STATE OF MICHIGAN PROCUREMENT

Department of Health and Human Services
235 South Grand Avenue, Lansing, MI 48913
P.O. Box 30037, Lansing, MI 48909

CONTRACT CHANGE NOTICE

Change Notice Number **02**
to
Contract Number **MA 200000002098**

CONTRACTOR	
	Mid-State Health Network
	530 West Ionia Street, Suite F
	Lansing, MI 48933
	Joseph Sedlock
	517-253-7525
	Joseph.sedlock@midstatehealthnetwork.org
	CV0054910

STATE			
	Program Manager	Jeff Wieferich	MDHHS
		517-335-0499	
		wieferichj@michigan.gov	
	Contract Administrator	Lance Kingsbury	MDHHS
		517-335-8170	
		kingsburyl@michigan.gov	

CONTRACT SUMMARY			
DESCRIPTION: Prepaid Inpatient Health Plan (PIHP)			
INITIAL EFFECTIVE DATE	**INITIAL EXPIRATION DATE**	**INITIAL AVAILABLE OPTIONS**	**EXPIRATION DATE BEFORE CHANGE(S) NOTED BELOW**
October 1, 2020	September 30, 2021	Seven, one-year	September 30, 2021
PAYMENT TERMS		**DELIVERY TIMEFRAME**	
Net 45		As Needed	
ALTERNATE PAYMENT OPTIONS			**EXTENDED PURCHASING**
☐ P-card ☐ Payment Request (PRC) ☐ Other			☐ Yes ☒ No
MINIMUM DELIVERY REQUIREMENTS			
N/A			

DESCRIPTION OF CHANGE NOTICE				
OPTION	**LENGTH OF OPTION**	**EXTENSION**	**LENGTH OF EXTENSION**	**REVISED EXP. DATE**
☐		☐		
CURRENT VALUE	**VALUE OF CHANGE NOTICE**	**ESTIMATED AGGREGATE CONTRACT VALUE**		
$580,891,282.00	$0.00	$580,891,282.00		

DESCRIPTION: Effective upon MDHHS signature, this amendment replaces or adds the following Sections in the contract.

FOR THE CONTRACTOR:

Mid-State Health Network
Company Name

E-SIGNED by Joseph Sedlock
on 2021-07-20 12:25:00 EDT
Authorized Agent Signature

Joseph Sedlock
Authorized Agent (Print or Type)

2021-07-20 12:25:00 UTC
Date

FOR THE STATE:

E-SIGNED by Christine H. Sanches
on 2021-07-20 14:24:43 EDT
Signature

Christine H. Sanches, Director
Name & Title

Michigan Department of Health and Human Services; Bureau of Grants and Purchasing
Agency

2021-07-20 14:24:43 UTC
Date

1. Standard Contract Terms
   Section 23. Termination for Cause, the following statement is hereby added:
   If the State takes action to cancel the Contract under the provisions of MCL 330.1232b, the State will follow the applicable notice and hearing requirement described in MCL 330.1232b(6).

2. Standard Contract Terms
   Section 24. Termination for Convenience, the following statement is hereby added:
   If the State takes action to cancel the Contract under the provisions of MCL 330.1232b, the State will follow the applicable notice and hearing requirement described in MCL 330.1232b(6).

3. Standard Contract Terms
   Section 36. Records Maintenance, Inspection, Examination, and Audit is hereby deleted and replaced in its entirety with the following:
   The State or its designee may audit Contractor to verify compliance with this Contract. Contractor must retain and provide to the State or its designee and the auditor general upon request, all financial and accounting records related to the Contract through the term of the Contract and for ten years after the latter of termination, expiration, or final payment under this Contract or any extension ("Audit Period"). If an audit, litigation, or other action involving the records is initiated before the end of the Audit Period, Contractor must retain the records until all issues are resolved.

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

   If any financial errors are revealed, the amount in error must be reflected as a credit or debit on subsequent invoices until the amount is paid or refunded. Any remaining balance at the end of the Contract must be paid or refunded within 45 calendar days.

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

4. Schedule A, Statement of Work
   Section 1. General Requirements, A. Service Area, 2. Target Population, a. is hereby deleted and replaced in its entirety with the following:
   a. The Contractor must serve Medicaid beneficiaries in the service area described in 1.A.1 above who require the Medicaid services included under: the 1115 Behavioral Health Demonstration Waiver; who are eligible for the Healthy Michigan Plan, the 1915(i) State Plan Benefit the Flint 1115 Waiver or Community Block Grant, who are enrolled in the 1915(c) HSW, one of the three 1915(c) waivers (HSW, CWP, SED); who are enrolled in the MIChild program; who are enrolled in the Maternity Outpatient Medical Services (MOMS) program; or for whom the Contractor has assumed or been assigned County of Financial Responsibility (COFR) status under Chapter 3 of the Mental Health Code.

5. Schedule A, Statement of Work
   Section 1. General Requirements, B. Customer Services Standards, 4. Customer Services Handbook Requirements, is hereby deleted and replaced in its entirety with the following:
   4. Customer Services Handbook Requirements
      The Contractor must comply with 42 CFR 438.10, including the following:
      a. Include the date of publication and version number in each Customer Services Handbook.
      b. Provide a current version of the Customer Services Handbook to the beneficiary upon first request of service and annually thereafter, or sooner if substantial revisions have been made.
      c. To the extent possible, provide each beneficiary with at least 30 days' notice before the

intended effective date of any change that the State defines as significant in the information specified in 42 CFR 438.10(g)(2). Significant is defined as any change that affects a beneficiary's Medicaid benefits, including but not limited to: Contractor contract information, authorization for services, covered benefits and co-pays.

d. The topics with asterisks (*) below must use the standard language templates (which can be found on the https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4868_44561---,00.html).
e. Ensure all information contained in the Customer Services Handbook is easily understood.
f. The information must be available in the prevalent non-English language(s) spoken in the Contractor's service area.
g. Obtain State approval, in writing, prior to publishing original and revised editions of the Customer Services Handbook.
h. Produce supplemental materials to the Customer Services Handbook, as needed, to ensure compliance with Contractual Requirements (e.g. inserts/stickers).
i. Use the State's description for each Medicaid covered service.
j. Include the following contact information for Medicaid Health Plans or Medicaid fee-for-service programs:
    i. Plan/program name
    ii. locations
    iii. telephone numbers
k. Include the following topics in the Customer Services Handbook:
    i. Topics Requiring use of MDHHS Template Language (which can be found on the https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4868_44561---,00.html):
        1. *Template #1: Confidentiality and Family Access to Information
        2. *Template #2: Coordination of Care
        3. *Template #3: Emergency and After-Hours Access to Services
        4. *Template #4: Definition of Terms
        5. *Template #5: Grievance and Appeals Process
        6. *Template #6: Accessibility and Accommodations
        7. *Template #7: Payment for Services
        8. *Template #8: Person-Centered Planning
        9. *Template #9: Recipient Rights
        10. *Template #10: Recovery and Resiliency
        11. *Template #11: Service Array
        12. *Template #12: Service Authorization
        13. *Template #13: Tag Lines
        14. *Template #14: Fraud, Waste and Abuse
    ii. Other Required Topics (not necessarily in this order)
        1. Benefits Provided by the Contractor
        2. How and where to access any benefits provided
        3. Access to out-of-network services
        4. Affiliate the names, addresses and phone numbers of the following personnel:
            a. Executive director
            b. Medical director
            c. Recipient rights officer
            d. Customer services
            e. Emergency
        5. Community resource list (and advocacy organizations) Index
        6. Right to information about Contractor operations (e.g., organizational chart, annual report) Services not covered under contract
        7. Welcome to PIHP
        8. What are customer services and what it can do for the individual; hours of operation and process for obtaining customer assistance after hours?
    iii. Other Suggested Topics
        1. Customer services phone number in the footer of each page
        2. Safety information
        3. Web Address

6. Schedule A, Statement of Work
   Section C. Payment Reform, 3. Responsibility for Payment of Authorized Services, letter f is hereby deleted and replaced in its entirety with the following:
   f. In accordance with 42 CFR 438.114(c)(1)(ii)(B), the Contractor is prohibited from denying payment for treatment obtained by a beneficiary when a representative of the Contractor instructs the beneficiary to seek emergency services. The attending emergency physician, or the provider actually treating the beneficiary, is responsible for determining when the beneficiary is sufficiently stabilized for transfer or discharge in accordance with 42 CFR 438.114(d)(3).

7. Schedule A, Statement of Work
   Section C. Payment Reform, 5. Liability for Payment is hereby added:
   5. Liability for Payment
      a. The Contractor must provide that its Medicaid beneficiaries are not held liable for Covered services provided to the beneficiary, for which the State does not pay the Contractor, or the Contractor does not pay the individual or health care provider that furnished the services under a contractual, referral, or other arrangement.

8. Schedule A, Statement of Work
   Section E. Access and Availability, 2. Network Requirements, letter e is hereby added:
   e. In accordance with 42 CFR 438.14, the Contractor must demonstrate that there are sufficient Indian Health Care Providers (IHCP) participating in the provider network to ensure timely access to services available under the Contract from such providers for Indian beneficiaries who are eligible to receive services.
      i. If timely access to covered services cannot be ensured due to few or no IHCPs, the Contractor must:
         1. Allow Indian beneficiaries to access out-of-State IHCPs; or
         2. Show good cause for disenrollment from both the Contractor and the State's managed care program in accordance with 42 CFR § 438.56(c).
      ii. The Contractor must permit Indian beneficiaries to obtain services covered under the Contract from out-of-network IHCPs from whom the beneficiary is otherwise eligible to receive such services.
      iii. The Contractor must permit an out-of-network IHCP to refer an Indian beneficiary to a network provider.

9. Schedule A, Statement of Work
   Section E. Access and Availability, 14. Recovery Policy, the website is hereby deleted and replaced with the following:
   https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4871_45835_48569-133156--,00.html

10. Schedule A, Statement of Work
    Section E. Access and Availability, 18. Indian Health Service/Tribally Operated Facility or program/Urban Indian Clinic (I/T/U), letter b is hereby added:
    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 the Contractor, it has the right to receive its applicable encounter rate published annually in the Federal Register by the Indian Health Service, or in the absence of a published encounter rate, the amount it would receive if the services were provided under the state plan's FFS payment methodology.

11. Schedule A, Statement of Work
    Section E. Access and Availability, 19. Persons Associated with the Corrections System, letter a. is hereby deleted and replaced in its entirety with the following:
    a. Under an arrangement between the Michigan Department of Corrections (MDOC) and the Michigan Department of Health and Human Services (MDHHS), the PIHP must be responsible for medically necessary community-based substance use disorder treatment services for individuals under the supervision of the Michigan Department of Corrections once those individuals are no longer incarcerated. These individuals are typically under parole or probation orders. Individuals referred by court and services through local community corrections (PA 511) systems must not be excluded from these Medicaid/Healthy

Michigan program funded medically necessary community-based substance use disorder treatment services.

12. Schedule A, Statement of Work
    Section E. Access and Availability, 22. Transition of Care is hereby added:
    22. Transition of Care
        Contractor must develop and implement a transition of care policy consistent with 42 CFR 438.62 and the MDHHS transition of care policy to ensure continuity of care for its beneficiaries.
        a. The Contractor's transition of care policy must ensure continued access to services during a transition from FFS to a managed care entity, or transition from one managed care entity to another when a beneficiary, in the absence of continued services, would suffer serious detriment to their health or be at risk of hospitalization or institutionalism.
        b. The transition of care policy must include at a minimum:
            i. Transitioning Beneficiaries have access to services consistent with the access they previously had.
            ii. Transitioning Beneficiaries must be permitted to retain their current provider for the time period required in MDHHS' transition of care policy, if that provider is not in the Contractor's network.
            iii. Transitioning Beneficiaries are referred to appropriate providers within the Contractor's network.
            iv. The Contractor, if previously serving a beneficiary must fully and timely comply with requests for historical utilization, data from the beneficiary's new contractor or MDHHS.
        c. The Contractor must include instructions to beneficiaries and potential beneficiaries on how to access continued services upon transition.

13. Schedule A, Statement of Work
    Section E. Access and Availability, 23. Provider Network Stability Plan is hereby added:
    The Contractor must maintain the Provider Network Stability Plan that outlines the actions taken to sustain and provide financial or operational support for their entire provider network during the COVID-19 pandemic response period. A status update on the plan must be submitted to the State at the end of each month through FY2021.

14. Schedule A, Statement of Work
    Section F. Covered Services, 7. Institution for Mental Disease (IMD) Services is hereby deleted and replaced in its entirety with the following:
    7. Institution for Mental Disease (IMD) Services
        a. The Contractor is responsible for providing the covered services in an IMD up to 15 days per month per individual if the following conditions are met:
            i. The IMD stay is a medically appropriate substitute for the covered setting under the State plan
            ii. The IMD stay is a cost-effective substitute for the setting under the State plan
            iii. The beneficiary is not required to use the alternative setting

15. Schedule A, Statement of Work
    Section F. Covered Services, 12. Long-Term Support Services is hereby added:
    12. 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. The Contractor must establish and maintain a member advisory committee. The member advisory committee must include a reasonably representative sample of the LTSS population, or other individuals representing those beneficiaries, covered under this Contract.

16. Schedule A, Statement of Work
    Section F. Covered Services, 13. Maternity Outpatient Medical Services (MOMS) is hereby added:
    13. Maternity Outpatient Medical Services (MOMS)
        a. The Contractor must provide medically necessary defined mental health benefits to women enrolled in the MOMS program.

17. Schedule A, Statement of Work
    Section H. Behavioral/Physical Health Integration, 3. Primary Care Coordination, letter b is hereby added:
    b. The Contractor must coordinate the services furnished to the beneficiary with the services beneficiary receives with Fee For Service (FFS) Medicaid.

18. Schedule A, Statement of Work
    Section J. Parity and Benefits, 1., is hereby deleted and replaced in its entirety with the following:
    The Contractor must ensure compliance with 42 CFR part 438, subpart K, Parity in Mental Health and Substance Use Disorder Benefits. The Contractor must comply with all applicable federal regulations, including the information requirements in the parity regulations, specifically 42 CFR 438.915 Availability of Information. The State will work with the Contractor to ensure the necessary changes to achieve full compliance are successfully implemented. The State will analyze parity compliance as part of routine monitoring of the Contractor.

19. Schedule A, Statement of Work
    Section K. Quality Improvement and Program Development, 2. Quality Assessment/Performance Improvement Program (QAPIP) and Standards, b. External Quality Review, i. is hereby deleted and replaced in its entirety with the following and ii is hereby added:
    i. The State will arrange for an annual, external independent review of the quality and outcomes, timeliness of, and access to covered services provided by the Contractor. The Contractor must address the findings of the external review through its QAPIP. The Contractor must develop and implement performance improvement goals, objectives and activities in response to the external review findings as part of the Contractor's QAPIP. A description of the performance improvement goals, objectives and activities developed and implemented in response to the external review findings will be included in the Contractor's QAPIP and provided to the State, annually, by February 28. The State may also require separate submission of an improvement plan specific to the findings of the external review.
    ii. If the Contractor has received accreditation by a private independent accrediting entity, it must authorize the private independent accrediting entity to provide the State a copy of its most recent accreditation review, including its accreditation status, survey type, and level (as applicable). When the Contractor has received accreditation by a private independent accrediting entity, it must authorize the private independent accrediting entity to provide the State a copy of its most recent accreditation review, recommended actions or improvements, corrective action plans, and summaries of findings. If the Contractor has received accreditation by a private independent accrediting entity, it must authorize the private independent accrediting entity to provide the State a copy of its most recent accreditation review, including the expiration date of the accreditation.

20. Schedule A, Statement of Work
    Section K. Quality Improvement and Program Development, 2. Quality Assessment/Performance Improvement Program (QAPIP) and Standards, letter c. LTSS Assessment is hereby added:
    c. LTSS Assessment
    The comprehensive QAPIP program must include mechanisms to assess the quality and appropriateness of care furnished to beneficiaries using LTSS, including an assessment of care between care settings and a comparison of services and supports received with those set forth in the beneficiary's treatment/service plan. The Contractor is required to implement mechanisms to comprehensively assess each Medicaid beneficiary identified as needing LTSS to identify any ongoing special conditions of the beneficiary that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate providers or individuals meeting LTSS service coordination requirements of the State or the Contractor as appropriate.

21. Schedule A, Statement of Work
    Section K. Quality Improvement and Program Development, 3. Annual Effectiveness Review, a. is hereby deleted and replaced in its entirety with the following:
    a. The Contractor must annually conduct an effectiveness review of its QAPIP. The effectiveness review must include analysis of whether there have been improvements in the quality of health care and services for beneficiary as a result of quality assessment and

improvement activities and interventions carried out by the Contractor. The analysis should take into consideration trends in service delivery and health outcomes over time and include monitoring of progress on performance goals and objectives. Information on the effectiveness of the Contractor's QAPIP must be provided annually to network providers and to recipients upon request. Information on the effectiveness of the Contractor's QAPIP must be provided to the State annually, no later than February 28.

22. Schedule A, Statement of Work
Section K. Quality Improvement and Program Development, 5. Other Quality Requirements is here be deleted and replaced in its entirety with the following:
    a. The Contractor must disseminate all practice guidelines it uses to all affected providers and, upon request, to beneficiaries. The Contractor must ensure decisions for utilization management, beneficiary education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. The Contractor must assure services are planned and delivered in a manner that reflects the values and expectations contained in the following guidelines:
        i. Inclusion Practice Guideline (which can be found on the MDHHS website: https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4868_4900---,00.html)
        ii. Housing Practice Guideline (which can be found on the MDHHS website: https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4868_4900---,00.html)
        iii. Consumerism Practice Guideline (which can be found on the MDHHS website: https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4868_4900---,00.html)
        iv. Personal Care in Non-Specialized Residential Settings (which can be found on the MDHHS website: https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4868_4900---,00.html)
        v. Family-Driven and Youth-Guided Policy and Practice Guideline (which can be found on the MDHHS website: https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4868_4900---,00.html)
        vi. Employment Works! Policy (which can be found on the MDHHS website: https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4868_4900---,00.html)

23. Schedule A, Statement of Work
Section L. Grievance and Appeals Process for Beneficiaries, 1. Grievance and Appeals Policies and Procedures is hereby deleted and replaced in its entirety with the following:
    1. Grievance and Appeals Policies and Procedures
        a. The Contractor must adhere to the requirements stated in the MDHHS Appeal and Resolution Grievance Processes Appeal Technical Requirement, which can be found at: https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4868_4900---,00.html.
        b. The Contractor must comply with 42 CFR 438.100, Enrollee Rights.
        c. Contractor must establish and maintain an internal process for the resolution of Grievances and Appeals from beneficiaries.
        d. Contractor must have written policies and procedures governing the resolution of Grievances and Appeals; A beneficiary, or a third party acting on behalf of a beneficiary, may file a Grievance or Appeal, orally or in writing, on any aspect of Covered services as specified in the definitions of Grievance and Appeal. Unless a beneficiary requests an expedited resolution, an oral appeal must be followed by a written, signed appeal.
        e. Contractor must seek the State’s approval of Contractor’s Grievance and Appeal policies prior to implementation. These written policies and procedures must meet the following requirements:
            i. Except as specifically exempted in this Section, the Contractor must administer an internal Grievance and Appeal procedure according to the requirements of MCL 500.2213 and 42 CFR 438.400 – 438.424 (Subpart F).
            ii. Contractor must cooperate with the Michigan Department of Insurance and Financial Services (DIFS) in the implementation of MCL 550.1901-1929, “Patient’s Rights to Independent Review Act”.
            iii. Contractor must have only one level of Appeal for beneficiaries. A beneficiary may file a Grievance and request an Appeal with the Contractor.
            iv. Contractor must make a determination on non-expedited Appeals not later than 30 Days after an Appeal is submitted in writing by the beneficiary. The 30 Day period

may be tolled; however, for any period of time the beneficiary is permitted to take under the Medicaid Appeals procedure and for a period of time that must not exceed 14 Days if (1) the beneficiary requests the extension or (2) The Contractor shows that there is need for additional information and how the delay is in the beneficiary's interest. The Contractor may not toll (suspend) the time frame for Appeal decisions other than as described in this Section.

v. Contractor must make a determination on Grievances within 90 Days of the submission of a Grievance.
vi. If Contractor extends the timeframes not at the request of the beneficiary, it must:
    1. Make reasonable efforts to give the beneficiary prompt oral notice of the delay.
    2. Within two Days, provide the beneficiary written notice of the reason for the decision to extend the timeframe and inform the beneficiary of the right to file an Appeal if he or she disagrees with that decision.
    3. Resolve the Appeal as expeditiously as the beneficiary's health condition requires and not later than the date the extension expires.
vii. If an Appeal is submitted by a third party, but does not include a signed document authorizing the third party to act as an authorized representative for the Beneficiary, the 30 Day time frame begins on the date an authorized representative document is received by the Contractor. The Contractor must notify the Beneficiary that an authorized representative form or document is required. For purposes of this Section, "third party" includes, but is not limited to, health care Providers.
viii. Contractor must provide written notice of resolution in a format and language that, at a minimum, meets the standard described in accordance with 42 CFR 438.10.
ix. The Contractor may extend the timeframe for processing a grievance by up to 14 calendar days if:
    1. The beneficiary requests the extension
    2. The Contractor shows there is need for additional information and that the delay is in the beneficiary's interest (upon the State's request).

24. Schedule A, Statement of Work
Section L. Grievance and Appeals Process for Beneficiaries, 5. Contractor Decisions Subject to Appeal, is hereby deleted and replaced in its entirety with the following (updated lettering):
    5. Contractor Decisions Subject to Appeal
        a. When the Contractor makes a decision subject to Appeal, as defined in this Contract, the Contractor must provide a written Adverse Benefit determination notice to the beneficiary and the requesting Provider, if applicable. The Contractor must mail the notice within the following timeframes:
        b. For termination, suspension, or reduction of previously authorized Medicaid- Services, within the timeframes specified in 42 CFR §§ 431.211,431.213, and 431.214.
        c. For denial of payment, at the time of any action affecting the claim.
        d. For standard service authorization decisions that deny or limit services, within the timeframe specified in§ 438.210(d)(1).
        e. If the Contractor meets the criteria set forth for extending the timeframe for standard service authorization decisions consistent with§ 438.210(d)(1)(ii), the Contractor must:
            i. Give the beneficiary written notice of the reason for the decision to extend the timeframe and inform the beneficiary of the right to file a Grievance if he or she disagrees with that decision; and
            ii. Issue and carry out its determination as expeditiously as the beneficiary's health condition requires and no later than the date the extension expires.
        f. For service authorization decisions not reached within the timeframes specified in § 438.210(d) (which constitutes a denial and is thus an adverse benefit determination), on the date that the timeframes expire.
        g. For expedited service authorization decisions, within the timeframes specified in § 438.210(d)(2). Contractor must continue the beneficiary's benefits if all the following conditions apply:
            i. The beneficiary files the request for an Appeal timely in accordance with 438.402(c)(1)(ii) and (c)(2)(ii)
            ii. The Appeal involves the termination, suspension, or reduction of a previously authorized services

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

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

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

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

25. Schedule A, Statement of Work
Section L. Grievance and Appeals Process for Beneficiaries, 6. Adverse Benefit Determination Notice, d. is hereby added:

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

26. Schedule A, Statement of Work
Section L. Grievance and Appeals Process for Beneficiaries, 8. Expedited Appeal Process, b.ii. and iv., are hereby deleted and replaced in its entirety with the following:

ii. The beneficiary or Provider must file an Expedited Appeal within 60 calendar days of the Adverse Benefit Determination.

iv. Contractor must provide written notice of resolution in a format and language that, at a minimum, meets the standard described in accordance with 42 CFR 438.10.
1. For notice of an expedited resolution, the Contractor must also make reasonable efforts to provide oral notice.

27. Schedule A, Statement of Work
Section M. Beneficiary Services, 1. Provider Directory, a. and f. are hereby deleted and replaced in its entirety with the following:

a. Contractor must maintain and publish a complete provider directory, including pharmacies, medical suppliers, ancillary health providers, independent facilitators and fiscal intermediaries, in hard copy and web-based formats.

f. Contractor's provider directory must contain, at a minimum, the following information:
i. provider name
ii. Address
iii. telephone number
iv. website URL
v. Services provided
vi. whether the provider is accepting new patients
vii. languages spoken, including American Sign Language (ASL)

viii. cultural and linguistic capabilities
ix. whether the providers' office/facility has accommodations for people with physical disabilities

28. Schedule A, Statement of Work
Section M. Beneficiary Services, 2. Written Materials, a. and a.iii. are hereby deleted and replaced in its entirety with the following:
    a. All informative materials, including the provider directory, intended to be distributed through written or other media (e.g. Electronic) to beneficiaries or the broader community that describe the availability of covered services and supports and how to access those supports and services, including but not limited to provider directories, beneficiary handbooks, appeal and grievance notices, and denial and termination notices, must meet the following standards:
        iii. All informative materials, including the provider directory, must be made available in paper form upon request and in an electronic form that can be electronically retained and printed. It must also be made available in a prominent and readily accessible location on the Contractor's website, in a machine-readable file and format. Information included in a paper provider directory must be updated at least monthly and electronic provider directories must be updated no later than 30 calendar days after the Contractor receives updated provider information.

29. Schedule A, Statement of Work
Section N. Provider Services, 4. Level of Care Utilization System (LOCUS), a., b., and c. are hereby deleted and replaced in its entirety with the following:
The Contractor must:
    a. Ensure that the LOCUS is incorporated into the initial assessment process for all individuals 18 and older seeking supports and services for a severe mental illness using one of the three State approved methods for scoring the tool:
        i. Use of the online scoring system Service Manager, through Journey Health-Deerfield Behavioral Health, with cost covered by BHDDA through the Mental Health Block Grant (MHBG) funding; or
        ii. Use of software Service Manager purchased through Journey Health-Deerfield Behavioral Health with costs covered by the State if they are not receiving Early Periodic Screening Diagnosis and Treatment Services (EPSDT) services. If the child/youth aged 18-21 years is receiving EPSDT services in the CMHSP system, the CAFAS needs to be completed at intake, quarterly and at exit up to age 21.
    b. Ensure that each individual 18 years and older with a severe mental illness has a LOCUS completed as part of any assessment and re-assessment process.
    c. Identify a regional trainer that will support regional training needs and participate in BHDDA ongoing training and education activities that will support the ongoing use of the tool.

30. Schedule A, Statement of Work
Section N. Provider Services, 9. Trauma Policy is hereby deleted and replaced in its entirety with the following:
The Contractor must develop a trauma-informed system in accordance with the MDHHS/BHDDA Trauma Policy which can be found on the MDHHS website:
https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4868_4900---,00.html

31. Schedule A, Statement of Work
Section N. Provider Services, 10. Substance Use Disorder (SUD) Services, the first paragraph is hereby deleted and replaced in its entirety with the following:
The Contractor must comply with the SUD Services Policy and Advisory Manual (which can be found on the MDHHS website: https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4871_45835_48569-133156--,00.html).

32. Schedule A, Statement of Work
Section N. Provider Services, 12. Critical Incidents, d. is hereby added:
    d. The Contractor must comply with the reporting requirements and guidelines identified in the Critical Incident Reporting and Event Notification Requirements which can be found on the MDHHS website: MDHHS - Policies & Practice Guidelines (michigan.gov)

33. Schedule A, Statement of Work
Section O. Health Information System, 4. Beneficiary Service Records is hereby deleted and replaced in its entirety with the following:
The Contractor must ensure that providers establish and maintain a comprehensive individual service record system consistent with the provisions of MSA Policy Bulletins, and appropriate State and federal statutes. The Contractor must ensure that providers maintain in a legible manner, via hard copy or electronic storage/imaging, recipient service records necessary to fully disclose and document the quantity, quality, appropriateness, and timeliness of services provided. The records must be retained according to the retention schedules in place by the Department of Technology, Management and Budget (DTMB) General Schedule #20 at: DTMB - General Schedules for Local Government (michigan.gov). This requirement must be extended to all of the Contractor's provider agencies.

34. Schedule A, Statement of Work
Section Q. Observance of State and Federal Laws and Regulations, 15. Service Requirements is hereby deleted and replaced in its entirety with the following:
15. Service Requirements
    a. The Contractor must limit Medicaid and MIChild services to those that are medically necessary and appropriate, and that conform to accepted standards of care.
    b. Contractor must operate the provision of their Medicaid services consistent with the applicable sections of the Social Security Act, the Code of Federal Regulations (CFR), the CMS/HCFA State Medicaid & State Operations Manuals, Michigan's Medicaid State Plan, and the Michigan Medicaid Provider Manual: Mental Health-Substance Abuse section.
    c. The Contractor must provide covered State plan or 1915(c) services (for beneficiaries enrolled in the 1915(c) Habilitation Supports Waiver) in sufficient amount, duration and scope to reasonably achieve the purpose of the service.
    d. Consistent with 42 CFR 440.210 and 42 CFR 440.220, services to recipients must not be reduced arbitrarily.
    e. Criteria for medical necessity and utilization control procedures that are consistent with the medical necessity criteria/service selection guidelines specified by the State and based on practice standards may be used to place appropriate limits on a service (42 CFR 440.230).

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

36. Schedule A. Statement of Work
Section R. Program Integrity, 2. is hereby deleted and replaced in its entirety with the following:
Biannual meetings will be held between MDHHS-OIG and all Contractor Compliance Officers to train and discuss fraud, waste and abuse.

37. Schedule A. Statement of Work
Section R. Program Integrity, 6. Overpayments, b. is hereby deleted and replaced in its entirety

with the following:
If the Contractor identifies an overpayment involving waste or abuse prior to identification by MDHHS-OIG, the Contractor must void or correct applicable encounters, should recover the overpayment and must report the overpayment on its quarterly submission (see Section R.8. Quarterly Submissions below).

38. Schedule A. Statement of Work
Section R. Program Integrity, 10. Contractor Ownership and Control Interest, d. is hereby deleted and replace in its entirety with the following:
    d. The Contractor must comply with the federal regulations to obtain, maintain, disclose, and furnish required information about ownership and control interests, business transactions, and criminal convictions as specified in 42 CFR §455.104-106. In addition, the Contractor must ensure that any and all contracts, agreements, purchase orders, or leases to obtain space, supplies, equipment or services provided under the Medicaid agreement require compliance with 42 CFR §455.104-106. Pursuant to 42 CFR § 455.104: the State will review ownership and control disclosures submitted by the Contractor and any of the Contractor's Subcontractors.

39. Schedule A, Statement of Work
Section 2.6. Use of Subcontractors, F. is hereby deleted and replaced in its entirety with the by the following and G. and H. are hereby added:
    F. The Contractor, and its subcontractors, as applicable, must retain, as applicable, beneficiary grievance and appeal records in accordance with 42 CFR 438.416, base data in 42 CFR 438.5(c), MLR reports in 42 CFR 438.8(k), and the data, information, and documentation specified in 42 CFR 438.604, 438.606, 438.608, and 438.610 for a period of no less than 10 years.
    G. 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 have the right to audit, evaluate, and inspect any books, records, contracts, computer, or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under this Contract with the State. The subcontractor must make available, for purposes of an audit, evaluation, or inspection under this Contract, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid beneficiaries. The right to audit under this Contract will exist through 10 years from the final date of the Contract period or from the date of completion of any audit, whichever is later.
    H. Accreditation of Subcontractors
    The Contractor must enter into agreements for treatment services provided through outpatient, Methadone, sub-acute detoxification and residential providers only with providers accredited by one of the following accrediting bodies: The Joint Commission (TJC formerly JCAHO); Commission on Accreditation of Rehabilitation Facilities (CARF); the American Osteopathic Association (AOA); Council on Accreditation of Services for Families and Children (COA); National Committee on Quality Assurance (NCQA), or Accreditation Association for Ambulatory Health Care (AAAHC). The Contractor must determine compliance through review of original correspondence from accreditation bodies to providers. Accreditation is not needed in order to provide access management system (AMS) services, whether these services are operated by a Contractor or through an agreement with the Contractor or for the provision of broker/generalist case management services. Accreditation is required for AMS providers that also provide treatment services and for case management providers that either also provide treatment services or provide therapeutic case management. Accreditation is not required for peer recovery and recovery support services when these are provided through a prevention license.

40. Schedule A, Statement of Work
Section 6. Reserved is hereby deleted and replace in its entirety with the following:
    6. Contractor Risk Management Strategy
        A. Risk Management Strategy
        Each Contractor must define the components of its risk management strategy that is consistent with general accounting principles as well as federal and State regulations.
        B. Contractor Assurance of Financial Risk Protection

1. The Contractor must provide, to the State, upon request, documentation that demonstrates financial risk protections sufficient to cover the Contractor's determination of risk. The Contractor must update this documentation any time there is a change in the information.
2. The Contractor may use one or a combination of measures to assure financial risk protection, including pledged assets, reinsurance, and creation of an ISF. The use of an ISF in this regard must be consistent with the requirements of OMB Circular 2 CFR 200 Subpart E. Please see Internal Service Fund Technical Requirement at the MDHHS website: MDHHS - Policies & Practice Guidelines (michigan.gov).
3. The Contractor must submit a specific written Risk Management Strategy to the Department (see Schedule E). The Risk Management strategy will identify the amount of reserves, insurance and other revenues to be used by the Contractor to assure that its risk commitment is met. Whenever General Funds are included as one of the listed revenue sources, the State may disapprove the list of revenue sources, in whole or in part, after review of the information provided and a meeting with the Contractor. Such a meeting will be convened within 45 days after submission of the risk management strategy. If disapproval is not provided within 60 days following this meeting, the use of General Funds will be considered to be allowed. Such disapproval will be provided in writing to the Contractor within 60 days of the first meeting between the State and the Contractor. Should circumstances change, the Contractor may submit a revision to its Risk Management Strategy at any time. The State will provide a response to this revision, when it changes the Contractor's intent to utilize General Funds to meet its risk commitment, within 30 days of submission.

41. Schedule A, Statement of Work
Section 8. Payment Terms, B. State Funding, 3. Children's Waiver Program Payments, c. is hereby added:
    c. Encounters must be processed and submitted on time, as defined in Section N. Provider Services, 7. Claims Management System and the Reporting Requirements in order to assure timely CWP service verification.

42. Schedule A, Statement of Work
Section 8. Payment Terms, B. State Funding, 4. Serious Emotional Disturbances Waiver Payments, f. is hereby added:
    f. Encounters must be processed and submitted on time, as defined in Section N. Provider Services, 7. Claims Management System, in order to assure timely SEDW service verification.

43. Schedule A, Statement of Work
Section 8. Payment Terms, D. Contractor Performance Bonus, first paragraph is hereby deleted and replaced in its entirety with the following:
    D. Contractor Performance Bonus
    Contract withholds and the Performance Bonus Incentive Program have been established to support program initiatives as specified in the MDHHS Medicaid Quality Strategy. Awards will be made to Contractors according to criteria established by the State. Criteria for Performance Bonus awards will include, but is not limited to, assessment of performance in quality of care, access to care and administrative functions. Each year, the State will establish and communicate to the Contractor the criteria and standards to be used for the performance bonus awards.

44. Schedule C. Definitions
The following definition is hereby added:
Maternity Outpatient Medical Services (MOMS): is a health coverage program operated by the State.

45. Schedule C. Definitions
The Medicaid Managed Specialty Service and Supports Program (MMSSSP) definition is hereby deleted and replaced in its entirety with the following:
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.

46. Schedule E. Contractor Reporting Requirements
The Financial Planning, Reporting and Settlement table is hereby deleted and replaced in its entirety with the following:

Due Date	Report Title	Report Frequency	Report Period	Reporting Mailbox
November 15	Program Integrity Activities	Quarterly	July 1 to September 30	Contractor's MDHHS OIG sFTP Area
February 15			October 1 to December 31	
May 15			January 1 to March 31	
August 15			April 1 to June 30	
November 15	Complete Subcontracted Entity List	Annually	Current	Contractor's MDHHS OIG sFTP Area
December 3	Risk Management Strategy	Annually	To cover the current fiscal year	MDHHS-BHDDA-Contracts-MGMT@michigan.gov
February 28	Effectiveness Review of the Contractor's QAPIP	Annually	October 1 to September 30	QMPMeasures@michigan.gov
March 13	DHHS Incentive Payment DHIP Report	Annually	October 1 to September 30	Electronic version of the DHIP CAFAS report (and if applicable PECAFAS report) for each CMHSP to Claudine Falkowski at falkowskic@michigan.gov
May 15	Member Grievances	Quarterly	May 15 for 1Q and 2Q data Aug 15 for 1Q, 2Q & 3Q data Nov 15 for 1Q, 2Q, 3Q & 4Q data	QMPMeasures@michigan.gov
August 15				
November 15				
May 15	Service Authorization Denials	Quarterly	May 15 for 1Q and 2Q data Aug 15 for 1Q, 2Q & 3Q data Nov 15 for 1Q, 2Q, 3Q & 4Q data	QMPMeasures@michigan.gov
August 15				
November 15				
May 31	Mid-Year Status Report	Mid-Year	October 1 to March 31	MDHHS-BHDDA-Contracts-MGMT@michigan.gov
May 31	Encounter Quality Initiative Report (EQI)	Four months	October to January	QMPMeasures@michigan.gov
June 1	SUD – Notice of Excess or Insufficient Funds	Projection	October 1 to September 30	MDHHS-BHDDA-Contracts-MGMT@michigan.gov
August 15	SUD – Charitable Choice Report	Annually	October 1 to September 30	MDHHS-BHDDA-Contracts-MGMT@michigan.gov
August 15	PIHP Medicaid FSR Bundle MA, HMP, Autism & SUD	Projection (Use tab in FSR Bundle)	October 1 to September 30	MDHHS-BHDDA-Contracts-MGMT@michigan.gov
August 15 November 15	Member Appeals	Semi-annually	Aug 15 for 1Q, 2Q & 3Q data Nov 15 for 1Q, 2Q, 3Q & 4Q data	QMPMeasures@michigan.gov
August 15 November 15	Provider Credentialing	Semi-annually	Aug 15 for 1Q, 2Q & 3Q data Nov 15 for 1Q, 2Q, 3Q & 4Q data	QMPMeasures@michigan.gov
September 30	Encounter Quality Initiative Report (EQI)	Eight Months	October to May	QMPMeasures@michigan.gov
October 1	Medicaid YEC Accrual	Final	October 1 to September 30	MDHHS-BHDDA-Contracts-MGMT@michigan.gov
October 1	SUD YEC Accrual	Final	October 1 to September 30	MDHHS-BHDDA-Contracts-MGMT@michigan.gov
October 30	Intensive Crisis Stabilization Services (ICSS) for Children Annual Data Report	Annually	October 1 to September 30	email completed report to ShaRon Crandell at creandells@michignan.gov

Due Date	Report Title	Report Frequency	Report Period	Reporting Mailbox
November 1	PIHP Medicaid FSR Bundle MA, HMP, Autism & SUD	Interim (Use tab in FSR Bundle)	October 1 to September 30	MDHHS-BHDDA-Contracts-MGMT@michigan.gov
November 15	Complete Subcontracted Entity List	Annually	Current	Contractor's MDHHS OIG sFTP Area
December 31	Medicaid Services Verification Report	Annually	October 1 to September 30	MDHHS-BHDDA-Contracts-MGMT@michigan.gov
February 21	Direct Care Wage Attestation Form	Annually	For the prior fiscal year ending September 30	MDHHS-BHDDA-Contracts-MGMT@michigan.gov
February 28	SUD – Primary Prevention Expenditures by Strategy Report	Annually	October 1 to September 30	MDHHS-BHDDA-Contracts-MGMT@michigan.gov
February 28	Network Adequacy Certification Report	Annually	October 1 to September 30	MDHHS-BHDDA-Contracts-MGMT@michigan.gov
February 28	SUD – Legislative Report/Section 408	Annually	October 1 to September 30	MDHHS-BHDDA-Contracts-MGMT@michigan.gov
February 28	PIHP Medicaid FSR Bundle - MA. HMP, Autism & SUD	Final (Use tab in FSR Bundle)	October 1 to September 30	MDHHS-BHDDA-Contracts-MGMT@michigan.gov
February 28	Encounter Quality Initiative Report (EQI)	Annually	October 1 to September 30	QMPMeasures@michigan.gov
February 28	PIHP Executive Administrative Expenditures Survey for Sec. 904(2)(k)	Annually	October 1 to September 30	MDHHS-BHDDA-Contracts-MGMT@michigan.gov
February 28	Medical Loss Ratio	Annually	October 1 to September 30	MDHHS-BHDDA-Contracts-MGMT@michigan.gov
February 28	Attestation to accuracy, completeness, and truthfulness of claims and payment data	Annually	For the prior fiscal year ending September 30	QMPMeasures@michigan.gov
March 31	SUD - Maintenance of Effort (MOE) Report	Annually	October 1 to September 30	MDHHS-BHDDA-Contracts-MGMT@michigan.gov
June 30	SUD – Audit Report	Annually	October 1 to September 30 (Due 9 months after close of fiscal year)	MDHHS-BHDDA-Contracts-MGMT@michigan.gov
30 Days after submission	Annual Audit Report, Management Letter, and CMHSP Response to the Management Letter.	Annually	October 1 to September 30	MDHHSAuditReports@michigan.gov
30 Days after submission	Compliance exam and plan of correction	Annually	October 1 to September 30	MDHHSAuditReports@michigan.gov

The following Contractor Non-Financial Reporting Requirements Schedule Including SUD Reports table is hereby deleted and replaced in its entirety with the following:

Due Date	Report Title	Report Period	Reporting Mailbox
The end of the month	Provider Network Stability Plan	Monthly	WieferichJ@michigan.gov
January 31	Children Referral Report	October 1 to December 31	MDHHS-BHDDA-Contracts-MGMT@michigan.gov
January 31	SUD – Injecting Drug Users 90% Capacity Treatment Report	October 1 to December 31	MDHHS-BHDDA-Contracts-MGMT@michigan.gov

Due Date	Report Title	Report Period	Reporting Mailbox
January 31	Veteran Services Navigator (VSN) Data Collection form	October 1 to December 31	Submit through: DCH-File Transfer
February 28	Effectiveness Review of the Contractor's QAPIP	Annually, October 1 to September 30	QMPMeasures@michigan.gov
February 28	Network Adequacy Certification Report	October 1 to September 30	MDHHS-BHDDA-Contracts-MGMT@michigan.gov
March 31	Performance Indicators	October 1 to December 31	QMPMeasures@michigan.gov
April 30	Children Referral Report	January 1 to March 31	MDHHS-BHDDA-Contracts-MGMT@michigan.gov
April 30	SUD – Injecting Drug Users 90% Capacity Treatment Report	January 1 to March 31	MDHHS-BHDDA-Contracts-MGMT@michigan.gov
April 30	Veteran Services Navigator (VSN) Data Collection form	January 1 to March 31	Submit through: DCH-File Transfer
April 30	Sentinel Events Data Report	October 1 to March 31	MDHHS-BHDDA-Contracts-MGMT@michigan.gov
June 30	Performance Indicators	January 1 to March 31	QMPMeasures@michigan.gov
July 1	Narrative report on findings and any actions taken to improve data quality on BH-TEDS military and veterans fields.	October 1 to March 31	Submit through: DCH-File Transfer
July 15	Compliance Check Report (CCR)		MDHHS-BHDDA-Contracts-MGMT@michigan.gov with cc to: ohs@michigan.gov and ColemanL7@michigan.gov
July 15	Michigan Gambling Disorder Prevention Project (MGDPP) 3Q Narrative Report*	April 1 to June 30	MDHHS-BHDDA-Contracts-MGMT@michigan.gov and a copy to LucasA3@michigan.gov.
July 31	Children Referral Report	April 1 to June 30	MDHHS-BHDDA-Contracts-MGMT@michigan.gov
July 31	SUD – Injecting Drug Users 90% Capacity Treatment Report	April 1 to June 30	MDHHS-BHDDA-Contracts-MGMT@michigan.gov
July 31	Veteran Services Navigator (VSN) Data Collection form	April 1 to June 30	Submit through: DCH-File Transfer
July 31	Increased data sharing with other providers/ ADT Narrative	October 1 to June 30	Submit through: DCH-File Transfer
September 30	Performance Indicators	April 1 to June 30	QMPMeasures@michigan.gov
October 31	Children Referral Report	July 1 to September 30	MDHHS-BHDDA-Contracts-MGMT@michigan.gov

Due Date	Report Title	Report Period	Reporting Mailbox
October 31	SUD – Injecting Drug Users 90% Capacity Treatment Report	July 1 to September 30	MDHHS-BHDDA-Contracts-MGMT@michigan.gov
October 31	SUD – Youth Access to Tobacco Activity Annual Report	October 1 to September 30	MDHHS-BHDDA-Contracts-MGMT@michigan.gov
October 31	Veteran Services Navigator (VSN) Data Collection form	October 1 to September 30	Submit through: DCH-File Transfer
October 31	Sentinel Events Data Report	April 1 to September 30	MDHHS-BHDDA-Contracts-MGMT@michigan.gov
TBD	SUD – Synar Coverage Study Canvassing Forms	Regions participating and Study Period TBD	MDHHS-BHDDA-Contracts-MGMT@michigan.gov
November 15	Performance Bonus Incentive Narrative on "Increased participation in patient-centered medical homes characteristics".	October 1 to September 30	MDHHS-BHDDA-Contracts-MGMT@michigan.gov
November 30	SUD – Communicable Disease (CD) Provider Information Report (Must submit only if PIHP funds CD services)	October 1 to September 30	MDHHS-BHDDA-Contracts-MGMT@michigan.gov
November 30	Women Specialty Services (WSS) Report	October 1 to September 30	MDHHS-BHDDA-Contracts-MGMT@michigan.gov
December 31	Performance Indicators	July 1 to September 30	QMPMeasures@michigan.gov
Monthly	SUD - Priority Populations Waiting List Deficiencies Report	October 1 – September 30 Due last day of month following month in which exception occurred. Must submit even if no data to report	MDHHS-BHDDA-Contracts-MGMT@michigan.gov
Monthly	SUD – Behavioral Health Treatment Episode Data Set (BH- TEDS)	October 1 to September 30 Due last day of each month. See resources at: http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html	Submit via DEG at : https://milogintp.michigan.gov.
Monthly (minimum 12 submissions per year)	SUD - Encounter Reporting via HIPPA 837 Standard Transactions	October 1 to September 30 See resources at: http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html	Submit via DEG at: https://milogintp.michigan.gov.
Monthly*	Consumer-Level Data 1. Quality Improvement 2. Encounters	October 1 to September 30. See resources at: http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html	MDHHS-BHDDA-Contracts-MGMT@michigan.gov
Monthly	Critical Incidents		Submit to PIHP Incident Warehouse at: https://mipihpwarehouse.org/MVC/Documentation