Executive Summary
MICHIGAN DEPARTMENT OF HEALTH & HUMAN SERVICES
Behavioral Health and Developmental Disabilities Administration
Changes to the FY 16 contract between MDHHS and the PIHPs

Additions and changes to the contract between the Michigan Prepaid Inpatient Health Plans for Medicaid Specialty Services and MDHHS

I. Contract effective date: October 1, 2015 through September 30, 2016

II. New sections to the contract boilerplate as follows:

18.1.13 HCBS Transition Implementation
The PIHPs will work with MDHHS to establish policy guidance and monitoring standards to assure full compliance with the Home and Community Based Setting requirements and the state's approved transition plan no later than March 2019 as required by the rule.

6.4 Medicaid Services Verification
PIHPs shall perform Verification of Medicaid claims in accordance of operational developments by MDHHS in collaboration with PIHPs and shall be finalized no later than September 30, 2015.

III. List of changes to the following contract sections. Additions are included in "bold" and deletion in "strikeout."

Part I: CONTRACTUAL SERVICES TERMS AND CONDITIONS

Changes to section 1.0 Purpose added to the end of the 3rd paragraph is as follows:

The PIHP shall manage its responsibilities in a manner that promotes maximum value, efficiency and effectiveness consistent with state and federal statute and applicable waiver standards. These values include limiting managed care administrative duplication thereby reducing avoidable costs while maximizing the medical loss ratio. The PIHP shall actively manage behavioral health services throughout its service area using standardized methods and measures for determination of need and appropriate delivery of service. The PIHP shall ensure that cost variances in services are supported by quantifiable measures of need to ensure accountability, value and efficiency. The PIHP shall minimize duplication of contracts and reviews for providers contracting with multiple CMHSPs in a region.

Changes to section 39.2 MDHHS Reviews is as follows:

1. As used in this section, a review is an examination or inspection by the MDHHS or its agent, of policies and practices, in an effort to verify compliance with requirements of this contract.
2. The MDHHS will schedule **onsite** reviews at mutually acceptable start dates to the extent possible, with the exception of those reviews for which advance announcement is prohibited by rule or federal regulation, or when the deputy director for the Health Care Administration determines that there is demonstrated threat to consumer health and welfare or substantial threats to access to care.

3. Except as precluded in 34.2 (2) above, the guideline, protocol and/or instrument to be used to review the PIHP, or a detailed agenda if no protocol exists, shall be provided to the PIHP at least 30 days prior to the review.

4. At the conclusion of the review, the MDHHS shall conduct an exit interview with the PIHP. The purpose of the exit interview is to allow the MDHHS to present the preliminary findings and recommendations.

5. Following the exit review, the MDHHS shall generate a report within 45 days identifying the findings and recommendations that require a response by the PIHP.
   
a. The PIHP shall have 30 days to provide a Plan of Correction (POC) for achieving compliance. The PIHP may also present new information to the MDHHS that demonstrates it was in compliance with the questioned provisions at the time of the review. (New information can be provided anytime between the exit interview and the POC). When access or care to individuals is a serious issue, the PIHP may be given a much shorter period to initiate corrective actions, and this condition may be established, in writing, as part of the exit conference identified in (4) above. If, during an MDHHS on-site visit, the site review team member identified an issue that places a participant in imminent risk to health or welfare, the site review team would invoke an immediate review and response by the PIHP, which must be completed in seven calendar days.
   
b. The MDHHS will review the POC, seek clarifying or additional information from the PIHP as needed, and issue an approval of the POC within 30 days of having required information from the PIHP. The MDHHS will take steps to monitor the PIHP's implementation of the POC as part of performance monitoring.
   
c. The MDHHS shall protect the confidentiality of the records, data and knowledge collected for or by individuals or committees assigned a peer review function in planning the process of review and in preparing the review or audit report for public release.

6. MDHHS follow-up will be conducted to ensure that remediation of out-of-compliance issues occurs within 90 days after the plan of correction is approved by MDHHS.
Part II: STATEMENT OF WORK

Changes to section 6.3 Customer Services: General 2nd paragraph added as follows:

The Customer Services Attachment to the PIHP contract requires the PIHP to provide individuals with the information outlined in 42 CFR 438.10(f)(4), which references information identified in 42 CFR 438.10 (f)(6). The information is currently required to be given out annually or sooner if substantial changes have been made. CMS has instructed the Department that 42 CFR 438.10(f)(4) requires that, if the state delegates this function, the PIHP must give each enrollee written notice of any significant change in the information specified in 438.10(f)(6) at least 30 days before the intended effective date of the change. Language regarding the 30-day timeframe will need to be added to the contract.

Changes to sub-section 7.9.3 The Standards Group (no longer used) to be changed to the following:

7.9.3 MDHHS Standard Consent Form
It is the intent of the parties to promote the use and acceptance of the standard release form that was created by MDHHS under Public Act 129 of 2014. Accordingly, the PIHPs have the opportunity to participate in the Department’s annual review of the DCH-3927 and to submit comments to the Department regarding challenges and successes with using DCH-3927.

There are remaining issues to be addressed before the standard consent form can be used to support electronic Health Information Exchange. However, for all non-electronic Health Information Exchange environments, the PIHP shall implement a written policy that requires the PIHP and its provider network to use, accept, and honor the standard release form that was created by MDHHS under Public Act 129 of 2014.

Changes to section 8.0 CONTRACT FINANCING as follows:

The rates included in attachment P 8.0.1 are in effect with the initial contract. Rates may be revised without formal amendment of the contract when these revisions are actuarially certified, approved by CMS as necessary to comply with the requirements of an Executive Order or MDCH appropriations and are incorporated by reference in this contract when transmitted in writing to the PIHP.

Changes to section 8.4.1.5 Expenditures for Medicaid 1915 State Plan, 1915(b)(3), 1915(c) and Healthy Michigan Services as follows:

On an ongoing basis, the PIHP can flexibly and interchangeably expend capitation payments received through the four three sources or “buckets.” Once capitation payments are received, the PIHP may spend any funds received on 1915(b) state plan, (b)(3), 1115 Healthy Michigan Plan, or 1915(c) waiver services. All funds must be spent
on Medicaid beneficiaries for Medicaid services. These funds cannot be used for expenditures for Healthy Michigan Services.

While there is flexibility in month-to-month expenditures and service utilization related to the four “buckets,” the PIHP must submit encounter data on service utilization - with transaction code modifiers that identify the service as 1915(b) state plan, (b)(3) services, or 1915(c) services – and this encounter data (including cost information) will serve as the basis for future 1915(b) state plan, (b)(3) services, and 1915(c) waiver interim payment rate development.

The PIHP has certain coverage obligations to Medicaid beneficiaries under the 1915(b) waiver (both state plan and (b)(3) services), the 1115 Healthy Michigan Plan, and to enrollees under the 1915(c) waiver. It must use capitation payments to address these obligations.

The PIHP must monitor and track revenues and expenditures on 1915(b) state plan services, (b)(3) services, and 1915(c) services and assure that aggregate expenditures for (b)(3) services do not grow or rise faster than the respective aggregate expenditures for 1915(b) state plan and 1915(c) services.

Expenditures for Healthy Michigan Services must be covered by Healthy Michigan Plan capitation payment only.

Changes to section 8.4.1.6 MDHHS Incentive – Monetary Payments adding the last paragraph to the section as follows:

The incentive payments will be adjusted upward or downward to ensure that aggregate fiscal year payment matches available funding. Therefore, these incentive payments are contingent upon available funds and can be terminated at any time if funds are not available.

Changes to section 8.4.2 Contract Withholds adding the last paragraph to the section as follows:

In accordance with section 105d (18) of Public Act 107 of 2013, the Department shall also withhold 0.75% of payments to PIHPS for the purpose of establishing a performance bonus incentive pool. Distribution of funds from the performance bonus incentive pool will be contingent on the PIHP's completion of the required performance of compliance metrics. Specific methodologies for implementing and distributing these withheld funds will be established by the Department after consultation with PIHPs and included in an amendment to the FY16 contract.

Changes to section 8.6.1 Risk Corridor adding the following to the end of the third paragraph:
The PIHP financial responsibility for liabilities for costs between 100% and 110% must first be paid from the PIHP’s ISF for risk funding or insurance for cost over-runs. The ISF balance shall be tracked by Medicaid and Healthy Michigan funds contributed. Each portion of the ISF shall retain its character as Medicaid and Healthy Michigan Funds and shall not be used for risk financing across the Medicaid and Healthy Michigan programs. Medicaid ISF amounts shall only be used for Medicaid cost over runs into the risk corridor and Healthy Michigan ISF amounts shall only be used for Healthy Michigan cost over runs into the risk corridor.

Changes to section 8.6.2 Savings and Reinvestment the following:

Provisions regarding the Medicaid and Healthy Michigan Plan savings and the PIHP reinvestment strategy are included in the following subsections. It should be noted that only a PIHP may earn and retain Medicaid/Healthy Michigan Plan savings. CA’s and CMHSPs may not earn or retain Medicaid/Healthy Michigan Plan savings. Note that these provisions may be limited or canceled by the closeout provision in Part I, Section 16.0 Closeout, and may be modified by actions stemming from Part II A, Section 9.0 Contract Remedies and Sanctions.

Changes to section 8.6.2.1 Medicaid Savings the following:

The PIHP may retain unexpended Medicaid Capitation funds up to 7.5% of the Medicaid/Healthy Michigan Plan pre-payment authorization. These funds shall be included in the PIHP reinvestment strategy as described below. All Medicaid savings funds reported at fiscal year-end must be expended within one fiscal year following the fiscal year earned for Medicaid services to Medicaid covered consumers. All Healthy Michigan Plan savings funds reported at fiscal year-end must be expended within one fiscal year following the fiscal year earned for Healthy Michigan Plan services to Healthy Michigan Plan covered consumers. If MDCHHS and CMS approval is required of the reinvestment plan the savings must be expended by the end of the fiscal year following the year the plan is approved. In the event that a final MDCHHS audit report creates new Medicaid/Healthy Michigan Plan savings, the PIHP will have one year following the date of the final audit report to expend those funds according to Section 8.6.2.2. Unexpended Medicaid/Healthy Michigan Plan savings shall be returned to the MDCHHS as part of the year-end settlement process. MDCHHS will return the federal share of the unexpended savings to CMS.

IV. The following attachments are new to the Contract: Not Applicable

V. The following attachments to the Contract are updated or revised:

P7.7.1.1 PIHP Reporting Requirements to include a new reporting requirement for BEHAVIORAL HEALTH TREATMENT EPISODE DATA SET
VI. The following attachments to the Contract are removed: Not Applicable

VII. Technical Corrections throughout the contract and attachments changing departmental references from “Michigan Department of Community Health (MDCH) or DCH” to “Michigan Department of Health & Human Services (MDHHS)”. References to the former OMB Circular A-87 “Cost Principles for State, Local, and Indian Tribal Governments” to the new combined entity OMB circular “2 CFR 200 Subpart E Cost Principles.” Other technical corrections include updating of names, addresses, and contact information as needed.