

SCHEDULE G – DEFINITIONS/EXPLANATION OF TERMS

Request for Proposal No. MA 25000002670 Prepaid Inpatient Health Plan (PIHP)

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

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

Actuarial Soundness: As defined in 42 CFR, **(a)** Actuarially sound capitation rates are projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the MCO, PIHP, or PAHP for the time period and the population covered under the terms of the contract, and such capitation rates are developed in accordance with the requirements in paragraph (b) of this Section.

(b) CMS review and approval of actuarially sound capitation rates. Capitation rates for MCOs, PIHPs, and PAHPs must be reviewed and approved by CMS as actuarially sound. To be approved by CMS, capitation rates must:

- (1)** Have been developed in accordance with standards specified in 42 CFR 438.5 and generally accepted actuarial principles and practices. Any proposed differences among capitation rates according to covered populations must be based on valid rate development standards and not based on the rate of Federal financial participation associated with the covered populations.
- (2)** Be appropriate for the populations to be covered and the services to be furnished under the contract.
- (3)** Be adequate to meet the requirements on MCOs, PIHPs, and PAHPs in 42 CFR 438.206, 438.207, and 438.208.
- (4)** Be specific to payments for each rate cell under the contract.
- (5)** Payments from any rate cell must not cross-subsidize or be cross-subsidized by payments for any other rate cell.
- (6)** Be certified by an actuary as meeting the applicable requirements of this part, including that the rates have been developed in accordance with the requirements specified in 42 CFR 438.3(c)(1)(ii) and (e).
- (7)** Meet any applicable special contract provisions as specified in 42 CFR 438.6.
- (8)** Be provided to CMS in a format and within a timeframe that meets requirements in 42 CFR 438.7.
- (9)** Be developed in such a way that the MCO, PIHP, or PAHP would reasonably achieve a medical loss ratio standard, as calculated under 42 CFR 438.8, of at least 85 percent for the rate year. The capitation rates may be developed in such a way that the MCO, PIHP, or PAHP would reasonably achieve a medical loss ratio standard greater than 85 percent, as calculated under 42 CFR 438.8, as long as the capitation rates are adequate for reasonable, appropriate, and attainable non-benefit costs.

Administrative Subcontractor: An entity that performs administrative functions required by this Contract, including functions which are delegated managed care functions. Administrative subcontractors do not directly provide clinical services. An administrative subcontractor cannot be a network provider. Examples include Credentials Verifications Organizations (CVOs), etc.

Autism Spectrum Disorder (ASD): Complex neurobiological disorder that present varying degrees of impairment in communication skills, social interactions, and restricted, repetitive, and stereotyped patterns of behavior, among other behavioral and physiological symptoms.

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

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

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

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

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

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

Capitation Rate: The fixed per person monthly rate payable to Contractor by the State for each Medicaid eligible person covered by the Specialty Behavioral Health Program, regardless of whether or not the individual who is eligible for Medicaid receives covered specialty services and supports during the month.

Clean Claim: As defined in MCL 400.111i. and 42 CFR 447.45 Timely Claims Payment, b, a clean claim is one that can be processed without obtaining additional information from the provider of the service or a third party. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

Community Mental Health Services Program (CMHSP): A CMHSP is a program that contracts

with the State to provide comprehensive General Fund behavioral health services in specific geographic service areas, regardless of an individual's ability to pay. (Michigan Mental Health Code 330.1100a, 330.1206). PIHPs contract with CMHSPs to provide Medicaid specialty behavioral health services and supports (MCL 330.1206).

Co-occurring disorder: The co-existence of both a mental health disorder and a substance use disorder.

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

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

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

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

Critical Incident: Critical Incidents are defined as the following Event Types: Suicide; Non-Suicide Death; Arrest; Emergency Medical Treatment; and Hospitalization. Event Sub-Type and Event Sub-Type Qualifiers include Hospitalization or Emergency Medical Treatment due to injuries that resulted from the use of physical management, medication errors or falls. Additional information related to Critical Incident Reporting can be found in the Critical Incident Reporting Technical Guidance Document.

Delegation: an agreement between Contractor and an individual, or other organization to perform certain functions that otherwise would be the responsibility of Contractor to perform. Contractor oversees and is accountable for any functions or responsibilities that are delegated to other entities whether the functions are provided by Contractor or other entities. Contractor may not delegate any managed care functions to network providers.

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

Emergency Intervention Services: Outpatient services provided to a person suffering from an acute problem of disturbed thought, behavior, mood, or social relationship which requires immediate intervention as defined by the client or the client's family or social unit as outlined in Mental Health Code (MHC) 330.2006.

Enrollment Capacity: The number of Enrollees or Potential Enrollees that the Contractor can serve through its Provider Network under a Contract with the State. Enrollment Capacity is determined by MDHHS in consultation with Contractor based upon its Provider Network organizational capacity, available risk-based capital, and Contractor's ability to meet Network adequacy and access to care standards and requirements of this Contract.

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

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

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

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

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

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

Highly Integrated Dual Special Needs Plans (HIDE SNP): HIDE SNP is a specific type of Medicare

Advantage plan designed to meet the needs of those dually eligible for Medicare and Medicaid. The HIDE SNP integrates long-term service and supports with managed care plans providing most health care benefits.

High-risk: A state of mental/emotional being and/or choices and actions that affect wellness.

Homeless: Persons that do not reside in a permanent dwelling or have a fixed mailing address. A homeless person is an individual who lacks a fixed and regular nighttime residence or whose nighttime residence is:

- A supervised public or private shelter designed to provide temporary accommodations for the homeless.
- A halfway house or similar accommodation which provides a temporary residence for individuals released from institutions.
- Home of another person.
- Place not designed or ordinarily used as a dwelling (e.g., building entrance or hallway, bus station, park, campsite, vehicle).

Intellectual/Developmental Disability: If applied to an individual older than 5 years of age, a severe, chronic condition that meets all the following requirements, as referenced in Mental Health Code (MHC) 333.110017:

- Is attributable to a mental or physical impairment or a combination of mental and physical impairments.
- Is manifested before the individual is 22 years old.
- Is likely to continue indefinitely.
- Results in substantial functional limitations in 3 or more of the following areas of major life activity:
 - Self-care.
 - Receptive and expressive language.
 - Learning.
 - Mobility.
 - Self-direction.
 - Capacity for independent living.
 - Economic self-sufficiency.
- Reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are of lifelong or extended duration and are individually planned and coordinated.
 - If applied to a minor from birth to 5 years of age, a substantial developmental delay or a specific congenital or acquired condition with a high probability of resulting in developmental disability as defined in subdivision (a) if services are not provided

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

Intensive Crisis Stabilization Services (ICSS): Structured treatment and support activities provided by an intensive crisis stabilization team that are designed to promptly address a crisis situation in order to avert a psychiatric admission or other out of home placement or to maintain a beneficiary in their home or present living arrangement who has recently returned from a psychiatric hospitalization or other out of home placement.

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

Level of Care Utilization System (LOCUS): The State-designated tool for assessing the level of mental health need for adults; a multi-dimensional assessment instrument used to determine the appropriate level of care for adults with mental health needs or co-occurring mental health and substance use disorder-related needs.

Managed Care Administration: An administrative cost category to which non-encounterable costs of Contractor or subcontractor must be assigned. Costs defined as managed care administration must be excluded from the unit cost and the independent rate model.

Managed Care Functions: Managed Care Functions are administrative activities the Contractor performs to fulfill the requirements of 42 CFR 438 and the terms of the Contract. Managed Care Functions include:

- Eligibility and coverage verification
- Provider network selection and management
- Contracted network provider training and compliance
- Claims processing
- Fraud prevention activities.
- Quality management and assessing performance measurement and improvement, including activities to improve health care quality
- Development and maintenance of a compliance program
- Staff qualifications and training
- Utilization management program
- Access management
- Maintenance of information technology systems
- Finance system and procedures
- Customer service
- Upholding enrollee rights and protections
- Beneficiary and provider grievance process
- Beneficiary appeals process
- Credentialing functions

If outside of this definition of managed care functions, responsibility can be delegated without notification to MDHHS.

Medicaid Health Plan (MHP): Managed care organizations that provide or arrange for the delivery

of comprehensive health care services to Medicaid beneficiaries. MHPs are contracted with to carry out the responsibilities of the Comprehensive Health Care Program (CHCP). A Highly Integrated Dual Eligible Special Needs Plan (HIDE SNP) is a category of Medicaid Health Plan. Contract language which mentions “Medicaid Health Plan” or “MHP” applies to all categories of Medicaid Health Plans. Contract language which mentions “Highly Integrated Dual Eligible Special Needs Plan” or “HIDE SNP” applies to that Medicaid Health Plan category only.

Medical Loss Ratio (MLR): The proportion of (i) incurred claims plus expenditures for activities that improve health care quality plus expenditures on activities to comply with certain program integrity requirements divided by (ii) adjusted premium revenue, as defined in 42 CFR § 438.8.

Medicaid Specialty Behavioral Health Program: This includes the following: 1115 Behavioral Health Demonstration Waiver and the 1915(c) Habilitation Supports Waiver, 1915(i) State Plan Amendment, Children’s Waiver Program (CWP), Serious Emotional Disturbance (SED), the MIChild program, MOMS program, and the 1115 Healthy Michigan Plan. This list is non-exhaustive and MDHHS reserves the right to add any future approved federal or state regulation changes.

Mental Health Framework (MHF): A MIHealthyLife initiative aimed at improving access to and coordination of mental health care across the Medicaid program. Under the Mental Health Framework, a MHP beneficiary’s level of mental health need, as determined through a State-identified standardized assessment tool, will determine which payer—the beneficiary’s MHP or PIHP—is responsible for their mental health coverage and care. This will require MHP coverage of mental health services for beneficiaries with lower levels of mental health need, so MHPs are accountable for more of these beneficiary’s continuum of care, and PIHP coverage of mental health services for beneficiaries with higher levels of mental health need. The MHF also promotes greater coordination of care between the two delivery systems.

Michigan Child and Adolescent Needs and Strengths (MichiCANS): The State-designated tool for assessing the level of mental health need for children and adolescents; a Michigan-specific version of the Child and Adolescent Needs and Strengths (CANS) that is a comprehensive information integration tool for use with infants, toddlers, children, youth and young adults, designed to summarize and organize information gathered from assessments and other sources. It is comprised of two components: the Screener and Comprehensive.

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

Network Provider Agreement: An agreement entered into by Contractor with any other individual, provider, CMHSP, or other organization that describes the conditions under which the provider agrees to furnish covered services to Contractor’s enrolled beneficiaries.

Network Provider: Any provider, group of providers, or entity that has a provider agreement with Contractor, and receives Medicaid funding directly or indirectly to order, refer or render covered services as a result.

Per Eligible Per Month (PEPM): A fixed monthly rate per Medicaid eligible person payable to

Contractor by the State for provision of Medicaid services defined within this Contract.

Post-stabilization Care Services: As defined in 42 CFR 438.114(a), covered services related to an emergency medical condition that are provided after a beneficiary is stabilized in order to maintain the stabilized condition, or, under the circumstances described in 42 CFR 438.114(e) to improve or resolve the beneficiary's condition.

Potential Enrollee: Medicaid Beneficiary who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program but is not yet an Enrollee in the Contractor's PIHP.

Prepaid Inpatient Health Plan (PIHP): A PIHP is an organization as defined in 42 CFR Part 438.

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

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

Sentinel Event: A patient safety event (not primarily related to the natural course of the [patient's] illness or underlying condition) that reaches a [patient] and results in death, severe harm (regardless of duration of harm), or permanent harm (regardless of severity of harm). [The Joint Commission \(TJC\) Effective January 1, 2022](#); Including any injury or death that occurs from the use of any BTP, physical management, restraint or seclusion [Technical Requirement for Behavioral Treatment Plans](#).

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

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

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

Vendor: An agreement entered into by Contractor with any individual or organization who agrees to perform a non-managed care function on behalf of Contractor related to securing or fulfilling Contractor's required contract activities and obligations under the terms of this Contract. Vendors do not refer or render any covered services. Examples of vendor services include Information Technology (IT) services, audit services, or financial services.

Warm Handoff: Time-sensitive, enrollee-specific planning identified by either the Transferring Entity or the Receiving Entity to ensure continuity of care during transition from one setting of care to another. Warm handoffs require collaborative planning between both entities and when at all possible, collaborative planning should occur prior to the transition.