiary's MHP within 48 hours of the beneficiary utilizing an emergency intervention service.

☐	I have reviewed the above requirement and agree.

I. Eligibility

1. Medicaid Eligibility
   a. MDHHS Health Services 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 as specified for enrollment in a PIHP.
2. For all 1915(i)SPA and 1915(c) Waiver programs, site reviews will be conducted on an annual basis. Contractors must comply with all site review policies and procedures provided by MDHHS. When repeat citations are observed, Contract enforcement mechanisms outlined in D. Contract Enforcement Methods may be utilized by MDHHS.
3. 1915(i)State Plan Amendment
   a. Contractor must identify Medicaid beneficiaries who are eligible for and meet the criteria for the 1915(i)SPA, per the approved 1915(i)SPA application, and submit eligible enrollees to the State for review and approval. Re-evaluation must be completed and submitted to the State for review and approval on an annual basis.
   b. The State will review and approve all disenrollments from the 1915(i)SPA.
   c. Contractor is responsible for the administration and oversight of the 1915(i)SPA and therefore must adhere to the requirements outlined in CMS approved 1915(i)SPA application.
      i. Contractor must carry out administrative and operational functions delegated by State to Contractor as specified in the CMS approved 1915(i)SPA application. These delegated functions include level of care determination; review of participant individual plans of service; prior authorization of services; utilization management; qualified provider enrollment; and quality assurance and quality improvement activities. Contractor assures adherence to HCBS requirements, timelines for evaluations and re-evaluations, oversight and monitoring of case status, and disenrollment process.
      ii. Contractor must ensure that services are provided in amount, scope, and duration as specified in the approved plan.
4. 1915(c) Habilitation Supports Waiver (HSW)
   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 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 enrollment applications; 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 Intermediate Care Facilities for individuals with Intellectual Disability (ICF/IID) or at highest risk of needing ICF/IID placement, young adult aging off CWP, or young adult aging off State Plan Private Duty Nursing service) in another service area where no certificate is available.
d. The State will review and approve all disenrollments from the HSW.
e. Contractor is responsible for the administration and oversight of the HSW and therefore must adhere to the requirements outlined in CMS approved 1915(c) HSW application.
    i. Contractor must carry out administrative and operational functions delegated by State to Contractor as specified in the CMS approved 1915(c) waiver application. These delegated functions include use of MDHHS clinical screening tool to identify potential enrollees to HSW; level of care determination; review of individual plans of service; prior authorization of waiver services; utilization management; qualified provider enrollment; quality assurance and quality improvement activities; slot utilization; monthly reporting of participants waiting for HSW enrollment. Contractor assures adherence to HCBS requirements, timelines for certification and recertification, maintenance of certification consent, oversight and monitoring of case status, and disenrollment process.
    ii. Contractor must ensure that services are provided in amount, scope, and duration as specified in the approved plan.

☐	I have reviewed the above requirements I.1 through I.4 and agree.

5. PIHP Enrollment and Disenrollment
    a. Enrollment Discrimination Prohibited.
        i. Contractor must not discriminate against individuals eligible to enroll on the basis of:
            1) Health status or the need for health services.
            2) Race, color, national origin, age, disability, sex, sexual orientation, gender identity or other factors identified in 42 CFR 438.3(d) and will not use any policy or practice that has the effect of discriminating as such.
        ii. Contractor must accept beneficiaries for enrollment in the order in which they apply without restriction.

b. Enrollment Services Contractor
    i. MDHHS contracts with an Enrollment Services Contractor to contact and educate Medicaid beneficiaries regarding managed care and assist beneficiaries to enroll, disenroll, and change enrollment with their Contractor. Because MDHHS holds the contract with the Enrollment Services Contractor, this Contract may reference MDHHS and by extension the Enrollment Services Contractor as directed by MDHHS.
c. Initial Enrollment and Automatic Reenrollment
    i. Contractor must accept as enrolled all beneficiaries listed on all HIPAA-compliant enrollment files/reports.
    ii. Beneficiaries disenrolled from the Contractor due to loss of Medicaid eligibility or other action will be retroactively reenrolled to the same Contractor automatically, provided eligibility is regained within two months.
d. Auto-Assignment of Beneficiaries during Initial Enrollment
    i. MDHHS will utilize a passive enrollment process for PIHP enrollment.
    ii. At initial enrollment, beneficiaries will be automatically assigned to a Contractor based on the Contractor's network capacity to accept new beneficiaries and performance in areas specified by MDHHS (e.g., quality metrics).
    iii. MDHHS will automatically assign a larger proportion of beneficiaries to the highest performing Contractors. Members of a family unit will be assigned together whenever possible.
    iv. MDHHS has the sole authority for determining the methodology and criteria used for auto-assignment of beneficiaries.
    v. Upon initial enrollment, beneficiaries will have a specified period of time as determined by MDHHS to change Contractor enrollment by contacting the Enrollment Services Contractor.
e. Enrollment Lock-In
    i. Enrollment with the Contractor will be for a period of 12 months. All enrollment changes will be approved and implemented by MDHHS.
f. Enrollment Effective Date
    i. Contractor must provide covered services and coordination for services to beneficiaries until their date of disenrollment. Changes in enrollment will be approved and implemented by MDHHS on a calendar-month basis unless the Contractor is notified of a mid-month disenrollment on the daily enrollment file.
    ii. When an individual is determined to be eligible, he or she is eligible for that entire month. Beneficiaries may be determined eligible retroactively.
    iii. With the exception of newborns and children enrolled in foster care, when an individual is determined to be Medicaid eligible, enrollment with a Contractor will occur on the first day of Medicaid eligibility and could be up to six months retroactive.
    iv. If the beneficiary is in any inpatient hospital setting on the date of enrollment Contractor will be responsible for the inpatient stay or any charges incurred prior to the date of discharge. Contractor must be responsible for all care from the date of discharge forward.
    v. If a beneficiary is disenrolled from a Contractor and is in any inpatient hospital setting on the date of disenrollment (last day of the month) the Contractor must be responsible for all charges incurred through the date of discharge.
g. Enrollment Errors By MDHHS
    i. If a non-eligible individual or a Medicaid beneficiary who resides outside the

Contractor's service area is enrolled with the Contractor and MDHHS is notified within 15 Days of the enrollment effective date, MDHHS will retroactively disenroll the individual and recoup the capitation payment from the Contractor. Contractor may recoup payments from its providers as allowed by Medicaid policy and Contractor's Provider Contracts. (Note: If MDHHS does not recoup the capitation payment, Contractor must not recoup payments to providers).

ii. With the exception of newborns, if a non-eligible individual is enrolled with a Contractor, and MDHHS is notified after 15 Days of enrollment effective date, MDHHS will disenroll the beneficiary prospectively the first day of the next available month.

iii. If a beneficiary is disenrolled due to retroactive loss of eligibility in error, MDHHS will confirm if Contractor received a capitation payment for the time period. If so, and beneficiary is still mandatory or voluntary for managed care, MDHHS will send a replacement enrollment to the Contractor when the eligibility is corrected. The replacement enrollment will have a retroactive date but is not a retroactive enrollment.

h. Beneficiaries Who Move Out of the Contractor's Service Area

i. Contractor must provide all covered services to a beneficiary who moved out of the Contractor's service area after the effective date of enrollment, until the beneficiary is disenrolled from the Contractor. Contractor may require beneficiaries to use network providers and provide transportation and/or authorize Out-of-Network providers to provide medically necessary services. Contractor may use its Utilization Management (UM) protocols for hospital admissions and specialty referrals for beneficiaries in this situation.

ii. Contractor will receive a capitation payment for these beneficiaries until disenrollment.

iii. When requesting disenrollment, Contractor must submit verifiable information that a beneficiary has moved out of the service area. MDHHS will expedite prospective disenrollments of beneficiaries and process all such disenrollments effective the next available month after confirmation the beneficiaries no longer reside in the Contractor's service area.

1) If the beneficiary's street address on the enrollment file is outside of the Contractor's service area but the County Code does not reflect the new address, the Contractor is responsible for requesting disenrollment within 15 Days of the enrollment effective date.

2) If the County Code on the enrollment file is outside of the Contractor's service area, MDHHS will automatically disenroll the beneficiary for the next available month.

i. Contractor Billing Issues and Complaint Resolution

i. When a complaint or billing issue is received by MDHHS, MDHHS will initiate contact with the Contractor.

ii. A complaint is any situation in which a beneficiary or a beneficiary's representative expresses a concern about the care or services provided. Types of complaints sent from MDHHS include, but are not limited to, any access to care issue, including mental health, transportation assistance, or other covered service.

1) Within 24-48 hours of receipt of a complaint, Contractor must provide MDHHS with an update on the resolution process or a description of resolution.

j. Mandatory Enrollment for Single PIHP Regions
    i. In a region with a single Contractor, Medicaid beneficiaries are mandatorily enrolled with the single Contractor, permitted:
        1) Beneficiaries have the option of obtaining services from any other network or non-Network Provider if the following conditions exist:
            a) The covered service, practitioner, or specialist is not available within the Contractor's network.
            b) The provider is not part of the network but is the main source of a service to the beneficiary.
            c) The only provider available to the beneficiary does not, because of moral or religious objections, provide the service the beneficiary seeks.
            d) Related services must be performed by the same provider and all of the services are not available within the Network.
            e) MDHHS determines other circumstances that warrant Out-of-Network treatment.

k. Disenrollment Requirements for Regions with Multiple Contractors (per 42 CFR 438.56)
    i. Disenrollment Discrimination Prohibited
        1) Disenrollment provisions apply to all beneficiaries equally, regardless of whether enrollment was mandatory or voluntary.
            a) Contractor may not request disenrollment because of a beneficiary's:
                i) Adverse change in physical or mental health status.
                ii) Utilization of medical services.
                iii) Diminished mental capacity, or uncooperative or disruptive behavior resulting from their special needs (except when their continued enrollment seriously impairs the entity's ability to furnish services to either this particular beneficiary or other beneficiaries.
    ii. Administrative Disenrollments
        1) Contractor may initiate disenrollment requests if a beneficiary's circumstances change such that the beneficiary no longer meets the criteria for enrollment with the Contractor as defined by MDHHS. Contractor must request disenrollment within 15 Days of identifying the administrative circumstance.
    iii. Disenrollment Requests Initiated by the Beneficiary
        1) Beneficiaries may request an exception to enrollment with Contractor if they have a serious medical condition and are undergoing active treatment for that condition with a physician who does not participate with the Contractor at the time of enrollment. The beneficiary must submit a medical exception request to MDHHS.
        2) The beneficiary may request a "disenrollment for cause" orally or in writing from current Contractor at any time during the enrollment period that would allow the beneficiary to enroll with another Contractor. Reasons cited in a request for disenrollment for cause may include:
            a) The beneficiary moves out of the Contractor's service area.
            b) Beneficiary's current Contractor does not, because of moral or religious objections, cover the service the beneficiary seeks.
            c) The beneficiary needs related services to be performed at the same

time; not all related services are available within the network; and the beneficiary's provider determines that receiving the services separately would subject the beneficiary to unnecessary risk.

d) Lack of access to providers or necessary specialty services covered under the Contract. A beneficiary must demonstrate that appropriate care is not available within the Contractor's provider network or through Out-of-Network Providers approved by the Contractor.

e) Concerns with quality of care.

3) Beneficiary may request disenrollment from the Contractor if the open enrollment period was not available due to a temporary loss of Medicaid eligibility. If the beneficiary is mandatorily enrolled and resides in a county with two available PIHPs, the beneficiary must choose another PIHP in which to enroll; the beneficiary may not return to FFS Medicaid.

4) Beneficiary may request disenrollment from the Contractor if the State imposes an intermediate Sanction in which all new enrollments including default enrollment have been suspended from the Contractor for violation of any requirement under sections 1903(m) or 1932 of the Social Security Act.

5) The effective date of an approved disenrollment must be no later than the first day of the second month following the month in which the beneficiary requests disenrollment. If the State fails to make a determination within this timeframe, the disenrollment is considered approved for the effective date that would have been established had the State complied with the required timeframe.

6) Each beneficiary will have an annual open enrollment period.

☐	I have reviewed the above requirement I.5 and agree.

6. 1915(c) Children's Waiver Program (CWP)
   a. Contractor must identify children who meet the eligibility criteria for the CWP Benefit Plan and submit documentation to the State for those children. MDHHS will review determinations for accuracy and reserves the right to make final eligibility determinations. For children determined ineligible for the CWP, Contractor, on behalf of the State, must inform 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 1915(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 CWP recipient per the Medicaid Provider Manual. MDHHS will review determinations for accuracy and reserves the right to make final Category of Care/Intensity of Care determinations.
   d. Contractor must ensure 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.

7. 1915(c) Serious Emotional Disability Waiver (SEDW)
   a. The intent of this program is to provide the HCBS Waiver, as approved by CMS for children with SED Benefit Plan, along with State Plan services in accordance with the Medicaid Provider Manual.
      The Contractor must:
      i. Assess eligibility for the SEDW and submit applications to the State for those children Contractor determines are eligible. MDHHS will review determinations for accuracy and reserves the right to make final eligibility determinations. 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. Carry out administrative and operational functions delegated to the Contractor by the State 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. Ensure that services are provided in amount, scope and duration as specified in the approved plan of service. When a child/youth is being served under the SEDW, Intensive Care Coordination with Wraparound (ICCW) is the recommended model to support the child, youth, young adult and their family through the planning process. At the preference of the child, youth, and their family, Targeted Case Management (TCM) may be utilized instead of ICCW.
      iv. Assure sufficient service capacity to meet the needs of SEDW recipients.
      v. 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 credentialed or non-credentialed provider, directly or contractually employed meets all applicable licensing, scope of practice, contractual and Medicaid Provider Manual qualifications and requirements. Contractor must ensure that staff and sub-contractors who oversee or deliver ICCW receive the MDHHS approved and required training on an annual basis.
      vi. Identify and implement a specific notification process for children entering or exiting foster care in coordination with local county MDHHS offices.
      vii. Participate in required SEDW technical assistance meetings and trainings.
      viii. Collect and report data, as requested, to MDHHS.

☐	I have reviewed the above requirements I.6 through I.7 and agree.

J. Parity and Benefits

1. Contractor must ensure compliance with 42 CFR part 438, subpart K, Parity in Mental Health and SUD 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 SUD 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 SUD 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 SUD 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 Limitations (NQTLs) for mental health or SUD 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 SUD 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.

☐	I have reviewed the above requirement and agree.

K. Quality Improvement and Program Development

1. Quality Assessment/Performance Improvement Program (QAPIP). 42 CFR 438.330
   Contractor must:
   a. Establish and implement an ongoing comprehensive QAPIP for the services it furnishes to its beneficiaries that includes:
      i. A minimum of one clinical and one nonclinical performance improvement project.
      ii. Performance measurement data which includes State required performance measures.
      iii. Mechanisms to detect both underutilization and overutilization of services.
      iv. Mechanism to assess the quality and appropriateness of care furnished to individuals with the following:
         1) Special healthcare needs and/or receiving LTSS as defined in the Comprehensive Quality Strategy.
         2) Receiving LTSS, including assessment of care between care settings and comparison of services and supports received with those set forth in the beneficiary's treatment service plan.
            a) Efforts to prevent detect, and remediate critical incidents based on requirements set forth in the home and community-based waiver

programs.

b. 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 the following:
   i. Trends in service delivery and health outcomes over time (including monitoring of progress on performance goals and objectives).
   ii. Information on the effectiveness of Contractor's QAPIP must be provided annually to network providers and to recipients upon request.
   iii. Information on the effectiveness of Contractor's QAPIP must be provided to the State annually, no later than February 28.

c. Refer to the QAPIP Technical Requirement for more detail, which can be found on the MDHHS website: https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/practiceguidelines.

2. External Quality Review 42 CFR 438.358
   a. The State will arrange for an annual, external independent review provided by an External Quality Review Organization (EQRO). Contractor must develop and implement performance improvement goals, objectives and activities in response to the external review findings as part of Contractor's QAPIP provided to the State, annually. The State may also require separate submission of an improvement plan specific to the findings of the external review.
   b. Contractor must effectively address the findings and recommendations for quality improvement made by the EQRO in accordance with timelines established by the EQRO and MDHHS relative to the nature of the finding.
3. Accreditation
   a. Contractor must have National Committee for Quality Assurance (NCQA) accreditation. Contractors with accreditation must provide proof of accreditation status. Contractors that are not currently accredited must provide a detailed plan to obtain NCQA accreditation. Contractor must also provide the State information regarding the Contractor's progress in achieving Health Equity Accreditation upon the State's request. Contractor must authorize the private independent accrediting entity to provide the State with a copy of its most recent accreditation review, including the following:
   b. Accreditation status, survey type, and level (as applicable).
      i. Recommended actions or improvements, corrective action plans, and summaries of findings.
      ii. Expiration date of the accreditation.
   c. Failure to obtain and/or maintain NCQA accreditation within the timeframes specified could result in enforcement mechanisms as identified in D. Contract Enforcement Methods. Utilization Management 42 CFR 438.210.
4. Utilization Management Incentives - Contractor must assure that compensation to individuals that conduct utilization management activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any beneficiary. 42 CFR 438.210(e).
5. Coverage and Authorization of Services
   a. The Contractor has in place, and follows, written policies and procedures for the processing of requests for initial and continuing authorizations. 42 CFR §438.210(b)(1). 42 CFR §457.1230(d).

b. The Contractor has in effect mechanisms to ensure consistent application of review criteria for authorization decisions and consults with the requesting provider for medical services when appropriate. 42 CFR §438.210(b)(2)(i) 42 CFR §457.1230(d).
c. The Contractor authorizes LTSS based on a member's current needs assessment and consistent with the person-centered service plan. 42 CFR §438.210(b)(2)(iii) Person-Centered Planning Practice Guideline–VI
d. Contractor must ensure that authorizations for services are provided within the required timeframes. Standard authorization decision must be made within seven (7) days of the request for service. Expedited authorizations must be made within 72 hours of the request for service.
e. Emergency services as defined in the Access Standards do not require a prior authorization. 42 CFR 438.114.
f. Post stabilization services require an authorization as expeditiously as the beneficiary's health condition requires, but no longer than 72 hours.
g. Contractor must ensure that any decision to deny or authorize a service in the amount scope and duration that is less than requested must be made by an individual who is qualified to address the medical, behavioral health, and long-term services and support needs.
h. Contractor must notify the requesting provider and give written notice of any decision to deny a service authorization request or authorize a service in an amount that is less than requested in accordance with 438.404.
i. The Contractor must report all service authorization data, excluding drugs, in accordance with 42 CFR 438.210(f). The following data must be aggregated for all services and be available publicly on its website:
    i. Services that require a prior authorization.
    ii. Percentage of standard prior authorization requests approved.
    iii. Percentage of standard prior authorization requests that were denied.
    iv. Percentage of standard prior authorization requests that were approved after an appeal.
    v. Percentage of prior authorization requests for which the timeframe for the review was extended and the request was approved.
    vi. Percentage of expedited prior authorization requests that were approved.
    vii. Percentage of expedited prior authorization requests that were denied.
    viii. Average and median time between the submission of the requests for expedited authorizations.
    ix. Average and median time between the submission of the requests for standard authorizations.

6. Timely Access to Care
    a. Contractor must ensure enrollees have access to emergency behavioral health care 24 hours per day, 7 days per week, in accordance with the access standards.
    b. Contractor must require that behavioral health office visits be available during regular and scheduled office hours.
    c. Contractor must ensure that beneficiaries have access to evening and weekend hours of operation in addition to scheduled daytime hours.
    d. Contractor must provide notice to beneficiaries of the hours and locations of service for their assigned Behavioral Health Providers' office hours.
    e. Contractor must ensure that Network Providers offer hours of operation that are no less than the hours of operation offered to commercial beneficiaries, or hours of operation comparable to Medicaid FFS, if the Provider serves only Medicaid

beneficiaries.

f. Contractor must meet, and require its Network Providers to meet, MDHHS standards for timely access to care and services for timely access to care and participate fully and completely in MDHHS efforts to assess network adequacy.
    i. The Contractor must educate its provider network regarding appointment timeliness requirements.

7. Consumer Survey
   Contractor must:
   a. Participate fully and completely with MDHHS requirements related to the annual patient experience survey of both their child and adult beneficiary population.
   b. Provide summary and beneficiary level data to MDHHS as requested.
   c. Provide an electronic or hard copy of the final survey analysis report developed by MDHHS to their network providers.
8. Performance Measure Data Quality, including but not limited to Home and Community-Based Quality Measures.
   a. MDHHS will review and validate all performance measure data for completeness and accuracy.
   b. Contractor must fully cooperate with all MDHHS efforts to monitor Contractor's compliance with the requirements of performance measure data validation.
   c. Contractor must comply with all MDHHS requests related to performance measure data collection, validation and monitoring in a timely manner as directed by MDHHS.
   d. Contractor must participate in reviews and assessments conducted by MDHHS or its designee, for the purpose of evaluating Contractor's collection, submission, and maintenance of performance measure data.
   e. Contractor must cooperate and comply with any audit arranged for by MDHHS to determine accuracy, truthfulness, and completeness of submitted performance measure data. Contractor must:
      i. Attend and participate in all MDHHS scheduled performance measure quality meetings.
      ii. Submit timely performance measure data in accordance with the MDHHS stated timeframes.
      iii. Submit complete and accurate performance measure data in accordance with the MDHHS outlined requirements.
      iv. Contractor failure to participate in MDHHS Performance Measure Data Quality activities and reviews in accordance with MDHHS standards may result in MDHHS contract remedies including but not limited to monetary Sanctions and other Sanctions, such as corrective action.
9. 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 ensure 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 Technical Requirement.
v. Family-Driven and Youth-Guided Policy and Practice Guideline
vi. Employment Works! Policy.

b. Contractor will participate in quality improvement activities for HIDE SNP members as directed by the State of Michigan.

☐	I have reviewed the above requirement and agree.

L. Grievance and Appeals Process for Beneficiaries

1. Grievance and Appeals General Requirements
   a. The Appeal and Grievance Resolution Processes Technical Requirement (is an extension of this Contract and must be adhered to by the Contractor, and can be found on the MDHHS website: https://www.michigan.gov/mdhhs/keep-mihealthy/mentalhealth/mentalhealth/practiceguidelines.
   b. Contractor must establish and maintain an internal process and must have written policies and procedures to govern the resolution of Grievances and Appeals from beneficiaries.
   c. Contractor must notify the beneficiary, in writing, of Contractor's decision on the Grievance or Appeal.
   d. Contractor must comply with 42 CFR 438.100, Enrollee Rights.
   e. 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.
   f. 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 system with procedures in place which align with the requirements of 42 CFR 438.400 – 438.424 (Subpart F).
      ii. Contractor must make a determination on non-expedited Appeals not later than 30 Days after an Appeal is submitted, orally or 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.
      iii. Contractor must make a determination on Grievances within 90 Days of the submission of a Grievance.
      iv. 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 (2) calendar 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 a Grievance if he or she disagrees with that decision.
         3) Issue and carry out its determination as expeditiously as the beneficiaries'

health condition requires and no later than the date the extension expires. (Per 42 CFR 438.404(c)(4); 42 CFR 438.408(c)(ii); 42 CFR 438.410).

v. 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.

2. Grievance and Appeal Procedure Requirements
Contractor's internal Grievance and Appeal procedure must follow and comply with all areas of 42 CFR 438 Subpart F as well as do the following: When the Contractor denies or approves a limited authorization of a verbal or written request for inclusion of a service in the IPOS, or one or more specific aspect of the amount, scope, and duration of a service, the Contractor must ensure that:
   a. The item is listed in a separate section of the IPOS titled "Requests Not Approved," and
   b. The Contractor provides an Adverse Benefit Determination that briefly but concretely sets forth its reasoning for not approving the request.
   c. This applies regardless of whether the non-approval or limited approval takes place during the person-centered planning process (e.g., before the planning meeting, after the planning meeting) or after its conclusion.
   d. In handling grievances and appeals, the Contractor must give enrollees any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.
   e. Contractor must provide that oral inquires seeking to Appeal an Adverse Benefit determination are treated as Appeals.
   f. 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.
   g. Contractor must provide the enrollee and his or her representative, the enrollee's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the 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 as specified in § 438.408(b) and (c).
   h. When the Contractor, denies or approves a limited authorization of a verbal or written request for inclusion of a service in the IPOS, or one or more specific aspect of the amount, scope, and duration of a service, the Contractor must ensure that:
      i. The item is listed in a separate section of the IPOS titled "Requests Not Approved," and
      ii. The Contractor provides an Adverse Benefit Determination that briefly but concretely sets forth its reasoning for not approving the request.
      iii. This applies regardless of whether the non-approval or limited approval takes place during the person-centered planning process (e.g., before the planning

meeting, after the planning meeting) or after its conclusion.

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.

☐	I have reviewed the above requirements L.1 through L.3 and agree.

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 process has 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).
6. Adverse Benefit Determination Notice
   a. Adverse Benefit determination notices involving Service Authorization Request

decisions that deny, or limit _services 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 action if (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 the plan for further services.
    4) The beneficiary's whereabouts are unknown, and the post office returns Contractor's mail directed to the beneficiary indicating no forwarding address.
    5) Contractor verified, with MDHHS, that the beneficiary has been accepted for Medicaid services 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 preadmission requirements.

b. The notice must include all components as outlined in the Appeal and Grievance Resolution Processes Technical Requirement and be mailed in a timely manner in accordance with 42 CFR 438.404.
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 those with special needs.

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 its Adverse 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 to request a State Fair Hearing.
e. Contractor must continue benefits while the appeal and State Fair Hearing are pending in accordance with 42 CFR 438.20.
f. Contractor must comply with 42 CFR 438.424 if the result of the State Fair Hearing is reversed.

8. Expedited Appeal Process
    a. Contractor's written policies and procedures governing the resolution of Appeals must include provisions for the 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 to provide oral notice.
9. Grievance and Appeals Records
    Contractor and its network providers/subcontractors as applicable, must maintain record of all Grievance and Appeals
    a. Grievance and appeal records must be retained for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.
    b. Contractor is required to maintain records of grievances and appeals and provide this information as requested by the state. The records of each grievance and appeal must contain information in accordance with 42 CFR 438.16.
10. Prior to when the Contractor reduces a participant's self-directed budget at an annual renewal or for any other reason, the Contractor must provide written justification to the beneficiary. The written justification must include specific reasoning for the reduction and why the Contractor determined the beneficiary does not need the same amount, duration, and scope of services that the beneficiary was previously assessed to need. A reduction in a self-directed budget must be in response to an identifiable change in the beneficiary's need. For the avoidance of doubt:
    a. A budget reduction and termination made during the term of an IPOS shall be treated as a "reduction, suspension, or termination" for purposes of internal appeal and Fair Hearing rules (including advance notice through an Adverse Benefit Determination notice and continuation of benefits, when applicable), and
    b. A budget reduction or termination made at annual renewal (e.g., during the person-centered planning process from the time of pre-planning and when the plan is signed) must be treated as a denial of requested service AND the beneficiary must be notified 14 calendar days before the PCP meeting for annual renewal.

☐	I have reviewed the above requirements L.4 through L.10 and agree.

M. Beneficiary Services

1. Provider Directory
   a. Contractor must maintain and publish a provider directory, which includes each of the provider types that are covered under the contract, including physicians (including specialists), hospitals, pharmacies, mental health and SUD providers, independent facilitators and financial management service providers, in paper form upon requests, and a searchable electronic formats. (42 CFR 438.10(h)(1)).
   b. Information included in a paper provider directory must be updated at least monthly if the Contractor does not have a mobile-enabled electronic directory or quarterly if the Contactor does have a mobile enabled electronic directory.
   c. Information included in an electronic provider directories must be updated no later than 30 calendar days after Contractor receives updated provider information.
   d. Directory must be made available on the Contractor's website in a machine-readable file. 42 CFR 438.10(h)(3).
   e. Paper form requests must be fulfilled within five business days, without charge to the beneficiary.
   f. Contractor provider directory must be organized by county.
   g. Contractor's provider directory must contain, at a minimum, the following information: (42 CFR 438.10(h)(1)).
      i. Provider name and any group affiliation.
      ii. Street address.
      iii. Telephone number.
      iv. Website URL.
      v. Specialty as appropriate.
      vi. Whether the provider is accepting new beneficiaries.
      vii. Cultural and linguistic capabilities, languages spoken (including American Sign Language) offered by the provider or skilled medical interpreter.
      viii. Whether the providers' office/facility has accommodations for people with physical disabilities.
      ix. Whether the provider offers covered services via telehealth.
2. Written Materials
   a. All Informative materials 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 limited to 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 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.

iv. All materials must 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 3% 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 that are critical to obtaining services 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 receive specialty supports and services:
   a) A listing of contracted providers that identifies provider name as well as any group affiliation, 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. Technical Advisory for Estimated 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 the consumers 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. The Technical Requirement for Explanation of Benefits 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 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). Notice to the beneficiary must be provided by the later of 30 calendar days prior to the effective date of the termination, or 15 calendar days after receipt or issuance of the termination notice.
4) Contractor must provide information to beneficiaries about managed care and care coordination responsibilities of Contractor, including:
   a) Information on the structure and operation of the Contractor.
   b) Upon request, physician incentive plans in use by Contractor or network

providers as set forth in 42 CFR 438.3(i).

c) Contractor must provide information on how to contact their designated person or entity for coordination of services as referenced in 42 CFR 438.208(b)(1).

☐	I have reviewed the above requirement and agree.

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 three years.
   b. Contractor must ensure that network providers residing and providing services in bordering states meet all applicable licensing and certification requirements within their state.
   c. 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 Credentialing and Recredentialing Processes which can be found at 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 underthis 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. Standardized Assessment of Mental Health Need
   a. Contractor must ensure that Qualified Mental Health Providers, as defined in the Medicaid Provider Manual, utilize the State's designated tools for assessing the level of mental health need of MHP beneficiaries seeking mental health services, in accordance with the Mental Health Framework Policy Bulletin [*MDHHS will be issuing a Mental Health Framework Policy Bulletin to reflect coverage responsibility and care coordination that will be effective with this Contract*].
      i. The State's designated tools for assessing mental health need include:
         1) The Michigan Child and Adolescent Needs and Strengths (MichiCANS) Screener for infants, toddlers, children, youth, and young adults under age 21, as described in O. Provider Services 4 Standardized Eligibility Tools for Children, Youth and Families.
         2) The Level of Care Utilization System (LOCUS) for adults (21 and older), as described in O. Provider Services 5. Level of Care Utilization System (LOCUS).

ii. The following categories of providers are Qualified Mental Health Providers, provided that assessment of mental health need is within their scope of practice:
   1) Qualified Mental Health Professionals, as defined in the Medicaid Provider Manual.
   2) Child Mental Health Professional, as defined in the Medicaid Provider Manual.
   3) Qualified Intellectual Disabilities Professionals, as defined in the Medicaid Provider Manual.

iii. Contractor must ensure that Qualified Mental Health Providers in its Provider Network:
   1) Complete all initial and ongoing training necessary to administer and complete the State-designated tools for assessing mental health need.
   2) Complete an assessment of mental health needs for beneficiaries they serve using the State's designated tools no more frequently than annually or upon a change in condition.
   3) Submit information on these assessments to MDHHS, as specified by MDHHS in the Mental Health Framework Policy Bulletin [*MDHHS will be issuing a Mental Health Framework Policy Bulletin to reflect coverage responsibility and care coordination that will be effective with this Contract*], within 24 hours of completing the assessment to a State-specific platform.

iv. Contractor must work with MDHHS and its network providers to ensure mental health assessments as described in this section are being completed in accordance with the Mental Health Framework Policy Bulletin [MDHHS will be issuing a Mental Health Framework Policy Bulletin to reflect coverage responsibility and care coordination that will be effective with this Contract]. This includes but is not limited to:
   1) Supporting Qualified Mental Health Providers in understanding and complying with the assessment requirements described in the Mental Health Framework Policy Bulletin [*MDHHS will be issuing a Mental Health Framework Policy Bulletin to reflect coverage responsibility and care coordination that will be effective with this Contract*].
   1) Notifying Qualified Mental Health Providers when annual assessments are due for beneficiaries they have historically served.
   2) Completing ongoing fidelity monitoring of the use of the State-designated tools.

v. For MHP beneficiaries, standardized assessment of mental health care using these State-designated tools will inform mental health coverage responsibility, as reflected in Schedule H – Medicaid Mental Health and SUD Payment Responsibility Grid.

☐	I have reviewed the above requirements N.1 through N.3 and agree.

4. Standardized Eligibility Determination Tools for Children, Youth and Families
   Contractor must:
   a. Ensure that network providers utilize standardized tools approved and required by MDHHS to assist in the determination of eligibility for specialty behavioral health services defined in the Medicaid Provider Manual and the Technical Requirement for Infants, Toddlers, Children, Youth, and Young Adults with SED and I/DD, located on

the MDHHS Policies and Practice Guidelines website here: https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/practiceguidelines.

i. Defined programs for which Contractor network providers will assess eligibility include:
   1) SEDW Program for Children.
   2) Children's Waiver Program (CWP).
   3) 1915(i) Needs Based Assessment as outlined in the Medicaid Provider Manual.
   4) Michigan Intensive Child and Adolescent Services including the following service areas:
      a) Respite.
      b) Intensive Care Coordination with Wraparound (ICCW).
      c) Home-Based Services.
      d) Youth Peer Supports.
      e) Parent Support Partners.
      f) Intensive Crisis Stabilization Services.

b. Collaborate with MDHHS for ongoing fidelity monitoring on use of the required tool(s).
c. Provide oversight and direction to providers in determining individualized services and intensity of care coordination for infants, toddlers, children, young adults, and families.
d. Ensure that the MDHHS required tools are completed at access, intake, annual assessment, and exit process in accordance with the Technical Requirement for Infants, Toddlers, Children, Youth, and Young Adults with SED and I/DD and that information gathered from the required tools inform treatment plans for all infants, toddlers, children, and young adults up to age 21 who are seeking supports and services for SED or I/DD. Contractor must also support completion of the tool when there is a significant change in life circumstances and/or a behavioral health event as defined in the Technical Requirement.
e. Ensure ratings for MDHHS required tools that have been completed by qualified raters in other child serving systems, by CCBHCs, or by Qualified Mental Health Professionals in the Contractor's or MHP's network are honored and accepted for use in service planning and eligibility determinations. Qualified raters may review and update the ratings with state required tools based on the results of clinical assessments and evaluations of major life events that constitute a change in condition.
f. Develop and maintain a network of certified assessors to ensure the timely completion of the state-required tools as identified in the Technical Requirement with costs covered by the State.
g. Ensure that appropriate staff (and sub-Contractors if applicable) can access, complete, and review associated records through Contractor's information technology systems, complying with state requirements for access permissions and any other administrative processes in place to protect Contractor, MDHHS, and staff who are accessing the information.
h. Ensure that network providers report completed assessment information and related data to MDHHS utilizing standards, templates, and related timelines and deadlines as specified by MDHHS. Assessment results must be submitted using MDHHS-specified information systems within 24 hours of completion of an assessment.
i. Ensure orientation of children, youth, families, providers, and other system partners to

the purpose and use of the standardized tools and processes.

j. Ensure that network providers serving Transition Age Youth / young adults:
   i. Have the capacity to provide the MichiCANS comprehensive to Transition Age Youth/young adults.
   ii. Complete the MichiCANS Screener for Transition Age Youths/young adults (up to 21) who request access to mental health or IDD services (if the Transition Age youth/young adult potentially has a severe mental illness and is referred to a provider of adult services, the LOCUS must be completed).
   iii. Provide information about the service continuum (including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)) to transition aged youths/young adults and associated family members/guardians (as appropriate).
   iv. Complete a MichiCANS comprehensive for a Transition Age Youth if the Transition Age Youth:
      1) Is referred to a provider of children's services.
      2) Requests EPSDT Services.
   v. Document the decision of Transition Age Youths and young adults (up to 21) and associated family members/guardians (as appropriate) to receive services from an adult services provider or children services provider.

5. Level of Care Utilization System (LOCUS) Contractor must:
   a. Ensure that network providers incorporate the LOCUS into the initial assessment and reassessment process for all individuals 18 and older seeking mental health services, consistent with Standardized Assessment and supports, using the MDHHS designated tool(s)approved methods for scoring the tool listed below unless otherwise indicated for transition age youth:
      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 seeking mental health services from Contractor or network providers has a LOCUS completed, including as part of any assessment and re-assessment process if they are receiving adult services.
      i. Ensure that the LOCUS is conducted no more frequently than annually or upon a change in condition.
   c. Ensure LOCUS assessments that have been completed by CCBHCs or Qualified Mental Health Professionals that are MHP network providers or Contractor network providers are honored and accepted for use in service planning and eligibility determinations.
   d. If the child / youth aged 18-21 years is receiving EPSDT in the CMHSP system, MDHHS designated tools must be completed at access, intake, annually, and exit through age 21. Contractor must also ensure the completion of the tool after significant life events as defined in the Technical Requirement for Infants, Toddlers, Children, Youth, and Young Adults with SED and I/DD, located on the MDHHS Policies and Practice Guidelines website here: https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/practiceguidelines.
   e. Collaborate with the State for ongoing fidelity monitoring on the use of the tool.
   f. Ensure that network providers provide the State with the composite score for each LOCUS that is completed in accordance with the established reporting guidelines. Assessment results must be submitted using MDHHS-specified information systems within 24 hours of completion of an assessment.

☐	I have reviewed the above requirements N.4 through N.5 and agree.

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 ensure 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
      i. 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
      i. Contractor or its network providers must not require any co-payments, recipient pay amounts, or other costsharing arrangements unless specifically authorized by the State. Network providers must not seek, nor accept,additional

supplemental payment for services authorized by Contractor.

f. Electronic Billing Capacity
   i. 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 ProviderManual. 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.7 (Provider Procurement) and Section 2.9 (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
         a) Hospital eligibility is determined by the State. Community hospitals, including Institutes for MentalDisease, 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
         a) 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 andboard 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
         a) 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
         a) 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 monthin each quarter.

5) Contractor Payment Obligations and Payment Process
   a) 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 Contractorreceiving the quarterly HRA gross adjustment from the State. The State acknowledges that payments can be made without a current contractual arrangement between Contractor/affiliateCMHSPs and the hospital receiving an HRA payment. Contractor delegation to affiliate CMHSPs is not allowed.
6) Contractor Reporting Requirements
   a) Financial status reports will continue to include HRApayment revenue and payment information requirements.

i. Contractor must pay no less than the state defined minimum rates for inpatient psychiatric services.

☐	I have reviewed the above requirements N.6 through N.7 and agree.

8. MDHHS Standard Consent Form
   a. 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
   a. Contractor must develop a trauma-informed system in accordance with the MDHHS 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 meet the requirements of the Public Health Code PA 368 of 1978 as it relates to SUD services, and Chapter 2A of the Mental Health Code PA 258 of 1974.
   c. Contractor must provide all SUD services (Prevention, Treatment and Recovery Supports) included within the Substance Abuse and Mental Health Services Administration's (SAMHSA) Substance Abuse Prevention and Treatment Block Grant (SUPTRS-BG) in order to provide services to those who are uninsured or under insured.
   d. Contractors must enter into separate grant agreements with MDHHS to receive SUPTRS-BG funds. See Appendix 2 for samples.

   e. Contractor must:
      i. Develop comprehensive plans for SUD 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 SUD Programs titled document)).

iii. Provide technical assistance for local SUD 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 SUD 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 SUD 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 network agreements with providers for SUD services.
ix. Contractor must meet the requirements of the Public Health Code PA 368 of 1978 as it relates to SUD services, and Chapter 2A of the Mental Health Code PA 258 of 1974.
x. Ensure network providers are appropriately licensed for the service(s) provided in accordance with Michigan Public Health Code, PA 368 of 1978 and Mental Health Code PA 258 of 1974.

11. Provider Network Oversight Management
    a. The provision of SUD treatment services must be based on the ASAM Level of Care (LOC) criteria.
        i. 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 indicatesall 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.
    b. Reimbursement for Services to Persons with Co-Occurring Disorders
        i. SUD funds may be used to reimburse providers for integrated mental health and SUD 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 SUDs 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 SUDs treatment provided to persons with co-occurring substance

use and mental health disorders.

c. 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. Contractor must meet all applicable ASAM LOC and SUD provider network adequacy standards set forth within the MDHHS Network Adequacy – Medicaid Specialty Behavioral Health Services Procedure.
   iii. The State Approved ASAM SUD treatment providers can be found in the Customer Relationship Management (CRM) system. Contractor must ensure that all the following LOCs are available for adult and adolescent populations:

Level of Care	ASAM Title
0.5	Early Intervention
1	Outpatient Long-Term Remission Monitoring
1.5	Outpatient Treatment Services
2.1	Intensive Outpatient Treatment Services
2.5	High-Intensity Outpatient Treatment Services
3.1	Clinically Managed Low Intensity Residential Services
3.5	Clinically Managed High Intensity Residential Services
3.7	Medically t Medically Managed Residential Treatment Services
3.7 BIO	BIO Medically Managed Biomedically Enhanced Residential Treatment
1.7	Medically Managed Outpatient
2.7	Medically Managed Intensive Outpatient Treatment
3.2-WM	Clinically Managed Residential Withdrawal Management
3.7-WM	Medically Monitored Inpatient Withdrawal Management

   iv. 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.

☐	I have reviewed the above requirements N.8 through N.11 and agree.

12. Electronic Visit Verification (EVV)
   a. Contractor must ensure its network providers 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 of either:
         1) An alternative EVV system that has been pre-approved by the State, which meets all the necessary system and reporting requirements and successfully integrates with the States' EVV solution aggregator.
         2) Participation in the State sponsored Statewide EVV system.
      ii. Personal Care Services (PCS) includes community living support and respite services that are provided in a beneficiary's home using Medicaid funding.
      iii. Contractor must ensure its network providers, or those of their CMHSP participants, stipulates the EVV system supports self-directed arrangements and is minimally burdensome or disruptive to care.
      iv. Contractor must ensure its network providers, or those of their CMHSP

participants, are adequately trained in EVV requirements and Michigan's practice and implementation standards. Contractor must also ensure all network providers are adequately trained in the specific EVV system/solution being used by their agency. Contractor must submit additional EVV documentation, data, and reporting to the state as requested.

13. Critical Incidents
    a. Contractor must report the following incidents for beneficiaries enrolled in the CWP, SEDW, HSW and the 1915(i) SPA: Suicide; Non-suicide death; Arrest of Consumer; Emergency Medical Treatment due to injury or Medication Error: Type of injury will include a subcategory for reporting injuries that resulted from the use of physical management or falls; Hospitalization due to Injury or Medication Error: Hospitalization due to injury related to the use of physical management or falls. Type of injury will include a subcategory for reporting injuries that resulted from the use of physical management. Further guidance on these requirements can be found in the Critical Incident Reporting Technical Guidance which can be found on the MDHHS Website: https://www.michigan.gov/en/mdhhs/keep-mi-healthy/mentalhealth/reporting.
    b. Contractor must comply with the reporting requirements identified in the Critical Incident Event Notification and SUD Sentinel Event Reporting Requirements which can be found on the MDHHS website: https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/practiceguidelines.
    c. When Contractor identifies a critical incident for a shared member with a HIDE SNP, Contractor must coordinate with the HIDE SNP to assure an appropriate resolution of the incident as necessary.
    d. When there is a critical incident involving a member enrolled in a HIDE SNP, Contractor must report to the HIDE SNP any critical incidents that are not already being reported through the PIHP's critical incident reporting system, the Office of Recipient Rights, DHHS-APS, or LARA.
14. World Health Organization Disability Assessment Schedule 2.0 (WHODAS)
    a. Contractor must use the WHODAS 2.0 as the assessment tool for Medicaid beneficiaries:
        i. Aged 18 and over.
        ii. With an intellectual and development disabilities diagnosis.
    b. The WHODAS is used to determine eligibility or recertification for services under the 1915i(SPA) and screening for eligibility in the HSW. The WHODAS 2.0 can also be used to inform the PCP processes.
15. Immediately Reportable Events
    a. Contractor is responsible for notifying MDHHS for the following events in accordance with the MDHHS Critical Incident Event Reporting Policy:
        i. Any death that occurs because of suspected staff member action or inaction or any death that is the subject of a recipient rights, licensing, or police investigation.
        ii. Relocation of a consumer's placement due to licensing suspension or revocation.
        iii. An occurrence that requires the relocation of any PIHP or provider panel service site, governance, or administrative operation for more than 24 hours.
        iv. The conviction of a PIHP or provider panel staff members for any offense related to the performance of their job duties or responsibilities which results in exclusion from participation in federal reimbursement.

v. Any changes to the composition of the provider network organizations including personnel change that may negatively affect access to care.
vi. Events which may be newsworthy or represent a community crisis must be reported to MDHHS immediately.

☐	I have reviewed the above requirements N.12 through N.15 and agree.

O. Management Information Systems

1. Contractor must maintain a Management Information Systems (MIS) that collects, analyzes, integrates, and reports data and can achieve the objectives of this Contract. 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.
         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, 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 must be followed.
2. Capabilities
   a. Management Information Systems capabilities are required for the following:
      i. Daily and monthly beneficiary enrollment and disenrollment files.
      ii. Capitation payments, including reconciliation of enrollment and capitation payments received.
      iii. Client registration and demographic information.

iv. Provider enrollment.
v. Third party liability activity.
vi. Claims payment and tracking.
vii. Grievance and appeal tracking.
viii. Utilization management, including tracking and analyzing services and costs by population group, and special needs categories as specified by the State.
ix. Encounter and demographic data reporting.
x. Quality measurement and reporting.
xi. HIPAA compliance.
xii. Uniform Business Practices (UBP) compliance.
xiii. Care Management.
xiv. Identifying and tracking Fraud, Waste and Abuse.
xv. 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.

3. Enrollment and Payment Files
MDHHS will provide HIPAA-compliant daily and monthly enrollment files to the Contractor via the File Transfer Service (FTS).
   a. Contractor's MIS must have the capability to utilize the HIPAA-compliant enrollment files to update each beneficiary's status in the MIS.
   b. Contractor must load the monthly enrollment audit file prior to the first of the month and distribute enrollment information to the Contractor's CMHSP's on or before the first of the month.
   c. Contractor must reconcile the daily and monthly waiver enrollment files to the monthly payment file within 120 Days of the end of each month.
      i. In the event that an issue or error with enrollment files becomes known, MDHHS will communicate the issue, status and working resolution with the Contractor.
      ii. Should the issue or error affect the Contractor's ability to reconcile enrollment files, MDHHS will communicate appropriate workarounds, operational revisions or revise deliverable requirements as appropriate to the outstanding issue or error.
   d. Contractor must ensure that MIS support staff have sufficient training and experience to manage files MDHHS sends to the Contractor via the FTS.
4. Beneficiary Medical Records
   a. Contractor must ensure that providers establish and maintain a comprehensive individual medical record system consistent with the provisions of MMP 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 medical 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.
   b. Contractor's medical records must be maintained in a detailed, comprehensive manner that conforms to good professional medical practice, permits effective professional medical review and medical audit processes, and facilitates a system for

follow-up treatment.
   i. Medical records must be signed and dated.
   ii. All medical records must be retained for at least 10 years
c. Contractor must have written policies and procedures for the maintenance of medical records so that those records are documented accurately and in a timely manner, are readily accessible, and permit prompt and systematic retrieval of information.
d. Contractor must have written plans for providing training and evaluating providers' compliance with the recognized medical records standards.
e. Contractor must have written policies and procedures to maintain the confidentiality of all medical records.
f. Contractor must comply with applicable State and federal laws regarding privacy and security of medical records and protected health information.

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 this information 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. Electronic Exchange of Client-Level Information
   a. Contractor must implement and maintain an electronic data system, by which Providers and other entities can send and receive client-level information for the purpose of care management and coordination.
   b. The electronic data system must meet all applicable State and federal guidelines for privacy and security of protected health information exchanged for the purposes of treatment, payment, or operations.
   c. Contractor must ensure capacity to, at a minimum, send/receive admission, discharge, and transfer (ADT) type messages or information to improve care management and care coordination at the plan level and within its provider network.
   d. Contractor must ensure capabilities to collect, store, and incorporate clinical quality information into their provider quality measurement and improvement programs to enhance the health plan's capacity to measure and improve the clinical health outcomes of beneficiaries.
8. Network Adequacy Provider (NAP) File
   a. Contractor must submit Network Adequacy Provider (NAP) files that contain a complete and accurate description of the Provider Network according to the specifications and format delineated by MDHHS.
   b. MDHHS utilizes the NAP file to ensure the Provider Networks identified for Contractors are adequate in terms of number, location, and hours of operation.
   c. The NAP file must contain all Network Providers, including all Sub-Network Providers (e.g. fiscal intermediary, etc.)
   d. Contractor must submit a NAP file that passes all MDHHS quality edits at least once per quarter and more frequently, if necessary, to ensure changes in the Contractor's Provider Network are reflected in the NAP file in a timely manner.

☐	I have reviewed the above requirement and agree.

P. Legal Expenses

1. All legal costs under this Contract shall be subject to 42 CFR Part 438 Managed Care; 45 CFR Part 95 -General Administration of Federal Financial Participation; 2 CFR Part 200 – Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards; applicable provisions of the Medicaid Provider Manual and this Contract.
2. Sufficient documentation must be maintained to support the allowability of legal expenses. Invoices must contain sufficient detail to evidence allowability.
3. Legal costs must be reasonable and necessary and allocable for the administration of:
   a. The program on behalf of the State of Michigan or Federal Government.
   b. Employment related matters (e.g., labor negotiation, employment allegations) in accordance with 2 CFR 200.435.
   c. Enforcement actions or audit findings issued by the State or CMS only under the following circumstances:
      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 before any hearing occurs.
4. The following legal expenses are not allowed:
   a. Legal expenses in connection with any criminal, civil, or administrative proceeding initiated by a governmental entity by against the Contractor, except as provided in 3.c. above.
   b. Legal expenses for the prosecution of claims against the State of Michigan or the Federal Government.
   c. Legal expenses contingent upon recovery of costs from the State of Michigan or the Federal Government.

☐	I have reviewed the above requirement and agree.

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. The Contractor must comply with any decision issued by an Administrative Law Judge in a Medicaid Fair Hearing.
   c. 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 along with any other applicable state laws, rules, regulations, and administrative procedures.
2. Compliance with False Claims Acts
   If the Contractor 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
   a. 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 must identify and recover from all other liable third parties, including court judgments or settlements when notified. 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 identify and recover all sources of third-party funds based on industry standards and MDHHS TPL Division Guidance.
ii. Contractor must implement written procedures for TPL recovery consistent with federal and state requirements. Contractor's use of best practices is strongly encouraged and must align with 42 USC 1396(a) (25), 42 CFR 433 Subpart D.
iii. Contractor, and MDHHS TPL Guidelines. The State will review these procedures for compliance. Contractor must submit a Risk Mitigation Plan within 30 days of a state request to address risks identified in the MDHHS TPL Dashboard. The Risk Mitigation Plan shall be in a format required by the State. (Effective after receiving two quarterly dashboards).
iv. Contractor must report third party collections through encounter data and aggregate data submissions as required.
v. Recovery data must be submitted in an electronic format as prescribed by the State.
vi. Contractor must recover payments from all applicable sources, including Medicare and private health insurers 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.
vii. The State will provide Contractor with known third party resource data via CHAMPS or through Eligibility Inquiry and Response file 270 requests. The most recent data will be provided 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.
viii. 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.
ix. For dually enrolled beneficiaries, Contractor must pay Medicare cost-sharing amounts regardless of prior authorization.
x. 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.
xi. Contractor must respond within 30 days of subrogation notification pursuant to MCL 400.106(10).
xii. 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 staff name(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.

xiii. 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 specified in 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.

☐	I have reviewed the above requirements Q.1 through Q.4 and agree.

5. Advance Directives Compliance
   a. 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 withthe 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
   a. 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 appliesto 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 orMedicaid; 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

credit 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 orservices must be smoke free.

7. Hatch Political Activity Act and Intergovernmental Personnel Act
   a. Contractor must comply with the Hatch Political Activity Act, 5 USC 1501-1508, and 7321-7326, 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 Act of 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
   a. 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 SUD 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.
      i. 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 as appropriate under this agreement.

ii. Contractor must ensure that any network provider 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.

iii. Contractor must only use the protected health data and information for the purposes of this Contract.

iv. 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.

v. 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.

vi. 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.

vii. Contractor must enter into a business associate agreement.

viii. 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.

ix. Contractor must have written policies and procedures for maintaining the confidentiality of all protected information.

10. Ethical Conduct
    a. 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
    a. 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 and 42 CFR 441.301(c)(1)(vi), 42 CFR 441.730(b), 42 CFR 441.720, 1915(c) Medicaid Waivers, 1915(i) State Plan Amendments.

12. Human Subject Research
    a. 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).

☐	I have reviewed the above requirements Q.5 through Q.12 and agree.

13. Fiscal Soundness of the Risk-Based Contractor
    a. 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 and Waivers
    a. Contractor must comply with provisions of the Medicaid Provider Manual and Medicaid Waivers.
    b. Contractors must ensure their network providers also comply with the provisions of the Medicaid Provider Manual and Medicaid Waivers.
    c. Contractors must also comply with provisions of the Medicaid policy developed under the formal policy consultation process, as established by Health Services.
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-SUD Section.
    c. Contractor must provide covered State plan, 1915(i)SPA 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 Services (HCBS)
    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 assessed 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, as requested. 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 completion of the HCBS Comprehensive Assessment for all new providers/settings. Contractor may provide provisional approval to the new provider as long as the setting does not qualify for heightened scrutiny and does not have restrictive features or setting wide policies. When a setting qualifies for heightened scrutiny and/or has restrictive features or setting wide policies, Contractor must communicate this to the HCBS 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 consistent with MDHHS requirements. Contractors must ensure providers complete this assessment and subsequent remediation/validation processes in order to be eligible for HCBS funding.
c. Contractor must not enter into new contracts with new providers of services (as defined by MDHHS) 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 or have restrictive features. 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 complete the comprehensive HCBS assessment consistent with MDHHS requirements. 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. 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.
d. Contractor must ensure that a physical assessment of the setting is conducted annually and the comprehensive assessments at least once every three years to ensure that the setting remains home and community based.
e. Please reference the Home and Community Based Setting Monitoring Requirements 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.
f. Contractor must ensure that all HCBS final rule requirements are met, as described in the Michigan Medicaid Provider Manual.

17. Electronic Visit Verification (EVV)
    a. 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. Application Programming Interface (API)
    a. In accordance with 42 CFR 438.242(b)(5), Contractor must implement an Application Programming Interface (API) as specified in 42 CFR 431.60 (beneficiary access to and exchange of data) as if such requirements applied directly to the Contractor.
19. Programs or Activities No Longer Authorized by Law
    a. 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.

☐	I have reviewed the above requirements Q.13 through Q.19 and agree.

R. Program Integrity

The State, MDHHS-Office of Inspector General (OIG) is responsible for overseeing the program integrity activities of Contractor and all subcontracted entities/network providers consistent with this Contract and the requirements under 42 CFR 438.608.

All requirements in this section of the Contract must be supported by Contractor internal policies and procedures to demonstrate implementation and compliance.

1. General:
    a. To the extent consistent with applicable Federal and State law, including, but not limited to 42 CFR Part 2, HIPAA, and the Michigan Mental Health Code, 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 per 42 CFR 438.230 and how Contractor will monitor those activities.
        i. Program integrity requirements under 42 CFR 438.608 cannot be delegated to a network provider.

1) The Contractor must conduct their own program integrity functions in accordance with 42 CFR 438.608. The Contractor is only permitted to delegate such activities to a third-party vendor hired and contracted to perform strictly these specific functions.
2) These functions must be performed on a monthly basis to ensure adequate oversight of the Contractor's network providers. This includes random and scheduled audits of network providers, including investigating complaints and conducting data mining activities to identify targets for audits/investigations.
3) Failure to conduct these routine activities may result in Contract remedies such as sanctions, credits, and/or liquidated damages

ii. The Contractor must also mandate the performance of such program integrity activities by their contracted network providers at the Community Mental Health (CMH) level.
1) This work will not replace the program integrity requirements of the Contractor.
2) The Contractor must also require their network providers to track and report all activities related to their program integrity oversight.
3) The program integrity efforts conducted by network providers must still be reported up through the Contractor and to MDHHS as part of compliance submission requirements.

c. 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.
d. 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.
e. Contractor must have written documentation of internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected Fraud, Waste, and Abuse activities. The arrangements or procedures must include the following:
i. Contractor must have a program integrity compliance program as defined in 42 CFR 438.608. The program integrity compliance program and plan must include, at a minimum, all of the following elements:
1) Written policies, procedures, and standards of conduct that articulate Contractor's commitment to comply with all applicable Fraud, Waste, and Abuse requirements and standards under this Contract, and all applicable Federal and State requirements.
a) Standards of Conduct – Contractor must have written standards of conduct that clearly state the Contractor's commitment to comply with all applicable statutory, regulatory and Medicaid program requirements. The standards of conduct must be written in an easy-to-read format and distributed to all employees. All employees must be required to certify that they have read, understand, and agree to comply with the standards.
b) Conflict of Interest – Contractor will uphold high ethical standards and is prohibited from holding or acquiring an interest that would

conflict with this Contract. Contractor will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain. Any potential conflicts of interest must receive internal, documented approval. Such documentation must be saved in accordance with applicable retention policies.

i) It is not permissible for the executive level staff or compliance officer of the Contractor to be employed by one of their network providers in such a capacity.

c) Written Compliance Policies and Procedures – Contractor must have comprehensive written compliance policies and procedures, developed under the direction of the compliance officer and Compliance Committee, which direct the operation of the compliance program. The written compliance policies and procedures must include, at a minimum, the following elements:

i) Duties and responsibilities of the compliance officer and Compliance Committees.
ii) How and when employees will be trained.
iii) Procedures for how employee reports of noncompliance will be handled.
iv) Guidelines on how the compliance department/officer will interact with other individuals and departments (e.g., human resources, legal counsel, etc.).
v) Duties and responsibilities of management in promoting compliance among employees and responding to reports of non-compliance.
vi) Ensuring that prospective employees receive appropriate background screening and agree to abide by the Contractor's code of conduct.
vii) Conducting periodic reviews, at least annually, of the code of conduct and the compliance policies and procedures.
viii) Procedures for the monitoring of compliance in Contractor and network provider systems and processes.
ix) Procedures for the monitoring of potential Fraud, Waste, and Abuse in provider billings and beneficiary utilization.
x) Procedures for performing an investigation of targets selected for audit, including triage and review processes.
xi) Reporting confidentiality and non-retaliation policy.
xii) 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.
xiii) Written policies and procedures pertaining to cooperation in investigations or prosecutions.
xiv) The prohibition of any managed care entity (MCE) employee also being employed or contracted with one of their subcontractors, network providers, or providers.

2) The designation of a compliance officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the Contract and who reports directly to the chief executive officer (CEO) and the Board of Directors.

a) Contractor must designate a compliance officer whose primary

responsibility is to oversee the implementation and maintenance of the compliance program. The CEO, chief financial officer (CFO), and chief operating officer (COO), or any other individuals operating in these roles, may not operate in the capacity of the compliance officer.

b) The compliance officer must have adequate authority and independence within the Contractor's organizational structure in order to make reports directly to the board of directors and/or to senior management concerning actual or potential cases of non-compliance.

c) The compliance officer must also report directly to corporate governance on the effectiveness and other operational aspects of the compliance program.

d) The compliance officer's responsibilities must encompass a broad range of duties including, but not limited to, the investigation of alleged misconduct, the development of policies and rules, training officers, directors, and staff, maintaining the compliance reporting mechanism and closely coordinating with the internal audit function of the Contractor.

3) Maintenance of a Regulatory Compliance Committee comprised of individuals from the Board of Directors and senior management charged with overseeing the Contractor's compliance program and its compliance with requirements under the Contract.

a) Contractor must establish a Regulatory Compliance Committee that will advise the compliance officer and assists in the maintenance of the compliance program.

b) The compliance officer will remain duty-bound to report on and correct alleged fraud and other misconduct.

c) The compliance officer must chair the Regulatory Compliance Committee.

d) The Regulatory Compliance Committee must meet no less than quarterly.

4) A system for annual 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.

a) Formal Training Programs – Contractor must provide general compliance training to all employees, officers, managers, supervisors, board members and long-term temporary employees that effectively communicates the requirements of the compliance program, including the company's code of conduct and applicable Medicaid statutory, regulatory, and contractual requirements.

i) Contractor must also determine under what circumstances it may be appropriate to train nonemployee agents and contractors.

ii) Employees, officers, managers, supervisors, and Board members must be required to attend compliance training sessions and to sign

certifications that they have completed the appropriate sessions.

iii) The initial compliance training for new employees must occur within 90 days of the date of hire.

iv) Contractor must provide annual refresher compliance training that highlights compliance program changes or other new developments. The refresher training should re-emphasize Medicaid statutory, regulatory, and contractual requirements and the Contractor's code of conduct.

b) Informal On-going Compliance Training – Contractor must employ additional, less formal means for communicating its compliance message such as posters, newsletters, and Intranet communications. The compliance officer must be responsible for the content of the compliance messages and materials distributed to employees and managers.

5) Effective lines of communication between the compliance officer and the Contractor's employees.

a) Hotline or Other System for Reporting Suspected Noncompliance – Contractor must have mechanisms in place for employees and others to report suspected or actual acts of non-compliance.

i) In order to encourage communications, confidentiality and non-retaliation policies must be developed and distributed to all employees.

ii) Contractor must use e-mails, newsletters, suggestion boxes, and other forms of information exchange to maintain open lines of communication.

iii) A separate mechanism, such as a toll-free hotline, must be employed to permit anonymous reporting of non-compliance.

iv) Matters reported through the hotline or other communication sources that suggest substantial violations of compliance policies or health care program statutes and regulations must be documented and investigated promptly to determine their veracity.

v) Contractor must create an environment in which employees feel free to report concerns or incidents of wrongdoing without fear of retaliation or retribution, when making a good faith report of non-compliance.

b) Routine Communication and Access to the compliance officer – Contractor must have a general "open door" policy for employee access to the compliance officer and the Compliance Department staff. Staff must be advised that the compliance officer's duties include answering routine questions regarding compliance or ethics issues.

i) The compliance officer must establish, implement, and maintain processes to inform the Contractor's employees of procedure changes, regulatory changes, and contractual changes.

☐	I have reviewed the above requirement R.1 and agree.

6) Enforcement of standards though well-publicized disciplinary guidelines.

a) Consistent Enforcement of Disciplinary Policies – Contractor must maintain written policies that apply appropriate disciplinary sanctions on those officers, managers, supervisors, and employees who fail to comply with the applicable statutory and Medicaid program requirements, and with the Contractor's written standards of conduct. These policies must include not only sanctions for actual noncompliance, but also for failure to detect non-compliance when routine observation or due diligence should have provided adequate clues or put one on notice. In addition, sanctions should be imposed for failure to report actual or suspected non-compliance.
   i) The policies must specify that certain violations, such as intentional misconduct or retaliating against an employee who reports a violation, carry more stringent disciplinary sanctions.
   ii) In all cases, disciplinary action must be applied on a case-by-case basis and in a consistent manner.
   iii) Contractor may identify a list of factors that will be considered before disciplinary action will be imposed. Such factors may include degree of intent, amount of financial harm to the company or the government or whether the wrongdoing was a single incident or lasted over a long period of time.

b) Employment of, and Contracting with, Ineligible Persons – Contractor must have written policies and procedures requiring a reasonable and prudent background investigation to determine whether prospective employees and prospective non-employee network providers or agents were ever criminally convicted, suspended, debarred, or excluded from participation in a federal program.
   i) Contractor must also conduct periodic reviews of current employees and/or subcontractors/network providers and agents to determine whether any have been suspended or debarred or are under criminal investigation or indictment. If an employee or non-employee agent or subcontractor/network provider is found to be ineligible, Contractor must have a written policy requiring the removal of the employee from direct responsibility for, or involvement with, the Medicaid program, or for the termination of the subcontract/network providers, as appropriate.

7) Establishment and implementation, and ongoing maintenance of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with requirements under the Contract.
   a) Auditing – Contractor must have a comprehensive internal audit system to ensure that the Contractor is in compliance with the range of contractual and other MDHHS requirements in critical operations areas. The internal auditors must be independent from the section/department under audit. The auditors must be competent to identify potential issues within the critical review areas and must

have access to existing audit resources, relevant personnel, and all relevant operational areas. Written reports must be provided to the compliance officer, the Compliance Committee and appropriate senior management. The reports must contain findings, recommendations and proposed corrective actions that are discussed with the compliance officer and senior management.

i) Contactor must ensure that regular, periodic evaluations of its compliance program occur to determine the program's overall effectiveness. This periodic evaluation of program effectiveness may be performed internally, either by the compliance officer or other internal source - or by an external organization. These periodic evaluations must be performed at least annually, or more frequently, as appropriate.

b) Monitoring – Contactor must maintain a system to actively monitor compliance in all operational areas. Contractor must have a means of following up on recommendations and corrective action plans resulting from either an internal compliance audit or MDHHS review to ensure timely implementation and evaluation.

i) Contractor must have a Questionnaire that includes questions regarding whether any exiting employee observed any violations of the compliance program, including the code of conduct, as well as any violations of applicable statutes, regulations, and Medicaid program requirements during the employee's tenure with the Contractor. The Compliance Department must review any positive responses to questions regarding compliance violations.

ii. Provision for prompt notification to MDHHS when it receives information about changes in an enrollee's circumstances that may affect the enrollee's eligibility, including but not limited to:
1) Changes in the enrollee's residence.
2) The death of an enrollee.

iii. Provision for notification to MDHHS-OIG when it receives information about a change in a network provider's circumstances that may adversely affect the network provider's eligibility to participate in the managed care program, including but not limited to, termination from the Contractor or Contractor's provider network or temporary suspension or payment suspension initiated by the Contractor or network provider.
1) When these actions are taken by the Contractor or network provider, the Contractor must promptly report the adverse action to MDHHS-OIG via sFTP using the provider adverse action and exclusion reporting form.
2) Any questions of whether to report such actions must be promptly presented to MDHHS-OIG for clarification prior to submission.

iv. Provision for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by enrollees and the application of such verification processes on a regular basis.
1) Contractor must have methods for identification, investigation, and referral of suspected Fraud cases (42 CFR § 455.13, 455.14, 455.21).
a) Contractor must respond to all MDHHS-OIG audit referrals with Contractor's initial findings report within the timeframe designated in

the MDHHS-OIG referral. Initial findings means prior to the provider receiving a final notice with appeal rights.

b) At a minimum, all allegations within MDHHS-OIG audit referrals to the Contractor must be investigated to either substantiate or refute any and all items within the complaint. In addition, a detailed summary of findings must be produced and include all items outlined in the audit referral. Insufficient investigations and/or summaries will be returned to the Contractor to have additional work performed until all items have been resolved.

c) Investigations related to MDHHS-OIG audit referrals must be initiated as soon as possible, but no later than 30 calendar days from the date sent by MDHHS-OIG.

i) Contractor may request a one-time extension in writing (email) to MDHHS-OIG no less than five (5) business days prior to the due date, if the Contractor is unable to provide the requested information within the designated timeframe. The request must include a status update and estimated date of completion.

ii) Unless MDHHS-OIG has granted a written extension as described above, Contractor may be subject to Contract remedies including but not limited to sanctions, credits, and/or liquidated damages.

2) Contractor must have adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist the Contractor in preventing and detecting potential Fraud, Waste, and Abuse activities.

a) Special Investigations Unit – The Contractor must operate a distinct Fraud, Waste, and Abuse Unit, Special Investigations Unit (SIU).

i) The investigators in the unit must detect and investigate Fraud, Waste, and Abuse by its Michigan Medicaid enrollees and providers. It must be separate from the Contractor's utilization review and quality of care functions. The unit can either be a part of the Contractor's corporate structure or operate under contract with the Contractor.

ii) Contractor must have at minimum one full-time equivalent (FTE) dedicated to Michigan Medicaid for every 100,000 Michigan Medicaid enrollees or fraction thereof.

1. While investigators may split time between multiple lines of business (or multiple states/regions) to be counted as a partial FTE, the Contractor must demonstrate that an individual dedicates a minimum of 25% of their time specifically to Michigan Medicaid SIU activities or program integrity functions in order for said individual to count towards the FTE requirement. Any individual under 25% dedication to Michigan Medicaid cannot have their work/percentage counted towards the FTE requirement.

iii) On a yearly basis, the Contractor's SIU must conduct program integrity training to improve information sharing between departments within the Contractor, such as Provider Credentialing, Payment Integrity, Customer Service, Human Resources, and the General Counsel, and to enhance referrals to the SIU regarding Fraud, Waste, and Abuse within the Contractor's Medicaid program.

1. The yearly training must include a component specific to Michigan Medicaid and the Contractor's approach to address current Fraud, Waste and Abuse within the program.

iv) Data Mining Activities – Contractor must have surveillance and utilization control programs and procedures (42 CFR § 456.3, 456.4, 456.23) to safeguard the Medicaid funds against unnecessary or inappropriate use of Medicaid services and against improper payments. Data Mining must be performed at least annually. Methods may include, but are not limited to statistical models, complex algorithms, and pattern recognition programs to detect possible fraudulent or abusive practices. The Contractor must report all data mining activities performed (including all program integrity cases opened as a result) within the previous quarter to MDHHS-OIG. See Quarterly Submissions section of this Contract for the method and timing of such reporting.

v) Preliminary Investigations – Contractor must promptly perform a preliminary investigation of all incidents of suspected Fraud, Waste, and Abuse. The Contractor must report all program integrity cases opened within the reporting period to MDHHS-OIG (see Quarterly Submissions section of this Contract for the method and timing of such reporting). All confirmed or suspected provider Fraud must immediately be reported to MDHHS-OIG (see Reporting Fraud, Waste, or Abuse section of this Contract).

vi) Audit Requirements – Contractor must conduct risk-based auditing and monitoring activities of provider transactions, including, but not limited to, claim payments, vendor contracts, credentialing activities and Quality of Care/Quality of Service concerns that indicate potential Fraud, Waste, or Abuse. These audits should include a retrospective medical and coding review on the relevant claims.

1. Any tips or grievances received by the Contractor must be triaged or otherwise addressed within 30 calendar days from the date of the complaint. Any resulting investigations must be initiated within 30 calendar days of the initial triage.

vii) Prepayment Review – If the Contractor subjects a provider to prepayment review or any review requiring the provider to submit documentation to support a claim prior to the Contractor considering it for payment, as a result of suspected Fraud, Waste and/or Abuse, the Contractor must notify MDHHS-OIG in accordance with the Quarterly Reporting requirements of this Contract for the method and timing of such reporting.

v. Provision for written policies for all employees of the Contactor, and of any contractor or agent, 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.

1) Contractor must include in any employee handbook a description of the laws and the rights of employees to be protected as whistleblowers.

vi. 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.

vii. 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.

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

☐	I have reviewed the above requirement R.1 and agree.

2. Once all applicable appeal periods have been exhausted, Contractor must adjust all associated encounter claims identified as part of their Program Integrity activities within 45 days. Failure to comply may result in a gross adjustment for the determined overpayment amount to be taken from Contractor.
   a. Contractor must resolve outstanding encounter corrections in the timeframe designated in any authorization granted by MDHHS-OIG.
   b. All adjustments must be performed regardless of recovery from the Network Provider.
3. Biannual meetings will be held between MDHHS-OIG and all Contractor Compliance Officers to train and discuss fraud, waste, and abuse.
4. Network Providers
   a. Contractor must include program integrity compliance provisions and guidelines in all contracts with network providers.
   b. When program integrity compliance activities are mandated to network providers at the CMH level, the network provider agreement 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 network provider.
      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 employees at all levels.

c. Annually, Contractor must submit a list of their 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 promptly 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. Contractor must cooperate fully in any further investigation or prosecution by any duly authorized government agency, whether administrative, civil, or criminal. Such cooperation must 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. Contractor must follow the procedures and examples contained within processes and associated guidance provided by MDHHS-OIG.
        i. Contractor, its providers, and other entities receiving monies originating by or through Michigan Medicaid must maintain books, records, documents and other evidence pertaining to services rendered, equipment, staff, financial records, medical records and the administrative costs and expenses incurred pursuant to this Contract as well as medical information relating to the individual enrollees as required for the purposes of audit, or administrative, civil and/or criminal investigations and/or prosecution or for the purposes of complying with the requirements set forth in this Contract.
        ii. Contractor must ensure within its own organization and pursuant to any agreement the Contractor may have with any other providers of service, including, but not limited to providers, or any person or entity receiving monies directly or indirectly by or through Michigan Medicaid, that MDHHS representatives and authorized federal and State personnel, including, but not limited to MDHHS-OIG, the Michigan Department of Attorney General, the US Department of Health and Human Services, US Office of Inspector General (DHHS OIG) and the Department of Justice (DOJ), and any other duly authorized State or federal agency must have immediate and complete access to all records pertaining to services provided to Michigan Medicaid enrollees, without first obtaining authorization from the enrollee to disclose such information (42 CFR § 455.21 and 42 CFR § 431.107).
        iii. Contractor, its providers, and any providers of service, including, but not limited to providers or any person or entity receiving monies directly or indirectly by or through Michigan Medicaid must retain and make all records (including, but not limited to, financial, dental and enrollee grievance and appeal records, base data in 42 CFR 438.5(c), Medical Loss Ratio (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) available at the Contractor's and/or the provider's expense for administrative, civil and/or criminal review, audit, or evaluation,

inspection, investigation and/or prosecution by authorized federal and state personnel, including representatives from the MDHHS-OIG, the Michigan Department of Attorney General, DHHS OIG and the DOJ, or any duly authorized State or federal agency for 10 years from the final date of the Contract period or from the date of completion of any audit, whichever is later.

1) Access will be either through on-site review of records or by any other means at the government agency's discretion and during normal business hours, unless there are exigent circumstances, in which case access will be at any time.
    a) Upon request, the Contractor or its provider must provide and make staff available to assist in such inspection, review, audit, investigation, monitoring, or evaluation, including the provision of adequate space on the premises to reasonably accommodate MDHHS-OIG or other state or federal agency.
2) Contractor must send all requested records to MDHHS-OIG within 30 Business Days of request unless otherwise specified by MDHHS or MDHHS rules and regulations.
3) Records other than PIHP records may be kept in an original paper state or preserved on micro media or electronic format. PIHP records must be maintained in their original form or may be converted to electronic format as long as the records are readable and/or legible. These records, books, documents, etc., must be available for any authorized federal and State personnel during the Contract period and 10 years thereafter, unless an audit, administrative, civil, or criminal investigation or prosecution is in progress or audit findings or administrative, civil, or criminal investigations or prosecutions are yet unresolved in which case records must be kept until all tasks or proceedings are completed.

iv. Contractor must maintain written policies and procedures pertaining to cooperation with any duly authorized government agency in investigations or prosecutions, including processes relating to the delegation of an inquiry.

c. MDHHS-OIG will perform post payment evaluations of the Contractor's Network Providers for any potential Fraud, Waste and Abuse and to recover overpayments made by the Contractor to their Network Providers when the post payment evaluation was initiated and performed by MDHHS-OIG.
    i. Contractor's Network Providers must adhere to the Medicaid Provider Manual.
    ii. Contractor's Network Providers must agree that MDHHS-OIG has the authority to conduct post payment evaluations of their claims.
    iii. Contractor's Network Providers must agree to follow the appeal process as outlined in Chapters 4 and 6 of the Administrative Procedures Act of 1969; MCL 24.2et seq. and MCL 24.3 et seq. for post payment evaluations conducted by MDHHS OIG.
    iv. Appeal and claim adjustment requirements outlined above must be included in the Contractor's:
    v. Provider enrollment agreements, and/or Provider manual – if the Provider enrollment agreements require Providers to adhere to the Contractor's provider manual. Prior to initiating a post payment evaluation of a Contractor's Network Provider, MDHHS-OIG will:
        1) Review the Contractor's quarterly submission information to determine whether the Contractor:

a) Performed a post payment evaluation of the Provider in the previous 12-month period or;
b) Is currently performing post payment evaluation of the Provider.

2) Contact the Contractor to determine whether the Contractor, any vendors, or any network providers have identified concerns with the Provider. The Contractor must respond to MDHHS-OIG within 10 Business Days of being contacted by MDHHS-OIG.
3) After MDHHS-OIG contacts Contractor, and during pendency of MDHHS-OIG's review, Contractor/network provider/vendor must not:
   a) Initiate a new investigation on the subject of MDHHS-OIG's investigation.
   b) Contact the subject of MDHHS-OIG's investigation about any matters related to the post payment evaluation.
4) The Contractor, its vendor, or its network provider may only initiate an investigation once they have requested and received written approval from MDHHS-OIG. Such requests will only be approved once MDHHS-OIG's investigation is closed and/or if the Contractor/network provider/vendor is investigating a separate scenario that MDHHS-OIG feels will not conflict with their investigation in any way.

vi. If MDHHS-OIG proceeds with a post payment evaluation, MDHHS-OIG will:
1) Limit the scope to dates of service that are at least one year old, and:
   a) Notify the Contractor in writing and request applicable information from the Contractor. (Applicable information may include, but is not limited to: detailed Contractor/network provider/vendor post payment evaluation history with the Provider, Contractor communication history with the Provider, signed provider enrollment agreement for the Provider, relevant Contractor policy, etc.) Contractor must provide MDHHS-OIG with the name of an individual that will act as the main Contractor contact for each post payment evaluation. Contractor must provide the requested information within 10 Business Days of MDHHS-OIG request.

vii. MDHHS-OIG will determine if the post payment evaluation will be performed using a claim-based audit or a sample/extrapolation. If an overpayment is identified during the post payment evaluation:
1) MDHHS-OIG will provide written preliminary results to both the Provider and Contractor. The Provider will be permitted opportunity to submit additional information by the due date indicated on the preliminary results letter (normally 30 Days) to substantiate their claims.
2) MDHHS-OIG will review any additional information submitted by the Provider received by the due date indicated in the preliminary results letter. MDHHS-OIG will issue the final written results (including appeal rights as outlined in Chapters four and six of the Administrative Procedures Act of 1969; MCL 24.2 et seq. and MCL 24.3 et seq.) to both the Contractor and the Provider. The Contractor will be notified if there are any changes to MDHHS-OIG's findings after the appeal period has concluded.
3) The Contractor/network provider/vendor must not:
   a) Contact the subject of MDHHS-OIG's investigation about any matters related to the investigation;
   b) Enter into or attempt to negotiate any settlement or agreement

regarding MDHHS-OIG's findings/overpayment; or

c) Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with MDHHS-OIG's findings/overpayment.
d) If the Provider does not appeal the final findings, MDHHS-OIG will proceed with recovering overpayments from the Contractor.
e) If the Provider appeals the final findings, MDHHS-OIG will not initiate recoupment from the Contractor until the appeal is resolved.
f) If the Provider appeals the final findings and the appeal is resolved in the State's favor, MDHHS-OIG will proceed with recovering the overpayment from the Contractor.

4) Pursuant to 42 U.S.C.1396b, the State has one year from the date of discovering an overpayment before it must refund the federal portion of the overpayment to the federal government, regardless of recovery from the Provider. Overpayments identified by the State will be recovered from the Contractor via an MDHHS withhold or offset from the next capitation payment or primary push pay to the Contractor.
5) Contractor is responsible for the recovery of overpayments from their Providers.
6) Contractor must make all necessary adjustments (i.e., for claim-based findings) to encounter data resulting from MDHHS-OIG post payment evaluations within the encounter data correction timeliness standard outlined in the Encounter Data Reporting Requirements section of this Contract. Contractor must notify MDHHS-OIG when the adjustments are complete.
    a) Contractor must ensure that the network provider also processes any associated claims corrections within their systems.
    b) Failure to comply with the encounter correction timeliness standard will result in Contractor incurring monetary Sanctions, as outlined in Section D Contract Enforcement Methods (Civil Monetary Contract Remedies, Credits and Liquidated Damages).
7) Contractor must resolve outstanding encounter corrections in the timeframe designated in any authorization granted by MDHHS-OIG.

☐	I have reviewed the above requirements R.2 through R.5 and agree.

6. Reporting Fraud, Waste, or Abuse
    a. Upon receipt of allegations involving fraud, waste, or abuse, regardless of entity (i.e., Contractor, employee, network provider, provider, or member), Contractor must perform a preliminary investigation.
    b. 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.
    c. 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:
        i. Promptly refer the matter to MDHHS-OIG and Attorney General-Health Care Fraud Division (AG-HCFD). These referrals must be made using the MDHHS-OIG

Fraud Referral Form. The form must be completed in its entirety, as well as follow the procedures and examples contained within the MDHHS-OIG guidance document.

ii. Share referral via secure File Transfer Process (sFTP) using Contractor's applicable MDHHS-OIG/AG-HCFD sFTP areas.

iii. Cooperate in presenting the fraud referral to the OIG and AG-HCFD at an agreed upon time and location.

iv. Defend their potential credible allegation of fraud in any appeal should the referral result in a suspension issued by MDHHS-OIG. After reporting a potential credible allegation of fraud, Contractor must not take any of the following actions unless otherwise instructed by OIG: Contact the subject of the referral about any matters related to the referral.

1) Enter into or attempt to negotiate any settlement or agreement regarding the referral with the subject of the referral; Accept any monetary or other thing of valuable consideration offered by the subject of the referral in connection with the findings/overpayment.

d. In the event the $5,000 threshold is not met, but there is still a heightened concern of a potential credible allegation of fraud (e.g., beneficiary harm or extenuating circumstances), the Contractor must reach out to discuss the possibility of a referral with their assigned analyst as there can be exceptions that warrant referral.

e. Upon making a referral, the Contractor must immediately cease all efforts to take adverse action against or collect overpayments from the referred provider until authorized by MDHHS-OIG.

f. If a draft/potential referral is declined prior to Contractor sending a final potential credible allegation of Fraud, Contractor must follow MDHHS-OIG reporting procedures.

g. If the State successfully prosecutes and makes a recovery based on a Contractor referral where the Contractor has sustained a documented loss, the State shall not be obligated to repay any monies recovered to the Contractor. Unless otherwise directed by the State, the correction of associated encounter claims is not required.

h. Contractor must refer all potential enrollee Fraud, Waste or Abuse that the Contractor identifies to MDHHS through https://www.michigan.gov/fraud (File a Complaint - Medicaid Complaint Form) or via a local MDHHS office. In addition, the Contractor must report all of Fraud, Waste and Abuse referrals made to MDHHS on their quarterly submission described in the Quarterly Submissions of this Contract.

i. Contractor must report all suspicion of waste or abuse on the Quarterly Submission described in the Quarterly Submissions section of this Contract.

j. 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

Contractor must report identified and/or recovered overpayments due to fraud, waste, or abuse to MDHHS-OIG.

a. 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.

b. 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 Quarterly Submissions section of this Contract).

c. If a network provider identifies an overpayment, they must agree to:
   i. Notify Contractor, in writing, of the reason for the overpayment and the date the overpayment was identified.
   ii. Return the overpayment to Contractor within 60 calendar days of the date the overpayment was identified.
d. Contractor must include a provision in all contracts with network providers giving Contractor the right to recover overpayments directly from providers for the post payment evaluations initiated and performed by the Contractor.
e. Treatment of recoveries made by the Contractor of overpayments to providers [in accordance with 42 CFR 438.608(d)(1)].
   i. When the Contractor recovers payments to providers:
      1) The Contractor may retain the recovered overpayment including those based upon fraud, waste or abuse.
      2) The Contractor must adjust encounter data related to the recovered funds appropriately within CHAMPS within 45 days of exhausting appeal periods for identified overpayments. Reporting of recoveries will occur via monthly, quarterly, and annual submissions to MDHHS-OIG using the corresponding templates provided.
      3) In the event the Contractor receives a repayment stemming from an external investigation (State or federal), the Contractor must contact MDHHS-OIG within 30 calendar days to initiate the return of any applicable funds. Any applicable documentation will be requested at such time.
   ii. Pursuant to 42 CFR § 438.608(d)(1)(iv), this provision does not apply to any amount of a recovery to be retained under False Claims Act cases or through other investigations.

8. Contractor must send all program integrity notifications and reports to the MDHHS-OIG sFTP. The Contractor must follow the procedures and examples contained within the MDHHS-OIG submission forms and accompanying guidance documents. See Schedule E for the listing of notification forms and reports and their respective due dates. If Compliance Review submissions are not submitted on or before the designated due date, Contractor will receive a score of "Not Met" and may be subject to Contract remedies including but not limited to sanctions, credits, and/or liquidated damages.
9. On a monthly basis, the Contractor must submit to MDHHS-OIG, in a format determined by MDHHS-OIG, a report detailing all overpayments identified, recovered, and adjusted within the previous month (42 CFR 438.608(a)(2)).

☐	I have reviewed the above requirements R.6 through R.9 and agree.

10. Quarterly Submissions
    a. Contractor must provide information on program integrity compliance activities performed quarterly using the template provided by the MDHHS-OIG. Data mining activities must be performed at least annually; monthly or quarterly application is considered the best practice standard. Program integrity compliance activities must be included.
    b. All program integrity activities performed each quarter must be reported to MDHHS-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 both the Contractor and its network providers (at the CMH level), 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.

11. Pursuant to 42 CFR § 438.608(d)(3), on an annual basis, Contractor must submit to MDHHS-OIG, in a format determined by MDHHS-OIG, an annual Program Integrity Report containing details of the improper payments identified, overpayments recovered, and costs avoided for the program integrity activities conducted by the Contractor for the preceding year. The report also must address the Contractor's plan of activities for the current and upcoming fiscal year. The report must include all provider and service-specific program integrity activities. The report must include an attestation confirming compliance with the requirements found in 42 CFR § 438.608 and 42 CFR § 438.610.
    a. Pursuant to 42 CFR § 438.606, the annual Program Integrity Report must be certified by either the Contractor's chief executive officer; chief financial officer; or an individual who reports directly to the chief executive officer or chief financial officer with delegated authority to sign for the chief executive officer or chief financial officer so that the chief executive officer or chief financial officer is ultimately responsible for the certification. The certification must attest that, based on best information, knowledge and belief, the information specified is accurate, complete, and truthful.
12. Any excluded individuals and entities discovered in the screening described in the Contractor Ownership and Control Interest section of this Contract, including the provider applications and credentialing documentation, must be reported to the federal HHS-OIG and MDHHS-OIG, in a format determined by MDHHS-OIG, within 20 Business Days of discovery.
13. Contractor must submit to MDHHS-OIG, in a format determined by MDHHS-OIG, a Quarterly Provider Prepayment Review Placement Log for providers placed on prepayment review as a result of a program integrity activity.
14. Provider Manual and Bulletins – Contractor must issue Provider Manual and Bulletins or

other means of provider communication to the providers of medical, behavioral, dental and any other services covered under this Contract. The manual and bulletins must serve as a source of information to providers regarding Medicaid covered services, policies and procedures, statutes, regulations, and special requirements to ensure all Contract requirements are being met. The Contractor may distribute the provider manual electronically (e.g., via its website) as long as providers are notified about how to obtain the electronic copy and how to request a hard copy at no charge to the provider. Should these items be captured within the subcontract/agreements, that would also meet Contractual requirements.

a. Contractor's Provider Manual must provide all of its providers with, at a minimum, the following information:
    i. Description of the Michigan Medicaid managed care program and covered populations.
    ii. Scope of Benefits.
    iii. Covered Services.
    iv. Emergency services responsibilities.
    v. Grievance/appeal procedures for both enrollee and provider.
    vi. Medical necessity standards and clinical practice guidelines.
    vii. Contractor's policies and procedures including, at a minimum, the following information:
        1) Policies regarding provider enrollment and participation.
        2) Policies detailing coverage and limits for all covered services.
        3) Policies and instructions for billing and reimbursement for all covered services.
        4) Policies regarding record retention.
        5) Policies regarding Fraud, Waste and Abuse.
        6) Policies and instructions regarding how to verify beneficiary eligibility.
    viii. Primary care physician responsibilities.
    ix. Requirements regarding background checks.
    x. Other network providers' responsibilities.
    xi. Prior authorization and referral procedures.
    xii. Claims submission protocols and standards, including instructions and all information necessary for a clean claim.
    xiii. Medical records standards.
    xiv. Payment policies.
    xv. Enrollee rights and responsibilities.
    xvi. Self-reporting mechanisms and polices.
b. Contractor must review its Provider Manual, Bulletins and all provider policies and procedures at least annually to ensure that Contractor's current practices and Contract requirements are reflected in the written policies and procedures.
c. Contractor must submit Provider Manual, Bulletin and or other means of provider communications to MDHHS-OIG upon request. Contractor must submit its network provider agreements to MDHHS-OIG upon request.

15. MDHHS-OIG Sanctions
    a. 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.

16. MDHHS-OIG Onsite Reviews
    a. MDHHS-OIG may conduct onsite reviews of Contractor and/or its subcontracted entities/network providers.
    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.

☐	I have reviewed the above requirements R.10 through R.16 and agree.

17. Contractor Ownership and Control Interest
    a. According to 42 CFR 438.610 Prohibited affiliations, Contractor may not knowingly have a relationship of the type described in paragraph (c) of this Section with the following:
        i. An individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation (FAR) 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 FAR at 48 CFR 2.101, of a person described in paragraph (a)(i) of this Section.
    b. Contractor may not knowingly have a relationship with an individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the act.
    c. The relationships described in paragraph (a) of this Section, are as follows:
        i. A director, officer, or partner of Contractor.
        ii. A subcontractor and/or network provider 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 subcontractor and/or 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.
    d. Contractor must agree and certify it does not employ or contract, directly or indirectly, with:
        i. Any individual or entity excluded from Medicaid or other federal health care program participation under Sections 1128 (42 U.S.C. § 1320a-7) or 1128A (42 U.S.C. § 1320a) of the Social Security Act for the provision of health care, utilization review, medical social work or administrative services or who could be excluded under Section 1128(b)(8) of the Social Security Act as being controlled by a sanctioned individual.
        ii. Any individual or entity discharged or suspended from doing business with Michigan Medicaid; or
        iii. Any entity that has a contractual relationship (direct or indirect) with an individual convicted of certain crimes as described in Section 1128(b)(8) of the Social Security Act.
    e. Contractor must provide written disclosure of any director, officer, partner, managing

employee, person with beneficial ownership of more than 5% of the Contractor's equity, network provider, subcontractor, or person with employment, consulting, or any other contractual agreement who is (or is affiliated with a person/ entity that is) debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing such order; and any individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Act.

f. If MDHHS learns that the Contractor has a prohibited relationship as described above and provided by FAR, Executive Order No. 12549, or under section 1128 or 1128A of the Act, MDHHS may continue an existing agreement with the Contractor unless CMS directs otherwise. MDHHS may not renew or otherwise extend the duration of an existing agreement with the Contractor unless CMS provides to MDHHS and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement despite prohibited affiliations.
g. MDHHS may refuse to enter into or renew a contract with the Contractor if any person who has an ownership or control interest in the Contractor, or who is an Agent or managing employee of the Contractor, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid, or the Title XX Services Program. Additionally, MDHHS may refuse to enter into or may terminate the Contract if it determines that the Contractor did not fully and accurately make any disclosure required under this section of the Contract.
h. Contractor must comply with the Federal regulations to obtain, maintain, disclose, and furnish required information about ownership and control interests, business transactions, and criminal convictions as specified in 42 CFR 455.104-106. In addition, Contractor must ensure that any and all contracts, agreements, purchase orders, or leases to obtain space, supplies, equipment, or services provided under the Medicaid agreement require compliance with 42 CFR §455.104-106.
i. Pursuant to 42 CFR 455.104: the State will review ownership and control disclosures submitted by Contractor and any of Contractor's subcontractors and/or network providers. 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 network provider and/or 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.

18. Network Provider Medicaid Enrollment – Pursuant to 42 CFR § 438.602(b)(1), all network providers of the Contractor must enroll with the Michigan Medicaid Program.
    a. The State will screen and enroll and periodically revalidate all enrolled Medicaid providers.
    b. Contractor must require all applicable network providers are enrolled in the Michigan Medicaid Program via the State's Medicaid Management Information System.
        i. Contractor may execute network provider agreements, pending the outcome of screening, enrollment, and revalidation, of up to 120 days but must terminate a network provider immediately upon notification from the State that the network provider cannot be enrolled or the expiration of one 120-day period without

enrollment of the provider, and notify affected enrollees.

c. Contractor must verify and monitor its network providers' Medicaid enrollment.
d. Exclusions Monitoring:
    i. At the time of provider enrollment or re-enrollment in Contractor's provider network, and whenever there is a change in ownership or control of the provider entity, 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.

19. Excluded Individuals and Entities – Contractor is prohibited from paying with funds received under this Contract for goods and services furnished by an excluded person, at the medical direction or on the prescription of an excluded person. (Social Security Act (SSA) section 1903(i)(2) of the Act; 42 CFR § 455.104, 42 CFR § 455.106, and 42 CFR § 1001.1901(b)). Contractor must monitor its network providers for excluded individuals and entities by requiring its network providers be actively enrolled with the Michigan Medicaid Program.
    a. Contractor must not make any payments for goods or services that directly or indirectly benefit any excluded individual or entity effective with the date of exclusion. The Contractor must immediately recover any payments for goods and services that benefit excluded individuals and entities that it discovers.
    b. Contractor is prohibited from entering into any employment, contractual and control relationships with any excluded individual or entity.
    c. Civil monetary credits may be imposed against the Contractor if it employs or enters into a contract with an excluded individual or entity to provide goods or services to enrollees (SSA section 1128A(a)(6)).
    d. An individual or entity is considered to have an ownership or control interest if they have direct or indirect ownership of 5% or more, or are a managing employee (e.g., a general manager, business manager, administrator, or director) who exercises operational or managerial control, or who directly or indirectly conducts day-to-day operations (SSA section 1126(b), 42 CFR § 455.104(a), and 42 CFR § 1001.1001(a)(1)).

e. Contractor must immediately terminate all beneficial, employment, and contractual and control relationships with any individual or entity excluded from participation by MDHHS immediately.

20. MDHHS OIG Liquidated Damages and Monetary Sanctions
    a. MDHHS OIG may pursue credits in accordance with this Contract if it is determined any of the following instances have occurred:
        i. Submissions of any type, including but not limited to Compliance Reviews, corrective action plans (CAPs), and/or audit result summaries are not uploaded by the required due date.
        ii. Requests for information from investigative staff are not returned by the due date.
        iii. A compliance review submission is scored as not met.

☐	I have reviewed the above requirements R.17 through R.20 and agree.

S. Fiscal Audits and Compliance Examinations

1. Audit and Compliance Examination:
    a. 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
    a. Contractor must submit to the State a Financial Statement Audit prepared in accordance with generally acceptedauditing standards (GAAS).
3. Compliance Examination
    a. Contractor must submit a contract end date (September 30) Compliance Examination conducted in accordance withthe 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 MDHHS Appeal Process for Compliance Examination Decisions 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
    a. 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. Management Decisions
    a. The State will issue a management decision on findings, comments, and questioned costs contained in ContractorFinancial 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 issustained; 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, asa way of mitigating disallowed costs. The appeal process available to Contractor relating to the State managementdecisions 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.

6. Other Audits
   a. The State or federal agencies may also conduct or arrange for additional audits to meet their needs.
7. 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. *Note – SUD related audits, including compliance with 1115 Behavioral Health Demonstration Waiver requirements are conducted independently by the Substance Use, Gambling and Epidemiology Division.
         2) The State will schedule desk 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 Health Services leadership determines that there is demonstrated threat to consumer health and welfare or substantial threats to access to care. Onsite reviews will be undertaken as needed and if indicated from desk review results.
         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 the findings and recommendations that require a response by Contractor.
         6) Contractor will have 30 days to provide a Correction Action Plan (CAP) for achieving compliance. Contractor may also present new information to the State

that 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 places a participant in imminent risk to health or welfare, the site review team would invoke an immediate review and response by Contractor, which must be completed in seven calendar days.

7) 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 having required information from Contractor. The State will take steps to monitor Contractor's implementation of the CAP as part of performance monitoring.
8) The State will protect the confidentiality of the records, data and knowledge collected for 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.
9) 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.

8. 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 Medicaid Specialty Behavioral Health Program 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.

Commented [SC1]: Are there any CMHs in the new Central Region who are not using SCA?

☐	I have reviewed the above requirement and agree.

T. Capital Reserve Requirements

To ensure sound financial management and solvency, each Contractor shall establish and maintain capital reserves in accordance with its governance structure and the requirements set forth in this section. MDHHS shall serve as the regulatory and oversight authority for Contractor financial performance and will receive and review all required financial reporting.

1. Financial Reporting Requirements
    a. Contractor must submit financial reports consistent with the standards and formats used by the Michigan Department of Insurance and Financial Services (MDIFS) for health maintenance organizations or risk-bearing entities unless otherwise specified by MDHHS.
    b. Reports shall be submitted to MDHHS on a scheduled determined by the State and shall include, at a minimum:
        1. Quarterly and annual financial statements,
        2. Financial information which would allow for calculation of risk-based capital (RBC) or an RBC-equivalent, and
        3. Any additional documentation requested as necessary to evaluate financial performance and solvency.
2. Initial Capital Reserve Requirements
    a. Contractors whose governance structure meets the definition of a private nonprofit corporation or public university must meet a capital reserve requirement at the start of the contract period. The specific reserve level will be a percentage of annual revenue, based on risk-based capital principles in alignment with applicable financial risk assumptions and shall be communicated separately by MDHHS.

   b. MDHHS will provide funding to Contractors whose governance structure meets the definition of a public body or governmental entity to meet the minimum capital reserve requirement during an initial transition and ramp-up period. The transition period and minimum reserve level will be determined by MDHHS based on risk-based capital principles in alignment with applicable financial risk assumptions and shall be communicated separately by MDHHS.

3. Ongoing Capital Reserve Maintenance
   a. All Contractors shall maintain the required minimum capital reserve throughout the duration of the contract period, in a manner consistent with sound actuarial and financial principles, and as determined by MDHHS.
4. Capital Reserve Limitations
   a. There shall be no upper limit imposed on capital reserves for Contractors whose governance structures meet the definition of a private nonprofit corporation or public university during the contract period.
   b. MDHHS may impose an upper limit on capital reserves, expressed as a percentage of annual revenue, to ensure appropriate stewardship of public funds, for Contractors whose governance structure meets the definition of a public body or governmental entity. If a Contractor subject to an upper reserve limit exceeds the State-imposed capital reserve threshold, the Contractor shall, upon direction from the State, either return excess reserves to the State or implement a State-approved corrective action plan to reinvest such reserves in alignment with Medicaid program goals. Specific requirements, including methods of return or allowable reinvestment strategies, will be defined by the State at a later time. Contractors will be required to comply with all instructions issued by the State to ensure alignment with financial accountability and public funding principles.
5. Disposition of Capital Reserves Upon Contract Termination
   a. Upon contract expiration, termination, or non-renewal, Contractors whose governance structure meets the definition of a private nonprofit corporation or public university shall retain all capital reserves after:
      1. Completion of claims run out and adjudication,
      2. Satisfaction of all outstanding financial liabilities, and
      3. Submission of final reconciliations and reports, as required by the Medicaid Agency.
   b. Upon contract expiration, termination, or non-renewal, Contractors whose governance structure meets the definition of a public body or governmental entity shall return any remaining capital reserves to the State within 90 days, less amounts needed to satisfy outstanding liabilities and obligations. Final disposition of returned funds shall be determined by MDHHS.
6. Corrective Action for Capital Reserve Deficiencies
   a. If, at any time, MDHHS determines through review of financial reports or other documentation that the Contractor's capital reserves fall below the required minimum levels established pursuant to this contract, MDHHS shall notify the Contractor in writing of the deficiency.
   b. Within 30 calendar days of receiving a notice of deficiency, the Contractor shall submit a written Corrective Action Plan (CAP) to MDHHS. The CAP must include:
      1. A clear explanation of the cause of the deficiency;
      2. Specific steps the Contractor will take to restore reserves to the required levels;
      3. A timeline for corrective actions, including milestone dates for monitoring

Commented [SC2]: May not shall.

Commented [SC3]: Reserves in excess of state-imposed limits have to be returned or a CAP implemented, at the State's discretion.

Commented [SC4]: Reserves have to be returned to the State.

progress;
4. Any requests for technical assistance, if applicable.

c. MDHHS may require more frequent financial reporting and oversight during the corrective action period, including monthly reserve status updates or cash flow statements.
d. The Contractor must remedy the reserve deficiency within 90 calendar days from the date of the State's approval of the CAP, unless a longer period is approved in writing by MDHHS based on extenuating circumstances and demonstrated progress.
e. Failure to resolve the deficiency within the required timeframe or MDHHS determination that the deficiency poses a risk to beneficiary access or program stability may result in the imposition of sanctions, including but not limited to:
    1. Suspension of auto-assignment,
    2. Suspension of all new enrollments,
    3. Redistribution of some or all members,
    4. Placement into receivership for rehabilitation, or
    5. Termination of the contract for cause
f. MDHHS may modify CAP requirements and oversight protocols based on the Contractor's governance structure, including the Contractor's access to outside funding, statutory authorities, and the nature of state financial support.
g. For Contractors whose governance structure meets the definition of a public body or governmental entity, MDHHS may provide technical assistance or temporary financial support to remediate deficiencies, at its discretion and subject to funding availability.

☐	I have reviewed the above requirement and agree.

U. Contractor Risk Management Strategy

1. Risk Management Strategy
    a. Each Contractor must define the components of its risk management strategy that is consistent with general accountingprinciples as well as federal and State regulations.
2. Contractor Assurance of Financial Risk Protection
    b. 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.
    c. Contractor may use one or a combination of measures to assure financial risk protection, including pledged assets, reinsurance, and creation of capital reserves.
    d. 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.

☐	I have reviewed the above requirement and agree.

V. Risk Corridor

1. The shared risk arrangements must cover all services provided under the behavioral health managed care program. The risk corridor is administered across all services, with no separation for mental health and SUD funding. The risk corridor applies to all Contractors, including private

nonprofit corporations, public universities, and public body/ governmental entities.

a. The State will implement a symmetric risk corridor to share financial risk between MDHHS and the Contractor based on the Contractor's financial performance relative to the target MLR. The corridor shall operate as follows:

Actual MLR Deviation from Target MLR	Contractor Share of Gains/Losses	State Share of Gains/Losses
Below -7%	0%	100%
-7 to -2%	20%	80%
-2% to +2%	100%	0%
+2% to +7%	20%	80%
Above +7%	0%	100%

b. Contractor will bear full financial risk on the first 2% deviation from the target MLR.
c. If Contractor's financial experience deviates by more than 2% but less than or equal to 7% from the target MLR, the Contractor will retain 20% of the gains or absorb 20% percent of the losses falling within this risk band, while the State will share the remaining 80%.
d. If the deviation exceeds 7% in either direction, the Contractor will not retain any further gains or be responsible for any further losses beyond this point. The State will assume full financial responsibility for amounts above the 7% threshold.
e. The risk corridor may be calculated based on an MLR that excludes general administrative costs. Contractor shall be fully responsible for all administrative costs incurred in the performance of its contractual obligations and bears the full risk for managing administrative expenditures within the established capitation payments. Only expenditures for eligible behavioral health services and quality improvement activities—as defined by the State—will be considered in the calculation. The State may limit the amount of quality improvement activity expenditures eligible for consideration in the risk corridor calculation. The State will provide additional technical guidance to define allowable expenditures, submission standards, and calculation methodology.
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. The risk corridor structure shall remain in effect for the full term of the contract. However, the State reserves the right to modify the terms of the risk corridor arrangement if necessary to ensure the financial sustainability of the Medicaid program or in response to significant changes in federal or state requirements.
h. 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.

2. Considerations for Public Body or Governmental Entity and Early Implementation Considerations include:
   a. Contractors whose governance structure meets the definition of a public body or governmental entity will be permitted, pending federal approval, the option of a transitional risk corridor period to limit downside risk and allow for accelerated capital accumulation. During this period, the State may offer temporary modifications to the standard risk corridor arrangement as part of the capital build-up strategy. Additional information regarding this

capital threshold shall be communicated separately by MDHHS.

b. The State may, at its discretion, implement payment timing adjustments, risk mitigation measures, or liquidity support during early implementation to ensure program viability and fiscal solvency.

☐	I have reviewed the above requirement and agree.

W. Financing

i. 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.

i☐	I have reviewed the above requirement and agree.

X. Innovation

1. Strategic Pillar
   a. As part of the 2025 public survey issued as part of the competitive procurement, the pillar below was established:
      i. Simplify the system with reduced bureaucracy
2. Innovation Approach

   Simplifying the system will involve innovation, on the part of both MDHHS and Contractors identified through the competitive procurement process. MDHHS proposes that the following will be part of future innovation processes, in addition to other priorities to be established in collaboration between MDHHS and Contractors. MDHHS reserves the right to update or remove these areas but provides them as examples of future priority areas for Contractors and areas of anticipated increased administrative efficiencies. Timing and direction of MDHHS will be further clarified.
   a. Standardized provider training content.
   b. Provider and staff member training reciprocity.
   c. A standardized bio-psychosocial assessment for MI and I/DD populations.
   d. Standardized process (as determined by priority population coordinators) for resolution of MDOC referrals of individuals in need of SUD treatment.
   e. Provider tools for PIHP network (e.g. service directory, care coordination).
   f. PIHP conducted SUD audit reciprocity.
   g. MDHHS-developed provider model contract.

☐	I have reviewed the above requirement and agree.

1.2 Transition

1. If this Contract is canceled or expires and is not renewed, the following will take effect by the dates established by MDHHS in writing:
   a. Within 45 days following the end date of this Contract, Contractor must provide interim financial, performance, and other reports as required.
   b. Within two years following the end date of this Contract, Contractor must provide final financial, performance, and other reports as required.
   c. Payment for any and all valid claims for services rendered to covered beneficiaries prior to the effective end date are the responsibility of Contractor.
   d. The portion of all Capital Reserves, 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.
   e. Reconciliation of equipment with a value exceeding $5,000, purchased by Contractor or its provider network with funds provided under this Contract, 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).
   f. 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.
2. Transition Phase
   a. As part of the Readiness Review, the Contractor must submit to MDHHS an Implementation Work Plan, received prior to the Operational Start Date, by the dates established by MDHHS in writing. The Implementation Work Plan will establish how the Contractor will fulfill contractual requirements prior to the Operational Start Date to support a successful transition. Specifically, verification of the following must be included as part of the Implementation Work Plan:
      i. Project management structure.
      ii. Timeline, including key activities and milestones.
      iii. Communication processes between MDHHS, Contractor, and prior PIHP entities and their network providers /CMHSPs.
      iv. Risk and issue identification and escalation processes.
      v. Processes for ensuring continuity of care for beneficiaries during the transition, following current MDHHS Transition of Care policy.
   b. The Contractor must provide weekly status reports that track implementation progress against the timeline in the Implementation Work Plan, in addition to risks and issues, for six (6) months following the Operational Start Date.
3. Readiness Review
   a. MDHHS will conduct a comprehensive Readiness Review of the contract prior to the

Operational Start Date in accordance with 42 CFR 438.66(d). The Readiness Review must begin at least three (3) months prior to Operational Start Date and include desk review of documents and on-site reviews. On-site reviews must include interviews with Contractor staff and key personnel that manage critical operational areas. The Contractor agrees to provide all materials required to complete the Readiness Review and make key personnel available as requested, by the dates established by MDHHS. The results of the Readiness Review shall be submitted to CMS by MDHHS for the determination to be made that the contract is approved under 42 CFR 438.3(a). The Readiness Review will cover, at minimum, the following areas:

i. Operations:
   1) Administrative staffing and resources.
   2) Beneficiary and provider communications.
   3) Policies and procedures.
   4) Grievance and appeals policies.
   5) Provider network management.
   6) Program integrity / compliance.
   7) Utilization management.
   8) Transition of care / care coordination.

ii. Financial management
   1) Financial reporting and monitoring.

iii. Systems management:
   1) Claims management.
   2) Encounter data and enrollment information management.

4. At the request of MDHHS, a walkthrough of any information systems, interfacing and reporting capability, and validity testing of encounter data, including IT testing and security assurances.
   a. The Contractor must have successfully met all Readiness Review requirements, as established by MDHHS, by the dates established by MDHHS in writing.
   b. Upon receipt of notification from MDHHS that a Readiness Review deficiency has been identified, the Contract has ten (10) calendar days to resolve the deficiency and document the correction of the deficiency. If the deficiency cannot be resolved within ten (10) calendar days, the Contractor is required to implement a corrective action plan.
   c. If the Contractor does not fully meet the Readiness Review criteria as established by MDHHS prior to the Operational Start Date, or is unable to resolve deficiencies, MDHHS may impose a monetary credit for each calendar day beyond the Operational Start Date that the Contractor is not operational. In addition, MDHHS shall not enroll potential beneficiaries into the Contractor until MDHHS has determined that the Contractor is ready and able to perform its obligation under the Contract as demonstrated during the Readiness Review. The Contractor must notify MDHHS of any changes to proposed key personnel identified in the RFP response prior to the Operational Start Date.
   d. System Readiness: The Contractor will define and test modifications to the Contractor's system(s) required to support the business functions of the Contract. The Contractor will produce data extracts and receive data transfers and transmissions. The Contractor must be able to demonstrate the ability to produce encounter files. If any defects are evident, the Contractor will develop resolution procedures to address the problem identified. The Contractor will provide MDHHS with test data files for systems and interface testing for all external interfaces.

e. The Contractor must participate in additional Readiness Reviews as required by MDHHS in accordance with 42 CFR 438.66(d)(1).
f. If a Readiness Review is not required, the Contractor must provide all documents that would have been submitted during the Readiness Review, as required by MDHHS.

☐	I have reviewed the above requirement and agree.

1.3 Specific Standards

1. IT Policies, Standards and Procedures (PSP)
   a. Contractors are advised that the State has methods, policies, standards and procedures that have been developed over the years.
   b. Contractors are expected to provide proposals that conform to State IT policies and standards. All services and products provided as a result of this RFP must comply with all applicable State IT policies and standards.
   c. Contractor is required to review all applicable links provided below and state compliance for the publicly available PSPs in their response.
   d. Non-public PSPs are available to bidders under NDA. Public IT Policies, Standards and Procedures (PSP): DTMB - IT Policies, Standards & Procedures (michigan.gov)

☐	I have reviewed the above requirement and agree.

2. Acceptable Use Policy
   a. 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.

☐	I have reviewed the above requirement and agree.

3. Mobile Responsiveness
   a. The Contractor's website must utilize responsive design practices to ensure the application is accessible via a mobile device.

☐	I have reviewed the above requirement and agree.
Bidders must provide a list of all mobile devices that are compatible with their website. Additionally, Bidder must provide list of features that can be performed via a mobile device either in this response box.	

4. ADA Compliance
   a. 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 the Contractor as part of the Solution must comply with the Digital Accessibility Standards. See Terms and Conditions Section 12 Accessibility Requirements for additional information. Applicable standards can be found at SOM Applications and Site Standards

(michigan.gov) under the SOM Digital Accessibility Guidelines heading.

☐	I have reviewed the above requirement and agree.
Bidder must provide details for how they will meet this requirement:	

1.4 User Type and Capacity

1. Contractor must be able to meet the expected number of concurrent Users of any offered online website based on the total number of enrolled members across the state.

☐	I have reviewed the above requirement and agree.
Bidder must explain how it will be able to support the expected number of concurrent Users. Bidder must also explain whether the website can scale up or down without affecting performance:	
Bidder must provide details regarding latency response time for (i.e., Generate Page Load, standardized reporting, ad hoc reporting):	
The Bidder must identify what network connectivity or equipment will the State be required to have to meet the expected latency response time:	

1.5 End-User Operating Environment

1. The SOM IT environment includes FedRAMP authorized major cloud providers and on-premises market leading virtualization environments, with supporting platforms that includes enterprise storage, monitoring, and management running in house and in cloud hosting provides.
2. Contractor must accommodate the latest browser versions (including mobile browsers) as well as some pre-existing browsers. To ensure that users are able to access online services, Contractor must ensure applications and websites display and function accurately in, at minimum, the two most recent major versions of the following browsers, without reliance on special plugins or extensions:
   a. Google Chrome
   b. Microsoft Edge
   c. Firefox
   d. Safari
3. Contractor must support the current and future State standard environment at no additional cost to the State.

☐	I have reviewed the above requirement and agree.
Bidder must describe any State system access requirements that are necessary for the Bidder to perform its obligations on a timely basis, including but not limited to, physical or remote access to State networks, servers, or individual workstations:	
Bidder must describe if it can comply with the current environment and how it intends to comply with any future changes to the user environment. And if not, describe what end user operating environment its website supports:	

Bidder must describe if it can support the original environment throughout the term of the contract:
Bidder must identify any plug-ins necessary for the proposed website to meet the system requirements of this request:

1.6 Migration

Bidder must explain Migration process if Bidder switches Hosting Provider.

1.7 Hosting

1. 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. Emergency Management Plan
   a. Business Continuity and Disaster Recovery Plan
      i. The Contractor must submit to MDHHS a Business Continuity and Disaster Recovery (BC-DR) Plan specifying what actions the Contractor must conduct to ensure the ongoing provision of covered services in a disaster or man-made emergency, including but not limited to localized acts of nature, accidents, and technological and/or attack-related emergencies.
      ii. Regardless of the architecture of its systems, the Contractor must develop, maintain, and be continually ready to invoke a BC-DR plan for restoring the application of software and current master files and for hardware backup in the event the production systems are disabled or destroyed. The BC-DR plan must limit service interruption to a period of twenty-four (24) hours and must ensure compliance with all contractual requirements. The records backup standards and the BC-DR plan must be developed and maintained for the entire Contract period.
      iii. The BC-DR plan must include a strategy for restoring day-to-day operations, including alternative locations for the Contractor to operate. The BC-DR plan must maintain database backups in a manner that eliminates service disruptions or data loss due to system or program failures or destruction. The Contractor's BC-DR plan must be submitted to MDHHS annually. If the approved plan is unchanged from the previous year, the Contractor must submit a certification to MDHHS that the prior year's plan is still in place (date) of each Contract year. Changes in the plan are due to MDHHS within ten (10) Business Days after the change.
      iv. In the event that the Contractor fails to demonstrate restoration of system functions per the standards outlined in this Contract, MDHHS shall employ contract enforcement methods in accordance with section D. Contract Enforcement Methods (Civil Monetary Contract Remedies, Credits and Liquidated Damages.
3. BC-DR Plan Inclusion
   At a minimum, the BC-DR plan must contain the following:
   a. Essential roles, responsibilities, and coordination efforts necessary to support recovery and business continuity.

b. Risk assessment procedures to comply with this Contract during disasters.
c. Procedures for data backup, disaster recovery including restoration of data, and emergency mode operations.
d. Procedures to allow facility access in support of restoration of lost data and to support emergency mode operations in the event of an emergency.
e. Procedures for emergency access to electronic information.
f. Communication plan specific to enrollees and providers during disasters, and policies and procedures provided to Contractor staff.
    i. Specific communication plans must be shared with MDHHS whenever an emergency situation occurs.
    ii. Contractor must publish guidance via website for enrollees and providers before, during, and after an emergency on how to receive services, contact information for emergencies, payment processes and any other information required by MDHHS.
    iii. Contractor must conduct provider outreach including daily communications to identify issues such as closures and re-openings, power outages, and evacuations.

4. BC-DR Required Scenarios
   At a minimum, the Contractor's BC-DR plan must address the following scenarios:
   a. The central computer installation and resident software are destroyed or damaged;
   b. System interruption or failure resulting from network, operating hardware, software, or operational errors that compromise the integrity of transactions that are active in a live system at the time of the outage;
   c. System interruption or failure resulting from network, operating hardware, software, or operational errors that do not compromise the integrity of transactions or data maintained in a live or archival system, but do prevent access to the system, i.e., cause unscheduled system unavailability; and
   d. Malicious acts, including malware or manipulation.
5. Disaster Declaration
   The Contractor must comply with the following provisions when a disaster is declared by a Governor's Executive Order and confirmed by MDHHS:
   a. Furnish covered services to an enrollee without any form of authorization, without regard to whether such services are provided by a participating or nonparticipating provider, and without regard to service limitations. Implement a readily available claims payment process to ensure providers are paid for services rendered before, during, and after the disaster, as medically necessary.

☐	I have reviewed the above requirement and agree.
Bidder must include a copy of its Disaster Recovery Plan either in this response box or identified here as an attachment to this RFP labelled as Disaster Recovery plan.	

1.8 Required Functionality Relating to Data Retention, Disposal, and Retrieval

1. The State has legal obligations to retain, dispose, and retrieve State Data along with obligations to manage and secure State Data. To meet these obligations, the Solution must allow the State to:
   a. retain all data for the entire length of the Contract.
   b. delete its data or request the deletion of its data, even data that may be stored offline or in backups.
   c. transfer its data back to the State or to a new vendor or new solution.

d. transfer its data to the Archives of Michigan as may be required by a retention and disposal schedule.
e. retrieve data, even data that may be stored offline or in backups.
f. Except as otherwise stated in the Contract, Contractor will not dispose of, delete, or destroy State Data without the prior written approval of the State.

☐	I confirm the above requirement and agree.
Bidder must review and explain how the data retention, disposal, and retrieval requirements will be met by the solution and describe its data management capabilities (storage limitations, duration, etc.). If the Solution does not allow the State to perform these activities itself, the bidder must explain how it will support the State's compliance with these requirements.	

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

2.1 Contractor Representative

1. 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. The Contractor must notify the Contract Administrator at least five calendar days before removing or assigning a new Contractor Representative.

☐	I have reviewed the above requirement and agree.
Bidder must identify its Contractor Representative:	

2.2 Contract Administrator

The Contract Administrator 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:
Marissa Gove **320 South Walnut Street** **Lansing, MI 48933** **Govem1@michigan.gov** **517-449-8952**	**[Name]** **[Street Address]** **[City, State, Zip]** **[Email]** **[Phone]**

2.3 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 Morningstar **400 South Pine Street** **Lansing, MI 48933** **morningstark@michigan.gov** **517-388-7421**	**[Name]** **[Street Address]** **[City, State, Zip]** **[Email]** **[Phone]**

2.4 Customer Service Number

Contractor must specify its 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.

☐	I have reviewed the above requirement and agree.
Bidder must identify its Customer Service Number:	

2.5 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.

☐	I have reviewed the above requirement and agree.

2.6 Key Personnel

1. 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.
2. 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. Chief Executive Officer (CEO)
   b. Chief Financial Officer (CFO)
   c. Medical Director
   d. Crisis and Care Management Director
   e. Children's Director
   f. Provider Network Director
   g. Claims manager
   h. Grievance and Appeals Coordinator (incl. recipient rights management)
   i. Compliance Director
   j. Quality Director
   k. Special Investigations Unit (SIU) Manager/Liaison
   l. Information Security Director
   m. Tribal Liaison
   n. Foster Care Liaison
3. Contractor must employ or contract for the positions identified below required under Substance Abuse Block Grant and Mental Health Block Grant. Contractors must enter into separate grant agreements with MDHHS to receive Mental Health Block Grant and Substance Use Prevention, Treatment, Recovery Supports Block Grant funds.
   a. Veteran Navigator
   b. Substance Use Disorder Services (SUDS) Director
   c. Women's Treatment Coordinator
   d. Prevention Coordinator
4. Contractor must ensure all staff have appropriate training, education, experience, appropriate licensure and liability insurance coverage to fulfill the requirements of the position.
5. Contractor must designate a member of its key personnel to consistently represent the PIHP to the State, including attending State-PIHP meetings. This individual is expected to actively participate and contribute to program improvement initiatives and engage in

discussions reflecting stakeholder feedback from both the State and the community.

6. Contractor must ensure 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-Office of Recipient Rights (ORR) for review and possible investigation.
7. Resumes for all staff listed above must be provided to the State upon request. Resumes must include detailed, chronological work experience.
8. Executive Personnel
   a. Contractor must inform the State, in writing, within seven (7) days of vacancies or staffing changes for the staff listed above.
   b. Contractor must fill vacancies for the staff listed above with qualified persons within six (6) months of the vacancy unless an extension is granted by the State.
9. The State has the right to recommend and approve in writing the initial assignment, as well as any proposed reassignment or replacement, of any Key Personnel. Before assigning an individual to any Key Personnel position, Contractor will notify the State of the proposed assignment, introduce the individual to the State's Project Manager, and provide the State with a resume and any other information about the individual reasonably requested by the State. The State reserves the right to interview the individual before granting written approval. In the event the State finds a proposed individual unacceptable, the State will provide a written explanation including reasonable detail outlining the reasons for the rejection. The State may require a 30-calendar day training period for replacement personnel.
10. Contractor will not remove any Key Personnel from their assigned roles on this Contract without the prior written consent of the State. The Contractor's removal of Key Personnel without the prior written consent of the State is an unauthorized removal ("Unauthorized Removal"). An Unauthorized Removal does not include replacing Key Personnel for reasons beyond the reasonable control of Contractor, including illness, disability, leave of absence, personal emergency circumstances, resignation, or for cause termination of the Key Personnel's employment. Any Unauthorized Removal may be considered by the State to be a material breach of this Contract, in respect of which the State may elect to terminate this Contract for cause under the **Termination for Cause** section of the Standard Contract Terms. It is further acknowledged that an Unauthorized Removal will interfere with the timely and proper completion of this Contract, to the loss and damage of the State, and that it would be impracticable and extremely difficult to fix the actual damage sustained by the State as a result of any Unauthorized Removal. Therefore, Contractor and the State agree that in the case of any Unauthorized Removal in respect of which the State does not elect to exercise its rights under Termination for Cause, Contractor will issue to the State the corresponding credits set forth below (each, an "Unauthorized Removal Credit"):
    a. For the Unauthorized Removal of any Key Personnel designated in the applicable Statement of Work, the credit amount will be $25,000.00 per individual if Contractor identifies a replacement approved by the State and assigns the replacement to shadow the Key Personnel who is leaving for a period of at least 30-calendar days before the Key Personnel's removal.
    b. If Contractor fails to assign a replacement to shadow the removed Key Personnel for at least 30-calendar days, in addition to the $25,000.00 credit specified above, Contractor will credit the State $833.33 per calendar day for each day of the 30-calendar day shadow period that the replacement Key Personnel does not shadow the removed Key Personnel, up to $25,000.00 maximum per individual. The total

Unauthorized Removal Credits that may be assessed per Unauthorized Removal and failure to provide 30-calendar days of shadowing will not exceed $50,000.00 per individual.

11. Contractor acknowledges and agrees that each of the Unauthorized Removal Credits assessed above: (i) is a reasonable estimate of and compensation for the anticipated or actual harm to the State that may arise from the Unauthorized Removal, which would be impossible or very difficult to accurately estimate; and (ii) may, at the State's option, be credited or set off against any fees or other charges payable to Contractor under this Contract.
12. The Contractor must identify the Key Personnel, indicate where they will be physically located, describe the functions they will perform, and provide current chronological résumés.
13. The Contractor must identify all Key Personnel that will be assigned to this contract in the table below which includes the following:
    a. Name and title of staff that will be designated as Key Personnel.
    b. Key Personnel years of experience in the current classification.
    c. Key Personnel's roles and responsibilities, as they relate to this RFP, if the Contractor is successful in being awarded the Contract. Descriptions of roles should be functional and not just by title.
    d. Identify if each Key Personnel is a direct, subcontract, or contract employee.
    e. Identify if each Key Personnel staff member is employed full-time (FT), part-time (PT) or temporary (T), including consultants used for the purpose of providing information for the proposal.
    f. List each Key Personnel staff member's length of employment or affiliation with the Contractor's organization.
    g. Identify each Key Personnel's percentage of work time devoted to this Contract.
    h. Identify where each Key Personnel staff member will be physically located (city and state) during the Contract performance.

☐	I have reviewed the above requirement and agree.

Bidder must provide their plan to fulfill the required key personnel positions listed above including a description of each position and timeline.

<Add more rows below as needed>

1. Name and Title	2. Years of Experience in Current Classification	3. Role(s) / Responsibilities	4. Direct / Subcontract/ Contract	5. FT PT T	6. Length of Employment	7. % of Work Time	8. Physical Location

14. The Contractor must provide **detailed, chronological resumes** of all proposed

Key Personnel, including a description of their work experience relevant to their purposed role as it relates to the RFP. Qualifications will be measured by education and experience with particular reference to experience on projects similar to that described in the RFP.

Bidder must provide the resumes and information as required above as an attachment to this RFP labelled as "Resumes".

2.7 Criminal Background Checks

1. 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.
2. Contractor must:
   a. 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.
      i. ICHAT: https://apps.michigan.gov/
      ii. Michigan Public Sex Offender Registry: https://mspsor.com/
      iii. National Sex Offender Registry: https://www.nsopw.gov/
3. 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
4. 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.
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 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.
6. 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.

☐	I have reviewed the above requirement and agree.

2.8 Organizational Chart/Contractor Organizational Structure

Contractor must provide annually a current organizational chart that lists staff members and subcontractors, by name and title. 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 management information systems. Effective linkages are determined by outcomes that reflect coordinated management.

Bidder must provide detailed information as required above as an attachment to this RFP labelled "Organizational Chart".

2.9 Use of Subcontractors

1. If the Contractor intends to utilize subcontractors, the Contractor must disclose the following:
   a. The legal business name; address; telephone number; a description of subcontractor's organization and the services it will provide; and information concerning subcontractor's ability to provide the Contract Activities.
   b. The relationship of the subcontractor to the Contractor.
   c. Whether the Contractor has a previous working experience with the subcontractor. If yes, provide the details of that previous relationship.
   d. A complete description of the Contract Activities that will be performed or provided by the subcontractor
   e. Geographically Disadvantaged Business Enterprise Sub-Contractors: If contractors plan to utilize subcontractors to perform more than 20% of the deliverables under this contract, at least 20% of that subcontracted work must be awarded to Michigan-based Geographically Disadvantaged Business Enterprises (GDBE). Contractor will submit a plan detailing all subcontractors to be used, including the percentage of the work to be done by each. Contractor must inform the State to the name and address of the GDBE, the percentage of the work they will complete, the total amount estimated to be paid to the GDBE, and provide evidence for their qualifications as a GDBE. If Contractor cannot find GDBE subcontractors to meet this requirement they must provide reasoning and justification to receive an exemption from this requirement from the State. (Existing business relationships will not be an approved reason for this.)
      i. GDBE definition: "Geographically-Disadvantaged Business Enterprise" means a person or entity that satisfies one or more of the following: (i) Is certified as a HUBZone Small Business Concern by the United States Small Business Administration. (ii) Has a principal place of business located within a Qualified Opportunity Zone within

Michigan. (iii) More than half of its employees have a principal residence located within a Qualified Opportunity Zone within Michigan, or both.

ii. Additional information on GDBEs can be found here:
   1) Michigan Qualified Opportunity Zone (QOZ) Map
   2) Michigan Supplier Community (MiSC) Page

Bidder must provide detailed information as requested in the above requirement(s).	
The legal business name, address, telephone number of the subcontractor(s).	
A description of subcontractor's organization and the services it will provide and information concerning subcontractor's ability to provide the Contract Activities.	
The relationship of the subcontractor to the Bidder.	
Is the subcontractor a GDBE?	Choose an item.
Whether the Bidder has a previous working experience with the subcontractor. If yes, provide the details of that previous relationship.	
A complete description of the Contract Activities that will be performed or provided by the subcontractor.	
Of the total bid, the price of the subcontractor's work.	

2. 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 administrative subcontractor through a written subcontract agreement as specified in 42 CFR 438.230.
3. 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:
   a. Administrative Subcontractors - entities that perform administrative functions required by this Contract, including functions which are delegated managed care functions. Administrative subcontractors do not directly provide clinical services. Examples include provider network development, claims payment, Credentials Verifications Organizations (CVOs), etc.
   b. Vendors – entities that perform administrative functions required by this Contract such as information technology (IT) services, audit, and financial services.

c. Contractor may not subcontract with or delegate managed care functions to contracted provider entities.

4. 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.
5. All subcontracts must fulfill the requirements of 42 CFR 434.6. All subcontracts are subject to review by the State at its discretion.
6. Contractor must 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.
7. 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.
8. 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/practiceguidelines for a model agreement. All agreements are subject to review by the State at its discretion.
    a. If Contractor identifies deficiencies or areas for improvement, Contractor and the Subcontractor must take corrective action, including when appropriate, revoking delegation or imposing other which could include sanctions if the Subcontractor's performance is inadequate. Contractor must provide:
    b. 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 their responsibilities; 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.
    c. Any information or documentation related to subcontractor deficiency, inadequacy, or non-compliance is due to MDHHS upon request. Responsive information to such request by MDHHS must be produced to MDHHS within ten (10) business days.
9. Contractor must develop, maintain online, 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.

10. Fiscal Viability of Subcontractors.
    a. 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.
11. 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).
    a. Providers must be reimbursed on a FFS basis.
    b. Contractor must make information on its payment rates available to providers that furnish services that may be covered under Contractor's private FFS plan.
    c. Contractor must pay for services of noncontract providers in accordance with 42 CFR 422.100(b)(2).
12. In accordance with 42 CFR 422.208, any physician incentive plan operated by a Contractor, or its subcontractor, must meet the following requirements:
    a. 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.
    b. 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 ensure that all physicians and physician groups at substantial financial risk have either aggregate or per-patient stop-loss protection in accordance with this Section.
13. For all physician incentive plans, Contractor must provide to CMS, and to any Medicaid beneficiary, the information specified in 42 CFR 422.210.
14. Contractor must provide a copy of specific contract language used for incentive, 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.
15. 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.
16. Beneficiary grievance and appeal records must be retained, as applicable by Contractor and its subcontractors, 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.
17. 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.

18. Accreditation of Network Providers
    As applicable, subcontractors 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). These accrediting agencies are also the recommended Accrediting Agencies for Community Mental Health Organizations. 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.

☐	I have reviewed the above requirement and agree.

2.10 Open Meetings Act and FOIA

A. All Contractors are required to hold open Board Meetings, with requirements being no less stringent than those contained within the Open Meetings Act (Act 267 of 1976). The Open Meetings Act establishes the following: Require certain meetings to be open to the public; to require notice and the keeping of minutes of meetings; to provide for enforcement; to provide for invalidation of decisions under certain circumstances; to provide credits; and to repeal certain acts and parts of acts. Specifically ,Contractor Governing Boards must adhere to the following principles for their Board meetings:

1. General Items
   a. Meetings of the Contractor Governing Board cannot be held unless public notice is given.
   b. After the first meeting of the calendar / fiscal year, the dates, times, and places for regular meetings must be set.
   c. There is no requirement for an agenda to be posted in advance.
2. Decisions
   a. All decisions of the Contractor Governing Board must be made at a meeting open to the public.
   b. Decisions include “a determination, action, vote, or disposition upon a motion, proposal, recommendation, resolution, order, ordinance, bill, or measure

related to the Contractor's obligations under the contract.

3. Closed Sessions
    a. Contractor Governing Boards may meet in a closed session only for one or more of the below purposes (MCL 15.268):
        i. To consider the dismissal, suspension, or disciplining of, or to hear complaints or charges brought against, or to consider a periodic personnel evaluation of, a public officer, employee, staff member, or individual agent, if the named person requests a closed hearing.
        ii. For strategy and negotiation sessions connected with the negotiation of a collective bargaining agreement if either negotiating party requests a closed hearing.
        iii. To consider the purchase or lease of real property up to the time an option to purchase or lease that real property is obtained.
        iv. To consult with its attorney regarding trial or settlement strategy in connection with specific pending litigation, but only if an open meeting would have a detrimental financial effect on the litigating or settlement position of the public body.
        v. To review and consider the contents of an application for employment or appointment to a public office if the candidate requests that the application remain confidential. However, all interviews by a public body for employment or appointment to a public office shall be held in an open meeting pursuant to this act.
        vi. To consider material exempt from discussion or disclosure by state or federal statute. But note – a board is not permitted to go into closed session to discuss an attorney's oral opinion, as opposed to a written legal memorandum.
    b. No decisions may be made in a closed session.
    c. Closed sessions must be conducted during an open meeting
    d. To enter a closed session, a motion must be duly made, seconded and adopted by a majority vote.
    e. Officers, employees, and private citizens (as appropriate) can join the closed session as required.
4. Attending Open Meetings
    a. All meetings must be open to the public and must be held in a place available to the general public.
    b. No individual may be excluded from a meeting open to the public, except for a breach of the peace committed at meetings.
    c. A person must be permitted to address a meeting of the Contractor Governing Board under rules established and recorded by the Contractor.
    d. Contractor Governing Board may adopt a rule imposing individual time limits for members of the public addressing the Governing Board.
    e. Whenever possible, the meeting must be held within the Contractor's geographical boundaries.
    f. The Contractor can schedule the public comment during the meeting at their discretion.
    g. The Contractor can establish reasonable regulations governing the televising or filming by the electronic media of a hearing open to the public in order to minimize any disruption to the hearing, but it may not prohibit such coverage.
    h. Members of the Contractor Governing Board must be physically present at meetings held within a physical space. Remote attendance is not allowed, except to accommodate the absence of a member of a public body due to the

member's military duty.

i. The Americans with Disabilities Act (ADA), 42 USC 12131 et seq, and Rehabilitation Act, MCL 395.81 et seq, require state and local boards and commissions to provide reasonable accommodations, which could include an option to participate virtually, to qualified individuals with a disability who request an accommodation in order to fully participate in a meeting as a board or commission member or as a member of the general public.

5. Minutes
   a. Meeting Minutes must show (at minimum) the date, time, place, members present, members absent, decisions made at a meeting open to the public, and the purpose or purposes for which a closed session is held.
   b. Proposed meeting minutes must be available for public inspection within 8 days after the applicable meeting. Approved minutes must be made available for public inspection within five days after the Contractor Governing Body's approval.
   c. Minutes must be approved at the board's next meeting.
   d. A separate set of minutes must be taken for closed sessions.
6. Other
   a. For the action of the Contractor Governing Board to be valid, they must be approved by a majority vote of a quorum.
   b. To determine the quorum, review the statute, charter provision or ordinance creating the board in question.
   c. Non-compliance with the principles of Open Meetings can result in contract enforcement methods as described in D. Contract Enforcement Methods (Civil Monetary Contract Remedies, Credits and Liquidated Damages**.**

B. Contractors will be required to adhere to the Freedom of Information Act (FOIA) (Act 442 of 1976). A summary of FOIA requirements is below. Records subject to FOIA are any writings prepared, owned, used, in the possession of, or retained by Contractor in the performance of any function under this Contract.

1. Records Request
   a. Unless otherwise agreed to in writing by the requestor, the Contractor must respond to a request for public record within five business days after receiving the request, or within 15 business days if 10-business day extension is taken, by doing one of the following:
      i. Granting the request.
      ii. Issuing a written notice denying the request.
      iii. Issuing a written notice granting the request in part and denying the request in part.
      iv. Issuing a notice requesting an additional 10 business days in which to respond to the request.
   b. Contractor must disclose all records, except to the extent that they fall within one of the statutorily-recognized exemptions. See MCL 15.243 for a list of exemptions from disclosure.
   c. Contractor may charge a fee for a record search, the necessary copying of a record for inspection, or for providing a copy of a record, and actual mailing, duplication, and labor costs. The fee may be waived or reduced if the Contractor determines it is in the interest of the public because searching for or furnishing copies of the record can be considered as primarily benefitting the general public. If the fee is more than $50.00, the Contractor may collect a deposit of not more than 50% of the total amount prior to processing the request.

2. Responses
    a. If a request for a record is denied in full or in part, the Contractor must issue a written notice to the requester not more than five business days after the Contractor receives the request or within 15 business days if a 10-business day extension is taken. A written notice denying a request for a record in whole or in part is a Contractor's final disclosure determination
    b. The written notice must contain an explanation of the basis for the exemption or, if applicable, a certification that the record being requested does not exist within the Contractor under the name given by the requester or by another name reasonably known to the Contractor. The notice must provide a description of the record that is being withheld or the information on the record that is redacted, if a redaction is made.

C. Contractor acknowledges that MDHHS is also subject to the requirements of FOIA and shall assist MDHHS with compliance in information disclosure.

☐	I have reviewed the above requirement and agree.

3. Project Management

3.1 Meetings

1. Mandatory Administrative Meetings
    a. Contractor Representatives
    Contractor representative must attend the following meetings. MDHHS reserves the right to add additional/delete meeting series' or change the frequency of these meetings.
        i. CEO (bimonthly)
        ii. Medical Directors Advisory Committee
        iii. Encounter Data Integrity Team (EDIT)
        iv. PIHP Operations (monthly)
        v. QIC (bimonthly)
        vi. Encounter Quality Initiative (EQI) Meeting (monthly)
    b. Contractor Collaboration
    Contractor must attend other meetings as directed by MDHHS for the purpose of performing Contract Requirements, improving workflows, and otherwise collaborating with MDHHS for benefit of enrollees, Contractors, and the State
2. Mandatory Stakeholder Meetings
    a. Contractor must facilitate or otherwise ensure all required meetings with entities named/described in this Contract (e.g., meetings with MHPs), take place as directed at requisite intervals.
3. Response Timeframes
    a. The Contractor must respond to requests from MDHHS in the following timelines:
        i. Requests acknowledged in writing within (1) Business Day and addressed within (5) Business Days or within the timeframe specified by MDHHS
        ii. Requests that come from the Governor's office or the Michigan legislature shall be addressed within (72) hours.

☐	I have reviewed the above requirement and agree.

3.2 Reporting

1. Release of Report Data
    a. Written Approval
        i. 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.
    b. Acceptable Use of State Data
        i. 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.
    c. Acceptable Use of Personally Identifiable Data
        i. 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.
        ii. Contractor must always comply with all laws and regulations applicable to the personally identifiable information.
    d. Acceptable Use of Contractor Data
        i. 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.
2. Uniform Data and Reporting
    a. 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.
    b. 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.

c. 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.
d. 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 SUD Reporting Requirements website at: https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/reporting.
e. Encounter Data Reporting
    i. 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 each recipient 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.
f. Encounter Data Reporting Requirements
    i. 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. To enable the State to 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.
    ii. Who to Report:

1) 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 SUD 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 MHP, or subcontract via another entity that contracts with a MHP to provide the Medicaid mental health outpatient benefit, should not report the consumer in this data set. 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.

iii. 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. The 837 includes a "header" and "trailer" that allows it to be uploaded to the CHAMPS system.
   4) 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.

g. 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.

h. 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.

i. 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-10and 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.

j. 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.

k. 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.

l. 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.

   i. **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.

   ii. 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.

   iii. **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.

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

   v. **4. Date of birth

Enter the date of birth of the beneficiary/consumer.

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

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

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

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

x. **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.

xi. *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.

xii. *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)

xiii. **12. Quantity of Service
Enter the number of units of service provided according to the unit code type. Only whole numbers should be reported.

xiv. 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).

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

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

xvii. **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).

xviii. **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).

xix. 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).

xx. **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 as applicable, 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).

3. Reporting Requirements for Behavioral Health Treatment Episode Data Set (BH-TEDS)
   a. Technical specifications, including 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).
   b. Reporting covered by these specifications includes the following:
      i. BH-TEDS Start Records (due monthly)
      ii. BH-TEDS Update/ Discharge /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 Hendall 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
      i. BH TEDS Data reporting will encompass Behavioral Health services provided to persons supported in whole or in part with MDHHS-administered funds.
   e. Policy:
      i. 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 conflictor difference exists between the State definitions and information developed by Contractoror 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 MichiganDepartment of Licensing and Regulatory Affairs (LARA) SUD services ID number. LARA ID numbers are the primary basis for recording and reporting data to theState at the program level.
3) There must be a PIHP 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 or delete-add in data uploads.
5) Contractor must make corrections to and resubmit 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 andare 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 localproviders 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 benecessary and warranted. Documentation will be forwarded accordingly.

f. Method for submission
   i. BH-TEDS data are to be submitted in a fixed length format, per the file specifications via MI-Login
g. Due dates

i. BH TEDS data are due monthly but may be submitted more frequently. Contractor is responsible for generating each month's data upload to theState 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.

h. Who to report
   i. Contractor must report BH-TEDS data for all individuals with mental health, intellectual/developmental disabilities, and/or SUDs 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 responsibilityis to a non-contracted provider during the 180-day continuity of care.

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

j. Ad Hoc Reporting
   i. 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.

4. Reports and Annual Appropriation Boilerplate Requirements
   a. Contractor must submit timely reports on annual appropriation boilerplate requirements.
5. Medical Loss Ratio (MLR) Reporting Requirements
   a. 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.
   b. 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.
   c. 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.
      i. 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.
   d. 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:
      i. Administrative costs.

ii. Taxes, licensing and regulatory fees, and other assessments and fees.
iii. Contribution to reserves, risk margin, and cost of capital.
iv. Other material non-benefit costs.

e. 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.
f. 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.
g. 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.
h. 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.
i. 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.
j. 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.
k. Contractor must attest to the accuracy of the calculation of the MLR in accordance with the MLR standards when submitting required MLR reports.

6. Finance Planning, Reporting and Settlement
   a. The final expenditure report must reflect incurred, but not paid claims. Contractor must provide financial reports on forms and formats specified by the State. Financial Status Report forms and instructions are posted to the State website and Contractor must follow the instructions at: https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/reporting (See Financial Planning, Reporting and Settlement Section of Schedule E).

b. Contractor must comply with accounting standards applicable to Contractor's organizational status, such as the following:
    i. Governmental Accounting Standards Board (GASB) standards for Generally Accepted Accounting Principles
    ii. Financial Accounting Standards Board (FASB)
    iii. Audit and Accounting Guide: State and Local Governments, current edition, by AICPA
    iv. 2 CFR 200 Subpart E

7. Public Health Reporting
    a. 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.
8. Annual Provider Survey Reporting
    a. 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.

☐	I have reviewed the above requirement and agree.
Bidder must explain its reporting capabilities and any reporting that is included in its proposal:	
Bidder must provide samples of required reports as attachments to this RFP. List file names here.	

3.3 Provider Enrollment

Contractor must abide by all provider enrollment policy as indicated within Medicaid Policy and the Medicaid Provider Manual.

☐	I have reviewed the above requirement and agree.

4. Authorizing Document

The appropriate authorizing document for the Contract will be the signed Master Agreement (MA). Contract activities will be paid for through MDHHS's Medicaid management information system (CHAMPS).

☐	I have reviewed the above requirement and agree.

5. Payment Methods

1. Contract Financing
    a. Unless otherwise directed by MDHHS, the following terms apply:
        i. 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.

ii. As per 42 CFR 438.608(c)(3) the Contractor must report to the State within 60 calendar days when it has identified the capitation payments or other payments in excess of amounts specified in the contract.

2. State Funding

The State's funding includes Specialty Behavioral Health Services and the Flint 1115 Waiver. The financing in this Contract is always contingent on the annual Appropriation Act. Specific financial detail regarding the State funding is provided in Schedules G and H. As per 42 CFR 438.608(c)(3), the Contractor and any Network Provider must report to the state within 60 calendar days when it has identified capitation payments or other payments in excess of amounts specified in the Contract.

a. 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 SUD as reflected in this Contract. PEPM payment is made to Contractor for enrolled 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.

i. 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 certificationregarding 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.

ii. 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 paymentwill include:

1) Base Rates for each Benefit Plan (BHMA, BHMA-MHP, BHHMP, BHHMP-MHP, HSW-MC**, SEDW-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".

2) Recovery of payments previously made for beneficiaries prior to MDHHS notification of death.
3) 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:

1) 834 – Eligibility
2) 820 – Payment/Remittance Advice
3) 837 – Encounter

iii. 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.

iv. Habilitation Supports Waiver (HSW) Payments

i. 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:
1) Has a developmental disability as defined by Michigan law.
2) Is Medicaid eligible as defined in the CMS approved waiver.
3) Is residing in a community setting.
4) Otherwise eligible for ICF/IID level of care services.

ii. Beneficiaries enrolled in the HSW Program may not be enrolled simultaneously in the MI Choice Waiver, PACE, or any other 1915(c) waiver programs, such as the CWP and 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.

iii. 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, 5. Claims Management System and the Reporting Requirements (see Schedule E), in order to assure timely HSW service verification.

iv. HSW Self-Directed (SD) Community Living Supports (CLS) Minimum Fee Schedule and HSW SD Overnight Health and Safety Supports (OHSS) Minimum Fee Schedule:
1) HSW SD CLS Minimum Fee Schedule:
a) For each HSW SD CLS recipient, the self-determination budget created jointly by the Contractor (or a subcontractor if delegated) and the recipient pursuant to Appendix E of the HSW shall provide for no less than the amounts set forth in Table 1 below (as adjusted pursuant to the inflationary adjustment in paragraph (i)(2) below) for each authorized unit of HSW SD CLS in the recipient's IPOS.

For each HSW SD CLS recipient, the self-determination budget created jointly by the Contractor (or a subcontractor if delegated) and the recipient pursuant to Appendix E of the HSW shall provide for no less than the amounts set forth in Table 1 below (as adjusted pursuant to the inflationary adjustment in paragraph (i)(2) below) for each authorized unit of HSW SD CLS in the recipient's IPOS. Table 1	
Service code	Unit (.25 hour) rate per recipient
H2015	$7.75
H2015UN (2 participants)	$3.87
H2015UP (3 participants)	$2.59
H2015UQ (4 participants)	$1.94
H2015UR (5 participants)	$1.56
H2015US (6+ participants)	$1.10

i) This means, for example, that if an IPOS provides that the HSW SD CLS recipient will receive 100 units per month of one-on-one HSW SD CLS (Service Code H2015, with a unit being a 15-minute increment), the funding in the associated budget for that HSW SD CLS must be equal to or greater than $775/month (100 units x $7.75 minimum rate). For the avoidance of doubt, it is understood and agreed that if an IPOS specifies 2-on-1 (or greater) CLS staffing in certain circumstances, then the budget shall be calculated, and the Contractor must pay, separately at the 1-on-1 rate for each staffer associated with the multiple staffing.

b) Inflationary adjustment: Effective for the rates applicable to SFY 2026 (beginning October 1, 2025) and thereafter, the rates in the HSW SD CLS Minimum Fee Schedule in each fiscal year, if the HSW SD CLS Minimum Fee Schedule is in effect as required herein, shall be the rate set forth in Table 1 (the "Base Rates") adjusted by the cumulative percentage change in the nationwide Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W) for the period beginning March 31, 2024 and ending on the March 31 preceding the start of the fiscal year in question (that is, the rates for SFY 2027 shall be the Base Rates adjusted by the percentage change in the CPI-W from March 31, 2024 to March 31, 2026), provided, however, that the rates in the HSW SD CLS Minimum Fee Schedule in any fiscal year, shall not be less than the Base Rates set forth in Table 1. For example:

c) If the CPI-W increases by 3 percent from March 31, 2024 to March 31, 2025, the rates applicable for SFY 2026 shall be the Base Rates increased by 3 percent.

d) If the CPI-W decreases by 3 percent from March 31, 2024 to March 31, 2025, the rates applicable for SFY 2026 shall be the Base Rates without any adjustment.

e) If the CPI-W increases by 5 percent from March 31, 2024 to March 31, 2026, the rates applicable for SFY 2027 shall be the Base Rates increased by 5 percent

2) HSW SD OHSS Minimum Fee Schedule:

a) A minimum fee schedule likewise applies to HSW SD OHSS services, with the table entries for HSW SD OHSS in effect

from time to time being 70% of those for HSW SD CLS then in effect.

3) Contractor must reimburse to the fiscal management service the amount determined by the approved budget (which shall be at least the amount determined by the HSW SD CLS Minimum Fee Schedule and HSW SD OHSS Minimum Fee Schedule) for HSW SD CLS and HSW SD OHSS units, respectively, actually performed during the term of the IPOS. Nothing in this section shall prohibit the Contractor from advancing funds to the fiscal intermediary in anticipation of such actual performance.

b. The Children's Waiver Program (CWP) Payments
   i. The 1915(c) CWP capitation payment will be made to Contractor based on CWP beneficiaries who have enrolled in the waiver program through the State's enrollment process.
   ii. Beneficiaries enrolled in the CWP may not be enrolled simultaneously in any other 1915(c) waiver programs, such as the HSW and 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.
   iii. Encounters must be processed and submitted on time, as defined in Section N. Provider Services, 5. Claims Management System and the Reporting Requirements in order to assure timely CWP service verification.

c. Serious Emotional Disturbance Waiver (SEDW) Payments
   i. The SEDW capitation payment will be made to Contractor based on SEDW beneficiaries who have enrolled in the waiver program through the MDHHS enrollment process.
   ii. Beneficiaries enrolled in the SEDW may not be enrolled simultaneously in any other 1915(c) waiver programs, such as the 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.
   iii. Encounters must be processed and submitted on time, as defined in Section N. Provider Services Claims Management System and the Reporting Requirements in order to assure timely SEDW service verification.

d. Expenditures for Specialty Behavioral Health Services (SBHS) and the Flint 1115 Waiver.
   i. Contractor may expend any funds received for SBHS. All funds must be spent on Medicaid beneficiaries for Medicaid services.
   ii. While there is flexibility in month-to-month expenditures and service utilization related to the different funding sources in SBHS, Contractor must submit encounter data on service utilization - with transaction code modifiers that identify the service for each specific SBHS program. The encounter data (including cost information) will serve as the basis for future SBHS capitated rate development.

e. 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 of covered 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.

f. SUDHH Payments
The State will provide a monthly case rate to Contractor based on the number of SUDHH beneficiaries with at leastone SUDHH service during a calendar month. Contractor will reimburse the SUDHHP for delivering health home services. Depending on the current services provided by the SUDHH Contractor can negotiate a rate with the HHP while following the requirements in the approved SPA, Michigan Medicaid Policy Bulletin and the SUDHH Handbook.

g. 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.

h. Premium Pay Hourly Wage Increase for Direct Care Workers (DCW)
    i. 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 Health Services 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.
    ii. 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.
    iii. 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 Section. V Risk Corridor of this contract.
    iv. All wage increase payments are subject to audit and potential recoupment. Providers must retain documentation that demonstrates the distribution of payments to eligible staff.

v. At MDHHS' request, Contractor must provide documentation demonstrating that Network Providers' Direct Care Workers receive any mandated SOM DCW "pass-through" wage increases. Acceptability of documentation is at MDHHS' sole discretion.

i. MDHHS Incentive Payment

i. The MDHHS Incentive Payment (DHIP) has been established to support program initiatives as specified in the MDHHS Medicaid Quality Strategy, including ensuring high quality and high levels of access to care. For the PIHPs to be eligible for an incentive payment, the child must meet the following requirements:

1) To receive the MDHHS Incentive Payment, the child must meet the following eligibility criteria:
   a) Have a SED as defined by Michigan Law.
   b) Eligible for Medicaid.
   c) Between the ages of 0 to 18.
   d) Be served in the MDHHS Foster Care System or Child Protective Services (Risk Categories I and II)
   e) Meet one of the following criteria:
      i) Service Criteria 1: At least one of the following services was provided in the eligible month:
         1. H2021 – Intensive Care Coordination with Wraparound
         2. H0036 – Home Based Services
         3. H2033 - Multi-Systemic Therapy (MST)
      ii) 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.

2) 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.

3) Quarterly incentive payments will occur as follows:
   a) April: Based on eligible children and the supporting encounter data submitted for October 1 – December 31.
   b) July: Based on eligible children and the supporting encounter data submitted for January 1 – March 31.
   c) October: Based on eligible children and the supporting encounter data submitted for April 1 – June 30.
   d) January: Based on eligible children and the supporting encounter data submitted for July 1 –September 30.dThe 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.

4) Contractor must complete and submit the annual report for each CMHSP in their Region. The annual report must outline how MDHHS incentive funding was utilized and how these payments

directly impact mental health services for children involved in child welfare. The Contractor must also include the total amount of annual MDHHS incentive funding they received and total amount and percentage passed down to CMHSPs. If the amount was less than 85% of the total amount received, Contractor must submit a written explanation at the same time as the aggregated annual report.

3. Where Found Model
   In the first contract year, PIHPs must submit a plan including action steps and time frames for shifting all current COFR arrangements to a "where found" model. The plan must include the number of current COFR arrangements, how capacity is being developed for bringing beneficiaries who chose to move into the region, and transition plans for beneficiaries who chose to move out of the PIHP and into the financially responsible PIHP. This report will continue to be required annually until all beneficiaries have been transitioned to live in the financially responsible PIHP. If the beneficiary is HSW enrolled, the PIHP must work with MDHHS on transferring HSW slots as needed.
4. Contractor Performance Withhold Award
   Contract Performance Withhold Award has 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 Withhold Award will include, but is not limited to, assessment of performance in quality-of-care access to care indicators, and beneficiary satisfaction. Each year, the State will establish and communicate to Contractor the criteria and standards to be used for the Performance Withhold Award.
   a. Performance Withhold Award Arrangements
      i. Withhold and Metrics
         The State will withhold 0.75% in FY28, 1.5% starting in FY29 and 2% starting in FY30 of BHMA, BHMA-MHP, BHHMP, BHHMP-MHP HSW-MC, CWP-MC, and SEDW-MC payments for the purpose of establishing a Performance Withhold Award. Distribution of funds from the Performance Withhold Award contingent on Contractor's results from the joint metrics 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
         The Performance Withhold Award will be distributed as follows:
         1) Contractor-only Pay for Performance Measure(s): 60%
         2) MHP/Contractor Joint Metrics: 40%
         3) The State will distribute earned funds by April 30 of each year.
      iii. 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.

iv. 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.

☐	I have reviewed the above requirement and agree.