**HEALTHWEST**

*FINANCE COMMITTEE MEETING MINUTES*

***September 11, 2026***
***8:00 a.m.***

**CALL TO ORDER**

The regular meeting of the Finance Committee was called to order by Committee Chair Fortenbacher at 8:00 a.m.

**ROLL CALL**

| | |
|---|---|
| Committee Members Present: | Jeff Fortenbacher, Janet Thomas, Thomas Hardy, Remington Sprague, M.D. |
| Committee Members Absent: | Charles Nash, John Weerstra, Michelle Hazekamp |
| Also Present: | Holly Brink, Rich Francisco, Brandy Carlson, Gina Maniaci Christy LaDronka, Kristi Chittenden, Casey Olson, Gina Kim, Carly Hysell, Anissa Goodno, Justin Robillard, Lea Streblow, Gary Ridley, Tasha Kuklewski, Jennifer Stewart, Melina Barrett, Kim Davis, Kaitlin Shaffer, Brandon Baskin, Jason Bates |

**ITEMS FOR CONSIDERATION**

*A.* *Approval of the Minutes of August 21, 2026*

It was moved by Dr. Sprague, seconded by Ms. Thomas, to approve the Finance Committee meeting minutes from August 21, 2026 as written.

**MOTION CARRIED**

*B.* *Approval of Expenditures for August 2026*

It was moved by Mr. Hardy, seconded by Dr. Sprague, to approve expenditures for the month of August 2026, in the total amount of $8,850,095.63.

**MOTION CARRIED**

*C.* *Monthly Report from the Chief Financial Officer*

Ms. Carlson, Chief Financial Officer, presented the July report, noting an overall cash balance of $4,421,401.22 as of July 31, 2026.

*D.* *Finance Update Memorandum*

Ms. Carlson, Chief Financial Officer, presented the Finance Update Memorandum.

*E.* *Authorization to Approve Contracting with Samaritan Way*

It was moved by Mr. Hardy, seconded by Dr. Sprague, to approve the HealthWest Executive Director to sign a contract with Samaritan Way Recovery Community from November 1, 2026 through September 30, 2027.

**MOTION CARRIED**

*F.* *Authorization to Approve Payment / Reimbursement from VitalCore Health Strategies, LLC*

It was moved by Mr. Hardy, seconded by Ms. Thomas, to approve the HealthWest Board of Directors to approve the purchase of and / or reimbursement from VitalCore and/or other utilized pharmacies for FY2027.

**MOTION CARRIED**

*G.* *Authorization to Approve Signing of the Lakeshore Regional Entity (LRE) Agreement*

It was moved by Mr. Hardy, seconded by Dr. Sprague, to approve the HealthWest Executive Director to sign the FY27 Lakeshore Regional Entity and HealthWest Agreement of the Medicaid Managed Specialty Supports and Services under the Section 1115 Behavioral Health Demonstration Waiver, including concurrent 1915(c)/(i) Waiver Programs, Flint 1115 Demonstration Waiver, and the Healthy Michigan Program, effective October 1, 2026, through September 30, 2027

**MOTION CARRIED**

## ***OLD BUSINESS***

There was no old business.

## ***NEW BUSINESS***

There was no new business.

## ***COMMUNICATIONS***

There was no communication.

## ***DIRECTOR'S COMMENTS***

**Rich Francisco, Executive Director provided an update:**

- **MDHHS/LRE updates:**
  - HW submitted some data to the LRE to understand the cost for some of our consumers in specialized residential settings. There is a greater need to understand the residential per diem rates we pay our providers on a regional basis. Ottawa County provided a template to review individuals that receive enhanced care and receive enhanced safety services from HW. The summary of the preliminary data revealed that we have about 58 individuals in these programs that utilize about 10 to 13% percent of the revenue (about 11M). Ottawa shared their data of about 17 consumers using about 6M of their revenue. We do serve individuals with high behavioral and high medical needs. The rest of the partner CMHSPs have also submitted the data and the LRE will be aggregating the results. The goal is to advocate with MDHHS for this population of individuals.
  - LRE/CMHSP FY27 contract review is completed and HW is ready to sign. We have resolved contract language changes and the areas of concern for HW have been removed from the contract. I mentioned that there were two areas of concern for HW in my past update to the board. One relates to provider network adequacy (inadequacy), and the other is related to notification to CMH related to delegated functions.

- CCBHC listening sessions continue to happen at the state level with CCBHCs and MDHHS. The goal is to hear back from CCBHCs on the pain points as CCBHC ends the demonstration. The last session was on the critical component of Care coordination and Targeted Case Management. It was an in-depth look at what the differences are and what the similarities are and how each is currently funded.

➢ **CMH Level updates:**

- HW has submitted an RFQ (Request for Qualifications) with the County to review our current role as a CMH and a county department. I have been in conversation with County leadership over the topic of becoming an authority. County leadership has been talking with other CMHSPs/County going through the process and what is involved. I have also been in contact with Lapeer County (from region 10) who is also going to pursue authority status. The goal of RFQ is to procure legal counsel who is an expert at the Mental Health code and is knowledgeable about the inner workings of the various CMHSP set ups, risks, and responsibilities. There will be only 3 more CMHSPs that will be tied to the County as department after Ottawa and Lapeer transitions. Macomb, Washtenaw, and Muskegon.
- HW Continues to focus on General Fund line item in the budget. With the impacts of CCBHC non-Medicaid and HR 1, we will surely need more funding in this area. At the director's forum, the same concern was brought by over 50% of the directors. There is going to be a separate discussion with the CCBHC Caucus in two weeks to discuss the issues related to this. The goal is to advocate for more GF dollars with MDHHS.

***AUDIENCE PARTICIPATION***

There was no audience participation.

***ADJOURNMENT***

There being no further business to come before the committee, the meeting adjourned at 8:27 a.m.

Respectfully,

Jeff Fortenbacher
Committee Chair

/hb

**PRELIMINARY MINUTES**
**To be approved at the Finance Meeting on**
**October 16, 2026**

HealthWest
Muskegon's Behavioral Wellness Connection

# FINANCE COMMITTEE

**September 11, 2026 – 8:00 a.m.**
**376 E. Apple Ave. Muskegon, MI 49442**

https://healthwest.zoom.us/j/92330401570?pwd=TFNHMWhnQmF5NVAybWRQVG54Tk1GZz09
One tap mobile: (309)205-3325, *92330401570# Passcode: 428623*

**Committee Chair: Jeff Fortenbacher**
**Committee Vice-Chair: Janet Thomas**

## AGENDA

| | | |
|---|---|---|
| 1. | Call to Order | Quorum |
| 2. | Approval of Agenda | Action |
| 3. | Items for Consideration | |
| | A. Approval of the Minutes of August 21, 2026 (Attachment #1 pg. 1-5) | Action |
| | B. Approval of the Expenditures for August 2026 (Attachment #2 pg. 6) | Action |
| | C. Monthly Report from the Chief Financial Officer (Attachment #3 pg. 7-10) | Information |
| | D. Finance Update Memorandum (Attachment #4 pg. 11) | Information |
| | E. Approval to Contract with Samaritan Way (Attachment #5 pg. 12) | Action |
| | F. Approval of Payment / Reimbursement from VitalCore Health Strategies, LLC (Attachment #6 pg. 13) | Action |
| | G. Approval to Sign LRE Agreement (Attachment #7 pg. 14-137) | Action |
| 4. | Old Business | |
| 5. | New Business | |
| 6. | Communication | Information |
| 7. | Director's Comments | Information |
| 8. | Audience Participation | |
| 9. | Adjournment | Action |

/hb

**HEALTHWEST**

*FINANCE COMMITTEE MEETING MINUTES*

***August 21, 2026***
***8:00 a.m.***

**CALL TO ORDER**

The regular meeting of the Finance Committee was called to order by Committee Chair Fortenbacher at 8:00 a.m.

**ROLL CALL**

| | |
|---|---|
| Committee Members Present: | Jeff Fortenbacher, Janet Thomas, Thomas Hardy, Michelle Hazekamp, John M. Weerstra, Remington Sprague, M.D. |
| Committee Members Absent: | Charles Nash |
| Also Present: | Holly Brink, Rich Francisco, Brandy Carlson, Gina Maniaci Christy LaDronka, Kristi Chittenden, Casey Olson, Mickey Wallace, Amber Berndt, Gina Kim, Carly Hysell, Jackie Farrar, Matt Campbell, Linda Anthony, Anissa Goodno, Justin Robillard, Malina Barrett, Lea Streblow, Jenn Hoeker, Amber Picard, Gary Ridley |
| Guests Present: | Angela Gasiewski |

**ITEMS FOR CONSIDERATION**

*A.* *Approval of the Minutes of July 10, 2026*

It was moved by Ms. Thomas, seconded by Mr. hardy, to approve the Finance Committee meeting minutes from July 10, 2026 as written.

**MOTION CARRIED**

*B.* *Approval of Expenditures for July 2026*

It was moved by Ms. Thomas, seconded by Mr. Hardy, to approve expenditures for the month of July 2026, in the total amount of $11,900,352.72.

**MOTION CARRIED**

*C.* *Monthly Report from the Chief Financial Officer*

Ms. Carlson, Chief Financial Officer, presented the June report, noting an overall cash balance of $10,633,432.13 as of June 30, 2026.

*D.* *Finance Update Memorandum*

Ms. Carlson, Chief Financial Officer, presented the Finance Update Memorandum.

*E.* *Authorization to Approve FY2026 Projected Budget Proposal*

It was moved by Mr. Hardy, seconded by Dr. Sprague, to approve the HealthWest FY2026 Projected Budget in the amount of $115,819,593 for both revenues and expenditures

**MOTION CARRIED**

*F.* *Authorization to Approve FY2027 Recommended Budget Proposal*

It was moved by Mr. Hardy, seconded by Dr. Sprague, to approve the HealthWest FY2027 Recommended Budget in the amount of $118,839,765 for both revenues and expenditures.

**MOTION CARRIED**

*G.* *Authorization to Enter Grant Funded Agreements*

It was moved by Mr. Hardy, seconded by Dr. Sprague, to approve acceptance of the FY2027 awarded grants identified on the attached grant schedule, including MDHHS grants. Federal grants, and LRE Sub-Awards, and to accept the requirements associated with those grants, for a total awarded amount of $4,232,826. Further, the Board acknowledges and accepts the FY2027 grant applications submitted and pending award consideration as identified in the Applied/Not Yet Awarded section of the attachment.

**MOTION CARRIED**

*H.* *Authorization to Approve the Five Funding Sources*

It was moved by Dr. Sprague, seconded by Mr. Hardy, to approve the FY26. Contracted Vendors/Providers listed under the five funding sources. The total budget for the five funding services is $54,725,429 effective August 28th, 2026. Through September 30th, 2026.

**MOTION CARRIED**

*I.* *Authorization to Approve FY27 Provider Network Category Budgets*

It was moved by Dr. Sprague, seconded by Ms. Thomas, to approve the HealthWest Board of Directors to approve the FY27 budget for the contracted Vendors/Providers listed under the five funding sources effective October 1, 2026. The total budget for the five funding services is $54,605,309. The agreements are dated October 1, 2025, through September 30, 2027.

**MOTION CARRIED**

*J.* *Authorization to Approve FY27 Vendors/Providers List*

It was moved by Ms. Thomas, seconded by Dr. Sprague, to approve the HealthWest Board of Directors to approve the Vendors listed on Attachment A and further authorize the payment of the contracts.

Mr. Hardy abstained from voting due to conflict of interest.

**MOTION CARRIED**

*K.* *Authorization to Approve Payment to Lease Landlords*

It was moved by Ms. Thomas, seconded by Mr. Hardy, to approve the HealthWest Executive Director to approve the above landlords for the HUD grant funding for Fiscal Year 2027, at a cost not to exceed the final HUD grant awarded dollars of $411,497 and approve departmental signature of the MSHDDA Agreement.

**MOTION CARRIED**

*L.* *Authorization to Approve Contracting with MDHHS*

It was moved by Mr. Hardy, seconded by Dr. Sprague, to approve the HealthWest Chief Financial Officer to sign the contract between Michigan Department of Health and Human Services and HealthWest for Managed Mental Health Supports and Services for the period of October 1, 2026, through September 30, 2027.

**MOTION CARRIED**

*M.* *Authorization to Approve Contracting with Rehmann, LLC*

It was moved by Mr. Hardy, seconded by Dr. Sprague, to approve the HealthWest to contract with Rehmann, LLC, 675 Robinson Road, Jackson for consulting services for FY2027.

**MOTION CARRIED**

*N.* *Authorization to Approve Extension of Contract with TBD Solutions, Inc.*

It was moved by Dr. Sprague, seconded by Mr. Hardy, to approve HealthWest to contract with TBD Solutions, Inc., 2930 Luceme Dr. SE, Grand Rapids, for professional services related to a crisis stabilization unit feasibility assessment.

**MOTION CARRIED**

*O.* *Authorization to Approve Including Allen Crossing Limited Dividend Housing Association to the Approved Landlords for HUD Programs*

It was moved by Mr. Weerstra, seconded by Mr. Hardy, to approve the HealthWest Executive Director to approve Allen Crossing Limited Dividend Housing Association for the HUD grant funding for Fiscal Year 2026.

**MOTION CARRIED**

*P.* *Authorization to Approve Entering Interagency Cash Transfer Agreement (ITCA) with West Michigan Rehabilitation Services (MRS)*

It was moved by Mr. Hardy, seconded by Mr. Weerstra, to approve the HealthWest Executive Director to sign an Interagency Cash Transger Agreement with Michigan Rehabilitation Services, effective October 1, 2026, through September 30, 2027, with a projected expenditure not to exceed $69,200.00.

**MOTION CARRIED**

*Q.* *Authorization to Approve Providers Transition to Potential Designated Collaborative Organization (DCO) Contracts*

It was moved by Mr. Hardy, seconded by Mr. Weerstra, to approve the HealthWest Executive Director to sign Designated Collaborative Organization (DCO) contracts with ACAC, Arbor Circle Corporation, Catholic Charities West Michigan, Family Outreach Center, and Wedgwood Christian Services, contingent upon approval by the Michigan Department of Health and Human Services (MDHHS), for the period of October 1, 2026, through September 30, 2028. Funding for these agreements is available within the approved substance use disorder (SUD) budget.

**MOTION CARRIED**

***OLD BUSINESS***

There was no old business.

***NEW BUSINESS***

There was no new business.

***COMMUNICATIONS***

There was no communication.

***DIRECTOR'S COMMENTS***

**Rich Francisco, Executive Director provided an update:**

- **LRE updates:**
  - Spending plan was discussed at the CEO Ops meeting on 8/19/2026. CMHSPs have submitted their spending plans to the LRE based on June projections and historical data, however, the Milliman certified rates have not been released yet. There was supposed to be a meeting with Milliman on 8/20/2026. However, that was moved to Monday. Although HW submitted a spending plan, we will likely update it based on the revenue rates published by Milliman, which we are hopeful will be shared next Monday.
  - The LRE did provide an update on the FY22 cost settlement with MDHHS regarding the 13M that MDHHS claims we owe them for that year. The hearing was earlier in the week and according to the LRE CEO, the judge wants to combine the other case with it citing that the 7.5% ISF is the issue and that it is not actuarially sound.

- **CMH Level updates:**
  - I did receive an email (8/20) from a large provider asking for a letter of intent and requesting HW to participate in a provider network in preparation for a rerelease of the Michigan Inpatient Health Plan Request for Proposal (PIHP bid out). Shortly thereafter, I received an email from our association cautioning us that private parties have been reaching out asking for participation in their network. Our association has not seen anything drop in on the SIGMA site which is the platform that DTMB uses to notify of any RFP being released. I will keep the board informed if any development in the RFP arises.
  - HW did receive the final numbers for the QBP payments. Many thanks to our staff for completing the review of the numbers and the data. Our preliminary numbers were expected to be around $1.397M, and in our final numbers, they came back at $1.512M. This was an increase of approximately 114k. This positive change was discovered that we did meet another metric which was missing during the preliminary release of the numbers.
  - Staff are working very hard at HW with many different efforts and initiatives happening from Same Day Access implementation, productivity benchmarks all the way to preparing for HR 1 (Big Beautiful Bill) changes that are coming. I do want to give the Customer Services team a shout out: Gary, Kelly, Jennifer, Lea, Brea, Amber, Gina, Doug, and Laura for leading another successful Health Wellness and Recovery Picnic last week. I also want to give the HW staff who volunteered in set-up and tear-down (huge shoutout). I was able to participate in the tear down crew and let me tell you it is a lot of work. Thank you for your time and participation.

***AUDIENCE PARTICIPATION***

There was no audience participation.

***ADJOURNMENT***

There being no further business to come before the committee, the meeting adjourned at 8:33 a.m.

Respectfully,

Jeff Fortenbacher
Committee Chair

/hb

**PRELIMINARY MINUTES**
**To be approved at the Finance Meeting on**
**September 11, 2026**

## REQUEST FOR HEALTHWEST BOARD CONSIDERATION AND AUTHORIZATION

| COMMITTEE | BUDGETED | NON-BUDGETED | PARTIALLY BUDGETED |
|---|---|---|---|
| Finance Committee | X | | |

| REQUESTING DIVISION | REQUEST DATE | REQUESTOR SIGNATURE |
|---|---|---|
| Finance | September 11, 2026 | Brandy Carlson, Chief Financial Officer |

**SUMMARY OF REQUEST (GENERAL DESCRIPTION, FINANCING, OTHER OPERATIONAL IMPACT, POSSIBLE ALTERNATIVES)**

Total expenditures for August 2026 were $8,850,095.63. Significant expenditure included:

- Beacon Services - $228,908.27 for Residential Services
- Cherry Street Services, Inc. - $207,004.20 for Substance Use Services
- Eastside Outpatient Services LLC - $101,053.04 for Substance Use Services
- Flatrock Manor - $112,107.60 for Residential Services
- Guardian Trac LLC - $129,410.03 for Fiscal Intermediary of Outpatient Services
- HGA Nonprofit Homes - $124,229.50 for Residential Services
- IvyRehab Michigan - $189,205.56 for Autism Services
- Mercy General Health Partners - $290,940.00 for Community Inpatient Services
- Pine Rest Christian Hospital - $313,194.98 for Community Inpatient Services
- Pioneer Resources - $615,914.54 for Autism, Outpatient and Residential Services
- Positive Behavior Support Corp - $100,670.00 for Autism Services
- Professional Rehabilitation Services - $217,992.00 for Autism Services
- South Ridge - $152,436.00 for Community Inpatient Services
- Stuart T Wilson CPA PC - $104,417.18 for Fiscal Intermediate of Outpatient Services
- Turning Leaf - $163,746.11 for Residential Services
- Walloon Lake Recovery Lodge - $144,029.20 for Substance Use Services

**SUGGESTED MOTION (STATE EXACTLY AS IT SHOULD APPEAR IN THE MINUTES)**

I move to approve expenditures for August 2026 totaling $8,850,095.63

| COMMITTEE DATE | COMMITTEE APPROVAL |
|---|---|
| September 11, 2026 | _____ Yes _____ No _____ Other |
| **BOARD DATE** | **BOARD APPROVAL** |
| September 25, 2026 | _____ Yes _____ No _____ Other |

HealthWest


July 2026

Board Report

**COMMUNITY MENTAL HEALTH**
**INTERIM BALANCE SHEET 2220**
**MENTAL HEALTH**

**July 31, 2026**

| ASSETS | THIS YEAR | LAST YEAR |
|---|---|---|
| Cash in Bank | 4,421,401.22 | 5,215,613.61 |
| Imprest (Petty) Cash | 1,600.00 | 1,600.00 |
| Due from Credit Cards | 325.00 | 290.25 |
| Accounts Receivable | 71,097.63 | 216,376.91 |
| Due From Other Funds | 41,217.25 | 9,120.18 |
| Prepaid Items | 605,646.68 | 436,856.95 |
| Due from other governments | 78,406.14 | 5,586,894.01 |
| Total Assets | $ 5,219,693.92 | $ 11,466,751.91 |
| **LIABILITIES AND EQUITY** | | |
| Accounts Payable | $ 93,234.19 | $ 31,893.10 |
| Undistributed Receipts | 16,573.92 | 20,094.20 |
| Due to Federal | - | - |
| Total Liabilities and Equity | $ 109,808.11 | $ 51,987.30 |
| **DEFFERED INFLOWS OF RESOURES** | | |
| Deferred Medicaid fee for services and capitation | $ 15,905.00 | $ - |
| Fund Balance at beginning of year | 417,630.85 | 942,565.51 |
| Nonspendable FB-Prepaids | 507,930.59 | |
| **Total Fund Balance | $ 925,561.44 | $ 942,565.51 |
| TOTAL LIABILITIES, DEFERRED INFLOWS OF RESOURCES, AND FUND BALANCE | $ 1,051,274.55 | $ 994,552.81 |
| NET OF REVENUES VS EXPENDITURES | $ 4,168,419.37 | $ 10,472,199.10 |
| Transferred to County Equipment Revolving Account for: | | |
| Mental Health Center Building (6660-0000-349.220) | $2,220,775.07 | $2,381,613.71 |
| Future Equipment Purchases (6660-0000-349.222) | $119,122.10 | $86,607.86 |

**COMMUNITY MENTAL HEALTH**
**INTERIM BALANCE SHEET 7930**
**CMH CLIENT FUNDS**

**July 31, 2026**

**ASSETS**

| | THIS YEAR | LAST YEAR |
|---|---|---|
| **Cash** | $ 292,595.20 | $ 517,422.66 |
| **Imprest Cash** | $ - | $ - |
| **Accounts Receivable** | $ - | $ - |
| **Total Assets** | $ 292,595.20 | $ 517,422.66 |

**LIABILITIES AND EQUITY**

| | | |
|---|---|---|
| **Accounts Payable** | $ - | $ 1,368.50 |
| **Due to Other Funds** | $ 2,782.93 | $ 9,061.76 |
| **Undistributed Receipts** | $ 289,812.27 | $ 506,992.40 |
| | $ 292,595.20 | $ 517,422.66 |

## HealthWest

### Statement of Revenues, Expenditures and Changes in Fund Balances

Budget to Actual

For the Period from October 1, 2025 through July 31, 2026

| | *Projected Budget | YTD Budget | YTD Actual | Over (Under) YTD Budget |
|---|---|---|---|---|
| **Revenues** | | | | |
| Medicaid funding: | | | | |
| Medicaid capitation | $ 59,828,768 | $ 49,857,307 | $ 48,939,638 | $ (917,669) |
| Medicaid - Autism capitation | 13,345,975 | 11,121,646 | 11,431,221 | 309,575 |
| Medicaid capitation - settlement | - | - | (9,842,907) | (9,842,907) |
| Healthy Michigan Plan | 6,256,128 | 5,213,440 | 5,804,624 | 591,184 |
| Healthy Michigan Plan - settlement | - | - | 2,308,180 | 2,308,180 |
| CCBHC Revenue | 24,513,925 | 20,428,271 | 22,649,146 | 2,220,875 |
| State General Fund: | | | | |
| Formula Fundings | 2,066,287 | 1,721,906 | 1,721,906 | - |
| Grant Revenue | 6,477,699 | 5,398,083 | 5,242,141 | (155,942) |
| Local revenue: | | | | |
| County appropriation | 706,819 | 589,016 | 589,010 | (6) |
| Client and third party fees | 631,435 | 526,196 | 422,137 | (104,059) |
| Quality Bonus Payment | 1,397,953 | 1,164,961 | - | (1,164,961) |
| Interest income | 280,250 | 233,542 | 186,911 | (46,631) |
| Other revenue | 314,354 | 261,962 | 517,830 | 255,868 |
| Total revenue | 115,819,593 | 96,516,330 | 89,969,837 | (6,546,493) |
| **Expenditures** | | | | |
| Salaries and wages | 29,971,270 | 24,976,058 | 25,363,754 | 387,696 |
| Fringe benefits | 19,528,821 | 16,274,018 | 16,003,310 | (270,708) |
| Staff professional development | 580,268 | 483,557 | 357,159 | (126,398) |
| Contractual expense | 58,663,990 | 48,886,658 | 48,238,539 | (648,119) |
| Overhead expense | 3,115,310 | 2,596,092 | 2,581,579 | (14,513) |
| Supplies | 927,816 | 773,180 | 671,049 | (102,131) |
| Utilities | 282,040 | 235,033 | 215,196 | (19,837) |
| Insurance | 468,073 | 390,061 | 468,073 | 78,012 |
| Capital outlay | (105) | (88) | (70) | 18 |
| Other expenses | 2,049,175 | 1,707,646 | 844,953 | (862,693) |
| Transfers | 232,935 | 194,113 | 232,932 | 38,819 |
| Total expenditures | 115,819,593 | 96,516,328 | 94,976,474 | (1,539,854) |
| Net change in fund balance | - | 2 | (5,006,637) | (5,006,639) |
| Fund balance, beginning of year | 925,562 | 925,562 | 925,562 | - |
| **Fund balance, end of year** | $ 925,562 | $ 925,564 | $ (4,081,075) | $ (5,006,639) |

* Pending final approval

HealthWest
Muskegon's Behavioral Wellness Connection

**MEMORANDUM**

Date: September 11, 2026

To: HealthWest Board of Directors
Rich Francisco, Executive Director

CC: Mark Eisenbarth, Muskegon County Administrator
Matt Farrar, Muskegon County Deputy Administrator
Angie Gasiewski, Muskegon County Director of Finance
Carly Hysell, HealthWest Director of Finance

From: Brandy Carlson, Chief Financial Officer

Subject: **Finance Update**

During the month of September, HealthWest brought the following motion to the County Commissioners for approval.

Move to authorize HealthWest Surplus Property Disposal Under the HealthWest Policy.

Move that the Muskegon County Board of Commissioners authorize HealthWest to dispose of surplus and obsolete property in accordance with HealthWest's Board-approved Surplus Property Disposal Policy, rather than the Muskegon County Surplus Property Policy, provided that:

1. HealthWest maintains documented procedures for the identification, valuation, transfer, sale, donation, recycling, or disposal of surplus assets;
2. All disposal activities comply with applicable federal, state, and local laws and regulations;
3. Records of all surplus property dispositions are maintained in accordance with applicable record-retention requirements and remain available for audit and review;
4. HealthWest provides periodic reporting to the County, upon request, regarding surplus asset disposals; and
5. This authorization applies only to assets owned and controlled by HealthWest and does not extend to other Muskegon County departments or agencies unless separately approved by the Board.

**The HealthWest Surplus Property Disposal Policy is substantially consistent with the Muskegon County Surplus Property Policy, with the exception of Section V.B.1.h., which permits employees to purchase surplus monitors and docking stations. Revenue generated from such sales shall be deposited into the appropriate HealthWest revenue account.**

# REQUEST FOR HEALTHWEST BOARD CONSIDERATION AND AUTHORIZATION

| COMMITTEE | BUDGETED | NON BUDGETED | PARTIALLY BUDGETED |
|---|---|---|---|
| Finance Committee | X | | |

| REQUESTING DIVISION | REQUEST DATE | REQUESTOR SIGNATURE |
|---|---|---|
| Provider Network | September 11, 2026 | Anissa Goodno, Provider Network Specialist |

**SUMMARY OF REQUEST (GENERAL DESCRIPTION, FINANCING, OTHER OPERATIONAL IMPACT, POSSIBLE ALTERNATIVES)**

HealthWest is seeking Board approval to enter into a service contract with **Samaritan Way**, a new Sober Living Provider in Muskegon. Contracting with this organization will expand HealthWest's access to safe transitional housing for our Consumers utilizing Outpatient Substance Use Disorder Treatment.

**Business Office:**
1465 Apple Avenue
Muskegon, MI 49442

**Recovery Residence:**
1364 Terrace Street
Muskegon, MI 49442
Capacity: 56
Co-Ed

**Contract Term:**
November 1, 2026-September 30, 2027

**Scope of Services:**

- Alcohol & Drug Halfway House Services/Recovery Housing – MARR Certified Level 3 Congregate Co-Ed Facility.
- Contract will allow support of 18% of total bed nights which is a maximum of 10 individuals per night for a total anticipated cost of $101,506.50
- Funding Source is SUD Block Grant and/or PA2

This organization has been credentialed with The Lakeshore Regional Entity as of August 27, 2026.

**SUGGESTED MOTION (STATE EXACTLY AS IT SHOULD APPEAR IN THE MINUTES)**

I move to authorize the HealthWest Executive Director to sign a contract with Samaritan Way Recovery Community from November 1, 2026 through September 30, 2027

| COMMITTEE DATE | COMMITTEE APPROVAL |
|---|---|
| September 11, 2026 | _____ Yes _____ No _____ Other |
| **BOARD DATE** | **BOARD APPROVAL** |
| September 25, 2026 | _____ Yes _____ No _____ Other |

HWB 128-F

## REQUEST FOR HEALTHWEST BOARD CONSIDERATION AND AUTHORIZATION

| COMMITTEE | BUDGETED | NON-BUDGETED | PARTIALLY BUDGETED |
|---|---|---|---|
| Finance Committee | X | | |

| REQUESTING DIVISION | REQUEST DATE | REQUESTOR SIGNATURE |
|---|---|---|
| Finance | September 11, 2026 | Jennifer Stewart, Director of SUD Prevention & Treatment |

SUMMARY OF REQUEST (GENERAL DESCRIPTION, FINANCING, OTHER OPERATIONAL IMPACT, POSSIBLE ALTERNATIVES)

Authorization is requested by the HealthWest Board to approve purchase from and/or reimbursement to VitalCore Health Strategies, LLC and various pharmacies through September 30, 2027.

The purchases/reimbursements will include:

- Purchase of various MOUD medications from Trinity Long Term Care pharmacy and/or alternative pharmacies as needed to obtain necessary medications.
- Reimbursement to VitalCore for MOUD injectable medications as prescribed by HealthWest providers. Wholesale cost orders of injectable medications must be approved by HealthWest to ensure appropriate funding is available for reimbursement. Orders placed by VitalCore without HealthWest's prior approval may not be reimbursed by HealthWest.

The total requested grant budget of $159,027.00 will cover the cost of Medications for Opioid Use Disorder (MOUD). The funding is through the Lakeshore Regional Entity under State Opioid Response Jail MOUD.

**SUGGESTED MOTION (STATE EXACTLY AS IT SHOULD APPEAR IN THE MINUTES)**

I move to authorize the HealthWest Board of Directors to approve the purchase of and/or reimbursement from VitalCore and/or other utilized pharmacies for FY2027.

| COMMITTEE DATE | COMMITTEE APPROVAL |
|---|---|
| September 11, 2026 | _____ Yes _____ No _____ Other |
| **BOARD DATE** | **BOARD APPROVAL** |
| September 25, 2026 | _____ Yes _____ No _____ Other |

HWB 129-F

## REQUEST FOR HEALTHWEST BOARD CONSIDERATION AND AUTHORIZATION

| COMMITTEE | BUDGETED | NON BUDGETED | PARTIALLY BUDGETED |
|---|---|---|---|
| Finance Committee | X | | |

| REQUESTING DIVISION | REQUEST DATE | REQUESTOR SIGNATURE |
|---|---|---|
| Administrative/Executive | September 11, 2026 | Rich Francisco, Executive Director |

**SUMMARY OF REQUEST (GENERAL DESCRIPTION, FINANCING, OTHER OPERATIONAL IMPACT, POSSIBLE ALTERNATIVES)**

HealthWest Board authorization is requested to approve the signing of the Lakeshore Regional Entity (LRE) and HealthWest Agreement of the Medicaid Managed Specialty Supports and Services provider under the following:

- 1115 Behavioral Health Demonstration Waiver
- Concurrent 1915(C)/(I) Waiver Program(s)
- Flint 1115 Demonstration Waiver
- The Healthy Michigan Program

The term of the agreement is October 1, 2026, through September 30, 2027.

**SUGGESTED MOTION (STATE EXACTLY AS IT SHOULD APPEAR IN THE MINUTES)**

I move to authorize the HealthWest Executive Director to sign the FY27 Lakeshore Regional Entity and HealthWest Agreement of the Medicaid Managed Specialty Supports and Services under the Section 1115 Behavioral Health Demonstration Waiver, including concurrent 1915(c)/(I) Waiver Programs, Flint 1115 Demonstration Waiver, and the Healthy Michigan Program, effective October 1, 2026, through September 30, 2027.

| COMMITTEE DATE | COMMITTEE APPROVAL |
|---|---|
| September 11, 2026 | _____ Yes _____ No _____ Other |
| **BOARD DATE** | **BOARD APPROVAL** |
| September 25, 2026 | _____ Yes _____ No _____ Other |

HWB 130-F

**CONTRACT**
**BY AND BETWEEN**
**LAKESHORE REGIONAL ENTITY**
**AND**
**[MEMBER NAME]**
**FOR**
**MEDICAID MANAGED SPECIALITY SUPPORTS AND SERVICES**
**PROVIDED UNDER**
**1115 BEHAVIORAL HEALTH DEMONSTRATION WAIVER**
**INCLUDING CONCURRENT 1915(C)/(I) WAIVER PROGRAM(S),**
**FLINT 1115 DEMONSTRATION WAIVER,**
**THE HEALTHY MICHIGAN PROGRAM**

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## STANDARD CONTRACT TERMS

This CONTRACT ("Contract") is agreed to between Lakeshore Regional Entity ("LRE") a Prepaid Inpatient Health Plan (PIHP) and _____ ("Member") (Party/Parties). This Contract shall be in effective from ~~November 15th, 2024~~October 1, 2026 ("Effective Date"), unless terminated, through September 30th, 202~~5~~7 ("Term").

This Contract may be extended, in increments no longer than twelve (12) months, through Amendment, as agreed to in writing by both Parties.

This Contract shall terminate immediately upon the effective date of termination of LRE's MDHHS/PIHP Master Contract.

**THE PARTIES AGREE AS FOLLOWS:**

**1. Responsibilities of Member**

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

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

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

**2. Notices**

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

| If to LRE | If to Member |
|---|---|
| Mary Marlatt-Dumas<br>Chief Executive Officer<br>5000 Hakes Drive<br>Norton Shores, Michigan 49441<br>marymd@lsre.org<br>231-769-2050 | |

**3. Performance Guarantee**

In accordance with 42 CFR 438, Member must at all times have sufficient financial resources to ensure performance of the Contract and must provide proof to LRE upon request.

**4. Insurance Requirements**

Member, at its sole expense, must maintain throughout the term of this contract the insurance coverage identified below. All required insurance must: (a) protect LRE from claims that may arise out of, are alleged to arise out of, or otherwise result from Member's performance; (b) notify LRE immediately if any insurance is cancelled; and (c) waive all rights against LRE for damages covered by insurance. Failure to maintain the required insurance does not limit this waiver.

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

| Required Limits | Additional Requirements |
|---|---|
| Commercial General Liability Insurance | |
| Minimum Limits:<br>$1,000,000 Each Occurrence<br>$1,000,000 Personal and Advertising Injury<br>$2,000,000 General Aggregate<br>$2,000,000 Products/Completed Operations | |
| Automobile Liability Insurance | |
| Minimum Limits:<br>$1,000,000 Per Accident | Policy must include Hired and Non-Owned Automobile Coverage |
| Workers Compensation Requirements | |
| Minimum Limits:<br>Coverage according to applicable laws governing work activities. | Waiver of subrogation, except where prohibited by law. |
| Employers Liability Insurance | |
| Minimum Limits:<br>$500,000 Each Accident<br>$500,000 Each Employee by Disease<br>$500,000 Aggregate Disease | |
| Privacy and Security Liability (Cyber Liability) Insurance | |
| Minimum Limits:<br>$1,000,000 Each Occurrence | Policy must cover information security and privacy liability, privacy notification costs, |

| | |
|---|---|
| $1,000,000 Annual Aggregate | regulatory defense and penalties, and website media content liability. |
| Professional Liability (Errors and Omissions) Insurance | |
| Minimum Limits:<br>$3,000,000 Each Occurrence<br>$3,000,000 Annual Aggregate | |

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

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

**5. Relationship of the Parties**

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

**6. Stop Payment**

MDHHS may suspend any or all activities under the MDHHS/PIHP Master Contract at any time. MDHHS will provide LRE with a written stop work order detailing the suspension. LRE will not pay for Contract Activities, Member's lost profits, or any additional compensation during a stop work period.

**7. Termination**

LRE may terminate this Contract in whole or in part without penalty, if Member, as determined by LRE: (i) endangers the value, integrity, or security of any facility, data, or personnel; (ii) becomes insolvent, petitions for bankruptcy court proceedings, or has an involuntary bankruptcy proceeding filed against it by any creditor. Any reference to specific breaches being material breaches within this Contract will not be construed to mean that other breaches are not material.

If LRE terminates this Contract under this Section, LRE will issue a termination notice specifying whether Member must: (i) cease performance or (ii) continue to perform for a specified period.

If LRE terminates this Contract for convenience, LRE will pay all reasonable costs, as determined by LRE, for LRE approved Transition Responsibilities to the extent the funds are available.

**8. Transition Responsibilities**

If this Contact is terminated, Member shall cooperate with LRE to implement a transition plan for all individuals served. LRE shall have the sole authority for approving the adequacy of the transition plan, including providing for the financing of said plan. The transition plan shall set forth the process and time frame for transition. Member shall assure continuity of care for all individuals served under this Contract until transitioned to and under the jurisdiction of another contractor selected by LRE.

**9. Return of Property**

Return of Property. Upon termination of this Contract, regardless of cause, each Party hereto shall return all documents, correspondence, files, records, papers, or other property of any kind to the other Party.

**10. Indemnification**

A. All liability to third parties, loss, or damage as a result of claims, demands, costs, or judgments arising out of activities to be carried out by LRE in the performance of this Agreement shall be the responsibility of LRE, and not the responsibility of Member, if the liability, loss, or damage is caused by, or arises out of, the actions or failure to act on the behalf of LRE, its other Subcontractors and/or Network Providers, and their officers, directors, employees and authorized representatives, provided that nothing herein shall be construed as a waiver of any governmental immunity that has been provided to LRE or its officers and employees by statute or court decisions.

B. All liability to third parties, loss, or damage as a result of claims, demands, costs, or judgments arising out of activities to be carried out by Member in the performance of this Agreement shall be the responsibility of Member, and not the responsibility of LRE, if the liability, loss, or damage is caused by, or arises out of, the actions or failure to act on the behalf of Member, its Network Providers, and their officers, directors, employees and authorized representatives, provided that nothing herein shall be construed as a waiver of any governmental immunity that has been provided to Member or its officers and employees by statute or court decisions.

C. In the event that liability to third parties, loss or damage arises as a result of activities conducted jointly by the parties hereto in fulfillment of their responsibilities under this Agreement, such liability, loss, or damage shall be borne by each party in relation to each party's responsibilities under the joint activities, provided that nothing herein shall be construed as a waiver of any public or governmental immunity granted to any of the parties hereto as provided by applicable statutes or court decisions.

**11. Limitation of Liability and Disclaimer of Damages**

In no event will LRE's aggregate liability to member under this contract, regardless of the form of action, whether in contract, tort, negligence, strict liability or by statute or otherwise, for

any claim related to or arising under this contract, exceed the maximum amount of fees payable under this contract. LRE is not liable for consequential, incidental, indirect, or special damages, regardless of the nature of the action.

**12. Disclosure of Litigation, or Other Proceeding**

Member must notify LRE within ten (10) calendar days of receiving notice of any litigation, investigation, arbitration, or other proceeding (collectively, "Proceeding") involving Member, contracted network provider, or an officer or director of Member or contracted network provider, that arises during the term of the Contract, including: (a) a criminal Proceeding; (b) a parole or probation Proceeding; (c) a Proceeding under the Sarbanes-Oxley Act; (d) a civil Proceeding involving: (1) a claim that might reasonably be expected to adversely affect Member's viability or financial stability; or (2) a governmental or public entity's claim or written allegation of fraud; or 3) any complaint related to the services provided in this Contract filed in a legal or administrative proceeding alleging Member or its contracted network provider discriminated against its employees, vendors, or suppliers during the performance of Contract activities and during the term of this Contract; or (e) a Proceeding involving any license that Member is required to possess in order to perform under this Contract.

**13. Non-Disclosure of Confidential Information**

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

A. Meaning of Confidential Information. For the purposes of this Contract, the term "Confidential Information" means all information and documentation of a party that: (a) has been marked "confidential" or with words of similar meaning, at the time of disclosure by such party; (b) if disclosed orally or not marked "confidential" or with words of similar meaning, was subsequently summarized in writing by the disclosing party and marked "confidential" or with words of similar meaning; or, (c) should reasonably be recognized as confidential information of the disclosing party. The term "Confidential Information" does not include any information or documentation that was or is: (a) subject to disclosure under the Michigan Freedom of Information Act (FOIA); (b) already in the possession of the receiving party without an obligation of confidentiality; (c) developed independently by the receiving party, as demonstrated by the receiving party, without violating the disclosing party's proprietary rights; (d) obtained from a source other than the disclosing party without an obligation of confidentiality; or, (e) publicly available when received, or thereafter became publicly available (other than through any unauthorized disclosure by, through, or on behalf of, the receiving party). For purposes of this Contract, in all cases and for all matters, State Data, as defined by the MDHHS Master Contract (Standard Contract Terms 33. State Data) is deemed to be Confidential Information.

B. Obligation of Confidentiality. The parties agree to hold all Confidential Information in strict confidence and not to copy, reproduce, sell, transfer, or otherwise dispose of, give

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

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

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

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

**14. Data Privacy and Information Security**

Undertaking by Member. Without limiting Member obligation of confidentiality as further described, Member is responsible for establishing and maintaining a data privacy and

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

A. Audit by Member. No less than annually, Member must conduct a comprehensive independent third-party audit of its data privacy and information security program and provide such audit findings to LRE.

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

C. Audit Findings. Member must implement any required safeguards as identified by LRE by any audit of Member's data privacy and information security program.

D. LRE's Right to Termination for Deficiencies. LRE reserves the right, to immediately terminate this Contract if LRE determines that Member fails or has failed to meet its obligations under this Section.

**15. Records Maintenance, Inspection, Examination, and Audit**

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

The State, CMS, LRE, the Office of the Inspector General, the Comptroller General, and their designees may, at any time, inspect and audit any records or documents of Member, or its network providers, and may, at any time, inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. The right to audit under this section exists for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

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

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

**16. Conflicts and Ethics**

Member will uphold high ethical standards and is prohibited from: (a) holding or acquiring an interest that would conflict with this Contract; (b) doing anything that creates an appearance of impropriety with respect to the award or performance of the Contract; (c) attempting to influence or appearing to influence any State or LRE employee by the direct or indirect offer of anything of value; or (d) paying or agreeing to pay any person, other than employees and consultants working for Member, any consideration contingent upon the award of the Contract. Member must ~~immediately~~ notify LRE of any violation or potential violation of these standards.

**17. Compliance with Law**

Member must comply with all federal, state and local laws, rules and regulations.

**18. Non-Discrimination**

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

**19. Unfair Labor Practice**

Member may not contract with any entity or organization which appears on the Unfair Labor Practice register compiled under MCL 423.322.

**20. Non-Exclusivity**

Nothing contained in this Contract is intended nor is to be construed as creating any requirements that the LRE contract with Member, nor does it provide Member with a right of first refusal for any future work. This Contract does not restrict LRE or Member from acquiring similar, equal, or like Contract Activities from other sources.

**21. Dispute Resolution**

Any dispute between Member(s) and LRE related to the interpretation or application of the terms of this Contract will be addressed in accordance with Article 5 of the LRE Operating Agreement as amended and incorporated herein.

**ARTICLE 5**

**DISPUTE**

5.1 **DISPUTE RESOLUTION PROCESS**.

Occasionally disputes may arise that cannot be resolved through amiable discussion. Any dispute between the Members and the ENTITY related to the interpretation or application of the Bylaws of the ENTITY or this Operating Agreement will be referred to Members for consideration pursuant to the procedures set forth in Section 5.1.1 thru 5.1.4. The resolution of said dispute will be final upon Majority vote of the ENTITY Board of Directors. Disputes between Members or Member/s and the ENTITY will be resolved as provided below. Dispute resolution procedures shall be conducted in accordance with the Conflict of Interest Policy.

5.1.1 **Step 1.** The Chief Executive Officer/Executive Director of the Members will attempt to resolve the dispute through discussion with each other or, as the case may be, and the ENTITY Chief Executive Officer.

5.1.2 **Step 2.** If the dispute remains unresolved, the Chief Executive Officer/Executive Director of the Member/s or the Chief Executive Officer of the ENTITY, as the case may be, will bring the matter to the Operations Advisory Council who will discuss the matter and render a written decision. The matter will be brought to the next scheduled Operations Committee who will discuss and render a decision within 15 calendar days.

5.1.3 **Step 3.** If the dispute continues to be unresolved to the satisfaction of the Member/s or the ENTITY, the parties will provide a written description of the issue in dispute and propose a solution to the next scheduled ENTITY Board of Directors meeting. The ENTITY Board of Directors will have thirty (30) calendar days to provide a written decision.

5.1.4 **Step 4.** If the Member(s) or the ENTITY remain dissatisfied, the Member(s) or the ENTITY may seek mediation, arbitration or legal recourse as provided by law.

~~22.~~ 5.2 **Schedules/Exhibits**

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All Schedules and Exhibits referenced herein and attached hereto are hereby incorporated by reference.

~~23.~~ 5.3 **Entire Agreement and Order of Precedence**

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This Contract, which includes Statement of Work, and schedules and exhibits, is the entire agreement of the parties related to the Contract Activities. This Contract supersedes and replaces all previous understandings and agreements between the parties for the Contract Activities. If there is a conflict between documents, the order of precedence is: (a) first, the MDHHS/PIHP Master Contract, excluding its schedules, exhibits, and Statement of Work; (b) second, Statement of Work as of the Effective Date; and (c) third, schedules expressly incorporated into this Contract as of the Effective Date.

~~24.~~ 5.4 **Severability**

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

~~25.~~5.5 **Waiver**

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

~~26.~~5.6 **Survival**

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

~~27.~~5.7 **Contract Modification**

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

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## FEDERAL PROVISIONS ADDENDUM

This addendum applies to purchases that will be paid for in whole or in part with funds obtained from the federal government. The provisions below are required, and the language is not negotiable. Member agrees to comply with all obligations under federal rules or regulations for such funding, including but not limited to the provisions contained in this addendum. If any provision below conflicts with the State's terms and conditions, including any attachments, schedules, or exhibits to this Contract, the provisions below take priority to the extent a provision is required by federal law; otherwise, the order of precedence set forth in the Contract applies. Further, Member agrees to, through a Contract Change Notice, append or modify specific federal provisions to this Contract, if reasonably necessary to keep LRE and Member in compliance with federal funding requirements, and comply with the terms set forth therein.

**A. Equal Employment Opportunity**

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

**B. Davis-Bacon Act (Prevailing Wage)**

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

**C. Copeland "Anti-Kickback" Act**

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

**D. Contract Work Hours and Safety Standards Act**

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

**E. Rights to Inventions Made Under a Contract or Agreement**

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

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

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

**(1) Clean Air Act**

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

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

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

**(2) Federal Water Pollution Control Act**

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

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

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

**G. Debarment and Suspension**

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

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

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

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

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

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

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

**I. Procurement of Recovered Materials**

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

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

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

(ii) Meeting contract performance requirements; or

(iii) At a reasonable price.

(2) Information about this requirement, along with the list of EPA- designated items, is available at EPA's Comprehensive Procurement Guidelines web site.

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

**J. Prohibition on Contracting for Covered Telecommunications Equipment or Services**

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

During performance of this Contract, Member agrees as follows:

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

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

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

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

(b) Prohibitions.

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

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

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

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

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

(c) Exceptions.

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

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

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

(d) Reporting requirement.

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

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

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

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

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

**K. Domestic Preferences for Procurements**

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

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

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

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

**L. Affirmative Socioeconomic Steps**

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

**M. Copyright and Data Rights**

Pursuant to 2 CFR § 200.315(b), the State may copyright any work which is subject to copyright and was developed, or for which ownership was acquired, under a federal award. The Federal awarding agency reserves a royalty-free, nonexclusive and irrevocable right to reproduce, publish, or otherwise use the work for Federal purposes, and to authorize others to do so.

**N. Additional FEMA Contract Provisions**

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

**O. Other Federal Contract Provisions**

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

## SCHEDULE A: STATEMENT OF WORK CONTRACT ACTIVITIES

### BACKGROUND

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

CMS has also approved a 1115 Demonstration Waiver titled the Healthy Michigan Plan (HMP) which provides health care coverage for adults who become eligible for Medicaid under Section 1902(2)(10)(A)(i)(VIII) of the Social Security Act. In Michigan, the 1115 Behavioral Health Demonstration Waiver and the Healthy Michigan Plan are managed on a shared risk basis by specialty PIHP contractors, selected through the Application for Participation (AFP) process which can be found on the MDHHS Website (Michigan Department of Health & Human Services).

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

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

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

### SCOPE

The purpose of this Contract is to engage Member in the provision of services under the 1115 Behavioral Health Demonstration Waiver Program, the Healthy Michigan Plan and relevant approved Waivers in the Region 3 PIHP designated service area and to provide a comprehensive array of specialty mental health and substance use disorder services and supports as indicated in this Contract. Member must manage its responsibilities in a manner that promotes maximum value, efficiency, and effectiveness consistent with state and federal statute, LRE Policies and Procedures, and applicable waiver standards. This includes limiting managed care administrative duplication thereby reducing avoidable costs while maximizing the Medical Loss Ratio (MLR). Member must actively manage behavioral health services for its geographical service area using standardized methods and measures for determination of need and appropriate delivery of service. Member must ensure that cost variances in services are supported by quantifiable measures of need to ensure accountability, value and efficiency.

**1. General Provisions**

A. Contract Authority.

1) This Contract is entered into pursuant to the authority granted Parties under the Michigan Mental Health Code; 42 CFR §438; PA500 of 2012; and the MDHHS/PIHP Master Contract.

2) This Contract is in accordance with the rules, regulations, and standards of MDHHS, adopted and promulgated in accordance with the Mental Health Code, Public Health Code, and Administrative Rules, all of which are incorporated herein by reference.

3) This Contract is in accordance with the standards as contained in the Application for Participation ("AFP") as they pertain to the provision of specialty services to eligible Medicaid beneficiaries and the plans of correction and subsequent plans or correction submitted by the PIHP and approved by MDHHS and any stated conditions, as reflected in the MDHHS approval for application, unless prohibited by federal or state law.

B. MDHHS/PIHP Master Contract. It is expressly understood by Parties that this Contract is subject to the terms and conditions of the MDHHS/PIHP Master Contract, and all references made therein, together with the Policies and Practice Guidelines set forth by MDHHS, all of which are incorporated herein by reference and may from time to time be amended.

**2. General Requirements**

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

A. Service Area.

1) Targeted Geographical Area for Implementation. Member must manage the 1115 Behavioral Health Demonstration Waiver Program and the Healthy Michigan Plan under the terms of this Contract for its geographic service area.

2) Target Population. Member must serve Medicaid beneficiaries in its service area who require the Medicaid services included under the 1115 Behavioral Health Demonstration Waiver; who are eligible for the Healthy Michigan Plan, the 1915(i) State Plan ~~Benefit~~Amendment (SPA), the Flint 1115 Waiver; who are enrolled in the 1915(c) waivers (HSW, CWP, SED); who are enrolled in the MIChild program; or for whom Member has assumed or been assigned County of Financial Responsibility (COFR) status under Chapter 3 of the Mental Health Code.

3) Home and Community Character. Member must assure that the residential (adult foster care, specialized residential, provider owned/controlled) and non-residential services (skill building, supported employment, community living supports, pre-vocational, out of home non-vocational) where individuals are supported by funds from the Medicaid 1915(c) waiver programs (Habilitation Supports Waiver, Children's Waiver, and Children's SED Waiver) maintain a home and community character

setting as required by federal regulation and the resultant, Michigan-specific, Home and Community Based Services State Transition Plan.

B. Customer Service Standards. Member must comply with Customer Services Standards in accordance with MDHHS/PIHP Master Contract and MDHHS and LRE policies and procedures. Specific managed care activities delegated to Member are outlined in **Schedule I: Delegation of Managed Care Function Activities**.

C. Payment Reform.

1) Data Reporting

a. In order to continually improve the performance of its contracted providers, Member must collect and report data in a consistent and coordinated manner in collaboration with LRE.

b. Member agrees to work collaboratively with LRE to develop standard measure specifications, data collection processes, baseline data, and reports that will be provided to Member and/or the State.

2) Responsibility for Payment of Authorized Services

a. Member will be responsible for payment for services that Member authorizes, including Medicaid substance use disorder services. This provision presumes Member and its Network Providers are fulfilling their responsibility to individuals according to terms specified in this Contract.

b. Services must not be delayed or denied as a result of a dispute of payment responsibility between two or more network providers. In the event there is an unresolved dispute between Member and Network Providers, either one may request LRE's and/or the State's involvement to resolve the dispute and make a determination. Likewise, services must not be delayed or denied as a result of a dispute of payment responsibility between Member and the Network Provider.

c. Member, or their designee, must be contacted for authorization for post-stabilization care. Member is financially responsible for post-stabilization specialty care services obtained which are pre-approved by Member, or their designee, if authorization is delegated to it by Member in accordance with 42 CFR 438.230.

d. Member is also responsible for post-stabilization care services when they are administered to maintain, improve or resolve the beneficiary's stabilized condition when:

i. Member does not respond to a request for pre-approval within one hour.

ii. Member cannot be contacted.

iii. Member's representative and the treating physician cannot reach an agreement concerning the beneficiary's care and a Member physician is not available for consultation. In this situation, Member must give the treating physician the opportunity to consult with Member physician and the treating

physician may continue with care of the patient until a Member physician is reached or one of the criteria of 42 CFR 422.133(c)(3) is met.

3) Financial responsibility for enrollees who are children is the county where the child and parents have primary residence. For temporary and permanent wards of the State or court (including tribal), financial responsibility is the county where the child 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, wraparound, case management or supports coordination) for up to 180 days prior to discharge.

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

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

6) Liability for Payment. Member must provide that its Medicaid beneficiaries are not held liable for Covered services provided to the beneficiary, for which LRE does not pay Member, or Member does not pay the individual or health care provider that furnished the services under a contractual, referral, or other arrangement.

D. Contract Remedies and Sanctions.

1) LRE will utilize a variety of means to assure compliance with Contract requirements. LRE will pursue remedial actions and possibly sanctions, consistent with Michigan's Mental Health Code, as needed to resolve outstanding contract violations and performance concerns. The application of remedies and sanctions shall be a matter of public record.

2) The pursuance of any remedial actions, up to and including revocation or modification of delegated activities or obligations under this Contract does not require a Contract amendment. The use of remedies and sanctions will typically follow a progressive approach. ~~, but~~ LRE reserves the right to deviate from the progression as needed to

seek correction of serious~~,~~ or repeated patterns of substantial non-compliance or performance problems. ~~LRE may pursue sanctions consistent with Section 330.1232b of the Michigan Mental Health Code.~~

Commented [PG1]: Inserted as a result of changes in the FY26 MDHHS/PIHP Contract. (General Requirements E.1-6)

~~2)~~ Member can utilize the dispute resolution provision of the Contract to dispute a contract compliance notice issued by LRE.

3) Before imposing a sanction on a Member, LRE will provide Member with timely written Contract compliance notice that explains both of the following:

   a. The compliance issue along with its statutory/regulatory/contractual basis and the objective evidence upon which the finding of fault is based.

   b. The opportunity to contest or dispute LRE's findings and intended sanction, prior to the imposition of the sanction.

4) LRE may do any of the following:

   a. Require a plan of correction and specified status reports that becomes a Contract performance objective.

   b. Impose financial sanctions.

   c. Initiate Contract termination.

E. Access and Availability.

1) Provider Network Services. Member is responsible for maintaining and continually evaluating an effective provider network that is adequate to fulfill the obligations of this contract. Member remains the accountable party for the Medicaid beneficiaries in its service area, as specified in 42 CFR 438.230. In this regard, and in compliance with e42 CFR Parts 438.414; 438.10(g)(2)(xi)(C)(D)(E) and 457.1260, Member must:

   a. Maintain a regular means of communicating and providing information on changes in policies and procedures to its providers.

   b. Have clearly written mechanisms to address provider grievances and complaints, and an appeal system to resolve disputes.

   c. Provide a copy of Member's prior authorization policies to the provider when the provider joins Member's provider network. Member must notify providers of any changes to prior authorization policies.

   d. Provide a copy of Member's grievance, appeal and fair hearing procedures and timeframes to the provider when the provider joins Member's provider network. Member must notify providers of any changes to those procedures or timeframes.

   e. Provide to LRE, in the format specified by LRE, provider agency information profiles that contain a complete listing and description of the provider network available to recipients in the service area.

   f. Assure that services are accessible, taking into account travel time, availability of public transportation, and other factors that may determine accessibility.

g. Assure that network providers do not segregate beneficiaries in any way from other individuals receiving their services.

2) Network Requirements.

a. Member 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. Member may also utilize qualified providers from outside Member's service area for the provision of covered services.

b. Member must consider anticipated enrollment and expected utilization of services.

c. Member must provide documentation on which the State bases its certification that Member complied with the State's requirements for availability and accessibility of services, including the adequacy of the provider network as referenced in 42 CFR Parts 438.604(a)(5); 438.606; 438.207(b) and 438.206.

d. Member must submit to LRE any other data, documentation, or information relating to the performance of LRE's obligations as required by the State as referenced in 42 CFR Parts 438.604(b) and 438.606.

e. In accordance with 42 CFR 438.14, Member 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 agreement 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, Member must:

(a) Allow Indian beneficiaries to access out-of-State IHCPs; or

(b) Show good cause for disenrollment from both LRE and the State's managed care program in accordance with 42 CFR § 438.56(c).

ii. Member must permit Indian beneficiaries to obtain services covered under the Agreement from out-of-network IHCPs from whom the beneficiary is otherwise eligible to receive such services.

iii. Member must permit an out-of-network IHCP to refer an Indian beneficiary to a network provider.

3) Changes in Provider Network.

a. Member must notify LRE within four (4) days of any changes to the composition of the provider network organizations that negatively affect access to care.

b. Member must have policies and/or procedures to address changes in its network that negatively affect access to care.

c. LRE may apply sanctions to Member if a network change that negatively affects beneficiaries' access to care is not reported timely, or Member is not willing or able to correct the issue.

4) Out of Network Providers.

   a. Member 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. Member must cover such Out-of-Network services for as long as Member's Provider Network is unable to provide adequate access to covered Medically Necessary services for the identified beneficiary(s).

   b. If Member cannot reasonably provide access to non-emergent Covered Services by a Network Provider within access requirements of this Contract, Member must include in its service authorization decision, the provision of Covered Services Out-of-Network.

   c. Member must coordinate with Out-of-Network providers with respect to payment and follow all applicable MDHHS policies to ensure the beneficiary is not liable for costs greater than would be expected for in network services including a prohibition on balance billing in compliance with 42 CFR 438.106, 42 CFR 438.116 and the Medicaid Provider Manual.

   d. Member must comply with all related Medicaid Policies regarding authorization and reimbursement for Out-of- Network providers.

      i. Member 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, Member must follow Medicaid Policy to determine the correct payment amount.

5) 1115 Behavioral Health Demonstration Waiver and Healthy Michigan Programs. Services may be provided at or through Member service sites or contractual provider locations. Unless otherwise noted in the Michigan Medicaid Provider Manual, mental health and intellectual/developmental disabilities services may also be provided in other locations in the community, including the beneficiary's home, according to individual need and clinical appropriateness.

6) Provider Procurement.

   a. Member is responsible for the development of their service delivery system and the establishment of sufficient administrative capabilities to carry out the requirements and obligations of this Contract. Where Member fulfills these responsibilities through network provider agreements, 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, Member:

      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 Member 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, Member's selection policies and procedures cannot discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatments. Also, Member 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.

7) Access Standards.

a. Member must ensure timely access to supports and services in the preferred language of the person served based on their language skills and in accordance with the Access Standards and timeliness standards, which can be found on the MDHHS Website, and report its performance on the standards as required.

b. Member 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.

8) Person Centered Planning.

a. The Michigan Mental Health Code, MCL 330.1712, establishes the right for all individuals to have an Individual Plan of Service (IPOS) developed through a person- centered planning process. Member must implement person-centered planning in accordance with the MDHHS Person-Centered Planning Policy which can be found on the MDHHS Website. In accordance with 42 CFR 438.208(b)(2)(i), the person-centered planning process must include coordination of services between settings of care which includes appropriate discharge planning for short and long-term hospitalizations. This provision is not a requirement of Substance Use Disorder Services.

b. Member must have a specially constituted committee, such as a Behavior Treatment Plan Review Committee, to review and approve or disapprove any plans that propose to use restrictive or intrusive interventions with individuals served by the public mental health system who exhibit seriously aggressive, self-injurious or other behaviors that place the individual or others at risk of physical harm. The Committee must substantially incorporate the standards in the

Standards for Behavior Treatment Plan Review Committees which can be found on the MDHHS Website.

9) Cultural Competence.

   a. The supports and services provided by Member (both directly and through contracted providers) must demonstrate an ongoing commitment to linguistic and cultural competence that ensures access and meaningful participation for all people in the service area. Such commitment includes acceptance and respect for the cultural values, beliefs and practices of the community, as well as the ability to apply an understanding of the relationships of language and culture to the delivery of supports and services.

   b. To effectively demonstrate such commitment, it is expected that Member has five components in place:

      i. a method of community assessment;

      ii. sufficient policy and procedure to reflect Member's value and practice expectations;

      iii. a method of service assessment and monitoring;

      iv. ongoing training to assure that staff are aware of, and able to effectively implement, policy; and

      v. the provision of supports and services within the cultural context of the recipient.

   c. Member must participate in efforts to promote the delivery of services in a culturally competent manner to all beneficiaries, including those with limited English proficiency and diverse cultural and ethnic backgrounds, and those who are Deaf, Hard of Hearing, and Deaf and Blind. Treatment will be modified to effectively serve individuals who are deaf, hard of hearing, and deaf and blind as determined by their language skills and preferences.

10) Self-Direction. Member will comply with, and ensure its network provider comply with, all elements of Participant-Directed Services outlined in the 1915(i)(1)(G)(iii), 1915(c) Appendix E HCBS waiver authorities and the Self-Directed Services Technical Requirements which can be found on the MDHHS Website. This provision is not a requirement of Substance Use Disorder Services.

11) Choice. In accordance with 42 CFR 438.6, Member must assure that beneficiaries are allowed to choose their health care professional, i.e., physician, therapist, etc. to the extent possible and appropriate.

12) Second Opinion. At Beneficiary request, Member must provide for a second opinion from a qualified Health Care Professional within network or arrange for the ability of the Beneficiary to obtain a second opinion outside the network, at no cost to the Beneficiary.

13) Denials by a Qualified Professional. Member must assure 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.

14) Recovery Policy. All Supports and Services provided to individuals with mental illness, including those with co-occurring conditions, must be based in the principles and practices of recovery outlined in the Michigan Recovery Council document, Recovery Policy and Practice Advisory which can be found on the MDHHS Website.

15) Nursing Home Placements. Member agrees to provide medically necessary specialty Medicaid Services to facilitate placement from or to divert admissions to a nursing home, for eligible Beneficiaries determined by the Omnibus Budget Reconciliation Act of 1987 ("OBRA") screening assessment to have a mental illness and/or intellectual or developmental disability and in need of placement and/or Covered Services. Funding allocated for OBRA placement and for treatment shall continue to be directed to this population.

16) Nursing Home Mental Health Services. Residents of nursing homes with mental health needs shall be given the same opportunity for access to Covered Services as other Beneficiaries covered by this Contract.

17) Payments to Federally Qualified Health Centers ("FQHC") and Rural Health Clinics ("RHC"). When Member pays FQHCs and RHCs for specialty services covered in the specialty services waivers, Member shall ensure that payments are no less than amounts paid to non-FQHC and non-RHC providers for similar services.

18) Indian Health Service/Tribally Operated Facility or program/Urban Indian Clinic (I/T/U).

    a. Member is required to pay any Indian Health Service, Tribal Operated Facility Organization/Program/Urban Indian Clinic (I/T/U), or I/T/U contractor, whether participating in Member's provider network or not, for Member 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 Member 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 Member, 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 the state plan's FFS payment methodology.

19) Persons Associated with the Corrections System.

a. Member is responsible for medically necessary community-based substance use treatment services for individuals under the supervision of the Michigan Department of Corrections once those individuals are no longer incarcerated. These individuals are typically under parole or probation orders. Individuals referred by court and services through local community corrections (PA 511) systems must not be excluded from these Medicaid/Healthy Michigan program funded medically necessary community-based substance use disorder treatment services.

b. Referrals, Screening and Assessment.

   i. Individuals under MDOC supervision are considered a priority population for assessment and admission for substance use disorder treatment services due to the public safety needs related to their MDOC involvement. Member must ensure timely access to supports and services in accordance with MDHHS Access Standards, which can be found on the MDHHS website (Michigan Department of Health & Human Services). The Code of Federal Regulations and the Michigan Public Health Code define the first four (4) priority population enrollees. The fifth population is established by MDHHS due to its high-risk nature. The priority populations are identified as follows and in the order of importance:

      (a) Pregnant injecting drug user.

      (b) Pregnant.

      (c) Injecting drug user

      (d) Parent at risk of losing their child(ren) due to substance use.

      (e) Individual under supervision of MDOC AND referred by MDOC OR individual being released directly from an MDOC facility without supervision AND referred by MDOC. Excludes individuals referred by court and services through local community corrections (PA 511 funded) systems.

      (f) All others.

20) Network Adequacy Standards. Member shall be responsible for maintaining a provider network, whether through direct-run services or contractual arrangements, in sufficient numbers, mix, and geographic locations throughout its designated service area to meet the needs of Beneficiaries to which it is responsible for the provision of Covered Services.

   a. In determining adequacy, Member must have a process that includes analysis of anticipated enrollment and expected utilization of Covered Services. Documentation of such analysis must be provided to LRE based standards on which the State bases its certification of network adequacy as referenced in 42 CFR §438.604(a)(5), §438.606, §438.206, and §438.207(b), including submission of any other data, documentation, or information related to the performance of

LRE's obligations as required by MDHHS pursuant to 42 CFR §438.604(b) and §438.606.

b. Member shall provide immediate notification to LRE when Covered Services cannot be provided within timely access standards due to inadequate capacity of direct-run or contracted service availability.

~~b. Failure to maintain network adequacy or timely access standards may result in an amendment to delegated managed care function activities to ensure compliance with MDHHS Master Contract requirements.~~

F. Covered Services.

1) General

a. Member 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. Member must operate consistent with all applicable Medicaid policies and publications for coverages and limitations. If new Medicaid services are added, expanded, eliminated, or otherwise changed, Member must implement the changes consistent with State direction and the terms of this Contract.

c. Member will be responsible for the operation of the 1115 Behavioral Health Demonstration Waiver, the Healthy Michigan Plan, the 1915(i) State Plan ~~Benefit~~Amendment, who are enrolled in one of the three 1915(c) waivers (Habilitation Supports Waiver, Children's Waiver Program, or the Waiver for Children with Serious Emotional Disturbances) and other public funding within its designated service area. Operation of the 1115 Behavioral Health Demonstration Waiver Program must conform to regulations applicable to the concurrent program and to each (i.e., 1115 Behavioral Health Demonstration Waiver and 1915 (c)) Waiver.

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

e. Member will be responsible for the Reciprocity Standards policy which can be found on the MDHHS Website.

2) 1115 Demonstration Waiver Services. Member is responsible for providing the covered services as described in the Michigan Medicaid Provider Manual.

3) 1915(c) Services. Member is responsible for provision of enhanced community support services for those beneficiaries in the service area who are enrolled in one of the three Michigan's 1915(c) Home and Community Based Services Waivers. Covered

services are described in the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter of the Michigan Medicaid Provider Manual.

4) 1915(i) State Plan Amendment (SPA) Services. Member is responsible for providing the covered services, as described in the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter of the Michigan Medicaid Provider Manual, for beneficiaries enrolled in the 1915(i)SPA.

~~4)~~5) Healthy Michigan Plan. Member is responsible for providing the covered services described in the Behavioral Health and Intellectual and Developmental Disability Supports and Services Mental Health/Substance Abuse Chapter of the Michigan Medicaid Provider Manual as well as the additional substance use disorder services and supports described in the Medicaid Provider Manual for individuals who are eligible for the Healthy Michigan Plan.

~~5)~~6) MIChild. Member must provide medically necessary defined mental health benefits to children enrolled in the MIChild program.

~~6)~~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 w 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 February 28, 2021.

b. Medicaid-eligible children and pregnant women who were served by the Flint water system during the specified period will be eligible for all services covered under the State plan. All such persons will have access to Targeted Case Management services under a fee for service contract between the State and Genesee Health Systems (GHS). The fee for service contract will provide the targeted case management services in accordance with the Special Terms and Conditions for the Flint Section 1115 Demonstration, Michigan Medicaid State Plan and Medicaid Policy.

~~7)~~8) Institution for Mental Disease (IMD) Services. Member is responsible for providing the covered services in an IMD up to 15 days per month per individual if the following conditions are met:

a. The IMD stay is a medically appropriate substitute for the covered setting under the State plan.

b. The IMD stay is a cost-effective substitute for the setting under the State plan.

c. The beneficiary is not required to use the alternative setting.

~~8)~~9) Early Periodic Screening, Diagnosis and Treatment (EPSDT).

a. Under Michigan's 1115 Behavioral Health Demonstration Waiver, Member is responsible for the provision of specialty services Medicaid benefits and must

make these benefits available to beneficiaries referred by a primary EPSDT screener, to correct or ameliorate a qualifying condition discovered through the screening process.

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

~~9)~~10) Special Health Care Needs. 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).

~~10)~~11) Long-Term Support Services. Long Term Services and Supports (LTSS) provided under this Contract must be provided in a setting which complies with the 42 CFR 441.301(c)(4) requirements for home and community-based settings.

G. Behavioral/Physical Health Integration.

1) Integrated Physical and Behavioral Health Care

Member must comply with LRE Policy and Procedure to ensure the integration of primary and specialty behavioral health services for b~~B~~eneficiaries, including efforts to focus on persons who have a chronic condition such as a serious and persistent mental health condition, SUD, I/DD.

Member shall utilize CareConnect360 (CC360) for shared care planning and care management documentation as required by MDHHS and LRE.

**Commented [PG2]:** General Requirements I.3

2) Primary Care Coordination

a. In accordance with 42 CFR Part 2 Member must ensure substance use disorder treatment services are coordinated with primary health care. Care Coordinating Agreements or joint referral agreements, by themselves, are not sufficient to show that Member has taken all appropriate steps related to coordination of care. Client treatment case file documentation is also necessary. Client treatment case files must include, at minimum, the primary care physician's name and address, a signed release of information for purposes of coordination, or a statement that the client has refused to sign a release.

b. Member must coordinate the services furnished to the beneficiary with the services the beneficiary receives with Fee for Service (FFS) Medicaid.

H. Eligibility.

1) Medicaid Eligibility - MDHHS Medicaid Services Administration administers the Medicaid program in Michigan. Eligibility is determined by the State with the sole authority to determine whether individuals or families meet eligibility requirements.

2) 1915(c) Habilitation Supports Waiver - Member 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 LRE for review and approval.

3) 1915(c) Children's Waiver Program

   a. Member must identify children who meet the eligibility criteria for the Children's Waiver Program Benefit Plan and submit to LRE prescreens for those children. For children determined ineligible for the CWP, Member informs the family of its right to request a Medicaid fair hearing by providing written adequate notice of denial of the CWP to the family.

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

   c. Member must determine the appropriate Category of Care/Intensity of Care and the amount of publicly funded hourly care for each Children's Waiver Program recipient per the Medicaid Provider Manual.

   d. Member must assure that services are provided in amount, scope, and duration as specified in the approved plan.

   e. Member must comply with LRE policy and procedure covering credentialing, temporary/provisional credentialing and re-credentialing processes for those individuals and organizational providers directly or contractually employed by Member, as it pertains to the rendering of services within the Children's Waiver Program.

   f. Member is responsible for ensuring that each provider, directly or contractually employed, credentialed or non-credentialed, meets all applicable licensing, scope of practice, contractual and Medicaid Provider Manual qualifications, and requirements.

4) 1915(c) Serious Emotional Disability Waiver (SEDW).

   a. The intent of this program is to provide Home and Community Based Waiver Services, as approved by Centers for Medicare and Medicaid Services (CMS) for children with Serious Emotional Disturbances Benefit Plan, along with state plan services in accordance with the Medicaid Provider Manual.

      i. Member must assess eligibility for the SEDW and submit applications to LRE for those children Member determines are eligible. For children determined ineligible for the SEDW, Member 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. Member must carry out administrative and operational functions 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. Member must assure that services are provided in amount, scope and duration as specified in the approved plan of service. Wraparound is a required service for all participants in the SEDW and Member must assure sufficient service capacity to meet the needs of SEDW recipients. When a child/youth is being served under the SEDW, 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. Member must comply with credentialing, temporary/provisional credentialing and re-credentialing processes for those individuals and organizational providers directly or contractually employed by Member, as it pertains to the rendering of services within the SEDW. Member 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. Member must ensure that staff and Network Providers who oversee or deliver ICCW receive the MDHHS approved and required training on an annual basis.

b. SEDW Child Welfare Project Procedural Requirements Member must:

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

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

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

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

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

I. Parity and Benefits.

1) Member must ensure compliance with 42 CFR part 438, subpart K, Parity in Mental Health and Substance Use Disorder Benefits. Member must comply with all applicable

federal regulations, including the information requirements in the parity regulations, specifically 42 CFR 438.915 Availability of Information. LRE will work with Member to ensure the necessary changes to achieve full compliance are successfully implemented. The State will analyze parity compliance as part of routine monitoring.

2) Member must use processes, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for mental health or substance use disorder benefits that are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for medical/surgical benefits as identified by the State, in the same classification.

3) Member must not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits as identified by the State, in the same classification furnished to beneficiaries (whether or not the benefits are furnished by the same Managed Care Plan (MCP).

4) Member may not apply any cumulative financial requirements for mental health or substance use disorder benefits in a classification (inpatient, outpatient, emergency care, prescription drugs) that accumulates separately from any established for medical/surgical benefits as identified by the State, in the same classification.

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

J. Quality Improvement and Program Development.

1) Utilization Management Incentives - Member must assure that compensation to individuals or entities that conduct utilization management activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any beneficiary.

2) Quality Assessment/Performance Improvement Program (QAPIP) and Standards - Member shall maintain a fully operational internal Quality Assessment and Performance Improvement Plan ("QAPIP") in accordance with the specifications of MDHHS Policies and Practice Guidelines and shall fully cooperate with LRE's QAPIP and utilization review activities in accordance with Regulations, MDHHS Policies and Practice Guidelines, and LRE Policies and Procedures.

3) Service and Utilization Management - Member must perform utilization management functions sufficient to control costs and minimize risk while assuring that medically necessary services are provided with appropriate quality of care.

4) Other Quality Requirements - Member must disseminate all practice guidelines, adopted by LRE, to all affected providers and, upon request, to beneficiaries. Member must ensure decisions for utilization management, beneficiary education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. Member must assure services are planned and delivered in a manner that reflects the values and expectations contained in the following guidelines:

   a. Inclusion Practice Guideline

   b. Housing Practice Guideline

   c. Consumerism Practice Guideline

   d. Personal Care in Non-Specialized Residential Settings

   e. Family-Driven and Youth-Guided Policy and Practice Guideline

   f. Employment Works! Policy

K. Grievance and Appeals Process for Beneficiaries. Member must comply with Grievance and Appeals standards and processes as outlined in the MDHHS/PIHP Master Contract and LRE Policy and Procedure.

L. Beneficiary Services.

1) Provider Directory: The Network Provider Directory must contain the required provider information defined in 42 CFR §438.10(h)(1)-(4) and must be made available in a machine-readable file and format in a prominent and readily accessible location on Member's website.

   a. Member shall submit a provider directory file as outlined in the LRE Data Submission Schedule, and as included in **Schedule E: Member Reporting Responsibilities**.

   b. Beneficiaries must be notified that the Provider Directory is available in paper form, free-of-charge, upon request.

   c. Member will comply with the delegated responsibilities outlined in **Schedule I: Delegation of Managed Care Function Responsibilities**.

M. Provider Services.

1) Health Care Practitioner Discretions

   a. Member may not prohibit, or otherwise restrict a health care professional acting within their lawful scope of practice from advising or advocating in the following areas on behalf of a beneficiary who is receiving services under this Contract:

      i. Beneficiary's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

ii. Any information the beneficiary needs in order to decide among all relevant treatment options.

iii. Risks, benefits, and consequences of treatment or non-treatment

iv. Beneficiary's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

2) Reserved.

3) Level of Care Utilization System (LOCUS) Member must:

b. Ensure that the LOCUS is incorporated into the initial process for all individuals 18 and older seeking supports and services for a severe mental illness using MDHHS approved methods for scoring the tool listed below:

i. Use of the online scoring system through State approved vendor with costs covered by the State.

ii. Use of software purchased through State approved vendor with costs covered by the State.

c. Ensure that each individual 18 years and older with a severe mental illness has a LOCUS completed as part of any assessment and re-assessment process if they are not receiving Early Periodic Screening Diagnosis and Treatment Services (EPSDT). If the child / youth aged 18-21 years is receiving EPSDT in the CMHSP system, the MDHHS approved assessment tool needs to be completed at intake, quarterly, and exit up to age 21.

d. Collaborate with LRE for ongoing fidelity monitoring on the use of the tool.

e. Provide LRE with the composite score for each LOCUS that is completed in accordance with the established reporting guidelines.

4) National Core Indicator (NCI) Surveys.

a. Member must provide, to LRE, the mailing addresses, pre-survey and background information, and demographics needed for the State or its designee to schedule and conduct the face-to-face surveys for the identified survey participants in their service area.

b. Member must coordinate appointments and, if required, obtain consent from beneficiaries.

c. Member must disseminate the survey results to the stakeholders in their service area(s) and utilize the results in their quality improvement activities.

d. Member must identify a specific individual to be the primary point of contact between Member, its designees, and the State.

5) 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. Member is responsible for ensuring the State approved assessment tool is implemented and fidelity is maintained.
c. Member must honor network reciprocity requirements including valid SUD assessment tool results performed by a qualified provider under agreement with an alternate PIHP.
    i. Member must ensure appropriate release of information authorizations are executed.

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

Member may require its Network Providers to meet the same standard as a condition for payment.

g. Vouchers - 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 Member that specifies credentialing and utilization review requirements. Voucher rates for such services must be predetermined by Member 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.

7) MDHHS Standard Consent Form. Michigan PA 129 of 2014 was enacted to promote the use and acceptance of a standard consent form. Member 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.

8) Trauma Policy. Member must develop a trauma-informed system in accordance with the MDHHS/BPHASA Trauma Policy, which can be found on the MDHHS Website.

9) Substance Use Disorder (SUD) Services.

   a. All SUD Treatment Services, including services to persons associated with MDOC, are delegated to Member.

   b. Member must comply with the SUD Services Policy and Advisory Manual, which can be found on the MDHHS Website.

   c. Member must:

      i. Develop comprehensive plans for substance use disorder treatment and rehabilitation services consistent with guidelines established by the State.

      ii. Review and comment to the Department of Licensing and Regulatory Affairs (LARA) on applications for licenses submitted by local treatment, rehabilitation, and prevention organizations (SUD Rules can be found at the LARA website).

      iii. Provide technical assistance for local substance use disorder service programs.

      iv. Follow financial requirements as described in this Contract and **Schedule E: Member Reporting Requirements**.

      v. Progress reporting requirements as described in **Schedule E: Member Reporting Requirements**.

      vi. Enter into subcontracts with providers for SUD services if necessary.

vii. Ensure Network Providers are appropriately licensed for the service(s) provided in accordance with Michigan Public Health Code, PA 368 of 1978.

d. SUD Provider Network Oversight Management

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

ii. Member must ensure that the provision of SUD treatment services are based on the ASAM Level of Care (LOC) criteria.

(g) If Member 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, Member may request a waiver of the accreditation requirement.

e. Reimbursement for Services to Persons with Co-Occurring Disorders

i. SUD funds may be used to reimburse providers for integrated mental health and substance use disorder treatment services to persons with co-occurring substance use and mental health disorders.

ii. Member may reimburse a Network Provider for substance use disorders treatment services for such persons who are receiving mental health treatment services through the CMHSP or network provider.

iii. Member may also reimburse a Network Provider for substance use disorders treatment provided to persons with co- occurring substance use and mental health disorders.

f. American Society of Addiction Medicine (ASAM) Level of Care (LOC) for Network Providers

i. Member must enter into network provider agreements for SUD treatment with organizations that provide services based on the current ASAM LOC only.

ii. State Approved ASAM SUD treatment providers can be found in the Customer Relationship Management (CRM) system. Member must ensure that to the extent licensing allows all ~~the following~~current ASAM LOCs are available for adult and adolescent populations.~~:~~

| ~~Level of Care~~ | ~~ASAM Title~~ |
|---|---|
| ~~0.5~~ | ~~Early Intervention~~ |
| ~~1~~ | ~~Outpatient Services~~ |
| ~~2.1~~ | ~~Intensive Outpatient Services~~ |
| ~~2.5~~ | ~~Partial Hospitalization Services~~ |

**Commented [PG3]:** Removed due to changes in LOC. Updated language allows for any future changes.

| | |
|---|---|
| ~~3.1~~ | ~~Clinically Managed Low Intensity Residential Services~~ |
| ~~3.3*~~ | ~~Clinically Managed Population Specific High Intensity Residential Services~~ |
| ~~3.5~~ | ~~Clinically Managed High Intensity Residential Services~~ |
| ~~3.7~~ | ~~Medically Monitored Intensive Inpatient Services~~ |
| ~~OTP Level 1**~~ | ~~Opioid Treatment Program~~ |
| ~~1-WM~~ | ~~Ambulatory Withdrawal Management without Extended On-Site Monitoring~~ |
| ~~2-WM~~ | ~~Ambulatory Withdrawal Management with Extended On-Site Monitoring~~ |
| ~~3.2-WM~~ | ~~Clinically Managed Residential Withdrawal Management~~ |
| ~~3.7-WM~~ | ~~Medically Monitored Inpatient Withdrawal Management~~ |

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

10) Electronic Visit Verification (EVV).

a. Member must ensure its Network Providers comply with 42 USC 1396b (or sec. 1903(I) of the Social Security Act) and the State's implementation timeline.

i. Member must provide evidence of compliance upon request. Compliance must be in the form of either:

1) An existing EVV system that meets State requirements as confirmed by Member's on-site review.

2) Participation in the State sponsored Statewide EVV system.

ii. Personal Care Services (PCS) includes community living support and respite services in a person's home, in a non-licensed setting.

iii. Member must ensure its Network Providers stipulate the EVV system supports self-directed arrangements and is minimally burdensome or disruptive to care.

11) Critical Incidents. Member must comply with the reporting requirements and guidelines identified in the Critical Incident, Event Notification, and SUD Sentinel Event Reporting Requirements which can be found on the MDHHS Website.

12) Health Information Systems. Member must ensure that all Health Information Systems used by Member and/or its Network Providers have the capacity to fulfill the obligations of this Contract. Member must maintain a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of this part. The system must provide information on areas including, but not limited to, utilization, claims, grievance and appeals, and disenrollment for other than loss of Medicaid eligibility. Member must develop, implement and maintain policies and procedures that describe how Member will comply with the requirements of this section.

13) Member must comply with the following:

a. 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).

b. 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.

c. Ensure that data received from providers is accurate and complete by:

   i. Verifying the accuracy and timeliness of reported data.

   ii. Screening the data for completeness, logic, and consistency.

   iii. 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.

d. Make all collected data available to LRE, the State and, upon request, to CMS.

14) Member must ensure all encounter data is complete and accurate for the purposes of rate calculations and quality and utilization management and must provide for:

a. Collection and maintenance of sufficient beneficiary encounter data to identify the provider who delivers any item(s) or service(s) to beneficiaries.

b. Submission of beneficiary encounter data to LRE at a frequency and level of detail to be specified by LRE, based on program administration, oversight, and program integrity needs.

c. Submission of all beneficiary encounter data that LRE is required to report under 42 CFR 438.818. Specifications for submitting encounter data to the State in standardized ASC X12N 837 and NCPDP formats.

15) Capabilities - Health Information Systems capabilities are required for the following:

a. Monthly downloads of Medicaid eligible information

b. Individual registration and demographic information

c. Provider enrollment

d. Third party liability activity

e. Claims payment system and tracking

f. Grievance and complaint tracking

g. Tracking and analyzing services and costs by population group, and special needs categories as specified by LRE and/or the State

h. Encounter and demographic data reporting

i. Quality indicator reporting

j. HIPAA compliance

k. Uniform Business Practices (UBP) compliance

l. Individual access and satisfaction

m. Utilization of Benefit Enrollment and Maintenance (834) and Payment Order Remittance Advice (820) reconciliation files as the primary source for eligibility determination for Member functions. Eligibility Inquiry and Response file (270/271) is intended as the primary tool for the CMHSP and provider system to determine eligibility.

16) Beneficiary Service Records.

a. Member must ensure that network providers establish and maintain a comprehensive individual service record system consistent with the provisions of MSA Policy Bulletins, and appropriate State and federal statutes.

b. Member must ensure that network providers maintain in a legible manner, via hard copy or electronic storage/imaging, recipient service records necessary to fully disclose and document the quantity, quality, appropriateness, and timeliness of services provided. The records must be retained according to the retention schedules in place by the Department of Technology, Management and Budget (DTMB) General Schedule #20. This requirement must be extended to all of Member's provider agencies.

c. Member must participate with the State and LRE in activities to standardize and consistently submit encounter data when the CMHSP identified as the County of Financial Responsibility (COFR) is not part of the region's geographic service area.

N. Legal Expenses.

1) Sufficient documentation must be maintained to support the allowability of legal expenses. Invoices must contain sufficient detail to evidence allowability. The following legal expenses are allowed:

a. Legal expenses required in the administration of the program on behalf of the State of Michigan or Federal Government.

b. Legal expenses relating to employer activities, labor negotiation, or in response to employment related issues or allegations, per 2 CFR 200.

c. Legal expenses incurred in the course of providing consumer care.

d. Legal expenses in response to enforcement action or audit findings issued by the State or CMS under the following circumstances:

i. Member prevails and the action is reversed, or any contested adjustment is reduced by 50 percent or more; or

ii. Member enters into a settlement agreement with the State or CMS prior to any Hearing. The following legal expenses are not allowed:

e. Legal expenses of responding to an action against Member by LRE, MDHHS, or CMS from initiating an enforcement action or issuing an audit finding, except those legal costs described above as allowable.

f. Legal expenses for the prosecution of claims against the State of Michigan or the Federal Government.

g. Legal expenses contingent upon recovery of costs from the State of Michigan or the Federal Government.

O. Observance of State and Federal Laws and Regulations.

1) General

a. Member must comply with all federal, state, and local laws, rules and regulations, and administrative procedures and implement any necessary changes in policies and procedures as required by the State.

b. Federal regulations governing contracts with risk-based managed care plans are specified in Section 1903(m) of the Social Security Act and 42 CFR Part 434 and will govern this Contract.

2) Compliance with False Claims Acts. If Member 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 CMHSP, and of any network provider or agent, that provides detailed information about the False Claims Act and other federal and state laws described in Section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers.

3) Third Party Liability Requirements. Third Party Liability (TPL) refers to health insurers, self-insured plans, group health plans, service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service to pay for care and services available under the approved Medicaid State Plan. Members are payers of last resort and will be required to identify and seek recovery from all other liable third parties in order to be made whole, including recoveries from any related court judgment or settlement if Member has been notified of the legal action. Member must follow the "Guidelines Used to Determine Cost Effectiveness and Time/Dollar Thresholds for Billing" as described in the State Medicaid Plan. Member may pursue cases below the thresholds at their discretion.

a. Member must seek to identify and recover all sources of TPL funds based on industry standards and those outlined by MDHHS TPL Division.

b. Member may retain all such collections as provided for in Section 226a of the Michigan Mental Health Code as applicable. If TPL resources are available and liability has been established, Member is required to follow Medicaid policy,

guidance, and all applicable state and federal statutes, the Medicaid Provider Manual, the Medicaid State Plan, and the TPL Guidelines and Best Practices Guidance for cost avoiding Medicaid Covered Services.

c. Member must follow Medicaid Policy, guidance and all applicable state and federal statutes regarding TPL. MDHHS TPL policy information can be found in federal regulations, Michigan Compiled Law, MDHHS Medicaid Provider Manual, Medicaid State Plan, and TPL Guidelines. Member use of best practices is strongly encouraged by the State and are available in the TPL Guidelines and Best Practices Guidance. Member must develop and implement written policies describing their procedures for TPL recovery. LRE will review Member's policies and procedures for compliance with this Contract and for consistency with TPL recovery requirements in 42 USC 1396(a) (25), 42 CFR 433 Subpart D.

d. Member must report TPL collections through encounter data submissions, as required by MDHHS.

e. Member must provide TPL recovery data to LRE in the electronic format prescribed by LRE.

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

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

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

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

j. Member must cooperate with TPL subrogation best practices including, but not limited to:

    i. Providing LRE with most recent contact information of Member's assigned TPL staff including staff name(s), fax and telephone numbers.

    ii. Informing LRE, in writing, within 14 Days of vacancy or staffing change of assigned TPL staff.

    iii. Reporting TPL quarterly subrogation activities to LRE on a template developed by the State.

k. Member is prohibited from recovering loss directly from the beneficiary.

4) Confidentiality.

   a. Member 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 Member from unauthorized disclosure.

   c. Member must provide safeguards that restrict the use or disclosure of information concerning beneficiaries to purposes directly connected with its administration of the Contract.

   d. Member must have written policies and procedures for maintaining the confidentiality of data, including medical records, client information, and appointment records.

5) Advance Directives Compliance. In accordance with 42 CFR 422.128 and 42 CFR 438.3(j), Member must maintain written policies and procedures for advance directives. Member 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. Member must inform individuals that grievances concerning noncompliance with the advance directive requirements may be filed with Customer Service. This must include prohibiting Member from conditioning the provision of care based on whether or not the individual has executed an advance directive.

6) Pro-Children Act. Member must comply with Public Law 103-227, also known as the Pro-Children Act of 1994, 20 USC 6081 et seq, which requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted by and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through state or local governments, by federal grant, contract, loan or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where Women, Infants, and Children (WIC) coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity. Member must assure that this language will be included in any sub-awards that

contain provisions for children's services. Member must assure, in addition to compliance with Public Law 103-227, any service or activity funded in whole or in part through this Member 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 Member. If activities or services are delivered in residential facilities or in facilities or areas that are not under the control of Member (e.g., a mall, residential facilities or private residence, restaurant or private work site), the activities or services must be smoke free.

7) Hatch Political Activity Act and Intergovernmental Personnel Act. Member must comply with the Hatch Political Activity Act, 5 USC 1501-1509, and 7324-7328, and the Intergovernmental Personnel Act of 1970, as amended by Title VI of the Civil Service Reform Act, Public Law 95-454, 42 USC 4728 - 4763. Federal funds cannot be used for partisan political purposes of any kind by any person or organization involved in the administration of federally assisted programs.

8) Limited English Proficiency.

   a. Member 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. Member is expected to take reasonable steps to provide meaningful access to each 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. Member 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. To the extent that LRE and Member are HIPAA Covered Entities and/or Programs under 42 CFR Part 2, each agrees that it will comply with HIPAA's Privacy Rule, Security Rule, Transaction and Code Set Rule and Breach Notification Rule and 42 CFR Part 2 (as now existing and as may be later amended) with respect to all Protected Health Information and substance use disorder treatment information that it generates, receives, maintains, uses, discloses or transmits in the performance of its functions

pursuant to this Contract. To the extent that LRE determines that Member is a HIPAA Business Associate of LRE, then LRE and Member will enter into a HIPAA Business Associate Agreement that complies with applicable laws and is in a form acceptable to both the State and LRE.

a. Member must not share any protected health data and information provided by LRE that falls within HIPAA requirements except as permitted or required by applicable law or to a network provider as appropriate under this Contract.

b. Member must include a provision in all service contracts with any network provider that the network provider will comply with all state and federal privacy and confidentiality laws and regulations, including but not limited to HIPAA and 42 CFR Part 2, when applicable.

c. Member must only use the protected health data and information for the purposes of this Contract.

d. Member 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 Member's employees.

e. Member must have a policy and procedure to ~~immediately report~~ report to LRE immediately upon becoming aware, or by exercising reasonable diligence would have known, ~~to LRE~~ any suspected or confirmed unauthorized use or disclosure of protected health data and information that falls under the HIPAA requirements, ~~of which Member becomes aware.~~ Member must work with LRE to mitigate the breach in accordance with LRE Policy and Procedure and ~~will~~ must provide assurances to LRE of corrective actions to prevent further unauthorized uses or disclosures.

**Commented [PG4]:** HSAG requirement per Compliance

f. Member must enter into a HIPAA Business Associate Agreement with LRE as required by 42 CFR 160

g. All recipient information, medical records, data and data elements collected, maintained, or used in the administration of this Contract must be protected by Member from unauthorized disclosure as required by state and federal regulations. Member must provide safeguards that restrict the use or disclosure of information concerning recipients to purposes directly connected with its administration of the Contract.

h. Member must have written policies and procedures for maintaining the confidentiality of all protected information.

10) Ethical Conduct. LRE 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 and

employees." 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. Parties are subject to the federal and state conflict of interest statutes and regulations that apply to the Member under this Contract, including Section 1902(a)(4)(C) and (D) of the Social Security Act: 41 U.S.C. Chapter 21 (formerly Section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423): 18 U.S.C. 207)): 18 U.S.C. 208: 42 CFR 438.58: 45 CFR Part 92: 45 CFR Part 74: 1978 PA 566: and MCL 330.1222.

12) Human Subject Research. Member must comply with Protection of Human Subjects Act, 45 CFR, Part 46, subpart A, Sections 46.101-124 and HIPAA. Member 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 the LRE'S IRB Chairperson or Executive Officer(s).

13) Medicaid Policy. Member must comply with provisions of Medicaid policy developed under the formal policy consultation process, as established by the Medical Assistance Program.

14) Service Requirements.

    a. Member must limit Medicaid and MIChild services to those that are medically necessary and appropriate, and that conform to accepted standards of care.

    b. Member 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: Behavioral Health and Intellectual and Developmental Disabilities Supports and Services section.

    c. Member must provide covered Medicaid State Plan or 1915(c) services (for beneficiaries enrolled in the Michigan Medicaid Managed Specialty Services and Supports Program) in sufficient amount, duration and scope to reasonably achieve the purpose of the service.

    d. Consistent with 42 CFR 440.210 and 42 CFR 440.220, services to recipients must not be reduced arbitrarily.

15) Home and Community Based Setting (HCBS) Transition Implementation.

a. To ensure compliance with the HCBS rule, LRE must complete the following: administer the survey process for new and existing providers, review and analyze data collected from the survey, notify providers of a need for corrective action (if required), develop a corrective action plan, ensure corrective action is implemented and monitor ongoing compliance. LRE will develop a process to ensure settings are surveyed with a frequency identified by the State. LRE will provide the State with its proposal to address those settings that do not comply with the required HCBS survey process, including timelines. LRE will provide updated reports to the State specifying survey activities taken and required remediation or validation activities as identified by the State.

b. Member must ensure that all new providers of HCBS services, existing providers who have changed physical location or have a new owner or licensee, or have added new HCBS services complete the HCBS Provisional Provider Application. LRE may provide provisional approval to the applicant as long as the setting does not qualify for heightened scrutiny. When a setting qualifies for heightened scrutiny, LRE must communicate this to the MDHHS HCBS Transition team, who will determine the required next steps, which may include an individualized consultation.

    i. LRE must ensure that provisionally approved providers and beneficiaries receive the comprehensive HCBS survey within 90 days of the beneficiaries' IPOS. LRE, with assistance from Member will ensure providers complete this survey and subsequent remediation/validation processes in order to be eligible for HCBS funding.

    ii. LRE must ensure that all HCBS final rule requirements are met, as described in the Michigan Medicaid Provider Manual.

c. Member must not enter into new contracts with new providers of services covered by the Federal HCBS Rule (42 CFR Parts 430,431, 435, 436, 440, 441 and 447) unless the provider has obtained provisional approval status through completion of the HCBS Provisional Provider Application, demonstrating that the provider does not require heightened scrutiny. Provisional approval allows a new provider or an existing provider with a new setting, service, or licensee to provide services to HCBS participants pending the full survey process. Providers and participants will receive the comprehensive HCBS survey within 90 days of the individual's plan of service. Providers will complete the HCBS survey and cooperate with LRE to demonstrate 100% compliance with the Federal HCBS rule and state requirements as promulgated by the MDHHS and documented in the Michigan Statewide Transition Plan. Failure to complete the provisional approval process and the ongoing compliance assessments will result in the exclusion from participating in Medicaid or Healthy Michigan Plan funded HCBS services. LRE must monitor Member provider panel annually for ongoing compliance with the HCBS rule and implement a system to remove providers from the region's network due to failure to meet requirements of the rule. LRE must maintain documentation

of this annual review and/or removal from its provider network. LRE must make all HCBS provider network status collected data available to the State and, upon request, to CMS.

d. LRE shall conduct annual assessments to ensure that the setting remains home and community based.

16) Electronic Visit Verification (EVV). In accordance with Section 12006(a) of the 21st Century Cures Act, Member must implement EVV for all Medicaid Personal Care Services (PCS) that require 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.

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

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

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, Member 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. Member must provide prompt notification to LRE when it receives information about changes in a beneficiary's circumstances that may affect the beneficiary's eligibility, including changes in the beneficiary's residence and the death of a beneficiary.

c. Member that makes or receives annual payments under this contract of at least $5,000,000 to a Network 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. Member must require all member's Network 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. Member must have a program integrity compliance program as defined in 42 CFR 438.608. The program integrity compliance program must include the following:

   i. Written policies and procedures that describe Member's commitment to comply with Federal and State fraud, waste and abuse standards enforced through well- publicized disciplinary guidelines.

   ii. The designation of a Compliance Officer who reports directly to the Chief Executive Officer/Executive Director and its Board of Directors, and a compliance committee, accountable to the senior management or Board of Directors, with effective lines of communication to Member's employees.

   iii. A system for training and education for the Compliance Officer, Member's senior management, and Member'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 Member's employees, "effective" training for the compliance officer means it cannot be conducted by the compliance officer to themself.

   iv. Provisions for Member'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 Member of the information regarding a potential compliance problem.

f. Dissemination of the contact information (addresses and toll-free telephone numbers) for reporting fraud, waste, or abuse by network provider of Member to Member, LRE and the MDHHS-OIG. Dissemination of this information must be made to all Member's Network Providers annually. Member must indicate that reporting of fraud, waste or abuse may be made anonymously.

2) Member Program Integrity Requirements.

   a. Designation of a Compliance Officer

   b. Submission to LRE of quarterly reports detailing program integrity compliance activities

   c. Assistance and guidance by Member with audits and investigations, upon request of LRE

d. Provisions for routine internal monitoring of program integrity compliance activities

e. Prompt response to potential offenses and implementation of corrective action plans

f. Prompt reporting of fraud, waste, and abuse to LRE

g. Implementation of training procedures regarding fraud, waste, and abuse for Member's employees at all levels

3) Member must maintain and provide to LRE upon request, a list of its network providers which includes 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).

4) Investigations. To the extent consistent with applicable law, including but not limited to 42 CFR Part 2, HIPAA, and the Michigan Mental Health Code, Member must cooperate fully in any investigation or prosecution by any duly authorized government agency, including but not limited to: MDHHS-OIG or the Department of Attorney General, whether administrative, civil, or criminal. Such cooperation shall include providing, upon request, information, access to records, and access to schedule interviews with designated Member 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. Member must follow the procedures and examples contained within processes and associated guidance provided by MDHHS-OIG.

5) Reporting Fraud, Waste, or Abuse.

   a. Upon receipt of allegations involving fraud, waste, or abuse regardless of entity (i.e., Member, employee, subcontracted entity, network provider), Member must promptly refer the matter to LRE Compliance Officer.

   b. Documents containing protected health information or protected personal information must be submitted in a manner that is compliant with applicable Federal and State privacy rules and regulations, including but not limited to HIPAA.

6) Overpayments.

   a. Member must report identified overpayments due to fraud, waste, or abuse to LRE in writing.

   b. If Member identifies an overpayment, Member agrees to:

      i. Notify LRE, in writing, of the reason for the overpayment and the date the overpayment was identified.

      ii. Return the overpayment to LRE within 30 calendar days of the date the overpayment was identified.

c. Member shall include a provision in all contracts with network providers giving Member the right to recover overpayments directly from network providers for the post payment evaluations initiated and performed by the Member. These overpayment provisions do not apply to any amount of a recovery to be retained under False Claims Act cases or through other investigations.

7) Network Provider Agreements. Member must submit its network provider agreements to LRE upon request.

8) MDHHS-OIG Sanctions. When MDHHS-OIG sanctions (suspends and/or terminates from the Medicaid Program) providers, including for a credible allegation of fraud under 42 CFR 455.23, Member must, at minimum, apply the same sanction to the Network Provider upon receipt of written notification of the sanction. Member may pursue additional measures/remedies independent of the State. If MDHHS OIG lifts a sanction, Member may elect to do the same.

9) MDHHS-OIG Onsite Reviews.

   a. MDHHS-OIG may conduct onsite reviews of Member and/or its 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, Member is required to comply with LRE and/or MDHHS-OIG's requests for documentation and information related to program integrity and compliance.

10) Member Ownership and Control Interest.

   a. According to 42 CFR 438.610 Prohibited Affiliations, Member may not knowingly have a relationship of the type described in paragraph (c) of this Section with the following:

      i. An individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

      ii. An individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation at 48 CFR 2.101, of a person described in paragraph (a)(i) of this Section.

   b. Member may not knowingly have a relationship with an individual or entity that is excluded from participation in any federal healthcare 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 Member.

      ii. A network provider of Member, as governed by 42 CFR 438.230.

iii. A person with beneficial ownership of five percent (5%) or more of Member's equity.

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

d. Member 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. LRE may refuse to enter into or renew a contract with Member if any person who has an ownership or control interest in Member, or who is an Agent or managing employee of Member, 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, LRE may refuse to enter into or may terminate the Contract if it determines that Member did not fully and accurately make any disclosure required under this section of the contract.

f. Member 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, Member 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.

g. Pursuant to 42 CFR 455.104: LRE will review ownership and control disclosures submitted by Member and any of Member's network providers. Member is required to identify and report whether an individual or entity with an ownership or control interest in the disclosing entity is related to another individual with an ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling and/or whether the individual or entity with an ownership or control interest in any subcontractor in which the disclosing entity has a five percent (5%) or more interest is related to another individual with ownership or control interest as a spouse, parent, child, or sibling. Member 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.

11) Network Provider Medicaid Enrollment. Pursuant to 42 CFR § 438.602(b)(1), all network providers of the Member providing services under this Contract must enroll with the Michigan Medicaid Program.

a. The State will screen and enroll, and periodically revalidate all enrolled Medicaid providers.

b. Member must require and ensure all applicable network providers are enrolled in the Michigan Medicaid Program via the State's Medicaid Management Information System.

i. Member 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. Member must verify and monitor its network providers' Medicaid enrollment.

12) Exclusion Monitoring.

a. Member must search the OIG exclusions database and the State of Michigan Sanctioned Provider list for all staff and Board members monthly to capture exclusions and reinstatements that have occurred since the last search.

b. Member must notify LRE immediately if search results indicate that any of their staff or individuals or entities with ownership or control interests in the organization are on the OIG exclusions database. Member must also provide notification to LRE if it has taken any administrative action that limits a provider's participation in the Medicaid program.

Q. Fiscal Audits and Compliance Examinations.

1) Required Audit and Compliance Examination

Member must submit to LRE a Financial Statement Audit and a Compliance Examination annually. Member 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 Reviews and Audits

a. LRE and state and/or federal agencies may conduct financial reviews and audits of Member regarding performance under this Contract. LRE will make good faith efforts to coordinate financial reviews and audits to minimize duplication of effort by Member and independent auditors conducting financial audits and compliance examinations.

b. Financial reviews and audits will focus on Member's compliance with State and federal laws, rules, regulations, policies, and waiver provisions, in addition to Contract provisions and LRE policy and procedure.

c. The State and/or federal agencies may inspect and audit any financial records of Member or its network providers. As used in this Section, an audit is an examination of Member's and its Network 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 Member's compliance with legal and contractual requirements.

3) Financial Management System

a. Member 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. Member must comply with generally accepted accounting principles (GAAP) for government units when preparing financial statements. Member and their Network Providers must use the principles and standards of 2 CFR 200 Subpart E for determining all costs related to the management and provision of MMSSSP services reported on the financial status report. The accounting and financial systems established by Member 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 Member must ensure consistent treatment of costs across different funding sources and assure proper allocation to costs to the appropriate source. Member must comply with the Standard Cost Allocation (SCA) methodology established by MDHHS when assigning the fund source and ensure Network Providers comply with SCA methodology.

c. Member 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.

R. Transition.

1) If this Contract is canceled or expires and is not renewed, the following will take effect:

a. Within 38 days following the end date of this Contract, Member must provide interim financial, performance, and other reports as required.

b. Within two years following the end date of this Contract, Member 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 Member.

d. Notwithstanding Paragraph S.1.c, all unspent Medicaid funds, and related interest, held by Member must be returned to LRE within 83 days, less amounts needed to cover outstanding claims or liabilities, unless otherwise directed in writing by LRE.

e. Reconciliation of equipment with a value exceeding $5,000, purchased by Member or its provider network with funds provided under this Contract, since January 1, 2015, will occur as part of settlement of this Contract. Member must submit, to LRE, an inventory of equipment meeting the above specifications within 38 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 Member 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 Member 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 Member'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 unless these records are transferred to a successor organization or Member is directed otherwise in writing by LRE.

**~~3.~~6 Specific Standards**

A. IT Policies, Standards and Procedures (PSP). All services and products provided as a result of this contract must comply with all applicable State IT policies and standards.

B. Acceptable Use Policy. To the extent that Member has access to the State's computer system, Member must comply with the State's Acceptable Use Policy. All Member 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 Member's access to the State's system if a violation occurs.

C. SOM Digital Standards. All software items provided by Member must adhere to the State of Michigan Application/Site Standards.

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

E. Hosting. Member 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.

## ~~4.~~7 Background Checks

A. Member must ensure background checks are completed on all Member's employees and all Network Provider employees prior to their assignment. Member must provide evidence to LRE upon request. Member is responsible for all costs associated with the background checks.

B. Member, 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.

C. Member must:

1) Conduct a search that reveals information substantially similar to information found on an Internet Criminal History Access Tool (ICHAT) check and a national and state sex offender registry check for each new employee, Network Provider, Network Provider employee, or volunteer (including students and interns) who works under this Contract.

   a. ICHAT: https://apps.michigan.gov/

   b. Michigan Public Sex Offender Registry: https://mspsor.com/

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

2) Conduct a Central Registry (CR) check for each new employee, Network Provider, Network Provider employee, or volunteer (including students and interns) who under this Contract works directly with children.

3) Require each new employee, network provider, network provider 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 LRE in writing of criminal convictions (felony or misdemeanor), pending felony charges, or placement on the CR as a perpetrator, at hire or within ten (10) days of the event after hiring.

4) Use information from the Medicaid Provider Manual (General Information for Providers; Section 6 – Denial of Enrollment, Termination and Suspension; Item 6.1 – Termination or Denial of Enrollment) and the Social Security Act (Subsection 1128(a)(b)), to determine whether to prohibit any employee, network provider, network provider employee, or volunteer (including students and interns) from performing work directly with enrollees or accessing enrollee information related to enrollees under this Contract, based on the results of a positive ICHAT response, reported criminal felony conviction, or perpetrator identification.

5) Use information from the Medicaid Provider Manual (General Information for Providers; Section 6 – Denial of Enrollment, Termination and Suspension; Item 6.1 – Termination or Denial of Enrollment) and the Social Security Act (Subsection 1128(a)(b)), to determine whether to prohibit any employee, network provider,

network provider 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.

**~~5.~~8 Staff Training**

Member must ensure all staff have appropriate training, education, experience, appropriate licensure and liability insurance coverage to fulfill the requirements of the position.

**~~6.~~9 Use of Subcontractors**

A. In accordance with 42 CFR 422.208, any physician incentive plan operated by Member, must meet the following requirements:

1) Member makes no specific payment, directly or indirectly, to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to any particular enrollee. Indirect payments may include offerings of monetary value (such as stock options or waivers of debt) measured in the present or future.

2) If the physician incentive plan places a physician or physician group at substantial financial risk (as determined in this Section) for services that the physician or physician group does not furnish itself, Member must assure that all physicians and physician groups at substantial financial risk have either aggregate or per-patient stop-loss protection in accordance with this Section.

a. For all physician incentive plans, Member must provide to CMS, and to any Medicaid beneficiary, the information specified in 42 CFR 422.210.

b. Member must provide a copy of specific contract language used for incentive, bonus, withhold or sanction provisions (including sub-capitations) to the State at least 30 days prior to the subcontract effective date. The State reserves the right to require an amendment of the subcontract if the provisions appear to jeopardize individuals' access to services. The State will provide notice of approval or disapproval of proposed contract language within 25 days of receipt.

B. In accordance with 42 CFR 447.325, Member 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.

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

D. 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 Member, or of Member's Network Provider, that pertain to any aspect of services and activities performed, or determination of amounts payable under this

Contract with LRE. Member 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.

E. Accreditation of SUD Network Providers. Member 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). Member, or its Network Provider, 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 Member or through an agreement with Network Provider(s) 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.

**~~7.~~10 Project Management**

A. Reporting.

   1) Release of Report Data

      a. Written Approval

         Member must obtain LRE's written approval prior to publishing or making formal public presentations of statistical 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 LRE to Member or its agents, network providers or representatives under the Contract.

      b. Acceptable Use of State Data

         Member must not use the State's data for any purpose other than providing the Services to beneficiaries covered under this Contract, 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 commercially exploited by or on behalf of Member. No employees of Member, 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. Member must not possess or assert any lien or other right against the State's data. Without limiting the generality of this Section, Member must only use personally identifiable information as strictly necessary to provide the Services to beneficiaries covered by Member under this Contract and must disclose the information only to its employees on a strict need-to-know basis.

ii. Member must always comply with all laws and regulations applicable to personally identifiable information.

B. Uniform Data Reporting.

1) To measure Member'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 rates, Member must provide LRE with uniform data and information as specified by LRE and 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 Member at least ninety (90) days before they are effective unless State or Federal law requires otherwise. Both parties must agree to other changes, beyond routine modifications, to the data reporting requirements.

2) Member's timeliness in submitting required reports and their accuracy will be monitored by LRE and will be considered by LRE in measuring the performance of Member. Regulations promulgated pursuant to the Balance Budget Act of 1997 require that the Chief Executive Officer (CEO) or designee of Member certify the accuracy of the data.

3) Member must cooperate with LRE in carrying out validation of data provided by Member by making recipient records available and a sample of its data and data collection protocols. Members must certify that the data they submit is accurate, complete, and truthful. An annual certification from and signed by the CEO or the Chief Financial Officer (CFO), or a designee who reports directly to either must be submitted annually. The certification must attest to the accuracy, completeness, and truthfulness of the information in each of the sets of data in this section.

4) LRE and Member 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.

C. Encounter Data Reporting.

In order to assess quality of care, determine utilization patterns and access to care for various health care services, affirm capitation rate calculations and estimates, Member must submit to LRE encounter data containing detail for each recipient encounter reflecting all services provided.

1) Encounter records shall be submitted at a frequency and via electronic media in the HIPAA compliance format as specified by LRE.

2) Encounter data provided by Member shall be subject to the quality standards for 837/5010 encounter submissions as established by MDHHS.

3) Encounter data must be reported to LRE, at minimum, monthly, unless more frequent timeliness standards are required by MDHHS.

4) Encounter level data must have a common identifier that will allow linkage between LRE's and Member's health information system.

5) Member will ensure, minimally, ninety percent (90%) of professional claims are submitted to LRE within sixty (60) days of the last day of the month in which the Covered Service was provided.

D. Reporting Requirements for Behavioral Health Treatment Episode Data Set (BH- TEDS). BHTEDS reporting will encompass behavioral health an SUD Covered Services provided to persons supported in whole or in party with MDHHS-administered funds, regardless of the type of co-pay or shared funding arrangement, and regardless of whether Member directly provides or contracts for the provision of Covered Services for all Beneficiaries for which is it financially responsible.

1) Member shall submit BHTEDS data in a fixed length format, per the file specifications.

2) Member shall report all BHTEDS record types as required by MDHHS BHTEDS reporting instructions, as periodically updated, at least monthly, unless more frequent timeliness standards are required by MDHHS or communicated to Member by LRE.

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

**~~8.~~11 Authorizing Document**

The appropriate authorizing document for services will be this Contract.

**~~9.~~12 Payment Terms**

The State's funding includes MMSSSP and the Flint 1115 Waiver. The financing in this Contract is always contingent on the annual Appropriation Act. CMHSPs within a PIHP may, but are not required to, use General Funds to provide services not covered under MMSSSP or underwrite a portion of the cost of covered services to these beneficiaries. The State reserves the right to disallow such use of General Funds if it believes that the CMHSP was not appropriately assigning costs in order to maximize the savings allowed within the risk corridors. As per 42 CFR 438.608(c)(3), the LRE and Members 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: LRE will reimburse Member as outlined in **Schedule H: Revenue Distribution**.

B. Habilitation Supports Waiver (HSW) Payments: The 1915(c) HSW capitation payment will be made to Member 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) Is otherwise eligible for Intermediate Care Facilities for individuals with Intellectual Disability (ICF/IID) level of care services.

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

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 **Schedule E: Member Reporting Requirements** in order to assure timely HSW service verification.

C. The Children's Waiver Program (CWP) Payments: The 1915(c) CWP capitation payment will be made to Member based on CWP beneficiaries who have enrolled through the State's 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) Is eligible for Intermediate Care Facilities for individuals with Intellectual Disability (ICF/IID) level of care services.

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

Encounters must be processed and submitted on time in order to ensure timely CWP service verification.

D. Serious Emotional Disturbance Waiver Payments: The SEDW capitation payment will be made to Member based on SEDW beneficiaries who have enrolled through the MDHHS enrollment process. Beneficiaries enrolled in the SEDW may not be enrolled simultaneously in any other 1915(c) waiver programs, such as the Children's Waiver

Program (CWP) and HSW. The capitation payment excludes individuals who reside, for an entire month, in any of the following: ICF/IID, Nursing Home, Child Caring Institution (CCI), or who are incarcerated. The SEDW capitation payment will be scheduled and/or adjusted to occur monthly. When applicable, additional payments may be scheduled.

E. Expenditures for MMSSSP and the Flint 1115 Waiver.

1) Member may expend any funds received for MMSSSP. All funds must be spent on Medicaid beneficiaries for Medicaid services. Surplus funding in either Medicaid or Healthy Michigan may be utilized to cover a funding deficit in either program. If a deficit still exists, the Medicaid or Healthy Michigan Plan risk reserve may be utilized. Medicaid or HMP risk reserve can fund a deficit in either program. The surplus funds must be used before the ISF can be utilized.

2) While there is flexibility in month-to-month expenditures and service utilization related to the different funding sources in MMSSSP, Member must submit encounter data on service utilization with transaction code modifiers that identify the service for each specific MMSSSP program. The encounter data (including cost information) will serve as the basis for future MMSSSP capitated rate development.

F. 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.

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

1) Based on current year's appropriations, MDHHS has implemented a wage increase for direct care workers, to be included on an ongoing basis. This applies to MDHHS programs and service codes as identified in MSA L Letters. The L Letters can be found on the MDHHS Website. Member must implement the hourly wage increase, with MDHHS providing increased capitation rates to cover the actual cost of these mandatory pay increases. Member must disperse these funds to eligible contracted providers employing individuals that qualify for the increase.

2) As this is a base wage increase, Member 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.

3) DCW wage increase funding will be a component of monthly capitation payments made to Member. Member is responsible for maintaining a record of DCW wage increase payments and is subject to the risk corridor cost settlement procedures.

4) All wage increase payments are subject to audit and potential recoupment. Network Providers must retain documentation that demonstrates the distribution of payments to eligible staff.

H. MDHHS Incentive Payment.

5) 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:

6) To receive the MDHHS Incentive Payment, the child must meet the eligibility criteria outlined in the MDHHS/PIHP Master contract.

7) Each incentive payment will be determined by comparing the Contractor's identified eligible children with the encounter data submitted. In order to assure timely incentive payment verification, valid encounters must be submitted within 90 days of the provision of the service regardless of the claim adjudication status. Late submissions will not be processed.

8) 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.

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

10) A MDHHS incentive payment will be made to LRE for beneficiaries meeting the requirements for such payment. Any DHHS incentive payment received will be passed on to the Member based on services delivered by the Member to beneficiaries identified in the payment detail from MDHHS.

11) The incentive payments will be made to the Member only after LRE receives the incentive payment from MDHHS for the Member's services. Payments to LRE are scheduled to occur quarterly. Each incentive payment will be determined by MDHHS by comparing the identified beneficiaries with the Member's encounter data submitted to LRE and then to MDHHS. Valid encounters must be submitted by the Member to LRE within thirty (30) days following the month of services regardless of the claim adjudication status in order to ensure timely incentive payment verification. Once LRE's quarterly incentive payment has taken place, there will not be any

opportunities for submission of eligible beneficiaries for a quarterly payment already completed. Only one payment rate will be available per month.

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

**~~10.~~13 Certification of Authority to Sign This Contract**

The persons signing this Contract on behalf of the Parties certify by said signatures that they are duly authorized to sign this Contract on behalf of each respective Party and that this Contract has been authorized by said Parties. This Contract shall be deemed executed, valid, enforceable, and binding upon the Parties once signed in handwriting or by electronic means and may be delivered by facsimile or electronic submission.

**[SIGNATURE PAGE TO FOLLOW]**

**IN WITNESS WHEREOF**, the authorized representatives of the Parties hereto have fully executed this Contract on the day and year first written above.

| | |
|---|---|
| **For LRE** | **For Member** |
| Name: Mary Marlatt-Dumas | Name: |
| Title: Chief Executive Officer | Title: Executive Director |
| Signed: _____ | Signed: _____ |
| Date: _____ | Date: _____ |

## EXHIBIT 1: BYRD ANTI-LOBBYING CERTIFICATION

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

**APPENDIX A, 44 C.F.R. PART 18 – CERTIFICATION REGARDING LOBBYING**

Certification for Contracts, Grants, Loans, and Cooperative Agreements

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

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

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

Member, enter Members name here, certifies or affirms the truthfulness and accuracy of each statement of its certification and disclosure, if any. In addition, Member understands and agrees that the provisions of 31 U.S.C. Chap. 38, Administrative Remedies for False Claims and Statements, apply to this certification and disclosure, if any.

Signature of Member's Authorized Official _____ Date _____

Name and Title of Member's Authorized _____

## SCHEDULE B: HIPAA BUSINESS ASSOCIATE AGREEMENT

The parties to this Business Associate Agreement ("Agreement") are Lakeshore Regional Entity and enter Members name here.

**1. RECITALS**

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

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

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

**~~2.~~14 AGREEMENT**

A. Definitions.

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

2) "Business Associate" has the same meaning as the term "business associate" at 45 CFR 160.103 and regarding this Agreement means.

3) "Covered Entity" has the same meaning as the term "covered entity" at 45 CFR 160.103 and regarding this Agreement Lakeshore Regional Entity.

4) "HIPAA Rules" means the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

B. Obligations of Business Associate.

Business Associate agrees to:

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

2) implement and use appropriate safeguards and comply with Subpart C of 45 CFR 164 regarding electronic protected health information, to prevent use or disclosure of PHI other than as provided in this Agreement. Business Associate must maintain, and provide a copy to the Covered Entity within ~~10~~ 5 days of a request from the Covered Entity, a comprehensive written information privacy and security program that includes security measures that reasonably and appropriately protect the

confidentiality, integrity, and availability of PHI relative to the size and complexity of the Business Associate's operations and the nature and the scope of its activities.

3) report to the Covered Entity within 24 hours any discovered prohibited use or disclosure of PHI, including breaches of Unsecured Protected Health Information as required by 45 CFR 164.410, and any Security Incident of which it becomes aware. If the Business Associate is responsible for any unauthorized use or disclosure of PHI, it must promptly act as required by applicable federal and State laws and regulations. Covered Entity and the Business Associate will cooperate in investigating whether a breach has occurred, to decide how to provide breach notifications to individuals, the federal Health and Human Services' Office for Civil Rights, and potentially the media.

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

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

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

7) maintain, and within ten days of a request from the Covered Entity make available, the information required to provide an accounting of disclosures to enable the Covered Entity to fulfill its obligations under 45 CFR § 164.528. Business Associate is not required to provide an accounting to the Covered Entity of disclosures: (i) to carry out treatment, payment or health care operations, as set forth in 45 CFR § 164.506; (ii) to individuals of PHI about them as set forth in 45 CFR § 164.502; (iii) under an authorization as provided in 45 CFR § 164.508; (iv) to persons involved in the individual's care or other notification purposes as set forth in 45 CFR § 164.510; (v) for national security or intelligence purposes as set forth in 45 CFR § 164.512(k)(2); (vi) to correctional institutions or law enforcement officials as set forth in 45 CFR § 164.512(k)(5); (vii) as part of a limited data set according to 45 CFR 164.514(e); or (viii) that occurred before the compliance date for the Covered Entity. Business Associate agrees to implement a process that allows for an accounting to be collected and

maintained by the Business Associate and its agents or Network Providers for at least six years before the request, but not before the compliance date of the Privacy Rule. At a minimum, such information must include: (i) the date of disclosure; (ii) the name of the entity or person who received PHI and, if known, the address of the entity or person; (iii) a brief description of PHI disclosed; and (iv) a brief statement of purpose of the disclosure that reasonably informs the individual of the basis for the disclosure or a copy of the written request for disclosure. If the request for an accounting is delivered directly to the Business Associate or its agents or Network Providers, the Business Associate must, within ten days of the receipt of the request, forward it to the Covered Entity in writing.

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

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

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

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

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

C. Permitted Uses and Disclosures by the Business Associate.

1) Business Associate may use or disclose PHI:

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

b. as required by law.

c. for Data Aggregation services relating to the health care operations of the Covered Entity;

d. to de-identify, consistent with 45 CFR 164.514(a) – (c), PHI it receives from the

D. Covered Entity. If the Business Associates de-identifies the PHI it receives from the Covered Entity, the Business Associate may use the de-identified information for any purpose not prohibited by the HIPAA Rules; and

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

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

E. Covered Entity's Obligations

Covered entity agrees to:

1) use its Security Measures to reasonably and appropriately maintain and ensure the confidentiality, integrity, and availability of PHI transmitted to the Business Associate under this Agreement until the PHI is received by the Business Associate.

2) provide the Business Associate with a copy of its Notice of Privacy Practices and must notify the Business Associate of any limitations in the Notice of Privacy Practices of the Covered Entity under 45 CFR 164.520 to the extent that such limitation may affect the Business Associate's use or disclosure of PHI.

3) notify the Business Associate of any changes in, or revocation of, the permission by an individual to use or disclose the individual's PHI to the extent that such changes may affect the Business Associate's use or disclosure of PHI.

4) notify the Business Associate of any restriction on the use or disclosure of PHI that the Covered Entity has agreed to or is required to abide by under 45 CFR 164.522 to the extent that such restriction may affect the Business Associate's use or disclosure of PHI.

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

G. Termination.

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

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

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

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

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

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

a. retain only that PHI which is necessary for the Business Associate to continue its proper management and administration or to carry out its legal responsibilities;

b. return to the Covered Entity (or, if agreed to by the Covered Entity in writing, destroy) the remaining PHI that the Business Associate still maintains in any form;

c. continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to electronic protected health information to prevent use or disclosure of the PHI, other than as provided for in this Section, for as long as the Business Associate retains the PHI;

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

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

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

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

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

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

L. Amendment. The parties acknowledge that state and federal laws relating to data security and privacy are rapidly evolving and that amendment of this Agreement may be required to provide for procedures to ensure compliance with such developments. The parties specifically agree to take such action as is necessary to implement the standards and requirements of HIPAA and the HIPAA Rules. Upon the request of either party, the other party agrees to promptly enter into negotiations concerning the terms of an amendment to this Agreement embodying written assurances consistent with the standards and requirements of HIPAA and the HIPAA Rules. Either party may terminate the Agreement upon thirty days written notice if (i) one party does not promptly enter into negotiations

to amend this Agreement when requested by the other party or (ii) the Business Associate does not enter into an amendment to this Agreement providing assurances regarding the safeguarding of PHI that the Covered Entity, in its sole discretion, deems sufficient to satisfy the standards and requirements of HIPAA or the HIPAA Rules.

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

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

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

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

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

R. Representatives and Notice.

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

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

Covered Entity Representative:

Name: Ione Myers

Title: Chief Information Officer

Address: 5000 Hakes Drive, Suite 250, Norton Shores, MI 49441

Phone: (231) 769-2044

Email: ionem@lsre.org

Business Associate Representative:

Name:

Title:

Address:

Phone:

Email:

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

## SCHEDULE C: DEFINITION / EXPLANATION OF TERMS

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

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

**Actuarial Soundness:** As defined in 42 CFR:

a) Actuarially sound capitation rates are projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the PIHP 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 PIHPs, must be reviewed and approved by CMS as actuarially sound. To be approved by CMS, capitation rates must:

   i. 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.

   ii. Be appropriate for the populations to be covered and the services to be furnished under the contract.

   iii. Be adequate to meet the requirements on PIHPs in 42 CFR 438.206, 438.207, and 438.208.

   iv. Be specific to payments for each rate cell under the contract. Payments from any rate cell must not cross-subsidized or be cross-subsidized by payments for any other rate cell. Be certified by an actuary as meeting the applicable requirements of this part, including that the rates have been developed in accordance with the requirements specified in 42 CFR438.3(c)(1)(ii) and (e). Meet any applicable special contract provisions as specified in 42 CFR 438.6. Be provided to CMS in a format and within a timeframe that meets requirements in 42 CFR 438.7. Be developed in such a way that the PIHP would reasonably achieve a medical loss ratio standard, as calculated under 42 CFR438.8, of at least 85 percent for the rate year. The capitation rates may be developed in such a way that the PIHP would reasonably achieve a medical loss ratio standard greater than 85 percent, as calculated under 42 CFR 438.8, as long as the capitation rates are adequate for reasonable, appropriate, and attainable non-benefit costs.

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

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

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

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

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

**Community Mental Health Services Program (CMHSP):** A CMHSP is considered a "Network Provider" under this Contract when directly engaged in the delivery, ordering, or referring of covered services to a beneficiary, and is considered a "Subcontractor" under this Contract when providing a function or service on behalf of LRE related, directly or indirectly, to the performance of LRE's obligations to the State under this Contract.

**Customer Relationship Management (CRM):** A customized technological platform, designed to streamline, automate, and simplify procedures related to the regulatory relationships between MDHHS BH and its customers: PIHPs, CMHSPs, CCBHC, SUD entities, and Michiganders.

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

employee of the CMHSP for purposes of the standard cost allocation methodology, EQI reporting, and MLR reporting, the provider must:

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

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

**Critical Incident:** Critical Incidents are defined as the following events: Suicide; Non-suicide death; Arrest of Consumer; Emergency Medical Treatment due to injury or Medication Error: Type of injury will include a subcategory for reporting injuries that resulted from the use of physical management; Hospitalization due to Injury or Medication Error: Hospitalization due to injury related to the use of physical management.

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

**Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT):** As defined in 42 CFR 440.40(b), EPSDT is Medicaid's comprehensive and preventive child health program for beneficiaries under age 21.

**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.

**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.

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

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

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

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

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

**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.

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

**MDHHS/PIHP Master Contract:** The agreement between MDHHS and LRE for administration of Medicaid Managed Specialty Supports and Services 1115 Demonstration Waiver, 1915(c)/(i) Waiver Program(s), the Healthy Michigan Program, and Flint 1115 Waiver.

**Medicaid Policy:** Includes all versions of the Medicaid Provider Manual, MDHHS Medicaid bulletins, Memos signed by the MDHHS Director of the Bureau of Specialty Behavioral Health Services, and all versions of MDHHS documents required by this contract that are posted on MDHHS' policy and practices website.

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

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

**Medicaid Provider Manual:** Medicaid Policy developed under the formal policy consultation process, as established by MDHHS.

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~~**Member**~~ **Employee:** A Member Employee is a person employed by Member 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).

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

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

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

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

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

**Prior Authorization (PA):** Refers to the process through which a health care provider ... obtains approval from a payer before providing care. Payers establish PA requirements to help control costs and ensure payment accuracy by verifying that an item or service is medically necessary, meets coverage criteria, and, for some payers, is consistent with standards of care.

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

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

**Sentinel Event:** A Patient Safety Event that reaches a patient and results in death, permanent harm, severe temporary harm and intervention required to sustain life. An event can also be considered a Sentinel Event even if the outcome was not death, permanent harm, severe temporary harm, and intervention required to sustain life.~~Is an "unexpected occurrence" involving death (not due to the natural course of a health condition) or serious physical or psychological injury, or risk thereof. Serious injury specifically includes permanent loss of limb or function. The phrase "or risk thereof" includes any process variation for which recurrence would carry a significant chance of a serious adverse outcome (JCAHO, 1998). Any injury or death that occurs from the use of any behavior intervention is considered a sentinel event.~~

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

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

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

**Subcontractor:** An individual, provider, CMHSP, or other organization that provides any function or service on behalf of LRE related to securing or fulfilling LRE's obligations under this Contract. Subcontractor does not include a network provider, unless the network provider is responsible

for services other than those that could be covered in a network provider agreement related only to the provision of covered services to beneficiaries.

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

## SCHEDULE D: RESERVED

## SCHEDULE E: MEMBER REPORTING REQUIREMENTS

***FY2027***

Member must provide the following reports to LRE as listed below and in accordance with LRE and MDHHS reporting standards, including required templates, formats, or recording procedures as defined.

All dates are subject to change based on MDHHS requirements. LRE will issue a letter of Change Notice when reporting due dates are revised, and Member shall be bound by the new date.

### FINANCIAL REPORTING

All financial reporting requirements, including templates, instructions, and submission deadlines, are maintained on the LRE Financial Reporting Site (SharePoint). Member responsible for reviewing and adhering to the materials and timelines posted on this site. All Finance Reports should be submitted to the LRE Financial Reporting Site (SharePoint).

LRE will update this site as changes occur. Member is bound by all updated requirements and due dates as posted.

| ~~Report Name~~ | ~~Due Date to LRE~~ |
|---|---|
| ~~**Behavioral Health Financial Status Report** (Previously Bucket Reports) Covering Previous 2 months~~ | ~~Due Monthly, **Wednesday** before Finance ROAT~~ |
| ~~**FY24 FSR Bundle**~~ | |
| ~~Interim~~ | ~~11/1/2024TBD~~ |
| ~~Final~~ | ~~TBD2/14/2025~~ |
| ~~**CMHSP Payment Reconciliation**~~ | |
| ~~October 1 – December 31~~ | ~~TBD1/23/2025~~ |
| ~~October 1 – March 31~~ | ~~TBD4/30/2025~~ |
| ~~**Encounter Quality Incentive (EQI) Report**~~ | |
| ~~FY24 - Period 3: October 1 – September 30~~ | ~~TBD2/14/2025~~ |
| ~~FY25 - Period 1: October 1 – January 31~~ | ~~TBD5/16/2025~~ |
| ~~FY25 - Period 2: October 1 – May 31~~ | ~~TBD8/16/2025~~ |
| ~~**FY24 Medical Loss Ratio (MLR)**~~ | ~~TBD2/14/2025~~ |
| ~~**Attestation to Claims and Payment Data** (prior year)~~ | ~~TBD2/28/2025~~ |
| ~~**FY24 DHHS Incentive Payment DHIP Report and Narrative**~~ | |
| ~~October 1 – September 30~~ | ~~TBD4/16/2025~~ |
| ~~**Milliman FY24 Period 3 EQI Observation Responses**~~ | ~~TBD4/16/2025~~ |
| ~~**FY25 Mid-Year Status Report**~~ | |
| ~~October 1 – March 31~~ | ~~TBD5/16/2025~~ |
| ~~**FY25 Projection FSR**~~ | |
| ~~October 1 – September 30~~ | ~~TBD8/1/2025~~ |
| ~~**FY26 Annual Spending Plan Report – Initial** (As needed thereafter for amendments)~~ | |
| ~~October 1 – September 30~~ | ~~TBD8/1/2025~~ |

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| ~~Annual Financial Audit, Management Letter, and Member Response to the Management Letter, Compliance Plan and Plan of Correction~~ | |
|---|---|
| ~~October 1 – September 30~~ | ~~30 Days After Submission~~ |
| ~~Managed Care Organization (MCO) Administration Details~~ | |
| ~~October 1 – September 30~~ | ~~TBD~~ |

## NON-FINANCIAL REPORTING SCHEDULE

| Report Name | Due Date to LRE | Where to Submit |
|---|---|---|
| **Litigation Report** | Within 10 days of receiving notification | compliance@lsre.org |
| **Immediately Reportable Event (IRE) Notification** | Follow Established LRE Submission Instructions | CIRE@lsre.org |
| **FUH Data Submission** | | |
| Data from Prior Week | Tuesday by noon, and Friday by 9:00am<br>FUH Files should ***NOT*** be submitted on the following dates due to holidays: 12/25/2026, 1/1/2027, 6/18/2027 | Follow File Specification Guidelines, and LRE FUH Procedure |
| **Ownership and Control Disclosure Form** | | |
| Information must be submitted, minimally, for all Managing Employees, which includes at minimum: Chief Executive Officer, Chief Financial Officer, Chief Information Officer, Chief Operations Officer, Chief Clinical Officer, and Board of Directors. | Upon submitting a proposal in accordance with MDHHS' procurement process<br>Upon executing the annual contract with LRE<br>Upon any renewal or extension of the LRE contract<br>Within 35 days after any changes in ownership of Member | Form will be sent to identified CMHSP staff to be completed via DocuSign |
| **Supplemental Network Adequacy Data Template** | 3/12/2027 | jimm@lsre.org |
| **Intensive Crisis Stabilization Services (ICSS) for Children Annual Data Report** | 10/15/2026 | sandis@lsre.org |
| **Quarterly Program Integrity Activity Report** | | |
| July 1 – September 30 | 10/30/2026 | Submit to LRE Compliance SharePoint folder |
| October 1 – December 30 | 1/29/2027 | |
| January 1 – March 31 | 4/30/2027 | |
| April 1 – June 30 | 7/30/2027 | |
| **Performance Indicators (MMBPIS)** | | |
| July 1 – September 30 | 12/15/2026 | Follow Established LRE Submission Instructions |
| October 1 – December 30 | 3/15/2027 | |
| January 1 – March 31 | 6/15/2027 | |
| April 1 – June 30 | 9/15/2027 | |
| **Critical Incident and Risk Events**<br>Monthly – for the previous month | Due the 15th of each month | Follow Established LRE Submission Instructions |
| **Provider Credentialing** | | |
| April 1 – June 30 | 11/2/2026 | pamb@lsre.org |
| October 1 – May 31 | 5/3/2027 | |
| **Affirmation Submission of Outbound ADTs** | 4/1/2027 | ionem@lsre.org |

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|---|---|---|
| Fiscal Year to Date | | |
| **Grievances and Service Authorization Denials** | | |
| July 1 – September 30 | 11/2/2026 | Follow Established LRE Submission Instructions |
| October 1 – December 30 | 2/1/2027 | |
| January 1 – March 31 | 5/3/2027 | |
| April 1 – June 30 | 8/2/2027 | |
| **LCID File Submission**<br>Submission Accepted on the submission date by 10:00am | | |
| | See IT Reporting Calendar approved by IT ROAT for submission dates | LRE LIDS System. Follow File Specification Guidelines |
| **Encounter Submission**<br>Submitted/Accepted on the submission date by 12:00pm | | |
| | See IT Reporting Calendar approved by IT ROAT for submission dates | LRE LIDS System |
| **BH-TEDS Submission**<br>Submitted/Accepted on the submission date before 9:00pm | | |
| | See IT Reporting Calendar approved by IT ROAT for submission dates | LRE LIDS System |
| **Provider Directory Data Submission** | | |
| | See IT Reporting Calendar approved by IT ROAT for submission dates | Follow File Specification Guidelines |

~~NON-FINANCIAL REPORTING SCHEDULE~~

| ~~Report Name~~ | ~~Due Date to LRE~~ | ~~Where to Submit~~ |
|---|---|---|
| ~~**Litigation Report**~~ | ~~Within 10 days of receiving notification~~ | ~~compliance@lsre.org~~ |
| ~~**Immediately Reportable Event Notification**~~ | ~~Within 48 hours of the event~~ | ~~compliance@lsre.org~~ |
| ~~**Ownership and Control Disclosure Form**~~ | | |
| ~~Information must be submitted, minimally, for the Member's Chief Executive Officer/Executive Director, Chief Financial Officer/Finance Director, and Chief Information Officer/Deputy Director, and all persons serving on the Board of Directors.~~ | ~~Upon submitting a proposal in accordance with MDHHS' procurement process~~ | ~~Form will be sent to identified CMHSP staff to be completed via DocuSign~~ |
| | ~~Upon executing the annual contract with LRE~~ | |
| | ~~Upon any renewal or extension of the LRE contract~~ | |
| | ~~Within 35 days after any changes in ownership of Member~~ | |
| ~~**FUH Data Submission**~~ | | |
| ~~Data from Prior Week~~ | ~~Tuesday by noon, and Friday by 8:30am~~ | ~~Follow File Specification Guidelines, and LRE FUH Procedure~~ |
| ~~**Quarterly Program Integrity Activity Report**~~ | | |
| ~~July 1 – September 30~~ | ~~TBD10/31/2024~~ | ~~Submit to LRE Compliance SharePoint folder~~ |
| ~~October 1 – December 30~~ | ~~TBD1/31/2025~~ | |
| ~~January 1 – March 31~~ | ~~TBD4/30/2025~~ | |
| ~~April 1 – June 30~~ | ~~TBD7/31/2025~~ | |
| ~~**Performance Indicators (MMBPIS)**~~ | | |

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|---|---|---|
| July 1 – September 30 | TBD12/15/2024 | Follow Established LRE Submission Instructions |
| October 1 – December 30 | TBD3/15/2025 | |
| January 1 – March 31 | TBD6/15/2025 | |
| April 1 – June 30 | TBD9/15/2025 | |
| **Critical Incident and Risk Events**<br>Monthly – for the previous month | Due the 15th of each month | Follow Established LRE Submission Instructions |
| **Provider Credentialing** | | |
| April 1 – June 30 | TBD11/1/2024 | pamb@lsre.org |
| October 1 – May 31 | TBD5/1/2025 | |
| **Affirmation Submission of Outbound ADTs**<br>Fiscal Year to Date | TBD4/1/2025 | ionem@lsre.org |
| **Narrative Report on findings and action taken to improve data quality on BHTEDS military and veteran fields**<br>Previous 12 Months | TBD5/15/2025 | ionem@lsre.org |
| **Grievances and Service Authorization Denials** | | |
| July 1 – September 30 | TBD11/1/2024 | |
| October 1 – December 30 | TBD2/3/2025 | |
| January 1 – March 31 | TBD5/1/2025 | |
| April 1 – June 30 | TBD8/1/2025 | |
| **LCID File Submission**<br>Submission Accepted on the submission date by 10:00am | | |
| | TBD10/9/2024 | TBD10/29/2024 |
| | TBD11/13/2024 | TBD11/27/2024 |
| | TBD12/11/2024 | TBD12/27/2024 |
| | TBD1/8/2025 | TBD1/29/2025 |
| | TBD2/12/2025 | TBD2/26/2025 |
| | TBD3/12/2025 | TBD3/26/2025 |
| | TBD4/9/2025 | TBD4/28/2025 |
| | TBD5/14/2025 | TBD5/28/2025 |
| | TBD6/11/2025 | TBD6/26/2025 |
| | TBD7/9/2025 | TBD7/29/2025 |
| | TBD8/13/2025 | TBD8/27/2025 |
| | TBD9/10/2025 | TBD9/26/2025 |
| **Encounter Submission**<br>Submitted/Accepted on the submission date by 12:00pm | | |

| | | | |
|---|---|---|---|
| | TBD10/9/2024 | TBD10/29/2024 | LRE LIDS System |
| | TBD11/13/2024 | TBD11/27/2024 | |
| | TBD12/11/2024 | TBD12/27/2024 | |
| | TBD1/8/2025 | TBD1/29/2025 | |
| | TBD2/12/2025 | TBD2/26/2025 | |
| | TBD3/12/2025 | TBD3/26/2025 | |
| | TBD4/9/2025 | TBD4/28/2025 | |
| | TBD5/14/2025 | TBD5/28/2025 | |
| | TBD6/11/2025 | TBD6/26/2025 | |
| | TBD7/9/2025 | TBD7/29/2025 | |
| | TBD8/13/2025 | TBD8/27/2025 | |
| | TBD9/10/2025 | TBD9/26/2025 | |
| **BH-TEDS Submission**<br>Submitted/Accepted on the submission date before 9:00pm | | | |
| | TBD10/8/2024 | TBD10/28/2024 | LRE LIDS System |
| | TBD11/12/2024 | TBD11/26/2024 | |
| | TBD12/10/2024 | TBD12/26/2024 | |
| | TBD1/7/2025 | TBD1/28/2025 | |
| | TBD2/11/2025 | TBD2/25/2025 | |
| | TBD3/11/2025 | TBD3/25/2025 | |
| | TBD4/8/2025 | TBD4/27/2025 | |
| | TBD5/13/2025 | TBD5/27/2025 | |
| | TBD6/10/2025 | TBD6/25/2025 | |
| | TBD7/8/2025 | TBD7/28/2025 | |
| | TBD8/12/2025 | TBD8/26/2025 | |
| | TBD9/9/2025 | TBD9/25/2025 | |
| **Provider Directory Data Submission** | | | |
| | TBD10/4/2024 | TBD10/18/2024 | TBDFollow File Specification Guidelines |
| | TBD11/1/2024 | TBD11/15/2024 | |
| | TBD12/13/2024 | TBD12/27/2024 | |
| | TBD1/10/2025 | TBD1/24/2025 | |
| | TBD2/7/2025 | TBD2/21/2025 | |
| | TBD3/7/2025 | TBD3/21/2025 | |
| | TBD4/4/2025 | TBD4/18/2025 | |
| | TBD5/2/25 | TBD5/16/25 TBD5/30/25 | |
| | TBD6/13/2025 | TBD6/27/2025 | |
| | TBD7/11/2025 | TBD7/25/2025 | |

| | | | |
|---|---|---|---|
| | ~~TBD~~8/8/2025 | ~~TBD~~8/22/2025 | |
| | ~~TBD~~9/5/2025 | ~~TBD~~9/19/2025 | |

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

The grid below indicates Medicaid Health Plan (MHP) and Prepaid Inpatient Health Plan (PIHP) coverage responsibility for mental health and substance use disorder services. It should be used by MHPs, PIHPs, Community Mental Health Service Programs, providers and others, as applicable, to determine the responsible entity for payment of mental health and substance use disorder services delivered to Enrollees.

This grid generally delineates coverage responsibility by the setting in which a service is provided. MDHHS reserves the right to modify this grid in the future and will update it in accordance with any change in MDHHS policy. All entities should follow Medicaid policy, as described in the Medicaid Provider Manual and the entity's contract with the State and as directed by MDHHS.

**Acronyms**:

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

**Notes**:

- For enrollees who are not enrolled in an MHP and receive FFS Medicaid, FFS is the responsible payer wherever the grid indicates MHP coverage responsibility.
- Unless otherwise indicated by the most current ICD-10-CM coding guidelines, list first the ICD-10 code for the diagnosis, condition, problem, or other reason for the encounter/visit that is shown in the medical record to be chiefly responsible for the services provided, followed by additional ICD-10 codes that describe any coexisting conditions.
- Specialty supports and services provided to individuals with an I/DD outlined in the Medicaid Provider Manual are the responsibility of the PIHP; physical health, mental health and substance use disorder services for these individuals should be covered in accordance with this grid and Medicaid policy.
- Prior authorization may apply to services included in this grid; see relevant coverage rules for additional information.
- Refer to the Medicaid Provider Manual for additional coverage and reimbursement information, including information for individuals enrolled in an Integrated Care Organization.



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| Setting in Which Service is Provided | | | | | |
|---|---|---|---|---|---|
| **Outpatient Office (e.g., Clinic, Physician Office)** | **Emergency Intervention Services and Post-Crisis Stabilization Services** | **Medical Emergency Department (ED)** | **Inpatient Acute Care Hospital** | **Inpatient Psychiatric Hospital or Inpatient Psychiatric Bed/Unit Within Acute Care Hospital** *Excludes State Psychiatric Hospitals* | **Nursing Facility** |
| **Mental Health Services for Individuals with Mild to Moderate Mental Illness or Whose Severity Has Not Yet Been Determined** NOTE: Unless otherwise specified, the payment responsibilities delineated in this table hold true regardless of whether the individual has concurrent SUD or I/DD. | | | | | |
| Payer responsible: Mixed, depending on outpatient setting.<br><br>The PIHP is responsible for outpatient mental health services provided at CCBHCs. The PIHP is also responsible for outpatient mental health services provided by SUD providers for individuals with co-occurring mental health and substance use disorders. (For outpatient emergency intervention and post-crisis stabilization services, see right.)<br><br>The MHP is responsible for outpatient mental health services provided in other office- or clinic-based settings to individuals with mild to moderate mental illness or whose severity has not yet been determined. This includes necessary screening. | Payer responsible: PIHP.<br><br>The PIHP is responsible for emergency intervention services and post-crisis stabilization services (in outpatient or residential settings) as outlined in the Intensive Crisis Stabilization Services section of the Medicaid Provider Manual.<br><br>If the provider believes that inpatient psychiatric hospital services and/or specialty mental health services and supports may be needed, the provider should contact the PIHP for a PAR. The PIHP is responsible for authorization of and payment for the PAR, which may be provided on-site, face-to-face, or over the telephone by the PIHP.<br><br>The PIHP is responsible for stabilization services following psychiatric hospitalization.<br><br>The PIHP and MHP should closely coordinate post-crisis stabilization services for shared enrollees. | Payer responsible: Mixed, depending on service provided.<br><br>The MHP is responsible for medical screening and stabilization services and any medical treatment associated with the episode of care, including treatment of mild-to-moderate mental illness provided in the ED.<br><br>If after medical screening and stabilization, a medical health professional believes that inpatient psychiatric hospital services and/or specialty mental health services and supports may be needed, the ED should contact the PIHP for a PAR. The PIHP is responsible for authorization of and payment for the PAR, which may be provided on-site, face-to-face, or over the telephone by the PIHP. | Payer responsible: Mixed, depending on service provided.<br><br>The MHP is responsible for all inpatient medical treatment associated with the episode of care, with the exception of inpatient psychiatric stays (see right).<br><br>If a medical health professional believes that inpatient psychiatric hospital services and/or specialty mental health services and supports may be needed, the hospital should contact the PIHP for a PAR. The PIHP is responsible for authorization of and payment for the PAR, which may be provided on-site, face-to-face, or over the telephone by the PIHP. | Payer responsible: PIHP.<br><br>The PIHP is responsible for all inpatient psychiatric stays, either in inpatient psychiatric hospitals or psychiatric beds/units within a general acute care hospital.<br><br>The PIHP provides the authorization for mental health inpatient admission and is responsible for mental health inpatient admission costs, including psychiatrists' fees. | Payer responsible: MHP or FFS, depending on beneficiary enrollment.<br><br>Nursing facilities complete the Pre-Admission Screening and Annual Resident Review (PASARR).<br><br>Mental health services provided by the nursing facility staff, as specified in the resident's plan of care, are included in the facility's per diem rate. Nursing facilities must provide mental health, I/DD or related condition services that are of lesser intensity than specialized services to all residents who need such services. |



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| Setting in Which Service is Provided | | | | | |
|---|---|---|---|---|---|
| **Outpatient Office (e.g., Clinic, Physician Office)** | **Emergency Intervention Services and Post-Crisis Stabilization Services** | **Medical Emergency Department (ED)** | **Inpatient Acute Care Hospital** | **Inpatient Psychiatric Hospital or Inpatient Psychiatric Bed/Unit Within Acute Care Hospital** *Excludes State Psychiatric Hospitals* | **Nursing Facility** |
| **Mental Health Services for Individuals with Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED)** NOTE: Unless otherwise specified, the payment responsibilities delineated in this table hold true regardless of whether the individual has concurrent SUD or I/DD. | | | | | |
| Payer responsible: PIHP<br><br>The PIHP is responsible for outpatient mental health services provided to individuals with SMI or SED. | Payer responsible: PIHP.<br><br>The PIHP is responsible for emergency intervention services and post-crisis stabilization services (in outpatient or residential settings) as outlined in the Intensive Crisis Stabilization Services section of the Medicaid Provider Manual.<br><br>If the provider believes that inpatient psychiatric hospital services and/or specialty mental health services and supports may be needed, the provider should contact the PIHP for a PAR. The PIHP is responsible for authorization of and payment for the PAR, which may be provided on-site, face-to-face, or over the telephone by the PIHP.<br><br>The PIHP is responsible for stabilization services following psychiatric hospitalization.<br><br>The PIHP and MHP should closely coordinate post-crisis stabilization services for shared enrollees. | Payer responsible: Mixed, depending on service provided.<br><br>The MHP is responsible for medical screening and stabilization services and any medical treatment associated with the episode of care.<br><br>If after medical screening and stabilization, a medical health professional believes that inpatient psychiatric hospital services and/or specialty mental health services and supports may be needed, the ED should contact the PIHP for a PAR. The PIHP is responsible for authorization of and payment for the PAR, which may be provided on-site, face-to-face, or over the telephone by the PIHP. | Payer responsible: Mixed, depending on service provided.<br><br>The MHP is responsible for all inpatient medical treatment associated with the episode of care, with the exception of inpatient psychiatric stays (see right).<br><br>If a medical health professional believes that inpatient psychiatric hospital services and/or specialty mental health services and supports may be needed, the hospital should contact the PIHP for a PAR. The PIHP is responsible for authorization of and payment for the PAR, which may be provided on-site, face-to-face, or over the telephone by the PIHP. | Payer responsible: PIHP.<br><br>The PIHP is responsible for all inpatient psychiatric stays, either in inpatient psychiatric hospitals or psychiatric beds/units within a general acute care hospital.<br><br>The PIHP provides the authorization for mental health inpatient admission and is responsible for mental health inpatient admission costs, including psychiatrists' fees. | Payer responsible: PIHP for specialized services.<br><br>Specialized services are those identified by the PASARR Level II and are provided or arranged by the PIHP. These services must be available to nursing facility individuals regardless of whether they are identified and required by the PASARR process, or whether the individual is determined to require additional services to be provided or arranged for by the State as specialized services. Individuals with a primary diagnosis of dementia are also covered by this requirement.<br><br>Specialized services are defined as those mental health services for residents who have a mental illness, I/DD or related condition which: 1) are of greater intensity than those normally required from a NF, 2) are provided in conjunction with usual NF services, 3) are determined through the PASARR process, 4) are provided or arranged for by the local CMHSP, *or* 5) result in the continuous and aggressive implementation of an individualized plan of care. |



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| Setting in Which Service is Provided | | |
|---|---|---|
| **ASAM Level 1: Outpatient and ASAM Level 2: Intensive Outpatient (IOP) and High-Intensity Outpatient (HIOP)** | **ASAM Level 3: Residential** | **ASAM Level 4: Inpatient** |
| **Substance Use Disorder (SUD) Treatment Services** | | |
| **Outpatient SUD Services Provided in Office-Based Setting**<br>Payer responsible: Mixed, depending on provider affiliation.<br>• The PIHP is responsible for office-based substance use treatment (OBSUT) services delivered by providers with a specialty SUD services contract with the PIHP and eligible SUD services provided by CCBHCs.<br>• The MHP is responsible for OBSUT services delivered by providers who do not have a specialty SUD services contract with the PIHP.<br><br>**Outpatient SUD Services Provided in Medical ED**<br>Payer responsible: MHP<br>• The MHP is responsible for ambulatory withdrawal management and bridge MAT services provided in the ED. If the enrollee is admitted for acute medical detoxification, the ED costs are rolled into the inpatient DRG.<br><br>**Outpatient SUD Services Provided in Other Settings and IOP, HIOP, and Partial Hospitalization Services**<br>Payer responsible: PIHP<br><br>**Ambulatory Withdrawal Management**<br>Payer responsible: Mixed, depending on setting and provider affiliation.<br>• The PIHP is responsible for ambulatory withdrawal management services provided at CCBHCs and CMHSPs.<br>• Payment responsibility for ambulatory withdrawal management services delivered in office-based settings should follow guidance for outpatient SUD services provided in office-based settings, as described above. | **Clinically and Medically Managed Residential Treatment**<br>Includes low intensity, population-specific high intensity, high intensity, and withdrawal management residential treatments.<br>Payer responsible: PIHP<br><br>**Nursing Facility**<br>Payer responsible: MHP or FFS, depending on beneficiary enrollment. Services rendered for the treatment of alcohol and drug use are an ancillary service and are not included in the facility's per diem rate. | **Medically Managed Inpatient Treatment**<br>Payer responsible: FFS, with one exception (see below).<br><br>FFS is responsible for medically managed intensive inpatient acute detox and associated potentially life-threatening substance-induced toxic conditions requiring acute medical monitoring or intervention and detoxification services in acute care settings.<br><br>Medically managed inpatient or medically monitored intensive inpatient SUD services may be provided during inpatient psychiatric stays as part of treating co-occurring mental health and SUD conditions. These services are the responsibility of the PIHP and reimbursed as part of existing payment arrangements. |

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| Setting in Which Service is Provided | | | | | |
|---|---|---|---|---|---|
| **Outpatient Office (e.g., Clinic, Physician Office)** | **Emergency Intervention Services and Post-Crisis Stabilization Services** | **Medical Emergency Department (ED)** | **Inpatient Acute Care Hospital** | **Inpatient Psychiatric Hospital or Inpatient Psychiatric Bed/Unit Within Acute Care Hospital** *Excludes State Psychiatric Hospitals* | **Nursing Facility** |
| **Medical Services – Professional and Facility Services, Including Diagnostic Tests** (e.g., Radiology and Laboratory Services, Including Toxicology Screening) | | | | | |
| Payer responsible: MHP. | Payer responsible: PIHP. | Payer responsible: MHP. | Payer responsible: MHP. | Payer responsible: Mixed, depending on service provided.<br><br>The PIHP is responsible for costs related to providing a psychiatric admission, history and physical.<br><br>The MHP is responsible for medical services. | Payer responsible: MHP or FFS depending on beneficiary enrollment.<br><br>Ancillary services (defined in the Nursing Facility Chapter of the Medicaid Provider Manual) should be billed to the MHP or FFS based upon beneficiary enrollment. |

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## SCHEDULE G: FY275 LOCAL FUNDING OBLIGATION SCHEDULE

**Contract No. MA 240000001079~~09~~ Prepaid Inpatient Health Plan (PIHP)**

~~Pursuant to PA 0121 of 2024~~

Schedule G will be provided via notice once available. ~~Counties (CMHSP)/Pre-paid Inpatient Health Plan Regional Entity~~

~~FY25 CMHSP Local Funding Amount Payment Due Dates~~

| | ~~11/16/2024~~ ~~Oct - Dec~~ | ~~02/15/2025~~ ~~Jan - Mar~~ | ~~05/17/2025~~ ~~Apr - Jun~~ | ~~08/16/2025~~ ~~Jul - Sept~~ | ~~Oct - Sept Total~~ |
|---|---|---|---|---|---|
| ~~Allegan~~ | ~~24,723~~ | ~~24,723~~ | ~~24,723~~ | ~~24,723~~ | ~~98,892~~ |
| ~~Kent (Network 180)~~ | ~~100,385~~ | ~~100,385~~ | ~~100,385~~ | ~~100,385~~ | ~~401,540~~ |
| ~~Muskegon (Health West)~~ | ~~58,233~~ | ~~58,233~~ | ~~58,233~~ | ~~58,233~~ | ~~232,932~~ |
| ~~Ottawa~~ | ~~47,163~~ | ~~47,163~~ | ~~47,163~~ | ~~47,163~~ | ~~188,652~~ |
| ~~Lake-Mason-Oceana (West MI)~~ | ~~21,383~~ | ~~21,383~~ | ~~21,383~~ | ~~21,383~~ | ~~85,532~~ |
| ~~**Region 3 - Lakeshore Regional Entity Total**~~ | ~~**251,887**~~ | ~~**251,887**~~ | ~~**251,887**~~ | ~~**251,887**~~ | ~~**1,007,548**~~ |

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## SCHEDULE H: REVENUE DISTRIBUTION

### MEDICAID PAYMENTS

LRE will reimburse Member in accordance with Article 4 of the LRE Operating Agreement as amended and incorporated herein.

**ARTICLE 4**

**FINANCIAL**

4.1 **ALLOCATION.** The ENTITY will provide for a funding system that is fair and uniform across Region 3.

4.1.1 **REVENUE DISTRIBUTION.**

4.1.1.1 **MEDICAID.** The primary source of the ENTITY's revenue will be Medicaid capitation received on a monthly basis from MDHHS. These payments will be for eligible enrollees covered by benefits or entitlements inclusive of, but not limited to, the Medicaid Contract, Autism Benefit, Substance Use Disorder Benefit and the Healthy Michigan (expanded Medicaid program), if any. Effective June 1, 2022, the ENTITY will distribute Medicaid dollars, if any, to the Members using the same methodology as MDHHS allocates the dollars to the ENTITY, or as contractually required. The gross funding will be adjusted by required withholds and ENTITY administrative costs as defined in Section 4.1.3.1 and by Planned Funding Adjustments, which are defined as increases or decreases to a Member's Medicaid funding as approved in a plan as agreed upon by the Members and as determined in the ENTITY's policy and/or procedure. This will determine the net funding level.

4.1.1.2 **BLOCK GRANTS.** The ENTITY Chief Executive Officer will receive the notification of Block Grants. Notification of receipt will be forwarded to all Members of the ENTITY Board of Directors. Funding will be distributed based on the award.

4.1.1.3 **SUBSTANCE USE DISORDER (SUD).** Separate policies and/or procedures for SUD prevention and treatment services (block grant and Public Act (PA2) Liquor Tax funding) will be created in accordance with State requirements to ensure proper distribution, accounting and reporting related to these funds.

4.1.1.4 **OTHER REVENUE SOURCES.** In addition to the revenue sources identified above, the ENTITY may receive other revenue. Upon receipt, the ENTITY will distribute these funds to the appropriate Members, as contractually required, if applicable, or according to policy and/or procedure.



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4.1.2 **RISK MANAGEMENT/TRANSITION FUNDING/SURPLUS FUNDS.** The ENTITY will establish policies and procedures to address Financial Risk Management, Transition Funding, and Surplus Funds

4.1.3 **CAPITAL AND OPERATING COSTS.**

4.1.3.1 **FINANCIAL SUPPORT FOR THE ENTITY.** Revenues for ENTITY expenses will come from current year regional revenues and approved by the ENTITY's Board of Directors.

4.1.3.2 **CAPTIAL.** As detailed in the Budget Section 4.5, the ENTITY can purchase and account for capital assets based on the approved budget.

4.1.3.3 **ENTITY ADMINISTRATIVE SURPLUS FUNDS.** Unspent ENTITY administrative funds (difference between the approved ENTITY administrative budgeted funds which have been withheld monthly by the ENTITY and actual funds spent) will become part of the overall Medicaid funds usable across the Region 3 for current operations. If the funds are not needed for operations, then they would be added to either the Medicaid Savings pooled funds or the ISF.

4.2 **ACCOUNTABILITY OF FUNDS.** The ENTITY Chief Financial Officer, with the assistance of the Chief Executive Officer, will provide the ENTITY Board with regular, detailed reports accounting for all the ENTITY's operations in accordance with ENTITY Board policy.

4.2.1 **CONTRACT RECONCILIATION.** Upon conclusion of each fiscal year of this Operating Agreement, final contract reconciliation shall be completed as a net cost settlement wherein the Medicaid funding prepaid by the ENTITY to each Member, and the total of the Member's expenditures pursuant to this Operating Agreement, will be reviewed and reconciled in direct accordance with the service and financial provisions hereunder. The contract reconciliation of this Operating Agreement will be completed in full compliance with MDHHS requirements and in accordance with the revenue and expenditure reconciliation process and requirements of the ENTITY's contract with MDHHS. The contract reconciliation for each fiscal year under this Operating Agreement will be completed in accordance with the timelines that have been established by ENTITY policy and/or procedure or contractual requirements.

4.2.2 **UNALLOWABLE COSTS/PAYBACKS.** Should a Member fail to fulfill its obligations as required under this Operating Agreement, resulting in unallowable Medicaid services and/or claims cost, it will not be reimbursed by the ENTITY for any such services and/or cost claims. The Member agrees to repay to the ENTITY any and all Medicaid payments made by the ENTITY to the Member for such unallowable services and/or cost claims. This reimbursement requirement will survive the dissolution of this Operating Agreement and repayment will be made by the Member to the ENTITY within sixty (60) days of the ENTITY's notification to the Member. In the event that the ENTITY, MDHHS, the State of Michigan, or the Federal government ever determines in any final revenue and

expenditure reconciliation and/or any final finance or service audit that a Member has been paid inappropriately per the ENTITY's expenditures of Medicaid funds pursuant to this Operating Agreement for services claims and/or cost claims of a Member which are later disallowed, the Member will repay the ENTITY for such disallowed payments within sixty (60) days of the ENTITY's final notification.

4.3 **PURCHASED CENTRALIZED SERVICES.** The ENTITY will be the manager of any centralized PIHP managed care services as provided in this Operating Agreement. The ENTITY may directly provide these services or arrange for provision by an outside vendor. The ENTITY may also choose to purchase its centralized services from a Member.

4.4 **RISK OBLIGATIONS (INSURANCE, REINSURANCE, INTERNAL SERVICE FUND).** The ENTITY will establish and maintain an Internal Service Fund (ISF) to manage its primary risk exposure under the Medicaid Contract. The Internal Service Fund will be developed, used and maintained in a manner to comply with applicable MDHHS Contract requirements. The Internal Service Fund will be sufficient to manage the Region 3 Medicaid risk and will not exceed the amount of the shared risk corridor financing in the Medicaid Contract.

4.5 **BUDGETS.** Establishing Budget for the ENTITY: Consistent with Michigan Complied Law (MCL) Section 141.412, the ENTITY shall hold a public hearing on its proposed budget. Notice of the hearing shall be by publication in newspapers of general circulation within the regional unit at least six (6) days before the hearing. The notice shall include the time and place of the hearing and shall state the place where a copy of the budget is available for public inspection. The annual budget must be presented to the Board of Directors for approval prior to the beginning of the fiscal year. Amendments to the budget must be prepared by ENTITY staff and presented to the Board of Directors for approval prior to expenditures being made and prior to year-end. The Annual Budget shall include a capital equipment budget.

4.6 **LOCAL MATCH OBLIGATIONS.** State Law permits a contribution from internal resources. Local funds will be used as a bona fide part of the State match required under the Medicaid program in order to increase capitation payments.

4.6.1 **LOCAL MATCH SUMISSION.** Members will submit local funds as a bona fide source of match for Medicaid to the ENTITY on a quarterly basis. These payments will be made in a reasonable timeframe to allow the ENTITY to process the local match payment to the State in accordance with the MDHHS payment schedule.

4.6.2 **LOCAL MATCH MONITORING.** The ENTITY and its Members will establish mechanisms to assure that the local match of each Member is funded and monitored no less than quarterly to assure adequacy of funding.

4.6.3 **RESPONSIBILITY TO NOTIFY.** Any Member that projects a problem or issue with local match funding will immediately notify the ENTITY Chief Financial Officer. A plan of correction will be completed and sent to the ENTITY Chief Financial Officer within ten (10) business days of the identification of the problem.

4.7 **ACCESS TO ACCOUNTING RECORDS.** The ENTITY shall maintain all pertinent financial and accounting records and evidence pertaining to this Operating Agreement based on financial and statistical records that can be verified by the Member and/or its auditors. Financial reporting shall be in accordance with generally accepted accounting principles and 2 CFR 200 (Cost Principles for State, Local and Indian Tribal Governments), as applicable to state and local governments, and as promulgated by the Governmental Accounting Standards Board (GASB). The Members, the ENTITY Board, the Federal government, the State of Michigan, or their designated representatives shall be allowed to inspect, review, copy, and/or audit all financial records pertaining to this Operating Agreement. 4.8 DEBT/THRESHHOLDS. Unanimous vote of the Members shall be obtained prior to the ENTITY incurring a debt in excess of $150,000.

## SCHEDULE I: DELEGATION OF MANAGED CARE FUNCTION ACTIVITIES

In accordance with MDHHS/PIHP Master Contract (Standard Contract Terms, Section 11: Subcontracting), ~~C~~certain Managed Care Function activities ~~for this program will~~ may be delegated by LRE to Member. This Exhibit ~~defines~~ outlines ~~the~~ Managed Care Function activity responsibilities of LRE and the Member. LRE retains oversight and monitoring responsibilities for the Managed Care performance of the region, irrespective of any defined delegation.

~~Notwithstanding any other provision of this Agreement, LRE may amend this **Schedule I** by written Change Notice to Member when LRE determines that such amendment is necessary to maintain compliance with LRE's contract with MDHHS, applicable federal or state law, regulation, policy, technical requirement, reporting requirement, or other MDHHS directive. Any such Change Notice shall identify the required amendment, the basis for the amendment, and the effective date. Member shall comply with the amended Schedule I as of the effective date stated in the Change Notice.~~

~~Notwithstanding any other provision of this Agreement, LRE may amend this **Schedule I** by written Change Notice to Member when LRE determines that such amendment is necessary to maintain compliance with LRE's contract with MDHHS, applicable federal or state law, regulation, policy, technical requirement, reporting requirement, or other MDHHS directive. Any Change Notice shall identify the required amendment, the basis for the amendment, and the effective date. Member shall comply with the amended Schedule I as of the effective date stated in the Change Notice.~~

~~LRE shall not modify delegated managed care functions arbitrarily and will provide written notice and, when practicable, opportunity for discussion.~~

**Commented [PG5]:** Review with Mary to determine need for negotiation with CMHSPs

Notwithstanding any relationship(s) that LRE may have with Member CMHSPs, LRE maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State (42 CFR 438.230(b)(1)).

| ENROLLEE RIGHTS AND ENROLLEE INFORMATION §438.100 | |
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| **ACTIVITY** | **RESPONSIBLE** |
| Language and Format | ☐ LRE<br>☐ MEMBER<br>☒ SHARED |
| Enrollee Rights and Protections | ☐ LRE<br>☒ MEMBER<br>☐ SHARED |
| Customer Services Handbook | ☐ LRE<br>☐ MEMBER<br>☒ SHARED |
| Enrollee Rights Notification | ☐ LRE<br>☒ MEMBER<br>☐ SHARED |
| Published Provider Directory | ☐ LRE<br>☐ MEMBER |

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| | ☒ SHARED |
| **AVAILABILITY OF SERVICES §438.206** | |
| **ACTIVITY** | **RESPONSIBLE** |
| Delivery Network | ☐ LRE<br>☒ MEMBER<br>☐ SHARED |
| Timely Access | ☐ LRE<br>☒ MEMBER<br>☐ SHARED |
| Access and Cultural Considerations | ☐ LRE<br>☒ MEMBER<br>☐ SHARED |
| Accessibility | ☐ LRE<br>☒ MEMBER<br>☐ SHARED |
| **ASSURANCES OF ADEQUATE CAPACITY AND SERVICES §438.207** | |
| **ACTIVITY** | **RESPONSIBLE** |
| Provider Network Adequacy Reporting | ☐ LRE<br>☐ MEMBER<br>☒ SHARED |
| Demonstration of Adequate Capacity | ☐ LRE<br>☐ MEMBER<br>☒ SHARED |
| **COORDINATION AND CONTINUITY OF CARE §438.208** | |
| **ACTIVITY** | **RESPONSIBLE** |
| Coordination and Continuity of Care for Enrollees | ☐ LRE<br>☒ MEMBER<br>☐ SHARED |
| Care Coordination with Medicaid Health Plans (MHP) for Shared Care Planning | ☐ LRE<br>☒ MEMBER<br>☐ SHARED |
| HCBS Person-Centered Planning Process/Service Plan | ☐ LRE<br>☒ MEMBER<br>☐ SHARED |
| Integrated Physical and Mental Health Care | ☐ LRE<br>☒ MEMBER<br>☐ SHARED |
| Primary Care Coordination | ☐ LRE<br>☒ MEMBER<br>☐ SHARED |
| **COVERAGE AND AUTHORIZATION OF SERVICES §438.210** | |
| **ACTIVITY** | **RESPONSIBLE** |
| Coverage | ☐ LRE<br>☒ MEMBER<br>☐ SHARED |
| Authorization of Services | ☐ LRE<br>☒ MEMBER |

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| | ☐ SHARED |
| Notice of Adverse Benefits Determination | ☐ LRE<br>☒ MEMBER<br>☐ SHARED |
| **PROVIDER SELECTION §438.214** | |
| **ACTIVITY** | **RESPONSIBLE** |
| Individual Practitioner Credentialing | ☐ LRE<br>☐ MEMBER<br>☒ SHARED |
| Organizational Credentialing | ☒ LRE<br>☐ MEMBER<br>☐ SHARED |
| Excluded Providers | ☐ LRE<br>☐ MEMBER<br>☒ SHARED |
| **GRIEVANCE AND APPEAL SYSTEMS §438.228** | |
| **ACTIVITY** | **RESPONSIBLE** |
| Appeal Review and Processing | ☐ LRE<br>☐ MEMBER<br>☒ SHARED |
| Grievance Review and Processing | ☐ LRE<br>☒ MEMBER<br>☐ SHARED |
| Provide Appeal and Grievance Rights Information | ☐ LRE<br>☒ MEMBER<br>☐ SHARED |
| Written Notice of Grievance Resolution | ☐ LRE<br>☐ MEMBER<br>☒ SHARED |
| **PRACTICE GUIDELINES §438.236** | |
| **ACTIVITY** | **RESPONSIBLE** |
| Adaption, Dissemination, and Application of Practice Guidelines | ☐ LRE<br>☐ MEMBER<br>☒ SHARED |
| **HEALTH INFORMATION SYSTEMS §438.242** | |
| **ACTIVITY** | **RESPONSIBLE** |
| Basic Elements of a Health Information System | ☐ LRE<br>☐ MEMBER<br>☒ SHARED |
| Data Submission | ☐ LRE<br>☐ MEMBER<br>☒ SHARED |
| **QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM (QAPIP) §438.330** | |
| **ACTIVITY** | **RESPONSIBLE** |
| Development of QAPIPs | ☐ LRE<br>☐ MEMBER<br>☒ SHARED |

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| Sentinel Events and Critical Incident Reporting | ☐ LRE<br>☐ MEMBER<br>☒ SHARED |
| Behavior Treatment Review | ☐ LRE<br>☐ MEMBER<br>☒ SHARED |
| Assessment of Member Experience | ☐ LRE<br>☐ MEMBER<br>☒ SHARED |
| **Program Integrity Requirements §438.330** | |
| **ACTIVITY** | **RESPONSIBLE** |
| Compliance Investigations | ☐ LRE<br>☐ MEMBER<br>☒ SHARED |
| OIG Activity Report | ☐ LRE<br>☐ MEMBER<br>☒ SHARED |
| OIG Annual Reports | ☐ LRE<br>☐ MEMBER<br>☒ SHARED |

## CONTRACTUAL RESPONSIBILITIES FOR MANAGED CARE FUNCTION ACTIVITIES

Member must maintain local policies and procedures addressing each responsibility in accordance with LRE policies and practices.

| ENROLLEE RIGHTS AND ENROLLEE INFORMATION §438.100 | | |
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| **ACTIVITY** | **LRE RESPONSIBILITY**<br>LRE to provide oversight and monitoring of Member activities and performance for all delegated Activities of Managed Care Functions | **MEMBER RESPONSIBILITY** |
| **Language and Format**<br>***Supporting Documents:***<br>- *MDHHS Customer Service Standards*<br>- *42 CFR 438.10* | Ensure all written materials that are critical to obtaining services meet all requirements outlined in the MDHHS Customer Service Standards. | - Ensure written materials are available in the prevalent non-English languages of the service area (spoken as the primary language by more than 5% of the population in the PIHPs Region.<br>- Written material must be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually impaired or have limited reading proficiency. Large print must be in a font size no smaller than 18 point.<br>- Enrollees / potential enrollees are informed that information is available in alternative formats and how to access those formats ~~and how to access those formats~~.<br>- ensure that written materials that are critical to obtaining services include information about how to request auxiliary aids and services and the toll-free and TTY/TDD telephone number of the PIHP's and/or CMHSPs' member/customer service unit. |
| **Enrollee Rights and Protections**<br>***Supporting Documents:***<br>- *42 CFR 438.10*<br>- *Policy 6.4 Guide to Services*<br>- *Policy*<br>- *MDHHS Customer Service Standards* | | - Ensure local communication with enrollees regarding the role and purpose of the Members Customer Services.<br>- Maintain policies and procedures to ensure compliance with all enrollee rights and protection requirements.<br>- Ensure enrollees can request and receive a copy of their medical records, and request that they be amended or corrected.<br>- Have mechanisms in place to ensure language needs of individuals served are assessed.<br>- Notify recipients that oral interpretation and written information is available in prevalent languages.<br>- Ensure oral interpretation of all languages is available free of charge.<br>- Provide accommodations in alternative languages where required.<br>- Notify recipients that information is available in alternative formats. |

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| **Customer Services Handbook**<br>***Supporting Documents:***<br>- *Policy 6.4 Guide to Services*<br>- *MDHHS Customer Service Standards* | LRE to publish and maintain Handbook in compliance with MDHHS requirements. | - Offer enrollees a printed copy of the Guide to Services.<br>- Publish the Guide to Services on Member's website. |
| **Enrollee Rights Notification**<br>***Supporting Documents:***<br>- *MDHHS Customer Service Standards*<br>- *LRE Policy 6.0 Customer Services,*<br>- *LRE Policy 6.1 and Procedure 6.1a Grievance and Appeals/Due Process* | | - Provide enrollees with current information regarding benefits, provider network, processes regarding access, service authorization, and grievance and appeal practices.<br>- Information Dissemination (Privacy Notices, benefit plan information). |
| **Published Provider Directory**<br>***Supporting Documents:***<br>- *LRE Policy 3.0 and Procedure 3.0a Information Systems*<br>- *Customer Services Standards*<br>- *Medicaid Care Regulations-2016 Final Rule Update* | LRE will publish and maintain Provider Directory which meets requirements outlined in 42 CFR 438.10. | - Submit provider data to the PIHP that includes complete and properly formatted data which meets all Provider Directory requirements.<br>- Offer a printed copy of the directory to enrollees upon request. |
| **AVAILABILITY OF SERVICES §438.206** | | |
| **ACTIVITY** | **LRE RESPONSIBILITY**<br>LRE to provide oversight and monitoring of Member activities and performance for all delegated Activities of Managed Care Functions | **MEMBER RESPONSIBILITY** |
| **Delivery Network**<br>***Source Documents:***<br>- *MDHHS Network Adequacy Standards*<br>- *MDHHS Access Systems Standards*<br>- *LRE Policy 4.7 Network Provider Dispute*<br>- *LRE Policy 4.2 Provider Network and Contract Management* | | - Ensure network of providers is sufficient in type and mix for enrollee service needs.<br>- Member maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract for all enrollees.<br>- Member gives 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.<br>- Member makes a good faith effort to give written notice of termination of a contracted provider to each enrollee 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 enrollee 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. (42 CFR §438.10(f)(1) |

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| | | - If Member's provider network is unable to provide necessary services covered under the contract for an enrollee, the Member must adequately and timely cover these services out of network for the enrollee, for as long as the Member's provider network is unable to provide them.<br>- Member must establish mechanisms to ensure compliance by Member and network providers and monitor network providers regularly to determine compliance. |
| **Timely Access**<br>***Source Documents:***<br>- *MDHHS Network Adequacy Standards* | | - Member and its network providers must ensure compliance with MDHHS Access System Standards for timely access to care and services, taking into account the urgency of the need for services.<br>- Member must offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid FFS.<br>- Member must ensure services included in the contract are available 24 hours a day, 7 days a week, when medically necessary. |
| **Access and Cultural Considerations**<br>***Source Documents:***<br>- *MDHHS Network Adequacy Standards*<br>- *MDHHS Access Systems Standards*<br>- *PIHP Customer Services Standards* | | - Member shall have written policies, procedures, and plans that demonstrate the capability of the Access System to meet the Standards.<br>- Member and its network providers must ensure compliance with MDHHS Access System Standards for timely access to care and services, taking into account the urgency of the need for services.<br>- Member and its Network Provider must deliver services in a culturally competent manner to all enrollees, 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.<br>- Member and Member's Provider Network will not exclude enrollees or treat them differently because of race, color, national origin, age, disability, or sex. |
| **Accessibility**<br>***Source Documents:***<br>- *MDHHS Access Systems Standards*<br>- *LRE Policy 13.10 Equity in Service Provision* | | Member and its network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities. |
| **ASSURANCES OF ADEQUATE CAPACITY AND SERVICES §438.207** | | |
| **ACTIVITY** | **LRE RESPONSIBILITY** | **MEMBER RESPONSIBILITY** |

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| | LRE to provide oversight and monitoring of Member activities and performance for all delegated Activities of Managed Care Functions | |
| **Provider Network Adequacy Reporting**<br><br>***Source Documents:***<br>- *42 CFR 438.68*<br>- *MDHHS Network Adequacy Standards* | LRE compiles required information submitted by Members and submits final report to MDHHS. | Member provides local data to the PIHP in the format specified by LRE to meet requirements for MDHHS Network Adequacy Standards. |
| **Demonstration of Adequate Capacity**<br><br>***Source Documents:***<br>- *42 CFR 438.68*<br>- *438.206(c)(1)*<br>- *MDHHS Network Adequacy Standards* | LRE gives assurances to MDHHS and provides supporting documentation that demonstrates capacity to serve the expected enrollment in its service area in accordance with MDHHS' standards for access to care under 42 438.207, including the standards at 438.68 and 438.206(c)(1). | - CMHSP must offer an appropriate range of services that is adequate for the anticipated number of enrollees in the service area.<br>- Member must maintain a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.<br>- Member must notify the LRE any time there has been a significant change (as defined by the State) in the operations that would affect the adequacy of capacity and services. |
| **COORDINATION AND CONTINUITY OF CARE §438.208** | | |
| **ACTIVITY** | **LRE RESPONSIBILITY**<br>LRE to provide oversight and monitoring of Member activities and performance for all delegated Activities of Managed Care Functions | **MEMBER RESPONSIBILITY** |
| **Coordination and Continuity of Care for Enrollees**<br><br>***Source Documents:***<br>- *LRE Policy 5.6 Care Coordination with Medicaid Health Plans*<br>- *LRE Procedure 5.6a Integrated Care Coordination Procedure* | | - For enrollees with special health care needs determined through an assessment to need a course of treatment or regular care monitoring, each CMHSP must have a mechanism in place to allow enrollees to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee's condition and identified needs.<br>- Member makes a best effort to conduct an initial health screening of each member's needs within 90 days of the effective date of enrollment for all new members.<br>- Member must ensure each member has an ongoing source of care appropriate to their needs and a person or entity formally responsible for coordinating the services furnished to the enrollee.<br>- Member will implement practices to encourage all beneficiaries eligible for specialty mental health services to include the results of any physical |

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| | | health care findings that relate to the delivery of specialty mental health services and supports in the person-centered plan. |
| **Care Coordination with Medicaid Health Plans (MHP) for Shared Care Planning**<br>***Source Documents:***<br>*LRE Policy 5.6 Integrated Care Coordination AND Procedure 5.6a Care Coordination with Medicaid Health Plans* | | Member must engage in care coordination with MHPs. |
| **HCBS Person-Centered Planning Process/Service Plan**<br>***Source Documents:***<br>- *MDHHS Person Centered Planning Guideline*<br>- *42 CFR 441.301*<br>- *42 CFR 441.503*<br>- *42 CFR 441.710* | | - Member must develop a treatment or service plan meeting the criteria in 42 CFR 438.208(c)(3)(i) through (v) for beneficiaries who require LTSS and must produce a treatment or service plan meeting the criteria in (c)(3)(iii-v) for beneficiaries with special health care needs that are determined through assessment to need a course of treatment or regular care monitoring.<br>- Member must ensure any modification of the conditions, under 42 CFR 441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan. |
| **Integrated Physical and Mental Health Care**<br>***Source Documents:***<br>*MDHHS Performance Based Incentive Program (PBIP)* | | - Member must develop service coordination agreements with pertinent public and private community-based organizations and providers to address issues related to shared consumer base. Agreements describe how disputes between agencies will be resolved.<br>- Member has procedures to ensure that services provided to the beneficiary are coordinated with the services the beneficiary receives from other MCOs and PIHPs.<br>- Member assures appropriate Follow-up After Hospitalization for Mental Illness (FUH)<br>- Member will implement practices to encourage all members 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.<br>- Implement practices to encourage all beneficiaries 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. |
| **Primary Care Coordination** | | - Member has policies and procedures to ensure coordination occurs between primary care physicians and Member and/or its network. |

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| | | - The CMHSP will initiate affirmative efforts to ensure the integration of primary and specialty behavioral health services for Medicaid members.<br>- The CMHSP will share with other providers servicing the enrollee with special health care needs the results of its identification and assessment of that enrollee's needs to prevent duplication of those activities. |
| **COVERAGE AND AUTHORIZATION OF SERVICES §438.210** | | |
| **ACTIVITY** | **LRE RESPONSIBILITY**<br>LRE to provide oversight and monitoring of Member activities and performance for all delegated Activities of Managed Care Functions | **MEMBER RESPONSIBILITY** |
| **Coverage**<br>***Supporting Documents:***<br>- *42 CFR 440.230*<br>- *42 CFR 441 Subpart B*<br>- *MDHHS Person Centered Planning Guideline*<br>- *LRE Utilization Management Plan*<br>- *LRE Policy 5.1 and Procedure 5.1a Person Centered Planning*<br>- *LRE Policy 5.15 Adoption of Clinical Practice Guidelines and Evidence Based Practices*<br>- *LRE Policy 6.0 Customer Services*<br>- *LRE Policy 5.0 and Procedure 5.0a Utilization Management, LRE Procedure 5.0b* Application of Milliman Care Guidelines | | - Member and Member's Network Providers, through the person-centered planning process, are required to ensure that services provided are medically necessary and delivered in the appropriate amount, scope, and duration to meet the individual's needs, and to achieve the purposes for which the services are furnished.<br>- Maintain a utilization management program which ensures appropriate delivery of medically necessary services in accordance with the Quality Assessment and Performance Improvement Programs for Specialty Prepaid Inpatient Health Plans.<br>- Authorize medically necessary supports and services.<br>- Have mechanisms to evaluate the effects of the UM program using data on beneficiary satisfaction, provider satisfaction, or other appropriate measures. |
| **Authorization of Services**<br>***Supporting Documents:***<br>- *42 CFR 438.404*<br>- *Appeal and Grievance Resolution Processes Technical Requirement*<br>- *LRE Policy 5.16 and Procedure 5.16a Service Authorization Extension Notification* | | - Ensure the utilization of Person Center Planning principles to determine the needs of individuals served.<br>- Ensure services are authorized based on Medical Necessity and are individualized for each person.<br>- Have mechanisms in effect to ensure consistent application of review criteria for authorization decisions.<br>- Mechanisms to identify and correct under-utilization as well as over utilization.<br>- Ensure compliance with Standard Authorization, Expedited Authorization, and Service Authorization Extension Notification requirements.<br>- Ensure compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for |

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| | | the individual or entity to deny, limit, or discontinue medically necessary services to any individual. |
| **Notice of Adverse Benefits Determination**<br>***Supporting Documents:***<br>- *42 CFR 438.404*<br>- *MDHHS Customer Service Standards*<br>- *MDHHS Appeal and Grievance Resolution Processes Technical Requirement*<br>- *LRE Policy 6.0 Customer Services*<br>- *LRE Policy 6.1 Grievance and Appeals/Due Process*<br>- *LRE Procedure 6.1a Grievance and Appeals Reporting* | | - Member must notify the requesting provider, and give the member written notice of any decision by the Member to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice must meet the requirements of 42 CFR 438.404 and the information requirements in 42 CFR 438.10.<br>- Ensure that information is provided to recipients regarding grievance and appeal processes, procedures, and time frames.<br>- Ensure providers under contract with Member receive grievance and appeal information at the time of entering a contract.<br>- Ensure recipients receive reasonable assistance in completing forms and navigating processes (including use of interpreter and TTY/TDD/TT) for grievances and appeals. |
| **PROVIDER SELECTION §438.214** | | |
| **ACTIVITY** | **LRE RESPONSIBILITY**<br>LRE to provide oversight and monitoring of Member activities and performance for all delegated Activities of Managed Care Functions | **MEMBER RESPONSIBILITY** |
| **Individual Practitioner Credentialing**<br>***Source Documents:***<br>- *MDHHS Policy Credentialing/re-credentialing Policy*<br>- *LRE Policy 4.4 Credentialing, Recredentialing* | | - Initial credentialing, temporary/provisional credentialing, and recredentialing of individual practitioners<br>- Have mechanisms in place for credentialing and recredentialing individual practitioners.<br>- Have mechanisms in place for ongoing monitoring, and intervention if appropriate, of individual practitioners as it relates to sanctions, complaints, and quality issues. |
| **Organizational Credentialing**<br>***Source Documents:***<br>- *MDHHS Policy Credentialing/re-credentialing Policy*<br>- *LRE Policy 4.4 Credentialing,* Recredentialing<br>- LRE Policy 4.7 and Procedure 4.7a Provider Dispute Resolution | - LRE must retain the right to approve, suspend, or terminate from participation in the provision of Medicaid funded services, a provider selected by that entity, and meet all requirements associated with the delegation of PIHP functions and is responsible for oversight regarding delegated credentialing or re- | |

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| | credentialing decisions. *42 CFR 438.214(e)*<br>- LRE retains responsibility for Organizational Credentialing in accordance with LRE and MDHHS Policy.<br>- Ensure that an individual credentialing, re-credentialing file is maintained for each credentialed provider in compliance with 42 CFR 438.214.<br>- Ensure an appeal process is available when credentialing or re-credentialing is denied, suspended, or terminated for any reason other than lack of need. | |
| **Excluded Providers**<br>***Source Documents:***<br>*LRE Policy 9.9 and Procedure 9.9a Excluded Providers* | - LRE to monitor organizational and disclosed staff exclusions.<br>- LRE will monitor provider disclosures activities. | - Member must have local policies to ensure Member and provider exclusion monitoring activities occur as required.<br>- Prior to employment, the agency/CMHSP verifies that the individual is not included in any excluded or sanctioned provider lists.<br>- At the time of enrollment and monthly thereafter, search the OIG exclusion database, the General Services Administration (GSA) and MDHHS to ensure individuals or entity have not been excluded from participating in federal health care programs.<br>- Member and Network Provider employment, consulting, or other agreements must contain language that require disclosure of any such convictions to agency.<br>- Have a policy and process to identify excluded individuals and notify the LRE when any disclosures are made by providers.<br>- Member may 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. |
| **GRIEVANCE AND APPEAL SYSTEMS §438.228** | | |
| **ACTIVITY** | **LRE RESPONSIBILITY**<br>LRE to provide oversight and monitoring of Member activities and performance for all delegated Activities of Managed Care Functions | **MEMBER RESPONSIBILITY** |

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| **Appeal Review and Processing**<br>***Supporting Documents:***<br>- *Policy 6.1 Grievance and Appeals/Due Process (with 6.1a Grievance and Appeals Reporting Procedure)*<br>- *MDHHS Grievance and Appeal Technical Requirement* | - The LRE is responsible for resolving appeals, and requests for Medicaid fair hearing.<br>- Annual audit and/or review of Appeals processes. | - Communicate requests for appeal and requests for fair hearing to the LRE.<br>- Compliance with grievance and appeal requirements, following policies and procedures for region. |
| **Grievance Review and Processing** | - Annual audit and/or review of Grievances processes.<br>- Accept, process, and resolve grievances in accordance with established Grievances and Appeals and Complaints processes. | Accept, process, and resolve grievances in accordance with established Grievances and Appeals and Complaints processes. |
| **Provide Appeal and Grievance Rights Information**<br>***Supporting Documents:***<br>- *Policy 6.1 Grievance and Appeals/Due Process (with 6.1a Grievance and Appeals Reporting Procedure)*<br>- *MDHHS Grievance and Appeal Technical Requirement* | | - Ensure that information is provided to recipients regarding grievance and appeal processes, procedures, and time frames.<br>- Ensure Network Providers receive grievance and appeal information at the time of entering a contract.<br>- Ensure recipients receive reasonable assistance in completing forms and navigating processes (including use of interpreter and TTY/TDD/TT) for grievances and appeals. |
| **Written Notice of Grievance Resolution**<br>***Supporting Documents:***<br>*MDHHS Grievance and Appeal Technical Requirement* | Facilitate resolution of local appeals and forward written disposition to the recipient, guardian and/or parent within 30 days. | Facilitate resolution of grievances and forward written disposition to the recipient, guardian and/or parent within 90 days. |
| **PRACTICE GUIDELINES §438.236** | | |
| **ACTIVITY** | **LRE RESPONSIBILITY**<br>LRE to provide oversight and monitoring of Member activities and performance for all delegated Activities of Managed Care Functions | **MEMBER RESPONSIBILITY** |
| **Adaption, Dissemination, and Application of Practice Guidelines**<br>***Source Documents:***<br>- *42 CFR 438.236*<br>- *MDHHS Practice Guidelines* | LRE will disseminate, review, and ensure adherence to regional adopted clinical practice guidelines that are based on valid and reliable clinical evidence and consider the needs of individuals served. | - Disseminates practice guidelines to all affected providers, individuals served and potential individuals served.<br>- Member must ensure, and ensure its Network Providers plan and deliver services in compliance with MDHHS Practice Guidelines. |

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| - *LRE Policy 5.15 Adoption of Clinical Practice Guidelines and Evidence Based Practices* | | |
| **HEALTH INFORMATION SYSTEMS §438.242** | | |
| **ACTIVITY** | **LRE RESPONSIBILITY**<br>LRE to provide oversight and monitoring of Member activities and performance for all delegated Activities of Managed Care Functions | **MEMBER RESPONSIBILITY** |
| **Basic Elements of a Health Information System** | LRE must comply with 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 | Collect and submit to LRE 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 method as may be specified by MDHHS. |
| **Data Submission** | LRE to provide 834 files to Member. | - Submits 837/Encounter Data to LRE monthly.<br>- Conduct dynamic eligibility checks directly into MDHHS system on a per client basis on first entry to care or as needed.<br>- 837/Encounter Data Error Resolution.<br>- The CMHSP submits refreshed Consumer List data to LRE on a regular basis, weekly at minimum.<br>- Submit BH-TEDS and QI files to LRE monthly.<br>- Participate in Health Information Exchanges (HIE) within the region as allowed by state and federal laws and regulations.<br>- The CMHSP has mechanisms in place to verify the validity and reliability of data submissions transmitted to LRE. |
| **QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM (QAPIP) §438.330** | | |
| **ACTIVITY** | **LRE RESPONSIBILITY**<br>LRE to provide oversight and monitoring of Member activities and performance for all delegated Activities of Managed Care Functions | **MEMBER RESPONSIBILITY** |
| **Development of QAPIPs**<br>***Supporting Documents:***<br>*MDHHS QAPIP for Specialty PIHPs Technical Requirement* | Establishment and implementation of an ongoing comprehensive quality assessment and performance improvement program (QAPIP) for | - Member shall fully cooperate with LRE's QAPIP and reporting requirements |

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| | service delivery in compliance with MDHHS QAPIP for Specialty PIHPs Technical Requirement. | |
| **Sentinel Events and Critical Incident Reporting**<br>***Supporting Documents:***<br>*LRE Policy 7.3 Critical Incident, Risk Event and Sentinel Event Reporting* | - LRE aggregates, analyzes, and submits Critical Incident and Risk Event data in accordance with MDHHS Requirements. | - Member will review and report critical incidents and risk events in accordance with policy and reporting requirements.<br>- Member will review Sentinel Events and Unexpected Deaths submit the Sentinel Event/Unexpected Death Form and any other supporting documentation the CMHSP deems necessary to give LRE an understanding of the Root Cause Analysis efforts to determine causality, if it exists. |
| **Behavior Treatment Review**<br>***Supporting Documents:***<br>- *LRE Policy 7.10 Behavior Treatment Review Committee*<br>- *MDHHS Behavior Treatment Plan Review Committees Technical Requirement*<br>- *MDHHS QAPIP for Specialty PIHPs Technical Requirement* | LRE aggregates, analyzes, and submits Behavior Treatment Review/HAB Waiver data in accordance with MDHHS Requirements. | Member must submit Behavior Treatment/HAB Waiver data as required. |
| **Assessment of Member Experience**<br>***Supporting Documents:***<br>*LRE Policy 6.11 and Procedure 6.11a Customer Satisfaction Survey* | - Create and maintain a Customer Services Satisfaction Survey in accordance with LRE Policy.<br>- Provide oversight, training, and assistance to both the CMHSP and Contracted Provider Staff regarding the survey as needed.<br>- Compile satisfaction survey data annually.<br>- Identify any areas of dissatisfaction and notify the CMHSP when an improvement plan is required.<br>- Document and monitor improvement plans. | - Coordinate local efforts with the LRE to complete all required MDHHS satisfaction surveys.<br>- Distribute satisfaction surveys and provide resulting data to LRE in accordance with LRE Policy and Procedure. |
| **PROGRAM INTEGRITY ACTIVITIES §438.608** | | |
| **ACTIVITY** | **LRE RESPONSIBILITY**<br>LRE to provide oversight and monitoring of Member activities and performance for all delegated Activities of Managed Care Functions | **MEMBER RESPONSIBILITY** |

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| **Compliance Investigations** | - Completion of PIHP level compliance inquiries for complaints reported directly to the PIHP.<br>- Completion of Preliminary Investigations for complaints reported directly to the PIHP or as a result of an Office of Inspector General referral.<br>- Completion of Full Investigations for as a result of an Office of Inspector General referral. | - Completion of CMHSP level compliance inquiries for complaints reported directly to the CMHSP.<br>- If the CMHSP determines its compliance inquiry results in a belief that Fraud, Waste, or Abuse exists, CMHSP must complete the LRE Fraud Waste & Abuse Referral form and submit to the PIHP Compliance Officer, or designee. |
| **OIG Activity Report** | Submission of quarterly Office of Inspector General activity report to the Office of Inspector General by the PIHP. | Submission of quarterly Office of Inspector General activity report to the PIHP. |
| **OIG Annual Reports** | Completion and submission of required annual reports to the OIG. | Submission of data to complete required annual reports to the OIG. |

# Combined CMHSP Feedback Grid

*Revised 9/1 based on most recent concerns/feedback from Network180.*

| Section | Brief Overview of Change | Change Rationale | Status | N180 Concern/Proposed Language (8/31) | LRE Response (8/31) |
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| Schedule A, Section E.20: Network Adequacy Standards | Adds language stating that failure to maintain network adequacy or timely access standards may result in amendment of delegated managed care function activities to maintain MDHHS compliance. | MDHHS holds LRE accountable for regional network adequacy and timely access standards, including potential remedial action or sanctions under General Requirements F.3.(a)(b). | Resolved | •Revised language is overly broad. It does not define situations where modification may be made, i.e. how will network adequacy standards be used to determine when/if modification meets the standard for "compliance" with any contract or regulation.<br>•MDHHS network adequacy standards are insufficiently defined to serve as the sole basis for modifying delegated functions.<br>•Delegated functions can still be modified without written agreement from CMHSPs.<br>•Language bypasses CMHSPs' dispute resolution process defined in the Regional Operating Agreement. | Language Removed. |
| Schedule I: Delegation of Managed Care Function Activities | Clarifies that managed care function activities may be delegated by LRE to CMHSPs and adds language allowing LRE to amend Schedule I by written Change Notice when necessary to maintain compliance with MDHHS contract requirements, law, regulation, policy, technical requirements, reporting requirements, or other MDHHS directives. | LRE retains ultimate responsibility to MDHHS for delegated managed care functions and needs ability to make targeted Schedule I updates without reopening the full agreement. | Resolved | •Grants overly broad power to modify agreement through Change Notice<br>•Delegation changes fundamentally change the nature of service delivery and are material contract changes that require written agreement by all parties.<br>•By passes procedures for dispute resolution, as defined in Regional Operating Agreement. | Language Removed. |
| Standard Contract Terms, 19. Unfair Labor Practice | Language removed | Remove language that imposes an absolute prohibition on Member contracting with entities appearing on the Unfair Labor Practice register. The MDHHS/PIHP Master Contract does not establish a corresponding prohibition on LRE or its subcontractors; rather, it identifies the State's statutory authority under MCL 423.324 to void a contract with a contractor or subcontractor appearing on the register. The existing LRE/CMHSP language therefore expands the underlying requirement beyond its intended scope. LRE will separately review and address appropriate monitoring and compliance processes through LRE | | | |
| Schedule A, Section D: Contract Remedies and Sanctions | Clarifies LRE's ability to pursue remedial actions and sanctions consistent with Section 330.1232b of the Michigan Mental Health Code, generally using a progressive approach while preserving flexibility for serious or repeated concerns. | Aligns with FY26 MDHHS/LRE Master Agreement General Requirements E.1-6 and supports LRE's ability to address contract concerns while maintaining dispute resolution. | Resolved | | |
| Schedule A, Section G: Behavioral/Physical Health Integration | Adds a requirement that CMHSPs use CareConnect360 for shared care planning and care management documentation as required by MDHHS and LRE. | Aligns with MDHHS expectations for behavioral and physical health integration, care coordination, and documentation under General Requirements I.3. | Resolved | | |
| Schedule A, Section I.9.f: ASAM Level of Care for Network Providers | Updates SUD network language to reference current ASAM Level of Care criteria and removes the static ASAM LOC table. | Reduces the risk that the agreement becomes outdated as ASAM terminology, levels, or approval processes change. | Resolved | | |
| Schedule A, HIPAA and 42 CFR Part 2 | Clarifies that CMHSPs must report suspected or confirmed unauthorized use or disclosure of protected health data to LRE immediately upon awareness or when the CMHSP should have known through reasonable diligence. Also clarifies mitigation and corrective action assurance expectations. | Strengthens privacy and security reporting expectations and supports LRE oversight responsibilities for HIPAA, 42 CFR Part 2, breach response, and corrective action monitoring. The change is also required due to HSAG Compliance Review findings. | Resolved | | |
| Schedule E: Member Reporting Requirements | Clarifies that CMHSPs must submit reports accurately and timely and that failure to do so constitutes a material breach. | Aligns the PIHP/CMHSP Agreement with MDHHS reporting standards and the MDHHS/LRE Master Agreement. Schedule E reporting dates will be updated for FY27 before routing agreements for signature. | Resolved | | |
| Schedule G: Local Funding Obligation Schedule | Schedule G remains fiscal-year-specific and will be updated once FY27 local funding obligation information is finalized. | Annual fiscal update rather than a substantive boilerplate change. Schedule must reflect the applicable MDHHS local funding obligation for the contract year. | Resolved | | |
| Schedule I: Enrollee Rights and Enrollee Information | Adds language requiring critical written materials to include information about requesting auxiliary aids and services and the toll-free and TTY/TDD number for the PIHP and/or CMHSP customer service unit. | Aligns delegated responsibilities with MDHHS Customer Service Standards and federal managed care requirements for accessibility, alternative formats, and enrollee information. | Resolved | | |

| Section | N180 Proposed Language | LRE response | N180 Analysis |
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| Schedule A, Section E.20: Network Adequacy Standards | Identify the trigger, advance notice to CMHSP, opportunity for CMHSP to cure the issue, and revenue consequence of losing the delegated function.<br><br>Remove clause or change to, "In compliance with MDHHS Master Contract, failure to maintain network adequacy or timely access standards may result in LRE requiring remedial or corrective action in accordance with the processes described herein." | LRE appreciates Network180's feedback and agrees that any identified network adequacy or timely access concern should be addressed through a thoughtful and collaborative process. Every identified network adequacy or timely access deficiency would be addressed consistent with LRE Policy 4.9 and 4.9a, including applicable review, monitoring, technical assistance, and corrective action processes.<br><br>Procedural language will be reviewed to ensure consistency with the contract, applicable regulations, and LRE policy. | Language changed to: b.c. Failure to maintain network adequacy or timely access standards may result in an amendment to delegated managed care function activities to ensure compliance [PG2.1] with MDHHS Master Contract requirements.<br><br>Amendment language allows LRE to make changes to meet legal requirements. N180 believes LRE could unilaterally change the contract. "to comply with the contract," i.e. meaning LRE could legally change the contract without mutual agreement. |

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| | | At the same time, LRE remains accountable to MDHHS for regional network adequacy and timely access standards and must retain the ability to take targeted action when a deficiency places regional compliance at risk. Any financial or delegation-related impact would be evaluated based on the specific circumstances and handled consistent with the agreement and applicable requirements. | |
| Schedule I: Delegation of Managed Care Function Activities | Any changes to this schedule MUST follow contract modification procedures already described, and include full appeal and dispute rights before any change is made effective.<br><br>Need clarity on intent of this | LRE understands the concern. The proposed language is not intended to broadly or arbitrarily change the managed care functions delegated to Network180. The intent is to allow targeted updates to Schedule I when necessary to maintain compliance with | LRE changed the language to: "Notwithstanding any other provision of this Agreement, LRE may amend this **Schedule I** by written Change Notice to Member when LRE determines that such amendment is necessary to maintain |

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| | addition and what LRE expects.<br><br>As drafted, this removes N180's negotiated say over which managed care functions are delegated to it vs. retained by LRE; it becomes an LRE-driven notice process rather than a mutual amendment. | MDHHS contract requirements, federal or state law, regulation, policy, technical requirements, reporting requirements, or other MDHHS directives.<br><br>LRE will provide written notice to affected CMHSPs and, when practicable, an opportunity for discussion before implementation. However, LRE retains ultimate accountability to MDHHS for delegated managed care functions and must preserve the ability to make required compliance updates without reopening the full agreement.<br><br>LRE is not in a position to accept language requiring | compliance with LRE's contract with MDHHS, applicable federal or state law, regulation, policy, technical requirement, reporting requirement, or other MDHHS directive. Any Change Notice shall identify the required amendment, the basis for the amendment, and the effective date. Member shall comply with the amended Schedule I as of the effective date stated in the Change Notice.<br><br>LRE shall not modify delegated managed care functions arbitrarily and will provide written notice and, when practicable, opportunity for discussion." |

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| | | all changes to Schedule I to follow the full contract modification process or be subject to appeal/dispute rights before becoming effective, as some changes may be required by MDHHS or may be time-sensitive. | Still allows LRE to change delegation with written notice, outside of existing amendment or dispute procedures. |