

STATE OF MICHIGAN
 DEPARTMENT OF TECHNOLOGY, MANAGEMENT AND BUDGET
 PROCUREMENT & REAL ESTATE SERVICES ADMINISTRATION
 P.O. BOX 30026, LANSING, MI 48909
 OR
 530 W. ALLEGAN, LANSING, MI 48933

January 14, 2011

CHANGE NOTICE NO. 2
TO
CONTRACT NO. 071B0200072
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF CONTRACTOR		TELEPHONE (248) 465-7366
Michigan Peer Review Organization 22670 Haggerty Road, Suite 100 Farmington Hills, MI 48335 mpetrul@mpro.org		Melody Petrul, RN
		BUYER/CA (517) 241-3768 Lance Kingsbury
Contract Compliance Inspector: Laura Dotson (517) 241-4686 Hospital Admissions Review and Certification – Michigan Department of Community Health		
CONTRACT PERIOD: From: January 1, 2010 To: December 31, 2012		
TERMS	1% Net 15	SHIPMENT N/A
F.O.B.	N/A	SHIPPED FROM N/A
MINIMUM DELIVERY REQUIREMENTS N/A		

NATURE OF CHANGE (S):

Effective immediately, the following Project Manager is hereby added to this Contract:

Donna O'Shesky
 Inpatient Audits and SWUR Contract Manager
 Michigan Department of Community Health
 400 S. Pine Street
 Lansing, MI 48909
 Phone: 517-355-5204
 Fax: 517-241-9087
 Email: OSheskyD@michigan.gov

All other terms, conditions, specifications and pricing remain unchanged.

AUTHORITY/REASON:

Per DTMB/Procurement & Real Estate Services Administration and Agency request.

TOTAL ESTIMATED CONTRACT VALUE REMAINS: \$8,351,520.00

**STATE OF MICHIGAN
 DEPARTMENT OF MANAGEMENT AND BUDGET
 PROCUREMENT & REAL ESTATE SERVICES ADMINISTRATION
 P.O. BOX 30026, LANSING, MI 48909
 OR
 530 W. ALLEGAN, LANSING, MI 48933**

December 8, 2010

**CHANGE NOTICE NO. 1
 TO
 CONTRACT NO. 071B0200072
 between
 THE STATE OF MICHIGAN
 and**

NAME & ADDRESS OF CONTRACTOR		TELEPHONE (248) 465-7366
Michigan Peer Review Organization 22670 Haggerty Road, Suite 100 Farmington Hills, MI 48335 mpetrul@mpro.org		Melody Petrul, RN
		BUYER/CA (517) 241-3768 Lance Kingsbury
Contract Compliance Inspector: Laura Dotson (517) 241-4686		
Hospital Admissions Review and Certification – Michigan Department of Community Health		
CONTRACT PERIOD:		From: January 1, 2010 To: December 31, 2012
TERMS	1% Net 15	SHIPMENT N/A
F.O.B.	N/A	SHIPPED FROM N/A
MINIMUM DELIVERY REQUIREMENTS N/A		

NATURE OF CHANGE (S):

Effective immediately, this contract is **INCREASED** by \$900,120.00 and the following changes are now incorporated (following this page).

All other terms, conditions, specifications and pricing remain unchanged.

AUTHORITY/REASON:

Per DTMB/Purchasing Operations, Agency request and approval of the State Administration Board on 12/7/2010.

TOTAL REVISED ESTIMATED CONTRACT VALUE: \$8,351,520.00

Contract Change Notice 1
Contract 071B0200072 – Michigan Peer Review Organization
Hospital Admissions Review and Certification

Section 1.012 is modified to read as follows:

1.012 Background

The Michigan Department of Community Health (MDCH) is the single state agency responsible for health policy, the purchase of health care services, the accountability of those services to ensure only appropriate, medically necessary services are provided to the Medicaid population.

The purpose of this Contract is:

- A. To have a qualified Contractor conduct telephonic/electronic authorization of inpatient services (PACER), selected durable medical equipment and medical supplies (DME/MS) and Ventilator Dependent Care Unit (VDCU) admissions and continued stays for the MDCH FFS Medicaid and CSHCS beneficiaries.
- B. To have a qualified Contractor conduct audits/utilization review of inpatient services, outpatient services, and emergency room services.
- C. Validation to determine compliance with Medicaid Policy & Guidelines as outlined in the Provider manuals and Bulletins; and to determine appropriateness of Medicaid coverage for all of the above services utilizing current standards of practice, the Michigan State Plan, and Federal Regulations.
- D. To provide for the private administration of a State-wide Long Term Care Admission Review and Certification system for Michigan's Medicaid Long Term Care Programs (Medicaid covered nursing facilities and MI Choice Waiver) that must utilize nursing facility level of care criteria. The Contractor will also conduct Long Term Care Nursing Facility Level of Care Exception Process reviews as exceptions to current Medicaid nursing facility eligibility as outlined in Medicaid Policy and the Medicaid Provider Manual. The Contractor will provide analytical reports regarding long term care utilization.

An audit is a post payment review of a statistically valid random sample of beneficiary records maintained by a provider to ensure services were medically necessary and billed correctly by that provider. [42 CFR 447.201, 447.202, and Social Welfare Act 280 of the Public Acts of 1939, Section 111a.(7)(d), 111b.(6), (7), & (23)]. A review is considered a random sample of beneficiary records maintained by a provider to ensure services were medically necessary and billed correctly by that provider. The Long Term Care Retrospective Reviews will be completed as per the requirements of Social Security Act §1919, [42 U.S.C. 1396r](a). MDCH has a Statistician that determines the statistically valid random sample audits.

Utilization review is also required. The Michigan State Plan states that the State of Michigan meets the requirements of 42 CFR 456 for the control of the utilization of inpatient and outpatient hospital services. The Michigan State Plan further states that the medical and utilization review requirements will be met through a contract with a Utilization and Quality Control Peer Review Organization as designated under 42 CFR 475.

Section 1902 (a)(30)(A) of the Social Security Act (the Act) requires that State Medicaid Agencies provide methods and procedures to safeguard against unnecessary utilization of care and services and to assure "efficiency, economy and quality of care." Under section 1902 (d), a State can contract with a QIO or QIO-like entity to perform medical and utilization review functions required by law. The contracts must be consistent with the QIO legislation. Section 1903 (a)(3)(C) of the Act specifies that 75 percent Federal Financial Participation is available for State expenditures for the performance of medical and utilization reviews or external quality reviews by a QIO, or by entity, which meets the requirements of section 1152 of the Act (i.e., "QIO-like entity").

LTC Retrospective Reviews are a post-payment review of a random sample of beneficiary records maintained by a provider to ensure services were medically necessary and billed correctly by that provider.

Section 1.021 is modified to read as follows:

Telephonic/Electronic Prior Authorization for MDCH Approved DME/MS and VDCU Admissions

1. The Contractor must perform a telephonic/electronic authorization in compliance with MDCH/Medicaid/CSHCS policies and procedures for selected DME/MS and VDCU for beneficiaries covered under the Medicaid Fee For Service [Title XIX] and Children's Special Health Care Services Program [Title V and Title V/XIX].
2. The Contractor must set up a process to receive and respond to requests for prior authorization for MDCH selected DMS/MS by telephone, fax or electronically through the MDCH CHAMPS system. These reviews include the MDCH selected DME/MS codes and VDCU admissions and continued stays.

The MDCH selected DME/MS include:

- a. Negative Wound Therapy
 - b. Enteral – Oral and Tube Feeding over 3000 calories and TPN
 - c. Infusion therapy
 - d. Home Uterine Activity Monitors
3. The Contractor must receive telephonic, electronic or faxed requests from the clinical practitioners and/or the Ventilator Dependent Unit and then provide the medical supplier with the prior authorization number, if approved. If denied, MPRO must send the beneficiary a notice of due process rights or departmental review.
 4. The Contractor must receive telephonic, electronic or faxed requests from the Ventilator Dependent Unit [VDCU] representative and provide the VDCU representative with the prior authorization number, if approved. If denied, MPRO must send the beneficiary a notice of due process rights or departmental review.
 5. The following are the mandatory elements for the program, the Contractor is not, however, constrained from supplementing this listing with additional steps, sub tasks or elements deemed necessary to permit the development of alternative approaches or the application of proprietary analytical techniques:
 - a. The telephone/computer system must be available from 8:00 a.m. – 5 p.m. Monday through Friday except for State approved/sanctioned holidays.
 - b. Notice on phone message of closures [state approved holidays or for training].
 - c. The Contractor must be HIPAA compliant.
 - d. Telephonic/Computer Electronic system must be in place on the Contract start date.
 - e. The Contractor must assign staff to represent MDCU in the Appeals Process.
 - f. The Contractor must establish and make available for practitioner use a fax or electronic submission information sheet that can be completed and submitted either electronically or faxed to and from the practitioner.
 - g. The Contractor must utilize MDCH Office of Medical Affairs physician for approval of denial or for consultation as to clinical appropriateness of care if required by MDCH. The Contractor must have available the appropriate subspecialists for reviews for CHSCS children as required in MDCH published policy.
 - h. The Contractor must utilize the MDCH CHAMPS Program.

Page 17 is modified to read as follows:

2. PACER Validation:

Random sample PACER authorization will be conducted as part of the process on all Medicaid Fee For Service (Title XIX), Children's Special Health Care Services dual eligible (Title V/XIX) beneficiaries who had a request for

PACER through the Contractor. The Registered Nurses performing this validation will not be the same Registered Nurses performing the PACER authorizations.

All cases provided by the MDCH contract manager that require a PACER authorization will be reviewed for PACER validation. The Contractor will validate all PACER authorization/tracking authorization numbers assigned for these beneficiaries for the date(s) of service included in the audit sample. The Contractor has the responsibility to have a system/process in place that will validate PACER authorization/tracking numbers assigned utilizing MDCH CHAMPS.

During review of the inpatient hospital medical records included in the sample, if it is determined the admission, transfer, readmission within 15 days or continued stay for inpatient rehabilitative facilities does not meet criteria for PACER authorization, the Contractor will request the information received from the provider at the time of the PACER request including both review coordinator and physician documentation. If it is determined the information in the hospital record matches the information provided at the time of the PACER request, the elective admission, transfer, readmission within 15 days or continued stay for inpatient rehabilitative facilities, will be allowed.

The Contractor will report the case to the MDCH Contract Manager as the PACER authorization was approved in error. If the information given at the time of the request differs from the information found in the hospital record and the information given at the time of the PACER authorization meets criteria, however, the hospital record does not; the hospital stay will be refunded to the MDCH.

Page 20 is modified to read as follows:

DME/MS, and VDCU Admissions Validations

A random sample of DME/MS authorizations and VDCU admission/continued stay authorization will be conducted as part of the review process on all Medicaid Fee For Service (Title XIX), Children's Special Health Care Services dual (Title V/XIX) beneficiaries who had a request DME/MS service or admission or continued stay in a VDCH through the Contractor. The Registered Nurses performing this validation will not be the same Registered Nurses performing the PACER authorizations.

The Contractor will be paid per review completed. The Contractor will validate all PACER authorization/tracking authorization numbers assigned for these beneficiaries for the date(s) of service included in the audit sample. The Contractor has the responsibility to have a system/process in place that will validate PACER authorization/tracking numbers assigned utilizing MDCH CHAMPS.

- a. During the review of medical records included in the audit sample, if it is determined that the approval did not meet MDCH standards of coverage, because documentation did not verify information provided by the clinical practitioners or the VDCU staff, the provider will be notified and a referral to the Medical Services Administration for review and determination of monetary recovery.
- b. If MPRO inappropriately authorizes a service that does not meet MDCH standards of coverage, approved criteria for exceptions, or is determined to be a medically appropriate exception, MPRO will be responsible for reimbursement to the State of coverage of an inappropriate service.

Section 1.022 is modified to read as follows:

1.022 Work and Deliverable

The Contractor must provide Deliverables/Services and staff, and otherwise do all things necessary for or incidental to the performance of work, as set forth below:

INPATIENT PRIOR AUTHORIZATION-PACER/MDCH SELECTED DME/MEDICAL SUPPLY TELEPHONIC

1. Maintain absolute confidentiality of providers and beneficiaries assuring that no disclosure of information that may identify provider(s) or beneficiary(s) is shared inappropriately.
2. The Contractor must provide for a PACER/selected DMB/medical supply telephonic prior authorization system and provide access and utilize the MDCH computer prior authorization system that must include, at a minimum, all of the following:
 - a. clinically experienced Registered Nurses to receive the authorization request, elicit all relevant information and reach an initial decision based on admission criteria approved by MDCH
 - b. use of appropriately qualified physicians and appropriate pediatric subspecialists or assigned MDCH OMA physician to assist the Registered Nurses in their decision as appropriate, to query requesters in all questioned requests and render all denial determinations
 - c. render and communicate by telephone/electronic computer system all authorization decisions on the same day requested
 - d. generate and communicate to the requesting provider a unique identifying PACER/PA authorization/tracking number for each authorized case
 - e. data processing storage and retrieval of all requests, i.e., documentation and disposition, requesting providers, and other information taken in by the system as part of the request for prior authorization
 - f. the Contractor will maintain a toll-free PACER/PA telephone number. The Contractor must answer all incoming phone calls promptly with average time to answer of less than 90 seconds
 - g. the Contractor must input all authorization decisions into the MDCH CHAMPS system.
3. The PACER system must certify as appropriate for Medicaid Fee For Service (Title XIX), Children's Special Health Care Services dual eligible (Title V/XIX) beneficiaries: all elective inpatient hospital admissions; all re-admissions within 15 days; all transfers between hospitals and between units within a single hospital having different Medicaid ID/National Provider Identifier/Taxonomy Code numbers or provider types; all admissions and continued stays for inpatient rehabilitative facilities.
4. The basis of the decisions must include the medical need and appropriateness of the following:
 - a. the condition to be treated on an inpatient basis
 - b. to have treatment continued for rehabilitative facilities
 - c. to be treated at another hospital if already hospitalized
 - d. to be re-hospitalized

Denials for inpatient admissions and any changes to the request must be transmitted to the MDCH. The Contractor must send an adverse action notice developed by the State Office of Administrative Hearings and Rules for MDCH to Medicaid and Medicaid/CSHCS dually enrolled beneficiaries utilizing the appropriate denial statement. The beneficiary will be notified of a denial of services for an elective admission. Transfers and readmissions within 15 days do not need a notice to the beneficiary as no services were suspended, terminated or reduced. An appeals form (DCH-092 Hearing Request) provided by the State must accompany the adverse action notice to the beneficiary. The adverse action notice and appeal form must be sent to the beneficiary the day of the adverse action. Copies of all adverse action notices must be sent to the MDCH Contract Manager on a monthly basis.

Providers are notified verbally at the time of the telephonic/computer request and given appeal rights verbally at the same time.

5. Authorizations for the MDCH selected DME/Medical Supply authorizations for Medicaid Fee For Service (Title XIX), Children's Special Health Care Services dual eligible (Title V/XIX) beneficiaries must be based on the MDCH published standards of coverage and/or exceptions based on medical necessity within established standards of practice.

Denials for MDCH selected DME/Medical supply authorizations and any changes to the request must be transmitted to the MDCH. The Contractor must send an adverse action notice developed by the State Office of Administrative Hearings and Rules for MDCH to Medicaid and Medicaid/CSHCS dually enrolled beneficiaries utilizing the appropriate denial statement. The beneficiary will be notified of a denial of within 10 days of the decision date. An appeals form (DCH-092 Hearing Request) provided by the State must accompany the adverse action notice to the beneficiary. The adverse action notice and appeal form must be sent to the beneficiary the day of the adverse action. Copies of all adverse action notices must be sent to the MDCH Contract Manager on a monthly basis.

A notice of department review must be sent to CSHCS only beneficiaries within 10 days of the decision date.

6. It is essential that the Contractor has the capability to access and utilize the MDCH electronic computer authorization/tracking for all PACER and MDCH selected DME/Medical supply requests.

The payment system reads the PACER and selected DME/Medical supply authorization/tracking numbers, compares information, and suspend or deny payment of inappropriate claims for various reasons by edits.

7. The Contractor must develop a process for PACER and selected DME/medical supply and it must include:
 - a. The review is initiated by the attending physician or designated other, by telephone or electronically, requesting prior authorization for a patient's elective admission, a transfer, readmission within 15 days, or continued stay for inpatient rehabilitative facilities, admission or continued stay for VDCU or MDCH selected DMB/medical supplies. The Contractor must have the capability, as defined by HIPAA, to receive and respond electronically to all prior authorization requests including the adverse action notice.
 - b. In a transfer/readmission within 15 days (to another hospital), should the transferring physician not obtain an authorization as required, the receiving physician or second hospital may request this before the beneficiary is discharged.
 - c. Any case request must include at the minimum; beneficiary ID number, sex, birth date, county of residence, procedure code, hospital name, transfer code (transfer, readmission, urgent/emergent/elective), discharge date of first admission, justification code (reason for admission), and patient's name (required for physician advisor referrals).
8. If the Severity of Illness/Intensity of Service (SI/IS) admission criteria approved by MDCH and/or Policy are met, the Contractor's nurse approves the admission and a PACER authorization/tracking number is issued to the physician. The number is valid for 30 days and must be entered for hospital claims for the admission.
9. If the criteria screens are not met or if there are any questions requiring medical judgment, the case must be referred to a Contractor's physician consultant or MDCH OMA designated physician by the Contractor's nurse. The Contractor's physician consultant may confer by telephone with the attending physician. Ninety eight percent of referral cases must be resolved, either approved or denied for Medicaid coverage by the Contractor during the same day of the request. All cases must be resolved within one working day of the request. Cases approved by the physician will be considered complete. The Contractor will report all adverse determinations to the MDCH after the reconsideration process is completed.
10. The Contractor must have a process to reconsider denials of all PACER and VDCU admissions and continued stays and MDCH selected DME/Medical supply reviews at the request of the provider, practitioner or VDCU. At a minimum, the process must include:
 - a. Reconsideration must be requested by the provider within three working days of receipt of the denial.

- b. The Contractor will provide a reconsideration of adverse determinations upon written request from the provider(s).
- c. All reconsiderations will be conducted by a like specialty physician (when applicable) who will consider the entire medical record and all additional written information supplied by the provider who performed the services. The Contractor must complete reconsideration decisions for elective admissions (excluding rehab) and retrospective PACER requests within 30 working days. The Contractor must complete reconsideration decisions for all transfers, rehab admissions and continued stay within one working day of receipt of the request or the date of receipt of written documentation.
- d. The Contractor must have a two-step review process to review all denials at the request of the hospital or physician. The original request, if denied by the Contractor review coordinator (RN), goes to the Contractor physician or MDCH OMA designated physician for review. If denied, the provider is verbally told of the denial and given appeal (reconsideration) rights. The second request (reconsideration) is submitted via a Request for Retrospective PACER Review form, (this may include a complete medical record), with a detailed description of the case including case specific information. If denied, the provider is informed verbally that they may appeal to MDCH.

Whenever possible the Contractor must match the reviewing physician specialty with that of the attending physician's. After the initial denial by the first physician, the affected parties have a right to reconsideration by a second physician.

11. Should the provider request an appeal of a denied PACER/VDCU admission and continued stay, and MDCH selected DME/Medical supplies from the Contractor they may appeal to MDCH. The provider is to submit the medical record for review to the MDCH Office of Medical Affairs. The Office of Medical Affairs will make the determination. Should the denied service be overturned, then a PACER number will be authorized by MDCH and assigned by the Contractor. Should the case be upheld by the Office of Medical Affairs, then a letter of denial will be sent by the Contractor. The MDCH Contract Manager will notify the Contractor of the PACER decision verbally and follow-up with a faxed memo. Provider appeals to the MDCH will be conducted so that whenever possible, multiple claim appeals from an individual provider will be heard together.
12. For the inpatient rehabilitative facility, inpatient stays beyond 30 days in the rehabilitation hospital require additional inpatient authorization. The provider must contact the Contractor between the 27th and 30th days if the stay is expected to exceed 30 days. If the extended stay is approved, a PACER authorization/tracking number is issued to the provider. If the stay is expected to exceed 60 days, the provider must call the Contractor between the 57th and 60th days of stay for additional inpatient authorization. If the additional extended stay is approved, the Contractor will issue another PACER authorization/tracking number to the provider. For any case not meeting admission criteria approved by the MDCH, the Contractor's nurse must refer the case to the Contractor's physician consultant. The remainder of the review and approval/disapproval process follows that of the PACER review. Any authorization denial of any extended stay review point terminates Medicaid coverage of the hospital stay.
13. The Contractor must have the capability to access and utilize the MDCH electronic prior authorization system.
14. Complete data for all requests must be individually stored and retrievable by the Contractor for seven years.
15. The Contractor must be able to provide the MDCH access to the Contractor's PACER Program, VDCU Program, and MDCH selected DME/medical supply program by a means determined by the MDCH within one month of startup.
16. All documents and/or information obtained by the Contractor from the MDCH in connection with this Contract must be kept confidential and must not be provided to any third party unless disclosure is approved in writing by the MDCH.
17. The Contractor must specify the number of staff dedicated to the duties explained in this Contract and provide credentialing data prior to the start of this Contract.
18. The PACER/VDCU/DME/Medical supply/Authorization Tracking number will be generated by MDCH/Community Health Automated Medicaid Processing System.

19. Grouper 26 is currently being used; however, the Grouper that was in effect all the time the services were provided must be utilized for Inpatient audits and Statewide Utilization Review. There are no modifiers/codes for retrospective exemptions to prior authorization. C. ii. 27 pertains to Inpatient/Outpatient audit process.

Section 2.023 is modified to read as follows:

2.023 Project Manager

The following individuals will oversee the project:

Michelle Mapes, PACER/LTC Immediate Review, MDCH Selected DME/Medical Supply
Michigan Department of Community Health
400 S. Pine St., Lansing MI 48909
MapesM@michigan.gov
Phone: 517-335-5572
Fax: 517-241-9087

Elizabeth Aastad, Long Term Care Contract Manager
Michigan Department of Community Health
400 S. Pine St., Lansing MI 48909
AastadL@michigan.gov
Phone: 517-241-2115
Fax: 517-241-8969

Renate Rademacher, Outpatient Hospital Contract Manager
Michigan Department of Community Health
400 S. Pine St., Lansing MI 48909
RademacherR@michigan.gov
Phone: 517-335-5070
Fax: 517-241-9087

Attachment A, Pricing

Pricing is modified to read as follows:

HOSPITAL ADMISSIONS REVIEW & CERTIFICATION FOR DEPARTMENT OF COMMUNITY HEALTH

Program		Projected Volume/Month (estimated)	Total Annual Per Program (estimated)	Unit Price	One Year Pricing	Three Year Pricing
PACER	FFS Reviews	900/month	10,800	\$56.75	\$ 612,900.00	\$1,838,700.00
	FFS Appeals	RN=6.25 hours	75 hours	\$27.00/per half hour	\$ 4,050.00	\$ 12,150.00
		MD=6.25 hours	75 hours	\$77.00/per half hour	\$ 11,550.00	\$ 34,650.00
Audits	Inpatient	1 audit	15	\$43,250	\$ 648,750.00	\$1,946,250.00
	Outpatient	1 audit	15	\$28,000	\$ 420,000.00	\$1,260,000.00
SWUR	Inpatient	320 reviews/month	3,840	\$80.00	\$ 307,200.00	\$ 921,600.00
	Outpatient	320 reviews/month	3,840	\$80.00	\$ 307,200.00	\$ 921,600.00
LTC	Immediate Reviews	8.33/month	100	\$124.50	\$ 12,450.00	\$ 37,350.00
	Exception Reviews	13.33/month	160	\$65.00	\$ 10,400.00	\$ 31,200.00
	Immediate & Exc Appeals	RN=8.33/month	100 hours	\$27.00/per half hour	\$ 5,400.00	\$ 16,200.00
		MD=8.33/month	100 hours	\$77.00/per half hour	\$ 15,400.00	\$ 46,200.00
	Retrospective Reviews	150/month	1,800	\$35.00	\$ 63,000.00	\$ 189,000.00
	Retrospective Appeals	RN=41.66 hours/month	500 hours	\$27.00/per half hour	\$ 27,000.00	\$ 81,000.00
		MD=20.83hours/month	250 hours	\$77.00/per half hour	\$ 38,500.00	\$ 115,500.00
DME/MS		600	7200	\$56.75	\$ 408,600.00	
	Reviews	RN=6.25	45	\$54.00	\$2,430.00	
	Appeals	MD = 6.25	45	\$154.00	\$6,930.00	
					\$ 417,960.00	\$905,580.00*
	Grand Total				\$2,901,760.00	\$8,356,980.00

*This change effective for 26 months out of 36 months.

STATE OF MICHIGAN
DEPARTMENT OF MANAGEMENT AND BUDGET
PURCHASING OPERATIONS
P.O. BOX 30026, LANSING, MI 48909
 OR
530 W. ALLEGAN, LANSING, MI 48933

December 9, 2009

NOTICE
TO
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between
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and

NAME & ADDRESS OF CONTRACTOR Michigan Peer Review Organization 22670 Haggerty Road, Suite 100 Farmington Hills, MI 48335 mpetrul@mpro.org		TELEPHONE (248) 465-7366 Melody Petrul, RN
		BUYER/CA (517) 373-7396 Andy Ghosh, CPPB
Contract Compliance Inspector: Laura Dotson (517) 241-4686 Hospital Admissions Review and Certification – Michigan Department of Community Health		
CONTRACT PERIOD: From: January 1, 2010 To: December 31, 2012		
TERMS 1% Net 15	SHIPMENT N/A	
F.O.B. N/A	SHIPPED FROM N/A	
MINIMUM DELIVERY REQUIREMENTS N/A		

The terms and conditions of this Contract are those of RFP #071I9200277, this Contract Agreement and the Contractor's quote dated 10/13/2009. In the event of any conflicts between the specifications, and terms and conditions, indicated by the State and those indicated by the Contractor, those of the State take precedence.

CURRENT AUTHORIZED SPEND LIMIT: \$7,451,400.00

**STATE OF MICHIGAN
 DEPARTMENT OF MANAGEMENT AND BUDGET
 PURCHASING OPERATIONS
 P.O. BOX 30026, LANSING, MI 48909
 OR
 530 W. ALLEGAN, LANSING, MI 48933**

**CONTRACT NO. 071B0200072
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 THE STATE OF MICHIGAN
 and**

NAME & ADDRESS OF CONTRACTOR Michigan Peer Review Organization 22670 Haggerty Road, Suite 100 Farmington Hills, MI 48335 <div style="text-align: right;">mpetrul@mpro.org</div>	TELEPHONE (248) 465-7366 Melody Petrul, RN BUYER/CA (517) 373-7396 Andy Ghosh, CPPB
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MINIMUM DELIVERY REQUIREMENTS <div style="text-align: center;">N/A</div>	
MISCELLANEOUS INFORMATION: <p>The terms and conditions of this Contract are those of RFP #071I9200277, this Contract Agreement and the Contractor's quote dated 10/13/2009. In the event of any conflicts between the specifications, and terms and conditions, indicated by the State and those indicated by the Contractor, those of the State take precedence.</p> <p>CURRENT AUTHORIZED SPEND LIMIT: \$7,451,400.00</p>	

THIS IS NOT AN ORDER: This Contract Agreement is awarded on the basis of our inquiry bearing the RFP #071I9200277. Orders for delivery may be issued directly by the Michigan Department of Community Health through the issuance of a Purchase Order Form.

FOR THE CONTRACTOR:

Michigan Peer Review Organization

Firm Name

Authorized Agent Signature

Authorized Agent (Print or Type)

Date

FOR THE STATE:

Signature

William C. Walsh, CPPB, Acting Director

Name/Title

Services Division, Purchasing Operations

Division

Date



STATE OF MICHIGAN
Department of Management and Budget
Purchasing Operations

Contract No. 071B0200072
Hospital Admissions Review and Certification for Department of Community Health

Buyer Name: Andy Ghosh, CPPB
Telephone Number: 517-373-7396
E-Mail Address: ghosha@michigan.gov



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ATTACHMENTS

- Attachment A, Pricing
- Attachment B – HIPAA Business Associate Addendum
- Referenced Attachments

**DEFINITIONS**

24x7x365 means 24 hours a day, seven days a week, and 365 days a year (including the 366th day in a leap year).

Additional Service means any Services within the scope of the Contract, but not specifically provided under any Statement of Work.

Audit Period means the seven year period following Contractor's provision of any work under the Contract.

Contractor(s) are those companies that submit a proposal in response to this CONTRACT.

Business Day means any day other than a Saturday, Sunday or State-recognized legal holiday from 8:00am EST through 5:00pm EST unless otherwise stated.

Blanket Purchase Order is an alternate term for Contract and is used in the Plan Sponsors' computer system.

CCI means Contract Compliance Inspector.

Days means calendar days unless otherwise specified.

Deleted – N/A means that section is not applicable or included in this CONTRACT. This is used as a placeholder to maintain consistent numbering.

Deliverable means physical goods and/or services required or identified in a Statement of Work.

DMB means the Michigan Department of Management and Budget.

Environmentally Preferable Products means a product or service that has a lesser or reduced effect on human health and the environment when compared with competing products or services that serve the same purpose. Such products or services may include, but are not limited to: those which contain recycled content, minimize waste, conserve energy or water, and reduce the amount of toxics either disposed of or consumed.

Hazardous Material means any material defined as hazardous under the latest version of federal Emergency Planning and Community Right-to-Know Act of 1986 (including revisions adopted during the term of the Contract).

Incident means any interruption in any function performed for the benefit of a Plan Sponsor.

Key Personnel means any personnel identified in **Section 1.031** as Key Personnel.

New Work means any Services/Deliverables outside the scope of the Contract and not specifically provided under any Statement of Work, such that once added will result in the need to provide the Contractor with additional consideration. "New Work" does not include Additional Service.

Ozone-depleting Substance means any substance the Environmental Protection Agency designates in 40 CFR part 82 as: (1) Class I, including, but not limited to, chlorofluorocarbons, halons, carbon tetrachloride, and methyl chloroform; or (2) Class II, including, but not limited to, hydrochlorofluorocarbons.

Post-Consumer Waste means any product generated by a business or consumer which has served its intended end use; and which has been separated or diverted from solid waste for the purpose of recycling into a usable commodity or product, and which does not include post-industrial waste.

Post-Industrial Waste means industrial by-products which would otherwise go to disposal and wastes generated after completion of a manufacturing process, but does not include internally generated scrap commonly returned to industrial or manufacturing processes.

Recycling means the series of activities by which materials that are no longer useful to the generator are collected, sorted, processed, and converted into raw materials and used in the production of new products. This definition excludes the use of these materials as a fuel substitute or for energy production.



Reuse means using a product or component of municipal solid waste in its original form more than once.

CONTRACT means a Request for Proposal designed to solicit proposals for services.

Services means any function performed for the benefit of the State.

SLA means Service Level Agreement.

Source Reduction means any practice that reduces the amount of any hazardous substance, pollutant, or contaminant entering any waste stream or otherwise released into the environment prior to recycling, energy recovery, treatment, or disposal.

State Location means any physical location where the State performs work. State Location may include state-owned, leased, or rented space.

Subcontractor means a company selected by the Contractor to perform a portion of the Services, but does not include independent contractors engaged by Contractor solely in a staff augmentation role.

Unauthorized Removal means the Contractor's removal of Key Personnel without the prior written consent of the State.

Waste Prevention means source reduction and reuse, but not recycling.

Pollution Prevention means the practice of minimizing the generation of waste at the source and, when wastes cannot be prevented, utilizing environmentally sound on-site or off-site reuse and recycling. The term includes equipment or technology modifications, process or procedure modifications, product reformulation or redesign, and raw material substitutions. Waste treatment, control, management, and disposal are not considered pollution prevention, per the definitions under Part 143, Waste Minimization, of the Natural Resources and Environmental Protection Act (NREPA), 1994 PA 451, as amended.

Work in Progress means a Deliverable that has been partially prepared, but has not been presented to the State for Approval.

Work Product refers to any data compilations, reports, and other media, materials, or other objects or works of authorship created or produced by the Contractor as a result of an in furtherance of performing the services required by the Contract.



Definitions by Michigan Department of Community Health

Admission criteria approved by MDCH: the most current edition of copyrighted criterion used to assess the clinical appropriateness of acute care admission; continued stay and discharge; and quality of care ensuring the proper care setting for the appropriate length of time.

Ambulatory Payment Classifications (APCs): According to Medicare/CMS, and as developed and implemented in 2000 by CMS - All services paid under OPSS are classified into groups called Ambulatory Payment Classifications known as APCs. Services represented by/in each APC are similar clinically and by the services/terms of the resources they require. A payment assignment or rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC for an encounter. Under OPSS/APC methodology - providers bill individual claim line, date of service - and a single claim is considered an 'encounter' which may be >1 DOS. Medicare considers the 'encounter' from start to finish of the OP visit - whereas under old FFS, we considered 'one' claim as a single DOS. OPSS allows for predictability of payment. The APCs are reviewed as needed to determine their level of specificity - if they need to be reassigned to a higher/lower APC for payment. Information is updated on a quarterly basis and published in the Federal Regs.

Annotations: information written in the audit workbook that is used by MDCH and the Contractor's Nurse Reviewer when reviewing medical records for audits. See Attachment F.

Beneficiary: all Medicaid eligible individuals in the Fee For Service Program, (FFS), (Title XIX), Children's Special Health Care Services Program, (CSHCS dual eligibles) (Title V/XIX), Medicare/Medicaid, Title XVIII/XIX).

CHAMPS: MDCH's Community Health Automated Medicaid Processing System

CEO: Chief Executive Officer

Coding Validation: means comparing principal and all secondary diagnosis and procedure codes billed to the Department with documentation in the beneficiaries medical record to determine the appropriateness and accuracy of the billed codes.

CPT Codes: Current Procedural Terminology Codes

Diagnosis Related Groups (DRG): the Department's reimbursement methodology for inpatient services which is a single payment per discharge which is calculated according to the billed diagnosis and procedure codes and other relative factors including, but not limited to, the patient's age.

Emergency Room Criteria: currently accepted standards of care for Emergency Department service consistent with coverage in Hospital Provider Manual Chapter III.

Exception Criteria: specific criteria developed by MDCH to determine whether or not the participant is at risk of imminent institutionalization.

HCPCS Codes: Healthcare Common Procedural Coding System Codes

Health Insurance Portability and Accountability Act (HIPAA): a Federal law that makes a number of changes that have the goal of allowing persons to qualify immediately for comparable health insurance coverage when they change their employment relationships. Title II, Subtitle F, of HIPAA gives the U.S. Department of Health and Human Services (DHHS) the authority to mandate the use of standards for electronic exchange of health care data; to specify what medical and administrative codes sets should be used within those standards; to require the use of national identification systems for health care patients, provider, payers (or plans), and employers (or sponsors); and to specify the types of measures required to protect the security and privacy of personally identifiable health care information. Also known as the Kennedy-Kassebaum Bill, the Kassebaum-Kennedy Bill, K2, or Public Law 104-191.

Inpatient Criteria: currently accepted standards of care for Inpatient Hospital service consistent with coverage in Hospital Provider Manual.



Long Term Care: for this CONTRACT only, Long Term Care includes those programs that are required to adhere to the Michigan Medicaid Nursing Facility Level of Care Determination definition; specifically Nursing Facilities, MI Choice Waiver Program for Elderly and Disabled, and the Program for All Inclusive Care for the Elderly (PACE).

MDS: Minimum Data Set-assessment information required for all nursing facility and MI Choice Program in Michigan.

MDS-HC: Minimum Data Set-Home Care assessment information required for all MI Choice Waiver programs in Michigan.

MI Choice Program: MI Choice is Michigan's 1915c(SSA) Home and Community Based Waiver for Elderly and Disabled. Services are provided to participants within the community to maintain the most integrated setting possible.

Michigan Department of Community Health (MDCH): the State of Michigan Department requesting the services.

Michigan Medicaid Nursing Facility Level of Care Determination: Medicaid criteria established by the Michigan Department of Community Health, utilized by Medicaid providers, to determine a beneficiary's medical/functional eligibility for nursing facility admission or MI Choice Waiver and PACE program enrollment.

NPI Number: National Provider Identifier is part of the HIPAA mandate requiring a standard unique identifier for health care providers.

Nurse Reviewer: a registered professional nurse with a current Michigan license and with appropriate education and clinical background, trained in the performance of utilization review, and quality assurance.

Nurse Review Report: a written report of the audited record by the nurse reviewer, see Attachment J.

Nursing Facility Level of Care Exception Process Criteria: Criteria established by the Michigan Department of Community Health, utilized by the Contractor, in determining Medicaid eligibility based on frailty for beneficiaries who do not meet the Michigan Medicaid Nursing Facility Level of Care Determination criteria.

Nursing Facility Level of Care: Each state that participates in the Medicaid program is required to provide nursing facility care as a mandatory state plan service. Each state must determine function/medical eligibility criteria to determine the appropriateness for that setting. Federal regulations state that Medicaid covered nursing facility care must include the following:

- (A) skilled nursing care and related services for residents who require medical or nursing care,
- (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons, or
- (C) on a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities.

Outpatient Services Criteria: currently accepted standards of care for Outpatient Department service consistent with coverage in Hospital Provider Manual.

PACE: The Program of All Inclusive Care for the Elderly, a capitated community program for persons with long term care needs. Funds are blended from both Medicare and Medicaid sources.

PACER: Prior Authorization Certification Evaluation Review. The Prior Authorization Certification Evaluation Review number consists of nine-digits. The first four digits are the Julian date; and the last five digits are the beneficiaries ID number coded into the prior authorization master report numbers by formula. The requestor for the authorization number supplies the beneficiaries ID number. The listing for the prior authorization master report numbers can be supplied by the MDCH.

PASARR: The Pre-Admission Screening/Annual Resident Review is required to be completed for all potential nursing facility residents. This review ensures that persons with mental health conditions are placed in the most appropriate setting.



Peer Review Organization or PRO: an organization that is URAC (Utilization Review Accreditation Commission) approved and experienced in utilization review and quality assurance which meets the guidelines set forth in 42 USC 1320(c) (1) and 42 CFR 475. Note: QIO- like entities satisfies the requirements of the CONTRACT and are qualified to bid on the proposal.

Physician Reviewer: a physician licensed to practice medicine in Michigan engaged in the active practice of medicine; board certified or board eligible in his/her specialty; with admitting privileges in one or more Michigan hospitals; and familiar with Medicare principles, experienced in Nursing Facility Care and Utilization Review.

Proposal: the response to this CONTRACT submitted to the Department by a Vendor.

Provider: Medicaid enrolled Provider for Inpatient Hospital, Outpatient Hospital/Emergency Room Hospital services, and Long Term Care Facilities.

RHIT: Registered Health Information Technologist with appropriate education and coding background trained in the performance of coding/DRG validations, International Classification of Diseases Ninth revision clinical modifications, (ICD-9-CM), Ambulatory Patient Groups (APG), Health Care Financing Administration Common Procedural Coding System (HCPC), and Current Procedural Terminology (CPT) methodologies.

SI/IS: Severity of Illness/Intensity of Service.

Taxonomy Code: Provider Taxonomy code set is an external non-medical data code set designed for use in classifying health care providers according to type or practitioner specialty in an electronic environment electronic environment, specifically within the American National Standards Institute (ANSI) Accredited Standards Committee (ASC) health care transaction.

Utilization Review Accreditation Commission (URAC): a non-profit charitable organization founded in 1990 to establish standards for the health care industry

Workbook: a comprehensive collection of data provided to the Contractor by MDCH for use by contract review staff. The data includes: the beneficiary name and date of birth; stratum number; beneficiary sample number; provider identification number; total payments made; date of service; services/codes billed; and date of payment. This book is to be utilized by contract review staff to document review findings from the medical record.



Article 1 – Statement of Work (SOW)

1.010 Project Identification

1.011 Project Request

This is a CONTRACT for Michigan Department of Community Health Statewide Hospital and Long Term Care Admission Certification and Review Program. This Contract is limited by the terms indicated in Article 2.

1.012 Background

The Michigan Department of Community Health is the single state agency responsible for health policy, the purchase of health care services, and accountability of those services to ensure only appropriate, medically necessary services are provided to the Medicaid population.

The purpose of this contract is to have a qualified Contractor conduct telephonic/electronic authorization of inpatient services; audits/utilization review of inpatient services, outpatient services, and emergency room services; including PACER validation to determine compliance with Medicaid Policy & Guidelines as outlined in the Provider Manuals and Bulletins; and to determine appropriateness of Medicaid coverage for all of the above services utilizing current standards of practice, the Michigan State Plan, and Federal Regulations.

Additionally, this contract is to provide for the private administration of a State-wide Long Term Care Admission Review and Certification system for Michigan's Medicaid Long Term Care Programs (Medicaid covered nursing facilities and MI Choice Waiver) that must utilize nursing facility level of care criteria. The Contractor will also conduct Long Term Care Nursing Facility Level of Care Exception Process reviews as exceptions to current Medicaid nursing facility eligibility as outlined in Medicaid Policy and the Medicaid Provider Manual. The Contractor will provide analytical reports regarding long term care utilization.

An audit is a post payment review of a statistically valid random sample of beneficiary records maintained by a provider to ensure services were medically necessary and billed correctly by that provider. [42 CFR 447.201, 447.202, and Social Welfare Act 280 of the Public Acts of 1939, Section 111a.(7)(d), 111b.(6), (7), & (23)]. A review is considered a random sample of beneficiary records maintained by a provider to ensure services were medically necessary and billed correctly by that provider. The Long Term Care Retrospective Reviews will be completed as per the requirements of Social Security Act §1919, [42 U.S.C. 1396r](a). MDCH has a Statistician that determines the statistically valid random sample audits.

Utilization review is also required. The Michigan State Plan states that the State of Michigan meets the requirements of 42 CFR 456 for the control of the utilization of inpatient and outpatient hospital services. The Michigan State Plan further states that the medical and utilization review requirements will be met through a contract with a Utilization and Quality Control Peer Review Organization as designated under 42 CFR 475.

Section 1902 (a)(30)(A) of the Social Security Act (the Act) requires that State Medicaid Agencies provide methods and procedures to safeguard against unnecessary utilization of care and services and to assure "efficiency, economy and quality of care." Under section 1902 (d), a State can contract with a QIO or QIO-like entity to perform medical and utilization review functions required by law. The contracts must be consistent with the QIO legislation. Section 1903 (a)(3)(C) of the Act specifies that 75% Federal Financial Participation is available for State expenditures for the performance of medical and utilization reviews or external quality reviews by a QIO, or by entity, which meets the requirements of section 1152 of the Act (i.e., "QIO-like entity").

LTC Retrospective Reviews are a post-payment review of a random sample of beneficiary records maintained by a provider to ensure services were medically necessary and billed correctly by that provider.

The contract shall be for three years beginning January 1, 2010 through December 31, 2012 with the option of two (2) one year renewals.

**1.020 Scope of Work and Deliverables****1.021 In Scope****PACER/LONG TERM CARE IMMEDIATE AND EXCEPTION REVIEW**

1. MDCH seeks a Contractor to perform a telephonic/electronic authorization in compliance with Medicaid Program Policy and Procedure. This inpatient authorization will be conducted on Medicaid Fee For Service (Title XIX), Children's Special Health Care Services (CSHCS) dual eligible (Title V/XIX) beneficiaries if the admission is not related to the CSHCS qualifying diagnosis. For Long-Term Care, the review will be conducted on Medicaid Fee For Service, and possibly Medicare/Medicaid beneficiaries.

2. The Contractor will conduct the following reviews:

- a. Inpatient Prior Authorization –PACER (Prior Authorization Certification Evaluation Review)- telephonic/electronic for Medicaid Fee For Service (Title XIX), Children's Special Health Care Services (CSHCS) dual eligible (Title V/XIX) beneficiaries if the admission is not related to the CSHCS qualifying diagnosis. MDCH anticipates approximately 10,800 calls annually.
- b. Long Term Care Immediate Reviews and Long Term Care Exception Reviews- telephonic/electronic reviews for exceptions to Michigan Medicaid Nursing Facility Level of Care Determination for Medicaid beneficiaries and MI Choice Waiver and Program Of All Inclusive Care For The Elderly (PACE) participants. MDCH anticipates approximately 160 Long Term Care Exception and 100 Long Term Care Immediate requests annually.

3. The following are the mandatory elements for the program, the Contractor is not, however, constrained from supplementing this listing with additional steps, sub tasks or elements deemed necessary to permit the development of alternative approaches or the application of proprietary analytical techniques:

- a. Responsibility for the authorization must be implemented no later than the first day of this contract.
- b. This process shall be continued through the contract termination date.
- c. The telephone/computer system shall be available from 8AM-5PM Monday through Friday except for State approved/sanctioned holidays.
- d. Providers will be notified thirty (30) days prior to an approved holiday.
- e. The Contractor must be HIPAA compliant.
- f. Telephonic/Computer Electronic system must be in place the first day of the contract.
- g. The Contractor must be available for the Appeals Process.
- h. The Contractor must have a system or process in place that allows the validation of the PACER authorizations:
 - i. Assigned PACER authorization/tracking numbers through the CHAMPS program.
 - ii. Documentation provided at the time of PACER request.
 - aa. Review Coordinator documentation.
 - bb. Physician Reviewer documentation.
- i. The Contractor must have a system or process in place that allows the validation of LTC Immediate Review and LTC Telephonic Exception Review.
 - i. Review Coordinator documentation and summary.



4. A copy of the information received from the provider at the time the PACER authorization was requested will be validated by the Contractor. The information received from the provider for PACER authorization both approvals and denials, including the Review Coordinator's and Physician's documentation, must be stored electronically or via hard copy for seven (7) years.
5. A copy of the information received from the provider at the time the LTC Immediate review was requested will be validated by the Contractor. The information received from the provider for the LTC Immediate review, including Review Coordinator's and Physician's documentation, must be stored electronically or via hard copy for seven (7) years.
6. A copy of the Review Coordinator's summary for the LTC Telephonic Exception review must be stored electronically for seven (7) years.
7. There is a new Medicaid Management Information System, prior to this there were Provider Types. The new system does not have provider types and is now categorized by Specialty Codes.
8. All Michigan Inpatient and Outpatient Hospitals are included in the Statewide Utilization Review. In 2008, there were 188 Michigan Inpatient/Outpatient Hospitals.

Contractor Response to Tasks:

PACER SUMMARY

MPRO will meet or exceed all of the objectives set forth by MDCH to provide Prior Authorization Certification Evaluation Review (PACER) in a timely and accurate manner. We will perform telephonic and electronic authorizations in compliance with Medicaid policies and procedures for inpatient services for the Medicaid Fee-for-Service (Title XIX) population. We will perform inpatient reviews for the Children's Special Health Care Services (CSHCS) beneficiaries if services are requested that are not related to the reason the beneficiary is receiving CSHCS. We will perform telephonic and electronic reviews for all requests for exceptions to the Michigan nursing facility level of care definition, using explicit exception criteria provided by MDCH. These reviews will continue for the Medicaid FFS population and the Medicare/Medicaid dually eligible, if requested by MDCH. We are ready to implement this component of our contract within the timeframes required by MDCH. In addition to mandatory program elements, we have added several supplemental program features that we believe enhance the results of this program.

INPATIENT PRIOR AUTHORIZATION/LONG TERM CARE REVIEWS

As a local entity, our experience gives us intimate knowledge of state Medicaid regulations and clinical practices. We will apply the benefit of our vast experience, our national credentials, and Michigan residency to continue our successful record of accomplishment on the inpatient review program and to develop and operate a successful, new, long term care exception review program. All nurses and physician reviewers involved in the PACER authorization process are experienced in utilization review and specifically trained in the PACER process.

We operate the long term care authorization program using the same core review process that has been developed, refined, and accepted by MDCH for more than 21 years. Our technological approach and review criteria meet the long term care exception criteria developed by MDCH. Our experience in long term care includes the past 5 years of performing this review for the State of Michigan and through our QIO contract.

MANDATORY ELEMENTS

The CONTRACT outlines several mandatory program elements for the Medicaid FFS Review contract. The following table summarizes these elements and our compliance plan.



MDCH Requirement	MPRO Compliance Plan
<p>Responsibility for the authorization process must be implemented by the first day of the contract.</p>	<p>MPRO currently complies with this requirement for the PACER authorization process. We have an operational PACER system that will be available on the first day of this contract.</p> <p>We comply with the long term care exception process and are ready to implement upon contract award. Our existing staff resources will continue to meet the requirements for the review.</p>
<p>The authorization process shall be continued through the contract termination date.</p>	<p>MPRO recognizes the importance of continuity and effective transition between vendors. We will operate the authorization process through the contract termination date and assist MDCH with any transitional activities.</p>
<p>The telephone/computer system shall be available between the hours of 8:00 AM and 5:00 PM, Monday through Friday, except for State-approved holidays.</p>	<p>MPRO will maintain continual accessibility of the telephone and computer system from 8:00 AM to 5:00 PM EST, Monday through Friday, except on State-approved/sanctioned holidays.</p> <p>The performance of our computer and phone systems is reliable. We are able to maintain access due to redundancies for both our computer and phone systems. In addition, we have a detailed disaster recovery plan.</p>
<p>Providers will be notified thirty (30) days prior to an approved holiday.</p>	<p>Each year MPRO obtains a list of State-approved holidays from MDCH and, in December, we notify all the hospitals, nursing facilities, MI Choice Waiver, and PACE Programs operating in the State of Michigan affected by the PACER program of the holiday schedule for the upcoming year. This currently exceeds MDCH's required 30-day notification period.</p> <p>In addition, during the review process, our nurses ensure they provide PACER program "clients" with verbal reminders of holidays at least two to five days prior to the scheduled holiday. Our "on hold" message for the 1-800 line also provides reminders of upcoming holidays.</p>
<p>The contractor will be HIPAA compliant.</p>	<p>MPRO is fully compliant with HIPAA regulations.</p>
<p>The telephonic/computer system must be in place the first day of the contract.</p>	<p>MPRO's telephone and computer systems are in place and fully operational. We expect to have access to CHAMPS upon implementation of the contract as well as the availability to perform long term care reviews. We have a mechanism in place for providers to initiate the PACER authorization process telephonically or electronically, or by accessing the MDCH web site.</p>



<p>The contractor must be available for the appeal process.</p>	<p>MPRO's nurse reviewers and physician reviewers are located within Michigan and are available to participate in the appeals process with our current Medicaid FFS Review contract. This availability will continue for the PACER and LTC exception appeals and will start immediately upon contract award.</p>
<p>The Contractor must have a process in place that allows validation of the PACER authorizations, including:</p> <ol style="list-style-type: none"> 1. Assigned PACER numbers 2. Documentation provided at the time of PACER request, including: <ul style="list-style-type: none"> ▪ Review Coordinator documentation ▪ Physician Reviewer documentation 	<p>MPRO currently has a PACER validation program in place for our Medicaid FFS review contract. For the contract beginning January 1, 2010, the PACER validations will take place through the inpatient audit program and Statewide Utilization Review (SWUR) program for inpatient services. We will validate each case selected for audit/SWUR that has a PACER assigned.</p> <p>We will maintain all documentation related to the PACER, including documentation from the Review Coordinator and physician reviewer. The authorization information is stored using the assigned PACER number and can be easily accessed by the auditor during the PACER validation process.</p>
<p>The Contractor must have a system or process in place that allows the validation of LTC Immediate Review and LTC Telephonic Exception Review.</p>	<p>MPRO currently has a system in place to validate the information presented at the immediate review/exception review. The validations occur through the retrospective long term care review program.</p>

VALIDATION AND STORAGE OF INFORMATION (PACER)

MPRO electronically stores all approval documentation for seven years, and we store denials both electronically and via hard copy for the same seven-year period. We store the electronic documentation in an online database for easy retrieval. We store hard copy denials, reconsiderations, and appeals in our secured medical records room for one year and then we send the documentation to a secure off-site storage facility for the remaining six years.

VALIDATION AND STORAGE OF INFORMATION (LTC IMMEDIATE REVIEW)

MPRO electronically stores all approval documentation for seven years, and we store denials both electronically and via hard copy for the same seven-year period. We store the electronic documentation in an online database for easy retrieval. We store hard copy denials, reconsiderations, and appeals in our secured medical records room for one year and then we send this documentation to a secure off-site storage facility for the remaining six years.

VALIDATION AND STORAGE OF REVIEW COORDINATOR'S SUMMARY FOR LTC TELEPHONIC EXCEPTION

MPRO electronically stores all LTC telephonic exception review summaries for seven years. We store hard copy denials and appeals in our secured medical records room for one year and then we send this documentation to a secure off-site storage facility for the remaining six years.

HOSPITAL AUDITS/STATEWIDE UTILIZATION REVIEW AND LONG TERM CARE RETROSPECTIVE ELIGIBILITY REVIEWS

Hospital audits will be conducted on Medicaid Fee For Service (Title XIX), Medicare/Medicaid dually eligible (Title XVIII/IXX), Children's Special Health Care Services dual eligible (Title V/XIX), utilizing statistically valid random samples. The average number of beneficiaries to be reviewed for each audit is two hundred fifty (250).



LTC Retrospective Reviews will be conducted on Medicaid Fee for Service (Title XIX) and Medicare/Medicaid beneficiaries (Title XVIII/XIX), of Nursing Facilities and MI Choice Waiver utilizing statistically valid random samples. The average number of Medicaid beneficiaries to be reviewed for the combined Medicaid reimbursed Nursing Facilities and MI Choice Waiver for each quarter is four hundred fifty (450).

For Statewide Utilization Review, utilization review will be conducted on Medicaid Fee For Service (Title XIX) and Children's Special Health Care Services dual eligible (Title V/XIX) beneficiaries. Medical records will be selected by a statewide random sample by facility of CHAMPS Specialty Code B205 that crosswalks to Legacy Provider Type 30 Inpatient Hospital and/or CHAMPS Specialty Codes B206 or B210 that crosswalks to Legacy Provider Type 40 Outpatient Hospital facilities. The Contractor will draw a random sample of twenty (20) records per facility per year. For Inpatient Hospital services, if the Contractor has flagged a PACER case(s), the case(s) may be substituted for one or more of the twenty (20) random cases selected for that facility. Approximately four (4) hospitals per week will be reviewed for a total of sixteen (16) hospitals per month. If an inpatient/outpatient hospital has been selected to be audited that year, they will be exempt from the Review for that year.

Random sample PACER validations will be conducted as part of the audit process on all Medicaid Fee For Service (Title XIX), Children's Special Health Care Services dual eligibles (Title V/XIX) beneficiaries who had a request for PACER through the Contractor. The Registered Nurses performing this validation will not be the same Registered Nurses performing the PACER authorizations.

The Contractor will be paid per audit/Statewide Utilization Review/LTC retrospective review completed.

1. Audits will be conducted on the following:

- a. Inpatient Hospital Services: Twelve (12) audits with the possibility of fifteen (15) audits will be completed each year. The review will include all inpatient services paid to the provider including but is not limited to medical detoxification, elective admissions, transfers, readmissions within fifteen (15) days, inpatient rehabilitative facilities.
- b. Outpatient Hospital/Emergency Room Services: Twelve (12) audits with the possibility of fifteen (15) audits will be completed each year. The review will include all Outpatient Hospital and Emergency Room services paid to the provider.
- c. For Hospital Audits, the Contractor will conduct up to 15 Inpatient Hospital and up to 15 Outpatient Hospital Audits selected by the Michigan Department of Community Health. For Statewide Utilization Review the Contractor selects approximately four (4) hospitals per week to be reviewed for a total of sixteen (16) hospitals per month for inpatient and outpatient hospital providers. For hospital audits up to 15 inpatient and 15 outpatient audits are conducted annually. The statistically valid random sample for audits is determined by the Michigan Department of Community Health statistician from the universe of paid claims for the provider to be audited for a designated time period.

Up to 15 Inpatient Hospital audits and 15 Outpatient Hospital audits will be audited on an annual basis. Michigan Department of Community Health selects the hospitals to be audited.

2. PACER Validation:

All cases included in the inpatient hospital audit sample that require a PACER authorization will be reviewed for PACER validation. The Contractor will validate all PACER authorization/tracking authorization numbers assigned for these beneficiaries for the date(s) of service included in the audit sample. The Contractor has the responsibility to have a system/process in place that will validate PACER authorization/tracking numbers assigned utilizing MDCH CHAMPS.

During review of the inpatient hospital medical records included in the audit sample, if it is determined the admission, transfer, readmission within fifteen (15) days or continued stay for inpatient rehabilitative facilities does not meet criteria for PACER authorization, the Contractor will request the information received from the provider at the time of the PACER request including both review coordinator and physician documentation. If it is determined the information in the hospital record matches the information provided at the time of the PACER request, the elective admission, transfer, readmission within fifteen (15) days or continued stay for inpatient rehabilitative facilities, will be allowed.



The Contractor will report the case to the MDCH Contract Manager as the PACER authorization was approved in error. If the information given at the time of the request differs from the information found in the hospital record and the information given at the time of the PACER authorization meets criteria, however, the hospital record does not; the hospital stay will be refunded to the MDCH.

In addition to the PACER validation performed as part of the audit process, PACER validation will be performed on medical records selected by a statewide random sample by facility of CHAMPS Specialty Code B205 that crosswalks to Legacy Provider Type 30 Inpatient Hospital facilities.

3. Utilization Review:

Utilization review will be performed on all records requested for the Audits. This will include Inpatient/Outpatient/Emergency Room/PACER services.

In addition to the utilization review performed as part of the Audit Process, utilization review will be performed on medical records selected by a statewide random sample by facility of CHAMPS Specialty Codes B205 that crosswalks to Legacy Provider Type 30 Inpatient Hospital and/or CHAMPS Specialty Codes B206 or B210 that crosswalks to Legacy Provider Type 40 Outpatient Hospital facilities.

4. Long Term Care Retrospective Review:

LTC Retrospective reviews will be performed based on current Michigan Medicaid Nursing Facility Level of Care Determination criteria or, for beneficiaries who qualified via the Nursing Facility Level of Care Exception criteria. Retrospective Reviews will be conducted for Medicaid beneficiaries of nursing facilities and MI Choice Waiver. Retrospective reviews are conducted strictly to determine appropriate utilization, however, serious quality issues will be referred by the Contractor to the Health Policy, Regulation, and Professions Administration.

Contractor Response:

MPRO has been successfully performing hospital audits, LTC retrospective reviews, and SWURs during the last five years in our contract with the State and we are prepared to continue performing these tasks upon contract award. The following provides a summary of each review type.

AUDITS

MPRO will conduct hospital audits on Medicaid Fee for Service (Title XIX), Medicare/Medicaid dually eligible (Title XVIII/IXX), Children's Special Health Care Services dual eligible (Title V/XIX) utilizing the statistically valid random sample produced by MDCH. The average number of beneficiaries for review per audit is 250.

MDCH will select 12 inpatient and 12 outpatient providers (with the possibility of 15 per audit type) to be audited each year. We will review all inpatient services paid to the provider including, but not limited to, medical detoxification, elective admissions, transfers, readmissions within 15 days, and inpatient rehabilitative facilities. Our RHITs will perform the coding validation of all inpatient audits. RNs will review each case for the appropriateness of the admission, continued stay, stability at discharge, and quality of care provided.

MPRO will review all outpatient hospital/ER services. The average number of beneficiaries for review per audit is 250. An RN performing the audit will validate each claim line on the audit. The RN will focus on whether services ordered were performed and coded accurately. In addition, the RN will review for appropriateness of setting and quality of care provided.

PACER VALIDATION

MPRO will continue to perform PACER validation for all inpatient audits and inpatient SWUR where prior authorization was obtained. The RN who made the PACER determination will not be the RN performing the audits. Validation includes evaluating the following:

- Does the admission fall into a category that required prior authorization (i.e., elective admissions, 15-day readmissions, transfers, rehabilitation admissions, and 30-day and 60-day rehabilitation continued stays)?
- If the admission falls into one of these categories, was a PACER number issued?



- If a PACER number was not issued, was there a reason (self-pay, other insurance at time of admission, etc.)?

PACER PROCESS

- A PACER number was obtained. The RN opens the PACER review and evaluates RN and physician reviews performed on the case. The RN confirms that the information provided telephonically is documented in the medical record. If the information provided is not substantiated in the medical record, the RN will recommend the provider refund the hospital stay to MDCH. If the information in the medical record supports the information provided during the prior telephonic authorization review, the RN approves the admission and notes “pacer validated.”
- If a PACER number should have been obtained, but was not, the RN notes this as “the record was insufficient to support the services paid by the program” in the audit. For the SWUR-inpatient program, the RN sends an educational letter to the provider advising him/her that prior authorization was indicated and codes it in our SWUR system that a PACER was not obtained.

If we identify that we issued a PACER in error, we will immediately notify MDCH.

UTILIZATION REVIEW

MPRO performs utilization review on all audit and SWUR-inpatient/outpatient cases, ER, and PACER services. Utilization review consists of the RN determining that services requested were performed in the appropriate setting. The RN evaluates an inpatient stay utilizing InterQual® criteria. An outpatient stay is assessed for the potential need for a higher level of care. On an ER visit, the RN ensures the patient received the correct services and the severity level assigned was accurate. The RN will consider MDCH 051 edits because these are typically non-ER visits and consider the ER severity level coding assignments. In addition, the medical stability of the patient will be assessed (EMTALA) at the time of discharge or transfer from the ER.

LONG TERM CARE RETROSPECTIVE REVIEW

MPRO will conduct LTC retrospective reviews on Medicaid Fee for Service (Title XIX) and Medicare/Medicaid beneficiaries (Title XVIII/XIX) of nursing facilities and MI Choice Waiver utilizing statistically valid random sampling selected by MDCH. The review volume anticipated is 450 beneficiaries per quarter. Our RNs will use the Level of Care Determination criteria for beneficiaries who qualified by means of the exception criteria to determine appropriate utilization.

The following table outlines the objectives for the audit/review processes:

Table 1: MDCH Objectives for the Audit/Review Program				
Topic	Population	Sampling Method	Sample Size	Audit or Review
1. Inpatient Hospital Services (including medical detoxification, elective admissions, transfers, re-admits within 15 days, and rehabilitative facilities)	Medicaid FFS (Title XIX), Medicare/Medicaid dual eligibles (Title XVIII/IXX), and Children’s Special Health Care Services (CSHCS) dual eligibles (Title V/XIX)	Statistically valid random sample	12 providers per year (with the possibility of 15) and approximately 250 beneficiaries per provider	Audit



<p>2. Inpatient Hospital Services (including medical detoxification, elective admissions, transfers, re-admits within 15 days, and rehabilitative facilities)</p>	<p>Medicaid FFS (Title XIX), Medicare/Medicaid dual eligibles (Title XVIII/IXX), and Children's Special Health Care Services (CSHCS) dual eligibles (Title V/XIX)</p>	<p>Random sample by facility of CHAMPS specialty code B205 that crosswalks to Legacy Provider Type 30 Inpatient Hospital</p>	<p>20 records per provider per year; approximately 16 hospitals selected per month Audited providers will be exempt from the review for that year</p>	<p>Review</p>
<p>3. Outpatient and ER Services</p>	<p>Medicaid FFS (Title XIX), Medicare/Medicaid dual eligibles (Title XVIII/IXX), and Children's Special Health Care Services (CSHCS) dual eligibles (Title V/XIX)</p>	<p>Statistically valid random sample</p>	<p>12 providers per year (with the possibility of 15) and approximately 250 beneficiaries per provider</p>	<p>Audit</p>
<p>4. Outpatient and ER Services</p>	<p>Medicaid FFS (Title XIX), Medicare/Medicaid dual eligibles (Title XVIII/IXX), and Children's Special Health Care Services (CSHCS) dual eligibles (Title V/XIX)</p>	<p>Random sample by facility of CHAMPS specialty code B206 or B210 that crosswalks to Legacy Provider Type 40 Outpatient Hospital</p>	<p>20 records per provider per year; approximately 16 hospitals selected per month Audited providers will be exempt from the review for that year</p>	<p>Review</p>
<p>3. Long Term Care Retrospective Review</p>	<p>Medicaid FFS (Title XIX) and Medicare/Medicaid beneficiaries (Title XVIII/XIX) admitted to a nursing facility, the MI Choice Waiver Program or the PACE Program</p>	<p>Targeted random sample of new monthly admissions</p>	<p>1,800 cases per year</p>	<p>Review</p>
<p>4. PACER Validation</p>	<p>Medicaid FFS (Title XIX) and Children's Special Health Care Services (CSHCS) dual eligibles (Title V/XIX) who had a request for a PACER authorization</p>	<p>Statistically valid random sample</p>	<p>All cases in the inpatient audit described in #1 & #2 that had a PACER request/authorization</p>	<p>Audit/Review</p>

**1.022 Work and Deliverable**

Contractor must provide Deliverables/Services and staff, and otherwise do all things necessary for or incidental to the performance of work, as set forth below:

INPATIENT PRIOR AUTHORIZATION-PACER-TELEPHONIC/ELECTRONIC REVIEW PROCESS

1. Maintain absolute confidentiality of providers and beneficiaries assuring that no disclosure of information that may identify provider(s) or beneficiary(s) is shared inappropriately.
2. The Contractor shall provide for PACER the telephonic prior authorization system and provide access and utilize the MDCH computer prior authorization system that shall include, at a minimum, all of the following:
 - a. clinically experienced Registered Nurses to receive the authorization request, elicit all relevant information and reach an initial decision based on admission criteria approved by MDCH
 - b. use of appropriately qualified physicians to assist the Registered Nurses in their decision as appropriate, to query requesters in all questioned requests and render all denial determinations
 - c. render and communicate by telephone/electronic computer system all authorization decisions on the same day requested
 - d. generate and communicate to the requesting provider a unique identifying PACER authorization/tracking number for each authorized case
 - e. data processing storage and retrieval of all requests, i.e., documentation and disposition, requesting providers, and other information taken in by the system as part of the request for prior authorization
 - f. the Contractor will maintain a toll-free PACER telephone number and electronic computer system for the providers to request a PACER authorization/tracking number. The Contractor shall answer all incoming phone calls promptly with average time to answer of less than ninety (90) seconds
3. The PACER system shall certify as appropriate for Medicaid Fee For Service (Title XIX), Children's Special Health Care Services dual eligible (Title V/XIX) beneficiaries: all elective inpatient hospital admissions; all re-admissions within fifteen (15) days; all transfers between hospitals and between units within a single hospital having different Medicaid ID/National Provider Identifier/Taxonomy Code numbers or provider types; all admissions and continued stays for inpatient rehabilitative facilities.
4. The basis of the decisions shall include the medical need and appropriateness of the following:
 - a. the condition to be treated on an inpatient basis
 - b. to have treatment continued for rehabilitative facilities
 - c. to be treated at another hospital if already hospitalized
 - d. to be re-hospitalized

Denials for inpatient admissions and any changes to the request shall be transmitted to the MDCH. The Contractor must send an adverse action notice developed by the State Office of Administrative Hearings and Rules for MDCH to Medicaid and Medicaid/CSHCS dually enrolled beneficiaries utilizing the appropriate denial statement. The beneficiary will be notified of a denial of services for an elective admission. Transfers and readmissions within fifteen (15) days do not need a notice to the beneficiary as no services were suspended, terminated or reduced. An appeals form (DCH-092 Hearing Request) provided by the State must accompany the adverse action notice to the beneficiary. The adverse action notice and appeal form must be sent to the beneficiary the day of the adverse action. Copies of all adverse action notices shall be sent to the MDCH Contract Manager on a monthly basis.

Providers are notified verbally at the time of the telephonic/computer request and given appeal rights verbally at the same time.



5. It is essential that the Contractor has the capability to access and utilize the MDCH electronic computer authorization/tracking for all PACER requests.

The payment system reads the PACER authorization/tracking numbers, compares information, and suspend or deny payment of inappropriate claims for various reasons by edits.

6. The Contractor shall develop a process for PACER and it must include:

a. The review is initiated by the attending physician or designated other, by telephone or electronically, requesting prior authorization for a patient's elective admission, a transfer, readmission within fifteen (15) days, or continued stay for inpatient rehabilitative facilities. The Contractor must have the capability, as defined by HIPAA, to receive and respond electronically to all prior authorization requests including the adverse action notice.

b. In a transfer/readmission within fifteen (15) days (to another hospital), should the transferring physician not obtain an authorization as required, the receiving physician or second hospital may request this before the beneficiary is discharged.

c. Any case request must include at the minimum; beneficiary ID number, sex, birth date, county of residence, procedure code, hospital name, transfer code (transfer, readmission, urgent/emergent/elective), discharge date of first admission, justification code (reason for admission), and patient's name (required for physician advisor referrals).

7. If the Severity of Illness/Intensity of Service (SI/IS) admission criteria approved by MDCH and/or Policy are met, the Contractor's nurse approves the admission and a PACER authorization/tracking number is issued to the physician. The number is valid for thirty (30) days and must be entered for hospital claims for the admission.

8. If the criteria screens are not met or if there are any questions requiring medical judgment, the case shall be referred to a Contractor's physician consultant by the Contractor's nurse. The Contractor's physician consultant may confer by telephone with the attending physician. Ninety eight percent (98%) of referral cases must be resolved, either approved or denied for Medicaid coverage by the Contractor during the same day of the request. All cases must be resolved within one working day of the request. Cases approved by the physician will be considered complete. The Contractor will report all adverse determinations to the MDCH after the reconsideration process is completed.

9. The Contractor shall have a process to reconsider denials of all PACER reviews at the request of the provider. At a minimum, the process must include:

a. Reconsideration must be requested by the provider within three (3) working days of receipt of the denial.

b. The Contractor will provide a reconsideration of adverse determinations upon written request from the provider(s).

c. All reconsiderations will be conducted by a like specialty physician (when applicable) who will consider the entire medical record and all additional written information supplied by the provider who performed the services. The Contractor must complete reconsideration decisions for elective admissions (excluding rehab) and retrospective PACER requests within thirty (30) working days. The Contractor must complete reconsideration decisions for all transfers, rehab admissions and continued stay within one (1) working day of receipt of the request or the date of receipt of written documentation.



- d. The Contractor shall have a two-step review process to review all denials at the request of the hospital or physician. The original request, if denied by the Contractor review coordinator (RN), goes to the Contractor physician for review. If denied, the provider is verbally told of the denial and given appeal (reconsideration) rights. The second request (reconsideration) is submitted via a Request for Retrospective PACER Review form, (this may include a complete medical record), with a detailed description of the case including case specific information. If denied, the provider is informed verbally that they may appeal to MDCH.
- e. Whenever possible the Contractor shall match the reviewing physician specialty with that of the attending physician's. After the initial denial by the first physician, the affected parties have a right to reconsideration by a second physician.
10. Should the provider request an appeal of a denied PACER from the Contractor they may appeal to MDCH. The provider is to submit the medical record for review to the MDCH Office of Medical Affairs. The Office of Medical Affairs will make the determination. Should the denied service be overturned, then a PACER number will be authorized by MDCH and assigned by the Contractor. Should the case be upheld by the Office of Medical Affairs, then a letter of denial will be sent by the Contractor. The MDCH Contract Manager will notify the Contractor of the PACER decision verbally and follow-up with a faxed memo. Provider appeals to the MDCH will be conducted so that whenever possible, multiple claim appeals from an individual provider will be heard together.
11. For the inpatient rehabilitative facility, inpatient stays beyond thirty (30) days in the rehabilitation hospital require additional inpatient authorization. The provider must contact the Contractor between the 27th and 30th days if the stay is expected to exceed thirty (30) days. If the extended stay is approved, a PACER authorization/tracking number is issued to the provider. If the stay is expected to exceed sixty (60) days, the provider must call the Contractor between the 57th and 60th days of stay for additional inpatient authorization. If the additional extended stay is approved, the Contractor will issue another PACER authorization/tracking number to the provider. For any case not meeting admission criteria approved by the MDCH, the Contractor's nurse shall refer the case to the Contractor's physician consultant. The remainder of the review and approval/disapproval process follows that of the PACER review. Any authorization denial of any extended stay review point terminates Medicaid coverage of the hospital stay.
12. The Contractor must have the capability to access and utilize the MDCH electronic prior authorization system.
13. Complete data for all requests shall be individually stored and retrievable by the Contractor for seven (7) years.
14. The Contractor must be able to provide the MDCH access to the Contractor's PACER Program by a means determined by the MDCH within one (1) month of startup.
15. All documents and/or information obtained by the Contractor from the MDCH in connection with this Contract shall be kept confidential and shall not be provided to any third party unless disclosure is approved in writing by the MDCH.
16. The Contractor shall specify the number of staff dedicated to the duties explained in this contract and provide credentialing data prior to the start of this Contract.
17. The PACER/Authorization Tracking number will be generated by MDCH/Community Health Automated Medicaid Processing System.
18. Grouper 26 is currently being used, however, the Grouper that was in effect all the time the services were provided must be utilized for Inpatient audits and Statewide Utilization Review. There are no modifiers/codes for retrospective exemptions to prior authorization. C. ii. 27 pertains to Inpatient/Outpatient audit process.



Contractor Response to Tasks:

OUR PACER PROCESS IS COMPLIANT, TIMELY, AND HAS BEEN OPERATING EFFECTIVELY FOR MORE THAN 21 YEARS.

MDCH projects that the contractor will complete approximately 10,800 cases on an annual basis. Of the PACER reviews MPRO processed during 2008, our RNs completed 9,099 and our physician reviewers completed 2,701 for inpatient review services. Approximately 93% of PACER authorization requests are approved. The PACER review process is conducted in accordance with the guidelines and timeframes established by MDCH. Our process ensures the utmost confidentiality of beneficiary and provider information, assuring that information is not disclosed to outside parties without appropriate consent. This section describes our review process and criteria use for PACER authorizations.

PACER REVIEW PROCESS

The review process begins when the attending provider or designated member of the provider's staff initiates a request for a PACER authorization via telephone or electronically through the MDCH web site. MPRO maintains a toll-free number dedicated to PACER review. Our nurse reviewers answer all calls promptly with an average time to answer of less than 90 seconds. A Michigan-licensed review nurse, RN/PACER Review Coordinator, conducts each PACER review. The RN/PACER Review Coordinators are experienced and cross-trained on all inpatient PACER review types. These qualifications ensure that they efficiently gather the necessary non-clinical and clinical information, refer to physician reviewers when appropriate, and accurately communicate authorization decisions to providers. Patient confidentiality is strictly maintained throughout the entire process.

TYPES OF REVIEW

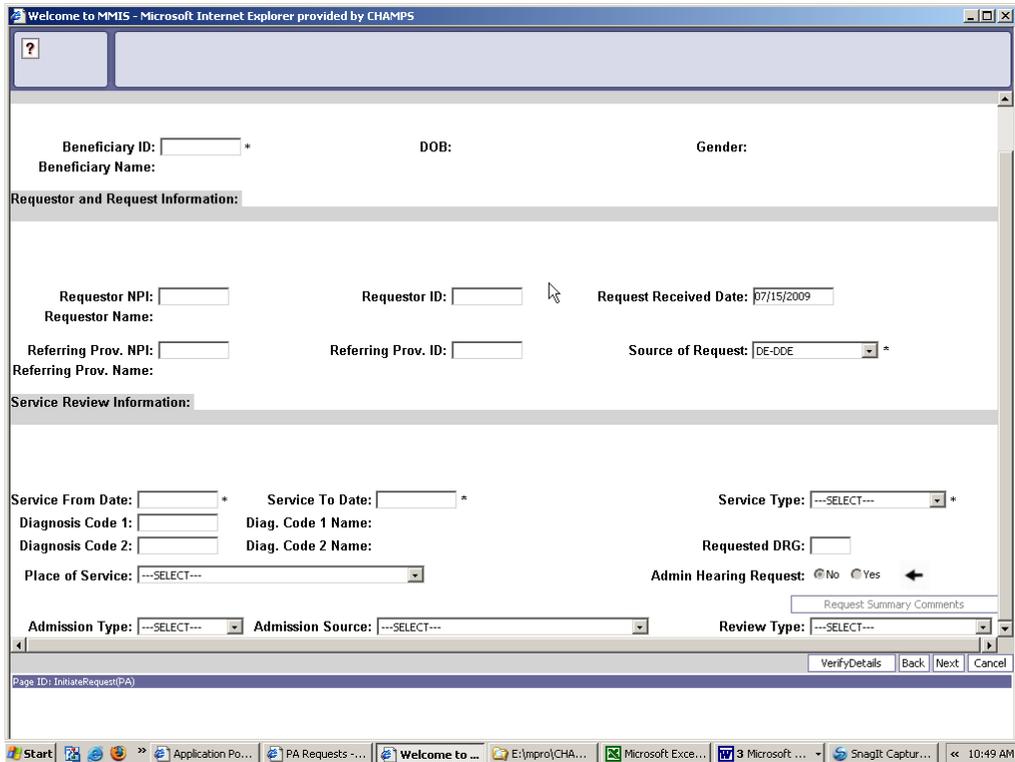
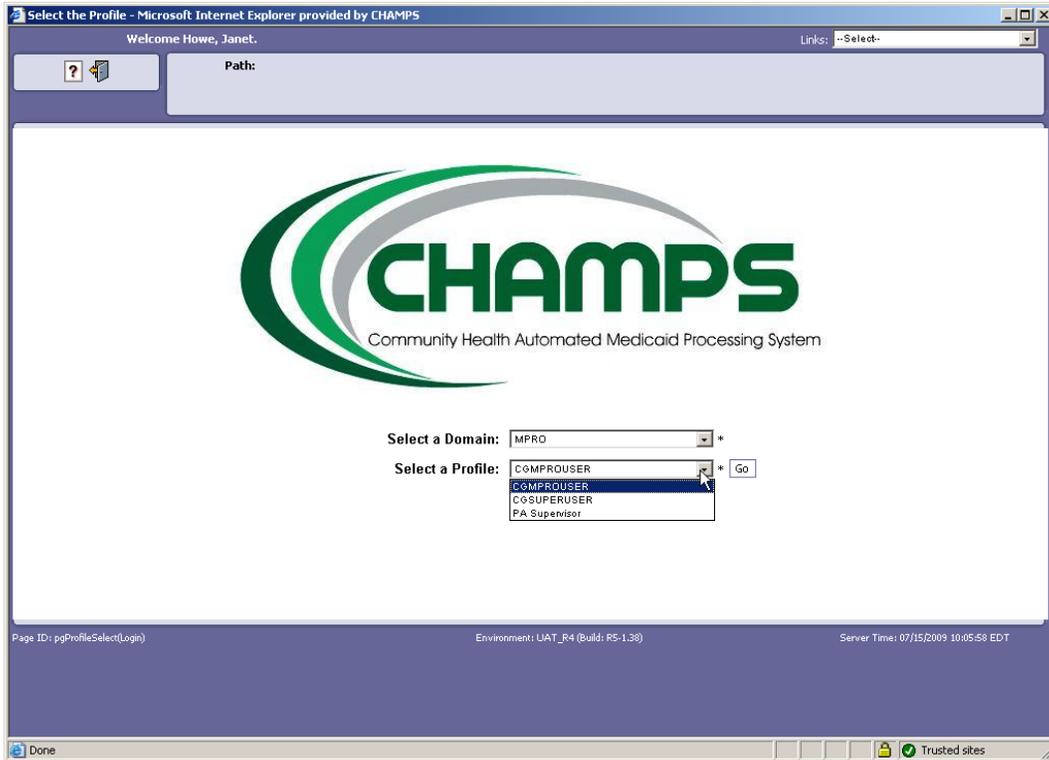
The clinical documentation required varies on the type of PACER review conducted. MPRO performs PACER authorizations for the following types of cases:

- All elective inpatient admissions;
- Transfers from acute facilities to rehabilitation facilities;
- Transfers from rehab facilities to acute facilities;
- Transfers from one acute facility to another acute facility;
- Any readmission to the same hospital within 15 days;
- Any readmission to a different hospital within 15 days;
- Admission reviews for rehabilitation facilities;
- Continued stay reviews for rehabilitation admissions at 30 days; and
- Continued stay review for rehabilitation admissions at 60 days.

In addition to the aforementioned requirements, MPRO will evaluate that, at a minimum, the case information includes: sex, birth date, county of residence, procedure code, hospital provider name, discharge date of first admission for readmission reviews, justification code, and the patient's name (if referring the case).

DOCUMENTATION OF NON-CLINICAL INFORMATION

The RN/PACER Review Coordinator collects and enters the beneficiary information, call information, and admission information. This is entered into CHAMPS.



The Review Coordinator searches the CHAMPS database using the Requestor and Request Information screen. The Review Coordinator enters a ten-digit beneficiary ID number in the Beneficiary ID box. If there are no duplicates, the Review Coordinator will 'add new request.' The following information is entered:



- Beneficiary ID (10 digits)
- Requestor NPI (Required Field)
- Source of Request (Paper or Phone)
- Service From Date (Admission Date)
- Service to Date (mm/dd/yy)
- Service Type (Hospital or Rehab)
- Admission Type (Urgent, Elective, Newborn)
- Review Type (Readmit, Elective, Transfer, Rehab 30 and 60)

After the entry of this information, the Review Coordinator clicks Next.

Entry continues on the PA Provider and Procedure Code Info screen and includes:

- The Servicing Provider (Requesting Provider)
- Code Qualifier
- Code

To complete the entry, the Review Coordinator clicks **Add**. This allows the system to create the episode of review.



PA Provider And Procedure Codes Info:

Tracking No.: _____ Beneficiary ID: _____ Beneficiary Name: _____
 Service From Date: _____ Service To Date: _____

Servicing Prov NPI: [] Servicing Prov ID: [] Code Qualifier: [] * Code : [] *
 Servicing Prov Name: _____

Proc From Date: [] * Proc To Date: [] * Line Status: [] *
 Modifier 1: [] Modifier 2: [] Modifier 3: [] Modifier 4: []
 Part Number: [] Specialty Code: []

Quantity And Amount:

Quantity/Units	Requested	Authorized
[]	[]	[]
\$ Amount	[]	[]

Auth Comments History: [] Auth Status: [] * Decision Maker: [] * Decision Date: [] *

Service Lines Grid:

Line #	Srcv Prov NPI	Srcv Prov ID	Code	Mod1	Mod2	Part Nbr	Req Units	Req \$ Amt	Auth Units	Auth \$ Amt	From Date	To Date	Status
[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]

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View Status History | Back | Next | Cancel

Above is the created service line for episode of review.

DOCUMENTATION OF CLINICAL INFORMATION

The Review Coordinator proceeds with questions related to the medical necessity of the admission, readmission, transfer, or rehab stay. The Review Coordinator adds the information to the **Auth Comments History** and then clicks **Add Comments**.

CommentsList - Microsoft Internet Explorer provided by CHAMPS

Tracking No.: _____

Close | Add Comments | Show All Comments

Comments:

Date & Time	Type	Comments	Created By

Page ID: dgPACommentsList(PA)

Done | Trusted sites

The Review Coordinator selects the comment type "Nurse Reviewer" and enters notes regarding the case.



To establish and maintain credibility with providers, the PACER authorization process uses clearly defined criteria in a consistent manner. In making the determination about whether to approve or refer the case to a physician reviewer, the Review Coordinator utilizes MDCH-approved InterQual® criteria to identify the severity of illness (SI) and intensity of service (IS). In addition, on a 15-day readmission, the Review Coordinator evaluates whether the patient appeared stable at the time of first discharge and considers if the readmission may have been because the patient was discharged prematurely. A premature discharge is any discharge in which the readmission could have been avoided if the appropriate care and services would have been provided during the first admission.

Transfer reviews adhere to Medicaid policy. The Medicaid Provider Manual, Billing and Reimbursement, Section 5.3 states: "Prior authorization for a transfer is granted only if the transfer is medically necessary and the care/treatment is not available at the transferring hospital. Transfer for convenience is not considered." Intake information includes the Review Coordinator evaluating the medical necessity of the transfer. A Review Coordinator will authorize the transfer if the care is medically necessary and the transferring hospital is not equipped to provide it.

The Review Coordinator enters the notes and clicks **OK**.



Welcome to MMIS - Microsoft Internet Explorer provided by CHAMPS

PA Provider And Procedure Codes Info:

Tracking No.: _____ Beneficiary ID: _____ Beneficiary Name: _____
 Service From Date: _____ Service To Date: _____

Servicing Prov NPI: [] Servicing Prov ID: [] Code Qualifier: [] + Code: [] +
 Servicing Prov Name: _____

Proc From Date: [] + Proc To Date: [] + Line Status: Requested [] +
 Modifier 1: [] Modifier 2: [] Modifier 3: [] Modifier 4: []
 Part Number: [] Specialty Code: []

Quantity And Amount:

	Requested	Authorized
Quantity/Units	[]	[]
\$ Amount	[]	[]

Add

Authorization Decision:

Auth Comments History [] **Auth Status:** Requested [] + **Decision Maker:** [] + **Decision Date:** []

Service Lines Grid:

Returned [] Deny [] Delete []

Line #	Svc Prov NPI	Svc Prov ID	Code	Mod1	Mod2	Part Nmbr	Req Units	Req \$ Amt	Auth Units	Auth \$ Amt	From Date	To Date	Status
[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]

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The Review Coordinator enters the determination in the following order:

- Line status decision
- Auth Status
- Decision Maker
- Decision Date (defaults to current date)
For PA review, enter actual date.

After the Auth Status and Decision Maker entry, another mandatory comment box opens. The Review Coordinator adds additional comments regarding the rationale behind the determination. Upon approval, an authorization/tracking number is issued and the case is completed. If the Review Coordinator is unable to approve the case, it is referred to a physician reviewer.



Welcome to MMIS - Microsoft Internet Explorer provided by CHAMPS

PA Provider And Procedure Codes Info:

Tracking No.: _____ Beneficiary ID: _____ Beneficiary Name: _____
 Service From Date: _____ Service To Date: _____

Servicing Prov NPI: _____ Servicing Prov ID: _____ Code Qualifier: _____ * Code: _____ *
 Servicing Prov Name: _____

Proc From Date: _____ * Proc To Date: _____ * Line Status: Requested *
 Modifier 1: _____ Modifier 2: _____ Modifier 3: _____ Modifier 4: _____
 Part Number: _____ Specialty Code: _____

Quantity And Amount:

	Requested	Authorized
Quantity/Units	_____	_____
\$ Amount	_____	_____

Add

Authorization Decision:

Auth Comments History: _____ Auth Status: Approved * Decision Maker: _____ * Decision Date: _____ *

Auth Status Comments: _____

Service Lines Grid:

Returned | Deny | Delete

Line #	Srcv Prov NPI	Srcv Prov ID	Code	Mod1	Mod2	Part Nmbr	Req Units	Req \$ Amt	Auth Units	Auth \$ Amt	From Date	To Date	Status

View Status History | Back | Next | Cancel

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PHYSICIAN REFERRAL AND REVIEW

All MPRO physician reviewers are board certified and in active practice. Physician reviewers are the only ones who make a denial determination. The physician reviewer uses clinical knowledge and judgment, knowledge of state and federal regulations, and additional clinical information obtained from discussions with the attending physician to determine if the proposed care is within the definition of current standards of care and is appropriate for Medicaid coverage. The physician reviewer determination is entered into CHAMPS and the rationale is documented in comments.

Physician reviewer referrals will continue to be resolved (approved or denied) during the same day as the request at a rate of 98%, and all cases will be resolved within one working day of the request. Approvals are completed cases.

RENDER AND COMMUNICATE DECISION

If the physician reviewer approves a referred case, the Review Coordinator contacts the provider and issues an authorization/tracking number. If the physician denies a case, the Review Coordinator notifies the provider of the denial and immediately advises him/her of the right to request reconsideration. For elective admission denials, the Review Coordinator sends the beneficiary an Adverse Action Notice. The appeals form (DCH-092 Hearing Request) is enclosed with this notice. MPRO uses the Adverse Action Notice developed by the State Office of Administrative Hearings and Rules for MDCH, which includes the appropriate denial statement. Transfers and 15-day readmissions do not receive written notification because they are not terminated, suspended, or reduced services.

MPRO sends all denials to MDCH along with a copy of each negative action letter. We ensure MDHC approves all letters and forms, and we ensure we are compliant with the content and timeframes required by the State.

RECONSIDERATION OF DENIALS

Following a denial of a review, MPRO verbally notifies the provider that he/she has three working days to request reconsideration. We also advise the provider that upon receipt of the written request to reconsider the denial, the case is reviewed by a physician of like specialty (when applicable), who is board certified and actively practicing. The physician reviewer considers all documentation supplied by the provider. MPRO has and will continue to complete reconsiderations for elective admissions (excluding rehab) and retrospective PACER requests within 30 working days.

We complete reconsiderations of all transfers, rehab admissions, and continued stays within one working day of receipt of the request or the date of receipt of written documentation.

After the reconsideration process is completed, we report all adverse determinations to MDCH.



APPEALS

Providers may appeal a denied PACER directly to MDCH. MPRO instructs the provider to submit the medical record to the MDCH Office of Medical Affairs (OMA). If OMA overturns a denied service, MDCH notifies MPRO and an authorization/tracking number is assigned. If the denial is upheld, OMA will notify MPRO, and we will send a letter to the provider upholding the denial.

The following flowcharts provide an overview of the five PACER review types.

Figure 1: PACER Elective Admission Review Process

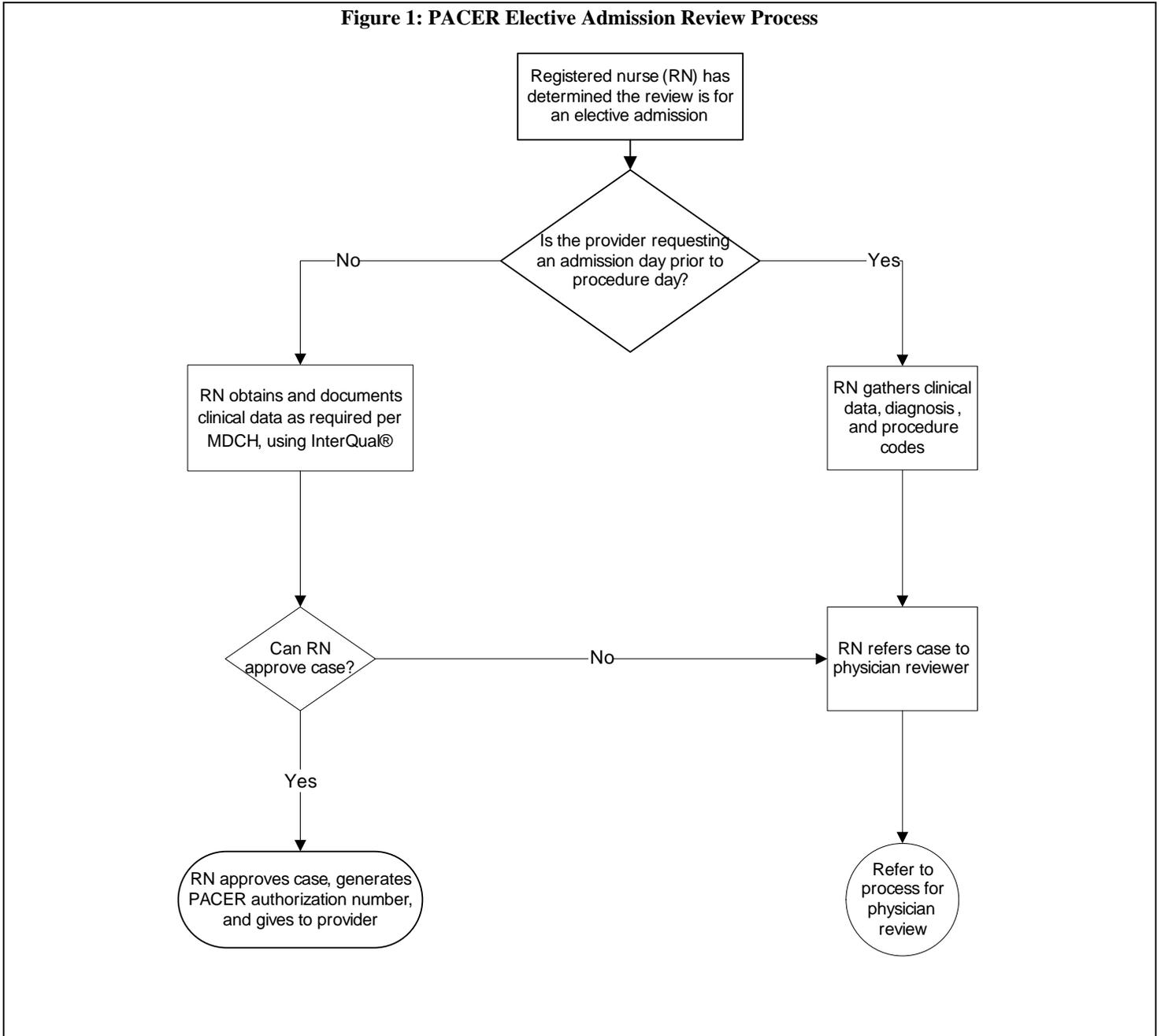




Figure 2: PACER Readmission Review Process

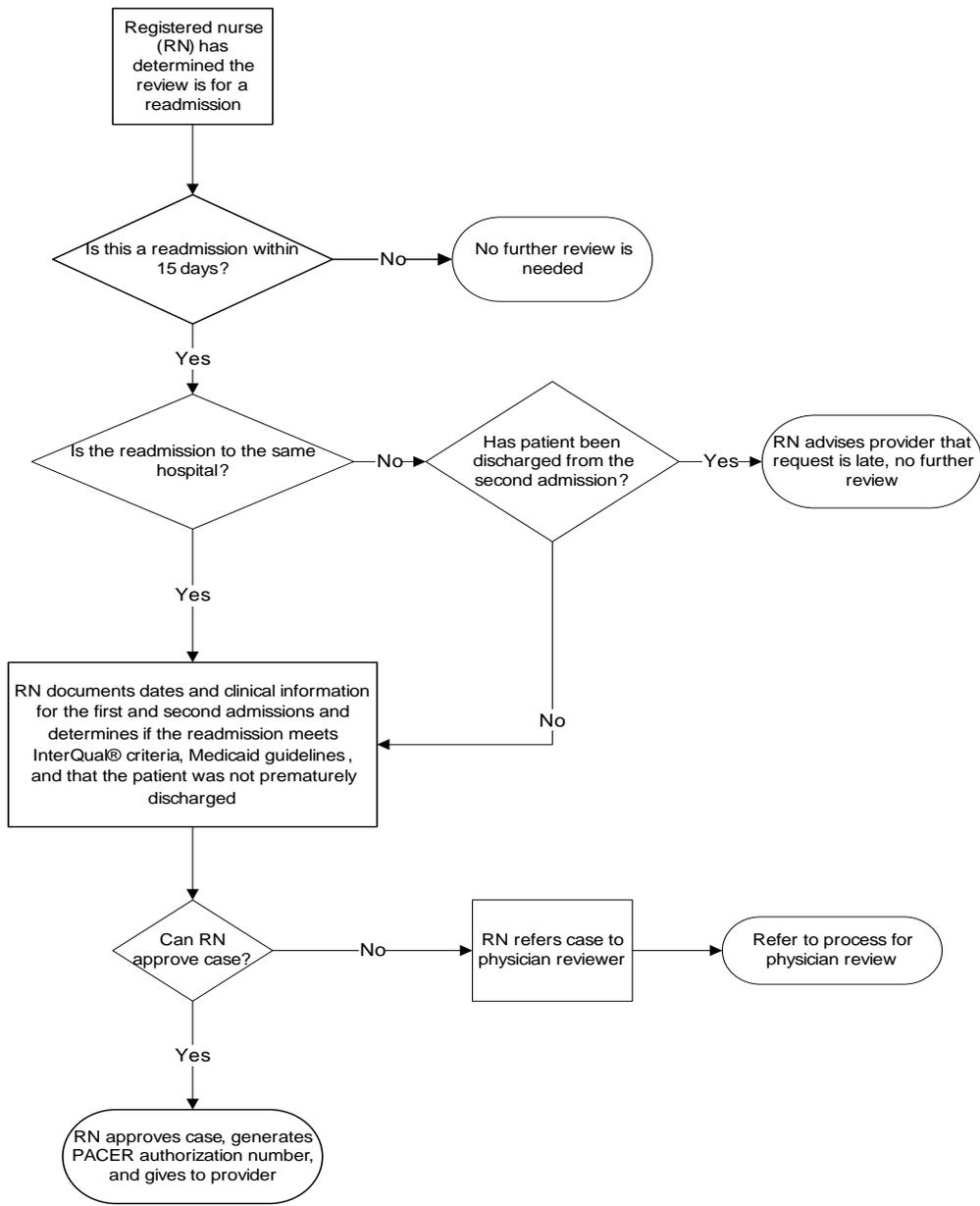




Figure 3: PACER Transfer Review Process

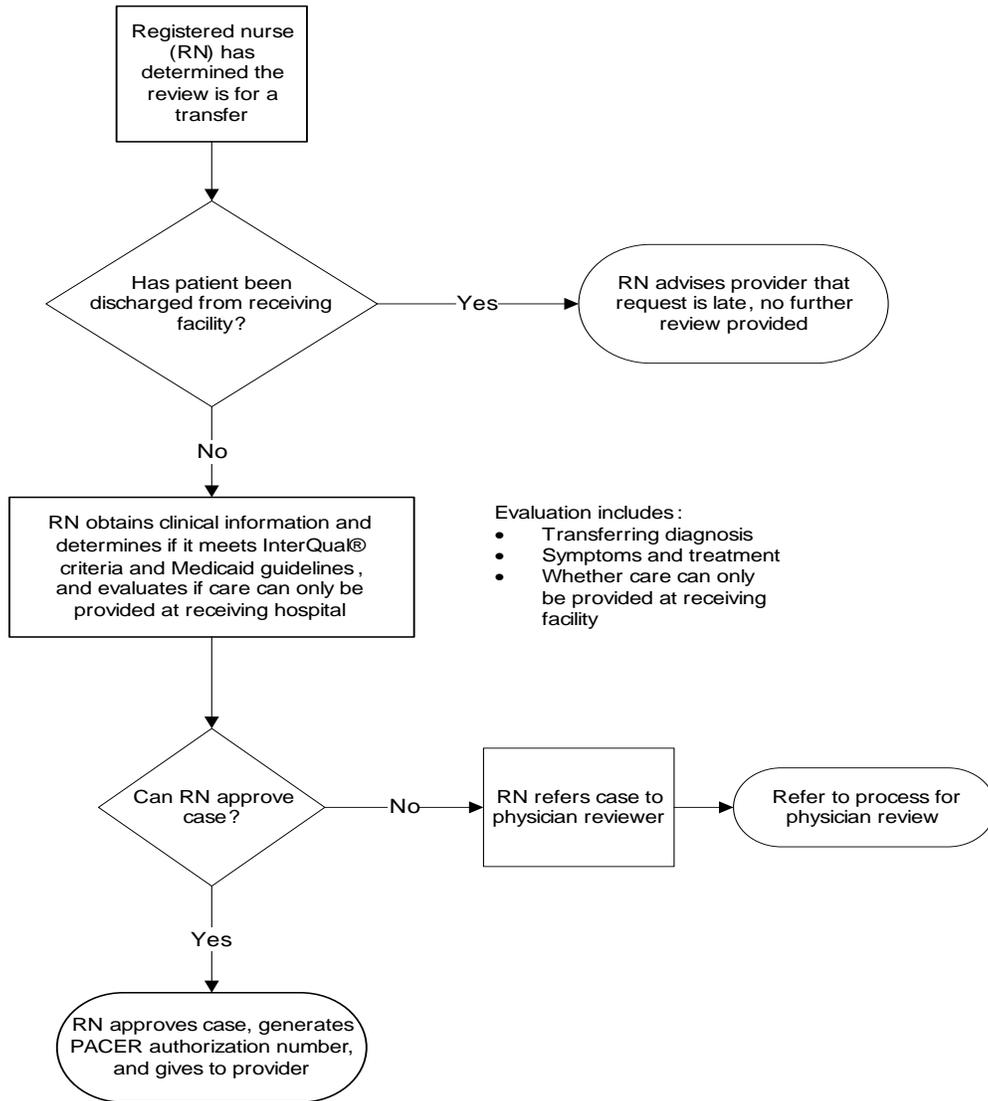




Figure 4: PACER Rehabilitation Continued Stay Review Process

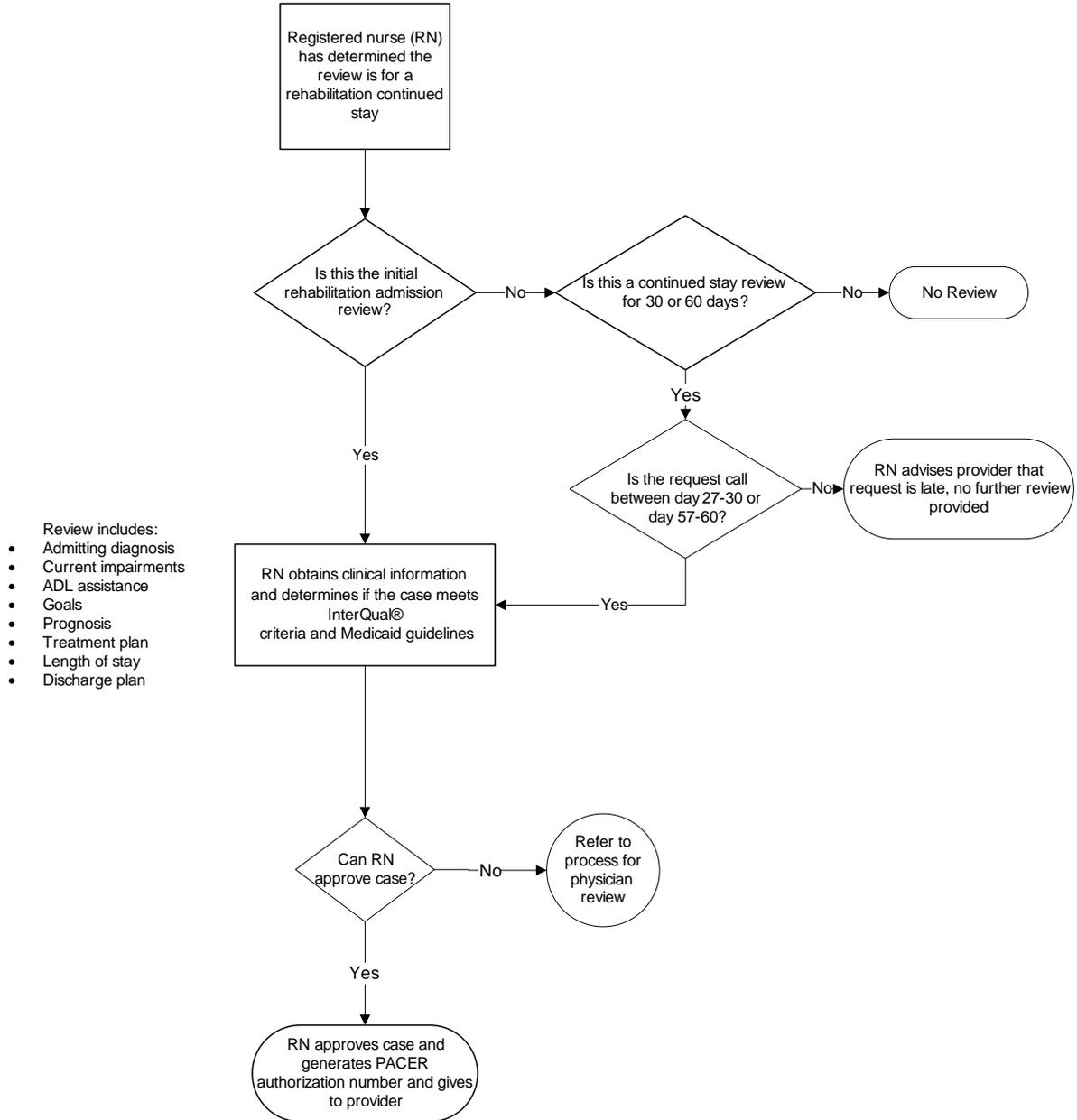
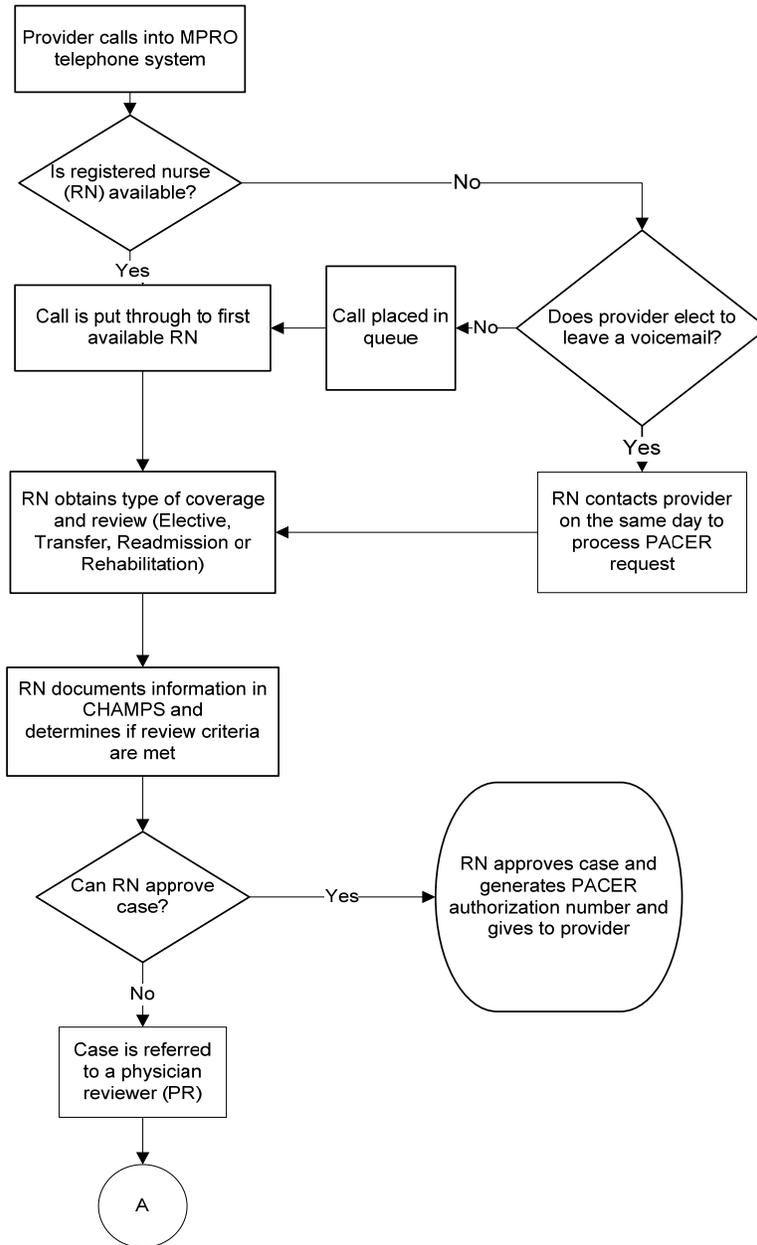




Figure 5: PACER Authorization



Inpatient Hospital, Long Term Care Immediate Review NOTICE OF NON-COVERAGE and Long Term Care Exception Review Process

1. Inpatient Hospital:
The hospital inpatient utilization review committee may issue a notice of non-coverage to the patient if it determines that the admission or continued stay in the hospital or nursing facility is not medically necessary.



If the patient or patient's representative disagrees with the notice, the patient or representative may contact the Contractor to appeal the decision. If the Contractor has previously issued an adverse determination for the period of hospitalization covered by the notice, the Contractor informs the patient or patient representative of concurrence with the hospital decision. If the Contractor has not previously issued an adverse determination for the period, a review of the medical record is conducted. The Contractor contacts the hospital program to obtain a copy of the medical record. A Contractor physician advisor reviews and issues a decision on the case within three (3) days of the receipt of the final determination and the related documentation. The Contractor will provide the written decision along with the Appeal Process if the Contractor agrees with the hospital provider.

If issued, the notice is the responsibility of the hospital/nursing facilities utilization review committee and is not related to any decision that may have been rendered by the Contractor on the case. The decision must be based on the findings of the utilization review committee and not on the determination of the Contractor.

As with any benefit denial, the beneficiary may request an administrative hearing.

The Administrative Tribunal provides an administrative hearing to appellants requesting a hearing who do not agree with a decision made by the MDCH or a MDCH contracted agency (i.e., any agency, organization, or health plan contracted by the MDCH) that either determines eligibility for a department program, or delivers a service provided under a department program to a beneficiary, patient or resident. The State Office of Administrative Hearings and Rules issues timely, clear, concise and legally accurate hearing decisions and orders. The State Office of Administrative Hearings and Rules Policy and Procedures Manual is located on the MDCH website www.Michigan.gov/mdch, click on links to Inside Community Health, Policy and Legal Affairs, State Office of Administrative Hearings and Rules. This website explains the process by which each different type of case is brought to completion.

2. Long Term Care Immediate Review:

- a. Maintain absolute confidentiality of providers and beneficiaries assuring that no disclosure of information that may identify provider(s) or beneficiary(s) is shared inappropriately.
- b. The Contractor shall provide an Immediate Review when the program/provider has issued an adverse/adequate action notice to the beneficiary and the beneficiary/beneficiary representative has requested an Immediate Review before noon of the first business day following receipt of the action notice.
- c. The Contractor's clinically experienced Registered Nurses shall provide Immediate Reviews upon request of the ineligible beneficiary/beneficiary representative as follows:
 - i. clinically experienced Registered Nurses shall receive the Immediate Review request by telephone or in writing from the beneficiary/beneficiary's representative and shall perform, at a minimum, all of the following:
 - aa. Elicit all relevant medical documentation (medical records from the past sixty (60) days from the date of the request for the Immediate Review, including physician and nursing progress notes, skilled therapy notes, plan of care, physician orders and logs identifying risk, services or therapy days, and the most current MDS (nursing facilities and PACE) or most current MDS-HC (MI Choice Waiver);
 - ii. complete all required fields in the Contractor's portion of the online Michigan Medicaid Nursing Facility Level of Care Determination
 - aa. Exception or Immediate Review
 - bb. Provider Call Date and Time
 - cc. NRC ID
 - dd. Information Summary
 - ee. Determination Date and Time
 - ff. RC ID
 - gg. Denial Upheld or Approved
 - hh. Approval Code (if Approved)
 - ii. Final Denial Letter Date (if Denied) (Attachment D-E)
 - iii. reach a determination based on current Nursing Facility Level of Care Exception criteria within three (3) business days of receiving medical documentation;



- iv. notify the provider and the ineligible beneficiary of the Immediate Review determination on the date of the determination:
 - aa. A determination of 'ineligibility' shall be issued in writing to the beneficiary/beneficiary's legal representative by way of an adequate or advanced action notice. The notices shall include appeal rights. An appeals form (DCH-092 Hearing Request) provided by the State shall accompany the adequate and advanced action notices.
 - bb. A determination of 'ineligibility' shall be issued to the provider telephonically within three business days of receiving medical documentation.
 - cc. A determination of 'eligibility' shall be issued telephonically to the beneficiary/beneficiary's legal representative and to the provider within three (3) business days of receiving medical documentation.
 - v. The Contractor shall maintain a toll-free telephone number for providers/programs and beneficiaries to request an Immediate Review. The Contractor shall answer all incoming phone calls promptly with average time to answer of less than ninety (90) seconds.
- d. The Contractor shall not perform an Immediate Review under the following conditions:
- i. An Exception Review or Retrospective Review has been conducted based on the same beneficiary's Michigan Medicaid Nursing Facility Level of Care Determination and/or review period;
 - ii. An ineligible Michigan Medicaid Nursing Facility Level of Care Determination does not exist in the online database for the same beneficiary under the same provider/program;
 - iii. If the provider has not issued an adequate or advanced action notice to the beneficiary/beneficiary's legal representative;
 - iv. If the MI Choice Waiver program participant has received an adequate action notice addressing **only** the **suspension** or **reduction** of MI Choice Program **services** and the suspension or reduction does not terminate the participant's eligibility in the MI Choice Waiver program;
 - v. If the Michigan Medicaid Nursing Facility Level of Care Determination was conducted for residents/participants who are not Medicaid eligible or Medicaid Pending beneficiaries.

Contractor Response to Tasks:

NOTICE OF NON-COVERAGE AND IMMEDIATE REVIEWS

When a hospital or long term care facility issues a notice of non-coverage letter for an admission or continued stay, the beneficiary or their representative may contact MPRO to appeal the decision. We have processed and responded to beneficiary appeals of hospital-issued notices of non-coverage as a part of our Medicare contract for more than 25 years. In addition, we currently perform this service for our Medicaid Fee-for-Service Review contract. Timeliness and consistency are critical elements of this review process. This section describes our long-standing process for hospital-issued notices of non-coverage.

Reviews related to hospital-issued notices of non-coverage and long term care immediate review requests are assigned to a RN/PACER Review Coordinator. The assigned Review Coordinator search CHAMPS and/or the web-based Level of Care Determination to determine if MPRO made a previous determination related to the case. If MPRO made a prior adverse determination regarding the hospital or long term care admission, no further review is conducted. The Review Coordinator notifies the beneficiary/representative that we are in agreement with the hospital or long term care facility's determination.



If the Review Coordinator discovers that there has not been a previous determination by MPRO related to the case, he or she contacts the hospital, long term care facility, or waiver agency to request a copy of the medical record. Once the record is obtained, the Review Coordinator reviews the case and, if it is a hospital-issued notice, coordinates with the physician reviewer who reviews the records and makes a decision on the case within three days of receipt of the medical records. Once a decision is made, the Review Coordinator will contact the provider and the beneficiary by telephone to inform them of the outcome. If MPRO agrees with the provider, we follow up the verbal notification with an Adverse Action Notice sent to the beneficiary. Enclosed with this notice is an appeals form DCH-092 Hearing Request. We use the Adverse Action Notice developed by the State Office of Administrative Hearings and Rules for MDCH, which includes the appropriate denial statement.

Long term care immediate review requests are handled in a similar manner except the case is not sent to a physician reviewer. The Review Coordinator makes the decision. MPRO will not perform reviews under the following conditions:

- An exception or retrospective review has been conducted based on the same beneficiary's MI Medicaid Level of Care Determination and/or review period;
- An ineligible MI Medicaid Nursing Facility Level of Care Determination does not exist in the online database for the same beneficiary under the same provider/program;
- If the provider has not issued an Adequate or Advanced Action Notice to the beneficiary/beneficiary's legal representative;
- If the MI Choice Waiver Program participant has received an adequate action notice addressing only the suspension or reduction of MI Choice Program services, and the suspension or reduction does not terminate the participant's eligibility in the MI Choice Waiver Program;
- If the MI Medicaid Nursing Facility Level of Care Determination was conducted for residents/participants who are not Medicaid-eligible or Medicaid-pending beneficiaries.

Once the Review Coordinator is confident the case is eligible to continue as an immediate review, he or she takes verbal information from the beneficiary or the beneficiary's representative. Then, the Review Coordinator contacts the long term care facility or MI Choice Waiver agency to obtain further information. The Review Coordinator:

- Advises the provider that relevant medical documentation is needed from the past 60 days from the date of the immediate review request. This may include physician information, nursing progress notes, skilled therapy information, plan of care, physician orders/logs identifying risk, services or therapy days, and most current MDS (nursing facilities and PACE) or most current MDS-HC (MI Choice Waiver).
- Considers all available information and determines if the beneficiary meets the MI Medicaid Exception Criteria (see Long Term Care Exception Criteria below)
- Logs into the State's Level of Care Determination web portal and pulls up the beneficiary
- Indicates that the case is an immediate review request
- Inputs the following information into the database:
 - Date/time of the request
 - His/her ID number
 - Case-specific information
 - Date and time of determination
 - Case determination (denial upheld or approved)
 - Approval code (if approved)
 - Final denial letter date (if denied)

On completion of the review, MPRO sends the beneficiary an Adequate/Adverse Action Notice with DCH-092 Hearing Request form if we concur that the patient does not meet exception criteria. It is the responsibility of the hospital or long term care facility's utilization review committee to decide whether to issue the notice of non-coverage based on their internal process.



If MPRO upholds the decision of the hospital or long term care facility, the beneficiary may appeal the decision by requesting an administrative hearing. The Administrative Tribunal has the responsibility for coordinating administrative hearings related to decisions made by MDCH or its contracted agencies, such as MPRO. The outcome of the administrative hearing is binding on all parties. Our Review Coordinator will assist with preparation and participate in any administrative hearings related to the case, as requested by MDCH.

LONG TERM CARE EXCEPTION REVIEW

1. Maintain absolute confidentiality of providers and beneficiaries assuring that no disclosure of information that may identify provider(s) or beneficiary(s) is shared inappropriately.
2. The Contractor's clinically experienced Registered Nurses shall provide telephonic Exception Reviews upon request of the provider/program who has determined the beneficiary to be ineligible as follows:
 - a. Clinically experienced Registered Nurses shall receive the Exception Review request(s) by telephone. The Contractor shall answer all incoming calls promptly with average time to answer of less than ninety (90) seconds;
 - b. The Exception Review may include all of the following medical information:
 - i. All relevant medical information, verbally (medical information from up to the last sixty (60) days from the date of the exception review request, which may include physician and nursing progress information, skilled therapy information, plan of care, physician orders and logs identifying risk, services or therapy days, and information from the most current MDS (nursing facilities and PACE) or most current MDS-HC (MI Choice Waiver);
 - c. Complete all required fields in the Contractor's portion of the online Michigan Medicaid Nursing Facility Level of Care Determination:
 - i. Exception or Immediate Review
 - ii. Provider Call Date and Time
 - iii. NRC ID
 - iv. Information Summary
 - v. Determination Date and Time
 - vi. RC ID
 - vii. Denial Upheld or Approved
 - viii. Approval Code (if Approved)
 - ix. Final denial letter date (if denied) see Attachment D-E
 - d. Reach a determination based on current Nursing Facility Level of Care Exception criteria within twenty-four (24) hours of the provider/program's call date/time;
 - e. Notify the provider of the Exception Review determination telephonically on the date of the determination:
 - i. A determination of 'ineligibility' shall be issued to the Provider telephonically.
 - ii. A determination of 'ineligibility' shall be issued in writing to the beneficiary/beneficiary's legal representative by way of an adequate or advanced action notice. The notices shall include appeal rights. An appeals form (DCH-092 Hearing Request) provided by the State shall accompany the adequate and advanced action notices.
 - f. The Contractor shall maintain a toll-free telephone number for providers/program to request a telephonic Exception Review. The Contractor shall answer all incoming phone calls promptly with average time to answer of less than ninety (90) seconds.



3. The Contractor shall not perform an Exception Review under the following conditions:
- a. An Immediate Review or Retrospective Review has been conducted based on the same beneficiary's Michigan Medicaid Nursing Facility Level of Care Determination and/or review period;
 - b. An ineligible Michigan Medicaid Nursing Facility Level of Care Determination does not exist in the online database for the same beneficiary under the same provider/program;
 - c. If the MI Choice Waiver program is addressing **only** the **suspension** or **reduction** of MI Choice Program **services** and the suspension or reduction does not terminate the participant's eligibility in the MI Choice Waiver program;
 - d. If the Michigan Medicaid Nursing Facility Level of Care Determination was conducted for residents/participants who are not Medicaid eligible or Medicaid Pending beneficiaries.

Contractor Response to Tasks:

LONG TERM CARE EXCEPTION REVIEW

In October 2004, MDCH implemented a program related to Level of Care Determinations for long term care facilities. MPRO is prepared to meet the projected review volume. Under this contract, we will act as MDCH's designee to review the requests for exceptions to the nursing facility Level of Care Determinations for the following populations:

- Medicaid Covered Nursing Facility Care;
- Michigan Choice Home and Community Based Waiver Program for Elderly and Disabled; and
- Program for All-Inclusive Care for the Elderly.

An exception review begins when a provider is unable to approve an admission or continued stay after performing their level of care assessment. The provider contacts MPRO and requests an exception review. The exception review provides another level for a Medicaid beneficiary to be assessed. As with all of our reviews, we maintain confidentiality of provider and beneficiary information. The following is the MDCH-developed exception criteria to which MPRO adheres.

LONG TERM CARE EXCEPTION CRITERIA

MPRO will continue to perform long term care exception reviews through a review of relevant clinical information based upon exception criteria determined by MDCH. The following is a summary of the current exception criteria from MDCH's policy.

Frailty

The beneficiary has a significant level of frailty as demonstrated by at least one of the following categories:

- Applicant demonstrates late loss Activities of Daily Living (ADLs) (i.e., bed mobility, toileting, transferring, and eating);
- Applicant performs ADLs independently, but requires an unreasonable amount of time;
- Applicant's performance is impacted by consistent shortness of breath, pain, or debilitating weakness during any activity;
- Applicant has experienced at least two falls in the home in the past month;
- Applicant continues to have difficulties managing medications despite the receipt of medication set-up services;
- Applicant exhibits evidence of poor nutrition, such as continued weight loss, despite the receipt of meal preparation services; and
- Applicant meets criteria for Door 3 when ER visits for clearly unstable conditions are considered.

Behaviors

The beneficiary has at least a one month history of any of the following behaviors and has exhibited two or more of these behaviors in the past seven days:

- Wandering;



- Verbal or physical abuse;
- Socially inappropriate behavior; or
- Resists care.

Treatments

The beneficiary has demonstrated a need for complex treatments or nursing care.

MPRO COMPLIANCE WITH LTC EXCEPTION REQUIREMENTS

The following table outlines MDCH's requirements for the long term care exception reviews and our compliance plan.

Table 2: Long Term Care Exception Process Requirements and MPRO Compliance Plan

MDCH Long Term Care Exception Requirements	MPRO Compliance Plan
Telephonic requests will be reviewed in real time and answered with an average time to answer of less than 90 seconds.	MPRO's existing toll free phone system has the capacity to serve the incoming long term care exception calls. It is available upon contract start-up.
Nurse reviewers will use specific MDCH-developed exception criteria to determine appropriate exceptions to the nursing facility level of care criteria.	MPRO follows the exception criteria in the Medicaid policy. Staff are trained and able to perform this review.
Approvals will be documented within the web based tool, citing the exception criteria used.	MPRO will work with MDCH to gain appropriate access to the web-based tool for performing reviews and documentation of findings. Each Review Coordinator will have access to the web-based tool on his/her desktop for data entry.
Beneficiaries and providers will be given appropriate denial notification as required by MDCH. Denials will be noted in the web-based tool.	MPRO is currently in compliance for all notices to beneficiaries and providers under our current FFS Review contract and LTC exception/immediate review contract. MPRO uses MDCH templates.
Contractor will represent MDCH in any administrative appeals.	MPRO currently represents MDCH in appeals related to the PACER program, audit program, long term care exception, and immediate reviews. The Review Coordinator participating in the long term care exception process will be available to provide documentation and to participate in any required appeal hearings.

**LONG TERM CARE EXCEPTION REVIEW PROCESS**

MPRO has experience in performing LTC exception reviews for the State of Michigan and our RNs are available to perform exception review upon provider request. A toll-free line is currently available for providers from 9:00 AM to 5:00 PM, Monday through Friday.

Initially, the RN asks the provider for the following:

- Is the person on Medicaid?
- Is the person Medicaid pending or Medicaid eligible?

If the answer to either question is yes, the RN proceeds with the review. The RN verifies the provider has entered the case specifics, as well as date and time, into the provider portion of the online Level of Care Determination. If the information has not been entered into the web portal, the RN informs the provider that the review cannot proceed.

MPRO will not review a case where an immediate or retrospective review has been conducted based on the same beneficiary's Level of Care Determination and/or review period. MPRO will not review a case when service(s) in the MI Choice Waiver program are being reduced or suspended but the Medicaid beneficiary still is receiving some waiver-covered services.

Once MPRO determines the review can continue, the RN inquires if the beneficiary had a prior Level of Care Determination completed and the date the Level of Care Determination was completed. The RN assessment determines whether this is an exception or immediate review (was an adequate action notice given).

The RN logs into the State's Level of Care Determination web portal and pulls up the beneficiary. The RN takes a verbal review from the provider, which includes medical information up to 60 days from the date of the exception review request such as physician orders or progress notes; nursing progress notes; skilled therapy information; plan of care; and logs identifying risk, services, or therapy days, and most current MDS (nursing facilities and PACE) or most current MDS-HC (MI Choice Waiver).

Concurrently, the RN enters the following information into the online Michigan Medicaid Nursing Facility Level of Care Determination web site:

- Exception or immediate review
- Provider call date/time
- NRC ID
- Information summary (information specific to the beneficiary)
- Determination date/time
- RC ID
- Denial upheld or approved
- Approval code (exception review criteria code), if approved
- Final denial date, if denied

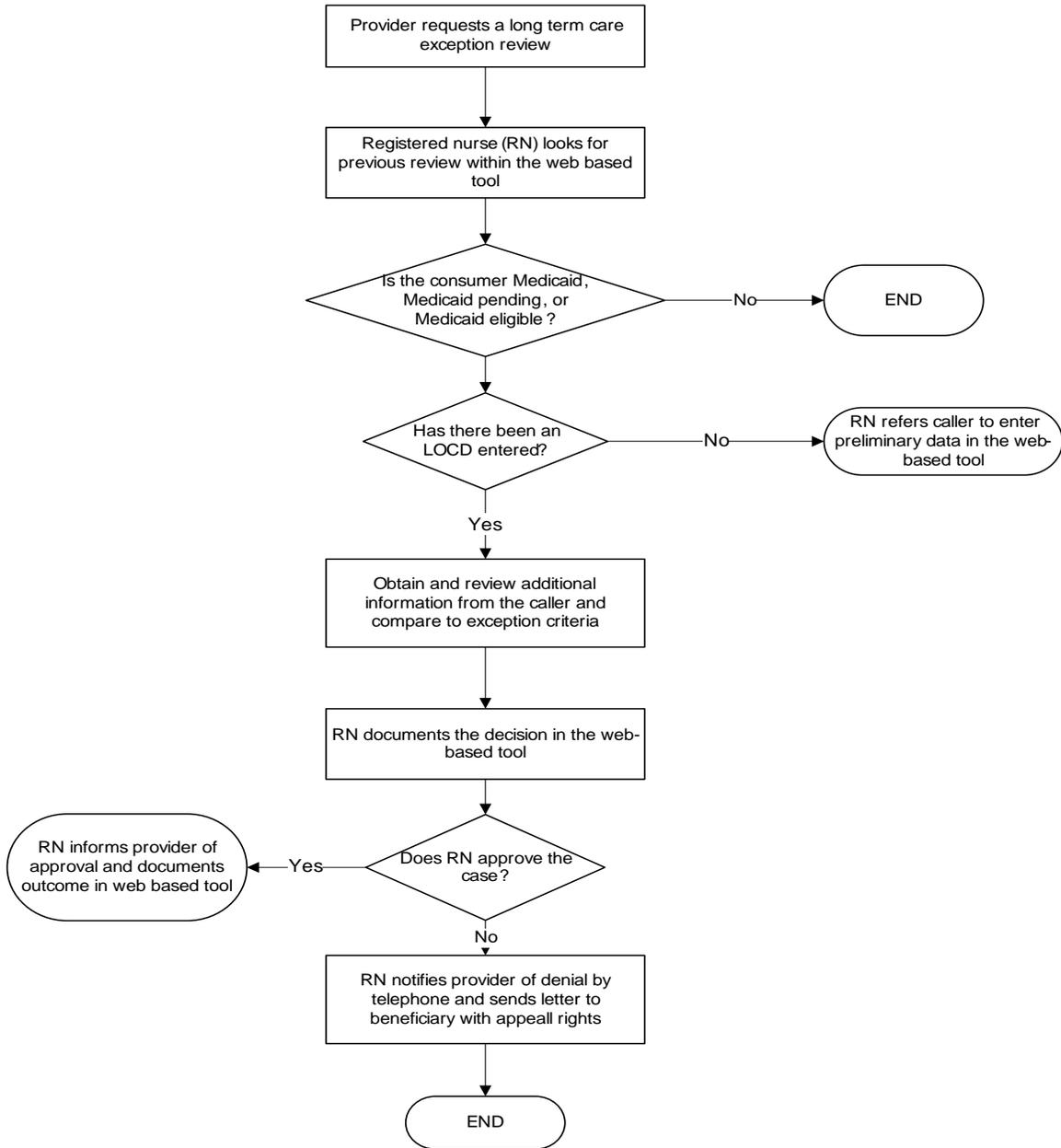
The RN bases the decision to approve or deny based on information the provider supplies. The RN offers questions pertaining to the exception criteria attempting to get a "snapshot" of the beneficiary. If the information meets one of the exception criteria, the RN approves the case. If the exception criterion is not met, the case is denied.

Generally, the RN makes the determination in real time and gives the provider an immediate decision during the call. In rare circumstances, it is necessary to delay the determination. However, we complete all determinations within 24 hours of the provider's/program's call date/time. If a determination is to deny, we send the appropriate denial letter, including a DCH-092 Hearing Request form, to the beneficiary advising of their right for further appeal.



The following is a high-level flow chart of the LTC exception review process.

Figure 6: Long Term Care Exception Review Process





APPEALS PROCESS FOR PACER AND LONG TERM CARE (IMMEDIATE) REVIEW

1. PACER Appeals:

Only after the internal appeals have been exhausted may any appeal be made directly to the MDCH. When such an appeal is made, the Contractor will provide the written reports and make direct testimony available to the MDCH as the MDCH deems necessary.

The MDCH allows the provider the right of appeal through the Medicaid Provider Reviews and Hearings Administrative Rules MAC (R400.3401-400.3425) under the authority conferred on the Director of the MDCH by Sections 6 and 9 of Act No. 280 of the Public Acts of 1939. The Contractor shall provide sufficient staff including RNs/Physicians for participation and testimony in the MDCH appeals process. This involvement shall begin at the Bureau Conference level and continue as required through the Administrative Law Judge (ALJ) level or until the provider has accepted a final decision of the case.

The Contractor will make decisions that may result in an appeal to the State. The Contractor must notify the Medicaid beneficiary in writing of any adverse action, i.e., denial, reduction, or termination of services and their appeal rights, when such denial, reduction, or termination results from the Prior Authorization process. The Department's Administrative Manual, Hearings and Appeals Section, contains the Department of Community Health's policies and procedures regarding administrative hearings. The Contractor must comply with this policy and all relevant federal regulations and state statutes. The Contractor shall prepare the hearing summary for all requests for hearings involving fee for service beneficiaries covered by this contract. The Contractor shall be solely responsible for presenting its position at the beneficiary's administrative hearing. The Contractor shall present the hearing summary and testify at all hearings involving the Department's fee-for-service beneficiaries covered by this contract.

2. Long Term Care Appeals:

a. Beneficiary Appeals

An ineligible beneficiary may appeal directly to the MDCH, and/or request an Immediate Review from the Contractor after an adverse/adequate action notice has been issued by the provider within the guidelines stated in the provider's adverse/adequate action notice. When an MDCH appeal is made, the Contractor will provide the written reports and make direct testimony available to the MDCH as the MDCH deems necessary.

The provider/program may request an Exception Review on behalf of the ineligible beneficiary without issuance of an adverse/adequate action notice to the ineligible beneficiary. If an Exception Review was conducted by the Contractor, then an Immediate Review may not be conducted by the Contractor if the Immediate Review is for the same beneficiary's LOCD for the same period.

The Contractor must have the capability, as defined by HIPAA, to receive and respond electronically to all prior authorization/Immediate and Exception Review requests including the adverse and adequate action notice. The Contractor must send an adverse/adequate action notice to all persons determined ineligible by the Contractor based on the Immediate or Exception review criteria who were seeking Medicaid coverage in one of the above listed FFS Long Term Care Programs utilizing the appropriate denial statement.

An appeals form (DCH-092 Hearing Request) and addressed stamped envelope provided by the State must accompany the adverse/adequate action notice. The adverse/adequate action notice and appeal form must be sent to the beneficiary or the beneficiary's legal representative on the day of the adverse/adequate action. Copies of all adverse/adequate action notice shall be stored by the Contractor for seven (7) years and be available upon request.



Contractor Response to Tasks:

APPEALS PROCESS FOR PACER AND LONG TERM CARE (IMMEDIATE) REVIEW

Due to our experience with the Medicaid Fee-For-Service Review contract and our ongoing Medicare contract, MPRO is experienced in the timely and accurate disposition of provider and beneficiary appeals. Our staff members are well versed in Medicaid requirements and are experienced in providing support documentation for each determination. We have the experience and trained staff to manage the PACER and long term care appeals. We are aware of the timeframes and we will meet or exceed them. We frequently participate in administrative hearings for MDCH and other customers and are experienced in providing expert testimony. This section outlines our process to comply with the appeals requirements.

PACER APPEALS

When MPRO's staff members make a determination that denies, reduces, or terminates services, and all internal appeal/reconsideration opportunities are exhausted, we inform the beneficiary, in writing, of his/her appeal rights. We include copies of applicable forms for filing an appeal with MDCH's Administrative Tribunal. The provider may also request an appeal to MDCH. The provider appeal process begins at the bureau conference level, and if the provider is dissatisfied with the decision, continues through the Administrative Law Judge level.

Our RNs and physician reviewers prepare and provide expert testimony at all hearings, as MDCH deems necessary. These staff members carefully review their findings, gather documentation, and prepare testimony for the hearing. Our staff routinely provides historical context to the MDCH staff attorney and state appeals officer assigned to the case in order to prepare him/her for the hearing.

LONG TERM CARE APPEALS

A long term care appeals process is available to beneficiaries who have been deemed ineligible. If the provider issues an adverse/adequate action notice, the beneficiary may request an immediate review or appeal directly to the Administrative Tribunal. If the beneficiary requests an immediate review, MPRO notifies the long term care nursing facility or MI Choice Waiver agency of the request and requests them to submit documentation to MPRO for review. If MPRO upholds the denial, the beneficiary is sent an adverse/adequate action notice with a DCH-092 Hearing Request appeals form.

Should the beneficiary appeal to the Administrative Tribunal and MPRO was involved in the denial, the RN involved in the determination participates in the hearing.

In the event the long term care nursing facility or MI Choice Waiver agency chooses not to issue an adverse/adequate action notice to the beneficiary, but believes the beneficiary may have service/care needs that may fall into exception criteria, they contact MPRO for an exception review. All review information is entered into Michigan Medicaid's Level of Care Determination web-based portal.

Our experienced RNs perform exception reviews utilizing MDCH-approved Exception Criteria. This review consists of evaluating beneficiaries care needs as they relate to frailty, behavior, and treatment needs.

If the RN is unable to approve the beneficiary under the MDCH-approved Exception Criteria, the RN issues an adverse/adequate action notice. This allows the beneficiary to appeal the determination to the Administrative Tribunal. Again, our staff is prepared to participate in any hearings related to our determination.

Per State regulations and CONTRACT requirements, MPRO will maintain all documentation for seven years.

HOSPITAL AUDIT/UTILIZATION

1. Hospital Audit Review Requirements:

The Contractor must maintain absolute confidentiality of providers and beneficiaries assuring that no disclosure of information that may identify provider(s) or beneficiary(s) is shared inappropriately. The Contractor must be in compliance with HIPAA. All documents and/or information obtained by the Contractor from the Department in connection with this Contract shall be kept confidential and shall not be provided to any third party unless disclosure is approved in writing by the Department.

The Contractor shall audit a statistically valid random sample as generated by the MDCH. The audit sample will contain the following: the provider name, review period, services or codes to be reviewed, dates of service, beneficiary's name and identification number, date and claim reference number paid.



The audit sample will be given to the Contractor by the MDCH. The Contractor will supply the audited provider (CEO and Health Information/Medical Records Manager) with a list of those beneficiaries to be reviewed thirty (30) calendar days prior to the audit begin date. The Contractor will go to each facility to copy/scan records utilizing their own equipment. The review of the copied records will occur at the Contractor's place of business. When the provider elects to copy/scan records, prior approval is needed from the MDCH Contract Manager. Once the records have been copied, reviewed, and a determination made, the Contractor shall write a Nurse Review Report. Each claim line in the workbook will be reviewed and documented with an annotation provided by the MDCH based on the documentation found in the medical record. If errors have been identified, a mis-payment amount of the sample is calculated by the MDCH. The mis-payment information is sent to the MDCH statistician for extrapolation of the mis-payment amount to the entire audit population. The Nurse Review Report will be reviewed by the MDCH prior to insertion into the Exhibit Book.

- a. For Inpatient review the Contractor will review medical records using the following criteria:
 - i. Medical necessity for admission, Severity of Illness/Intensity of Service (SI/IS) utilizing admission criteria approved by the MDCH per body system.
 - ii. Continued stay criteria utilizing admission criteria approved by the MDCH per body system for inpatient rehabilitation.
 - iii. Discharge criteria, admission criteria approved by the MDCH criteria per body system.
 - iv. Review for correct procedure.
 - v. Review for diagnosis coding via DRG assignment validation.
 - vi. Quality of care shall be monitored in each audit utilizing admission criteria approved by the MDCH.
 - vii. Services were performed in the appropriate setting.
 - viii. Services performed are in compliance with Medicaid Program Policy and Federal/State Statutes.
 - ix. Services performed are in accordance with current professional standards of care.
 - x. If the IPH stay is related to the CSHCS qualifying diagnosis and changes are made to the hospital stay (e.g., recoded or not allowed), the changes will be reported to the MDCH Contract Manager at the end of the audit review via the template provided by the MDCH.

- b. For Outpatient and Emergency Room Services review the Contractor will review medical records using the following criteria:
 - i. Services were performed in the appropriate setting.
 - ii. Services performed are in compliance with Medicaid Program Policy and Federal/State Statutes.
 - iii. Services performed are in accordance with current professional standards of care.
 - iv. Services performed are medically necessary in appropriate scope, duration, and intensity.
 - v. Verify procedure code/Ambulatory Payment Classification codes/revenue codes billed.
 - vi. Verify adherence to EMTALA, (for Emergency Room Services only).
 - vii. Quality of care provided to the beneficiary will be reviewed.
 - viii. When the amount paid is lower than the fee screen, the Contractor will need to check eligibility via list provided by the MDCH to determine if the beneficiary is dual eligible Medicare/Medicaid. If the amount paid by Medicaid is for co-pay or deductible only, the (DOC) documented annotation will be used.
 - ix. If the OPH services are related to the CSHCS qualifying diagnosis and changes are made (e.g., recoded or not allowed), the changes will be reported to the MDCH Contract Manager at the end of the audit review via the template provided by the MDCH.



2. Audit Review Process:

The Contractor shall have a system in place comprised of Nurse Reviewers with audit/utilization review and quality review experience in all types of review processes.

- a. The Contractor is expected to complete Utilization Review of all audit cases selected by the MDCH.

The Audit Review Process for Inpatient/Outpatient /Emergency Room includes the following:

Contractor receives "Workbook" from MDCH.

- i. The inpatient audit workbook will include an alphabetical and numeric beneficiary list; audit worksheets which include diagnosis, procedure and revenue codes; sample and population summary statistics plus a DRG code list.
 - ii. The outpatient/emergency room audit workbook will include an alphabetical and numeric beneficiary list; audit worksheets; paid procedure code, Ambulatory Payment Classification (APCs); procedure code on line, revenue code on line for sample; sample and population summary statistics.
- b. The MDCH will provide an accordion file containing file folders for Analysis (Nurse Review Report), and correspondence (copies of letters) and reports.
 - c. Prior to beginning the audit the Nurse Reviewer will complete the following:
 - i. Review and copy all Medicaid policy and procedures pertinent to the audit sample.
 - ii. Review and copy all procedure/APC/revenue codes/appropriate Grouper/ICD-9-CM/ICD-10-CM included in the audit sample.
 - iii. Review and copy all fee screens for procedure/APC/revenue codes included in the audit sample.
 - iv. Contact the provider within one (1) week of assignment to schedule an appointment to copy records.
 - v. Send a confirmation letter to the provider (CEO and Health Information/Medical Records Manager) following the initial contact reiterating the information provided during the initial contact. A copy of the correspondence will be kept with the audit file.

The items listed above (2c, i-iii) will be what were in effect for the time period of the audit.

- d. Contractor copies/scans medical records at the provider's place of business utilizing the Contractor's own equipment. When the provider elects to copy/scan records, prior approval is needed from the MDCH Contract Manager. An on-site visit consists of an introduction, including presentation of credentials, picture identification, the legal basis and the reason for the audit. (To determine compliance with Medicaid policy and guidelines; to verify services billed and paid to Medicaid were provided.)
- e. Contractor reviews medical records at the Contractor's place of business. If after collating, documentation is found to be missing, a letter is sent to the provider (CEO and Health Information/Medical Records Manager). A copy of the correspondence will be kept with the audit file. The Contractor's Nurse Reviewer should initiate review of records on hand while waiting for missing documentation.
- f. The initial review shall be conducted by the Nurse Reviewer utilizing the appropriate criteria. All claim lines in the sample are adjudicated based on the medical record review using annotations.



g. After receipt and review of any missing documentation, the Nurse Reviewer writes the Nurse Review Report. The Nurse Review Report will include:

- i. Reason for the Review.
- ii. Sample Statistics.
- iii. Summary of Field Activities.
- iv. Nurse Review Findings and Attachments.

The Contractor will submit the workbook and Nurse Review Report and copies of 2 c, i-iii, and 2e to the MDCH.

h. Mis-payment amount of the audit sample is calculated by the MDCH and sent to the MDCH Statistician.

i. Extrapolation of the mis-payment amount to the entire audit population shall be made by the MDCH Statistician.

j. The MDCH will create and review the "Exhibit Book" and make five (5) copies.

k. The MDCH will notify the provider in writing of audit results, appeal rights, and hearing dates.

3. PACER Validation Requirements:

For PACER validation, the Contractor will review records in the audit sample using the following criteria:

- a. Medical necessity for admission, Severity of Illness/Intensity of Service (SI/IS) utilizing admission criteria approved by the MDCH per body system.
- b. Continued stay criteria utilizing admission criteria approved by the MDCH per body system for inpatient rehabilitation.
- c. Discharge criteria utilizing admission criteria approved by the MDCH per body system.
- d. Services were performed in the appropriate setting.
- e. Services performed are in compliance with Medicaid Program Policy and Federal/State Statutes.
- f. Services performed are in accordance with current professional standards of care.
- g. PACER authorization/tracking number obtained for readmissions within fifteen (15) days, transfers, elective admissions, and continued stays for rehabilitative facilities.

4. PACER Validation Process:

The validation process of the PACER review includes the criteria listed above under PACER Validation, 1, a-g:

During the record review, if the criteria are not met for the PACER authorization the documentation used by the Contractor for the PACER authorization will be reviewed. This will include:

- a. PACER authorization/tracking number.
- b. Documentation provided at the time of the PACER request.
 - i. Review Coordinator documentation.
 - ii. Physician Reviewer documentation.



Contractor Response to Tasks:

HOSPITAL AUDIT/UTILIZATION REVIEW SUMMARY

MPRO's hospital audit and utilization review process will fulfill MDCH's regulatory requirements for the control of utilization of inpatient hospital services, as well as its mandate to ensure that only appropriate and necessary services are provided to the Medicaid population in the most economical manner.

The primary objectives of the inpatient and outpatient/ER audits are to determine medical necessity, appropriate setting, and correct billing of the services by each provider. The PACER validation reviews determine the accuracy of the authorization process used by the PACER Review Coordinators, as well as evaluate the accuracy of the provider's medical record documentation compared to the clinical information provided by telephone. RNs who are not part of the PACER program conduct the PACER validation reviews. Utilization review is performed for all inpatient, outpatient/ER, and PACER validation audits.

The long term care reviews are designed to ensure that the beneficiaries admitted to a nursing facility or the PACE program, including any admissions based upon MDCH's exception criteria or professional judgment, meet the level of care criteria designed by MDCH.

MPRO has designed a solution to provide a sound, criteria-based, independent audit/review outcome that meets MDCH's objectives. The reviews consider appropriate utilization and quality of care issues, as required by MDCH.

HOSPITAL AUDIT/UTILIZATION REVIEW REQUIREMENTS

To establish and maintain credibility with providers, the audit and review processes must use clearly defined criteria in a consistent manner. The CONTRACT outlines criteria that are required for each of the audit and review processes. These criteria vary based upon the type of services reviewed and the setting where care is provided. The following table outlines the criteria used for each.

Table 3: Summary of Criteria for Each Type of Audit

Description of Review Criteria	Inpatient Audit	Outpatient/ER Audit
Medical necessity for admission, Severity of Illness/Intensity of Services (SI/IS) utilizing InterQual [®] criteria per body system	√	
Continued stay criteria utilizing InterQual [®] criteria per body system for inpatient rehabilitation	√	
Discharge criteria InterQual [®] per body system	√	
Review for correct procedure	√	
Review for diagnosis coding via DRG assignment validation	√	
Quality of care shall be monitored in each audit utilizing admission criteria approved by MDCH	√	√
Services were performed in the appropriate setting	√	√
Services performed are in compliance with Medicaid Program Policy and Federal/State statutes	√	√
Services performed are in accordance with current professional standards of care	√	√
Services performed are medically necessary in appropriate scope, duration, and intensity	√	√
Verify procedure code billed	√	√
Verify procedure code/ambulatory payment classification/revenue codes billed		√
Verify adherence to EMTALA, for ER services only		√
PACER number obtained for readmissions within 15 days, transfers, elective admissions, and continued stays for rehabilitative facilities	√	
PACER number validated	√	
Services related to CSHCS qualifying diagnosis	√	√



Through our current contract with the State of Michigan, our review staff is familiar with InterQual® criteria, Medicaid program policy, and other criteria described above. Section 1.031 outlines the detailed qualifications and knowledge of our review staff.

In addition to using sound and valid criteria, another key aspect of this process is maintaining confidentiality of information. Our review team follows MPRO's HIPAA-compliant confidentiality and disclosure policy and adheres to the terms of MDCH's HIPAA requirements. Audit documentation, claims information, medical records, and findings are maintained in strict confidence and not disclosed to third parties without the prior written approval of MDCH.

MDCH has outlined its requirements and expectations for the audit process. Key requirements and MPRO's compliance plan for the audits are listed in the table below.

Table 4: Key Audit Requirements and MPRO Compliance Plan

Audit Requirement	MPRO Compliance Plan
Contractor will maintain confidentiality of providers and beneficiaries and ensure no disclosure takes place.	MPRO has a comprehensive HIPAA-compliant policy and procedure related to confidentiality.
Conduct audits from a statistically valid random sample as generated by MDCH.	MPRO's review team will use the MDCH determined sample to conduct the audits. We have a process in place to receive these files from MDCH for the outpatient/ER audits and inpatient audits.
Contractor will contact the provider within one week of assignment to schedule an appointment to scan/copy the medical records.	MPRO's support technicians and RNs currently notify the providers within this timeframe. This policy will continue.
Contractor will send confirmation letter to provider.	MPRO's RNs send a letter to the CEO and Health Information/Medical Records Manager following the initial contact with the provider. The letter reiterates information conveyed during the initial contact. The RN will keep a copy of this letter in the accordion folder.
Contractor will supply the provider with a list of those beneficiaries to be audited 30 calendar days prior to the audit.	MPRO currently complies with this requirement for the outpatient/ER audits and inpatient audits.
Contractor will go to each facility to copy/scan the records utilizing their own equipment.	MPRO currently uses a portable scanner to obtain images of the medical records on site at the provider location, and this process will continue. If a provider elects to copy/scan the medical records, MDCH requires prior approval.
Contractor will notify the provider of any missing documentation.	During the exit interview, MPRO's support technician advises the provider about missing documentation. Upon return to the office, the RN follows up with a letter advising the provider of relevant missing documentation. The RN also sends the letter to the CEO and Health Information/Medical Records Manager.



<p>Contractor will review and copy all relevant Medicaid policies and procedures pertinent to the audit sample.</p>	<p>MPRO currently reviews and copies all relevant Medicaid policies and procedures pertinent to the audit sample for the inpatient and outpatient audits. Our RNs include this information in the accordion file supplied by MDCH.</p>
<p>Contractor will review and copy all relevant procedure codes, APCs, diagnostic codes, fee screens, revenue codes, and Grouper pertinent to the audit sample.</p>	<p>MPRO currently reviews and copies all relevant procedure codes, APCs, diagnostic codes, fee screens, revenue codes, and Grouper pertinent to the audit sample for the inpatient and outpatient audits. Our RNs include this information in the accordion file supplied by MDCH.</p>
<p>The review will occur at the Contractor’s place of business.</p>	<p>MPRO has a fully staffed office located in Farmington Hills, Michigan. Reviews for our current contract with MDCH take place at this location. We have office space available to continue reviews and manage volume increases.</p>
<p>Once the records have been reviewed and a determination made, the Contractor shall write a Nurse Review Report.</p>	<p>The RN assigned to each audit writes the Nurse Review Report in the format specified in the CONTRACT. Our RNs are trained in preparing these reports.</p>
<p>Contractor will include all relevant documentation in the accordion file prior to sending the Nurse Review Report and workbooks to MDCH.</p>	<p>MPRO’s RNs currently include a telephone log of conversations with the provider, confirmation letters, missing record documentation, CSHCS report, dual eligible report, and other relevant documentation in the accordion file sent to MDCH.</p>

HOSPITAL AUDIT/UTILIZATION REVIEW PROCESS

MPRO has designed a comprehensive and streamlined audit process that fulfills the requirements outlined in the CONTRACT. Our process includes features that are already in place under our current FFS review contract for outpatient/ER audits and inpatient audits. Our trained and highly skilled audit team has experience in inpatient, outpatient, ER, and long term care services, as described in Section 1.031. In addition, board-certified physicians representing a wide variety of specialties are available throughout the audit process in a consultative role. This section will provide a description of the review process for outpatient/ER and inpatient audits, including flow charts of the process.

AUDIT PROCESS

The audit process begins with the transmission of the audit sample from MDCH to MPRO through the audit workbook. There will be one workbook for each provider audited under the outpatient/ER audit program and the inpatient audit program. MDCH also will provide an accordion file with folders for analysis to support the Nurse Review Reports and correspondence. The audit workbooks will contain the following documentation:

- Alphabetical and numeric beneficiary lists;
- Audit worksheets;
- Line paid procedure codes;
- Ambulatory Payment Classifications (APCs);
- Procedure code on line;
- Procedure code and revenue code on line for sample;
- DRG code lists (for inpatient audits only); and
- Sample and population summary statistics.



The audit workbooks and related documentation will be sent to the Director of Medical Review Services, who will serve as the primary contact for MDCH. She will assign the audit to an audit coordinator, who is also a RN. For the inpatient audits, a coder who is a Registered Health Information Technologist (RHIT) also will be assigned to the audit. The RN/Audit Coordinator will be responsible for coordinating all audit activities within MPRO and with the provider.

Pre-Audit Preparation

The RN/Audit Coordinator will begin by gathering all relevant documentation needed to perform the audit. This includes Medicaid policy and procedures, definitions of procedure and revenue codes, Ambulatory Payment Classifications, appropriate DRG grouper and ICD-9/ICD-10 codes, as well as the applicable Medicaid fee screens that were in effect during the time of the audit. Within the first week of the assignment, the RN/Audit Coordinator will contact the provider to schedule a date to obtain the records and send out a confirmation letter. Thirty calendar days prior to the audit, the RN/Audit Coordinator will mail the list of beneficiaries and dates of service to the provider so that the medical records can be pulled for scanning on the date of the scheduled visit.

On-Site Visit to Obtain Records

On the scheduled audit date, audit support technicians will visit the provider site with a portable scanner to obtain the records for the audit. Upon arrival at the provider site, the audit support technicians will present their identification and introduce themselves to the provider representative. They will present a brief description of the audit process and the legal basis and reason for the audit, which is to determine compliance with Medicaid policy and guidelines and to verify services billed and paid to Medicaid were provided. The audit support technicians will clearly indicate that we are conducting the audit under contract with and on behalf of MDCH. The audit support technicians will respond to any questions the provider might have and then proceed with scanning the medical records.

Prior to completion of the scanning/copying, the audit support technicians verbally advise the provider about any missing records. Once the records are scanned, they are brought back to the MPRO office and saved to a CD. If documentation is missing, the RN/Audit Coordinator sends a letter to the CEO and Health Information/Medical Records Manager of the provider advising of the missing documentation. The RN/Audit Coordinator places a copy of this letter in the accordion file.

Review Process

After obtaining the records, the review process will begin. Each record is reviewed against the claim line detail information provided in the workbook and documentation gathered in the pre-audit process. The MDCH annotations provided in the audit workbook are used to document the findings. The review criteria used depends upon the type of audit being conducted. This section will outline the specific review criteria used and the process used to evaluate the medical record against the defined criteria.



For outpatient/ER audits, the RN/Audit Coordinator will review the information in the following table.

Table 5: Outpatient Audit Criteria and Review Process

Outpatient Review Criteria	Reviewer Type	Review Process
Quality of care utilizing appropriate criteria	RN	Assess the medical record for gross and flagrant quality issues and refer to the physician reviewer if any issues are found.
Services were performed in the appropriate setting	RN	Determine whether services performed were appropriate for the outpatient/ER setting based upon Medicaid Guidelines.
Services performed are in compliance with Medicaid Program Policy and Federal/ State statutes	RN	Compare services and documentation to the requirements of the Medicaid program.
Services performed are in accordance with current professional standards of care	RN	Determine if services performed meet current knowledge of practice standards and professional judgment. If there is a question by the reviewer that the practice standard may not have been met, the case is referred to a physician reviewer.
Services performed are medically necessary in appropriate scope, duration and intensity	RN	Review the services documented in the medical record against Medicaid guidelines and clinical professional judgment.
Verify procedure code billed, revenue code, APC	RN	Compare the procedure billed against the procedure documented in the medical record. Use the Current Procedural Terminology (CPT) for the given year. Changes are entered into WebStrat [®] , which is a database that takes coding changes and regroups them to see if the APC changes.
Verify Adherence to EMTALA for ER services	RN	Determine whether a medical screening exam was performed by a physician in the ER.



For the inpatient audits, the review will be divided between the RN/Audit Coordinator and the RHIT/Coder, as follows.

Table 6: Inpatient Audit Criteria and Review Process

Inpatient Review Criteria	Reviewer Type	Review Process
Medical necessity for admission, Severity of Illness/Intensity of Services (SI/IS) using InterQual [®] criteria per body system	RN	Compare clinical information in the medical record to the relevant SI/IS criteria. Professional judgment is used to determine if the criteria are met. If the criteria are not met, refer the case to a physician reviewer.
Continued stay criteria using InterQual [®] criteria per body system for inpatient rehabilitation	RN	Compare clinical information in the medical record to the relevant continued stay criteria. If the criteria are not met, refer the case to a physician reviewer.
PACER validation	RN	Compare the telephonic authorization review with the actual medical record documentation. If there is a discrepancy and the patient did not meet SI/IS criteria as indicated, the case will be denied. If prior authorization should have been obtained but was not, the case will be considered as insufficient documentation.
Discharge criteria InterQual [®] per body system	RN	Review medical record to validate condition at discharge to determine if the patient was medically stable for discharge.
Review for correct procedure	RHIT	Compare the procedure billed against the procedure documented in the medical record. Use the following documents for verification: ICD-9-CM Volume 3, Medical Grouper, and AHA Coding Clinics.
Review for diagnosis coding via DRG assignment validation	RHIT	Compare the diagnosis billed against the clinical information documented in the medical record. Use the following documents for verification: ICD-9-CM Volumes 1 and 2, Medical Grouper, and AHA Coding Clinics.
Review for Quality of care	RN/RHIT	Assess the record for any gross and flagrant quality of care issues using quality categories. Refer issues to the physician reviewer.
Services were performed in the appropriate setting	RN	Determine whether the services performed were appropriate for the inpatient setting based upon Medicaid Guidelines and InterQual [®] criteria.
Services performed are in compliance with Medicaid Program Policy and Federal/State statutes	RHIT/RN	Compare the services and documentation to the requirements of the Michigan Department of Community Health Hospital Manual.



<p>Services performed are in accordance with current professional standards of care</p>	<p>RN</p>	<p>Evaluate if services performed are based on current knowledge of practice standards and professional judgment. If in doubt, refer to physician reviewer.</p>
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Physician Reviewers are available throughout the audit process to answer questions or provide input for the RN/Audit Coordinator or RHIT to make a final determination. All cases where the RN/Audit Coordinator is recommending a denial are reviewed by a physician who will provide the final rationale and documentation to support the decision.

The RN/Audit Coordinator performs PACER validation by comparing the telephonic authorization review documentation with the actual medical record documentation. If there is a discrepancy and the patient did not meet SI/IS as indicated, the case will be denied. If prior authorization should have been obtained, but was not, the case will be considered as insufficient documentation. The RN/Audit Coordinator will include this information in the report.

Final Audit Findings and Nurse Review Report Preparation

After the review has been completed, the RN/Audit Coordinator collates the documentation needed to produce the report. If an RHIT participated in the audit, the RN/Audit Coordinator and RHIT work together on the findings necessary for the report. The documentation includes the results of each record review and any correspondence related to missing records. The RN/Audit Coordinator prepares the report and includes: the reason for the review; sample statistics; summary of field activities; and nurse review findings and attachments.

Once the RN/Audit Coordinator and/or RHIT draft the report, our Director of Medical Review Services reviews the report. The Director makes the final determination regarding completeness and accuracy of the audit. After the Director approves all documentation, the RN/Audit Coordinator sends the workbook, Nurse Review Report, and copies of relevant documentation to the MDCH contract manager. MPRO will complete three inpatient and three outpatient audits per quarter. The following is a flow chart of the Inpatient and ER/Outpatient audit process.



Figure 7: Inpatient Audit Process

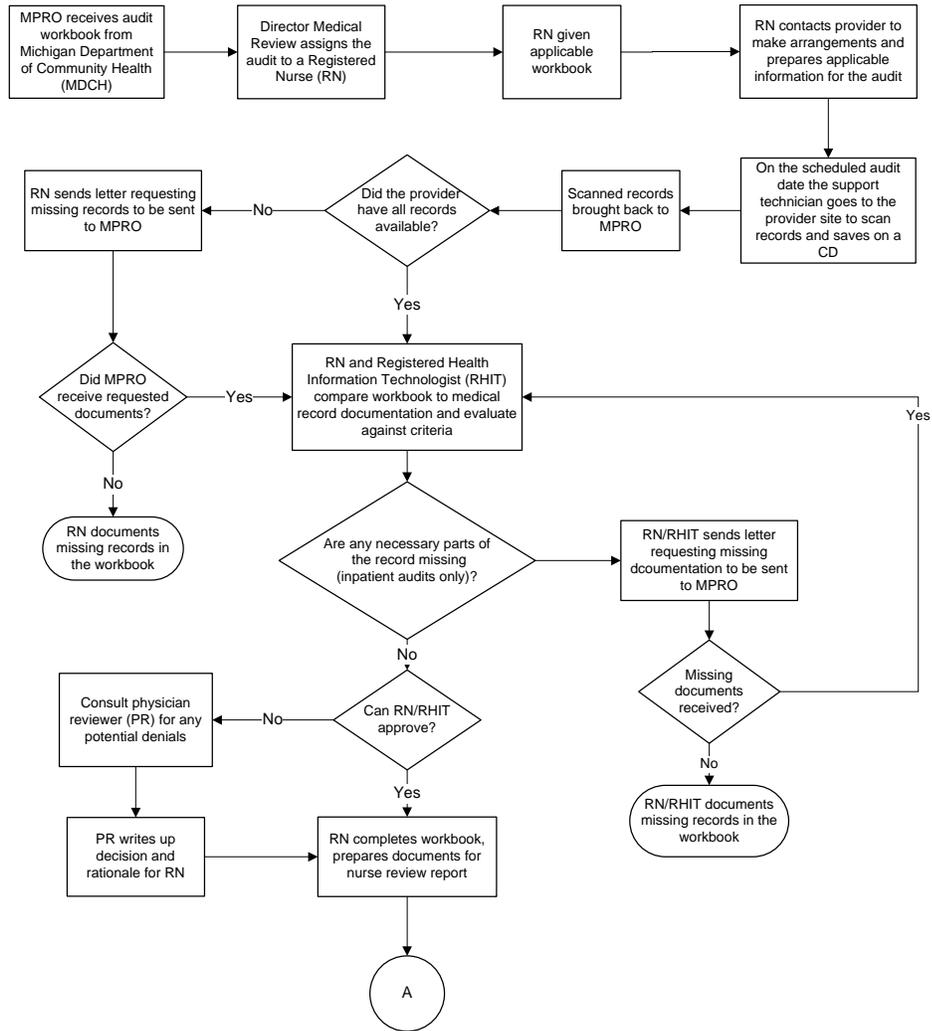
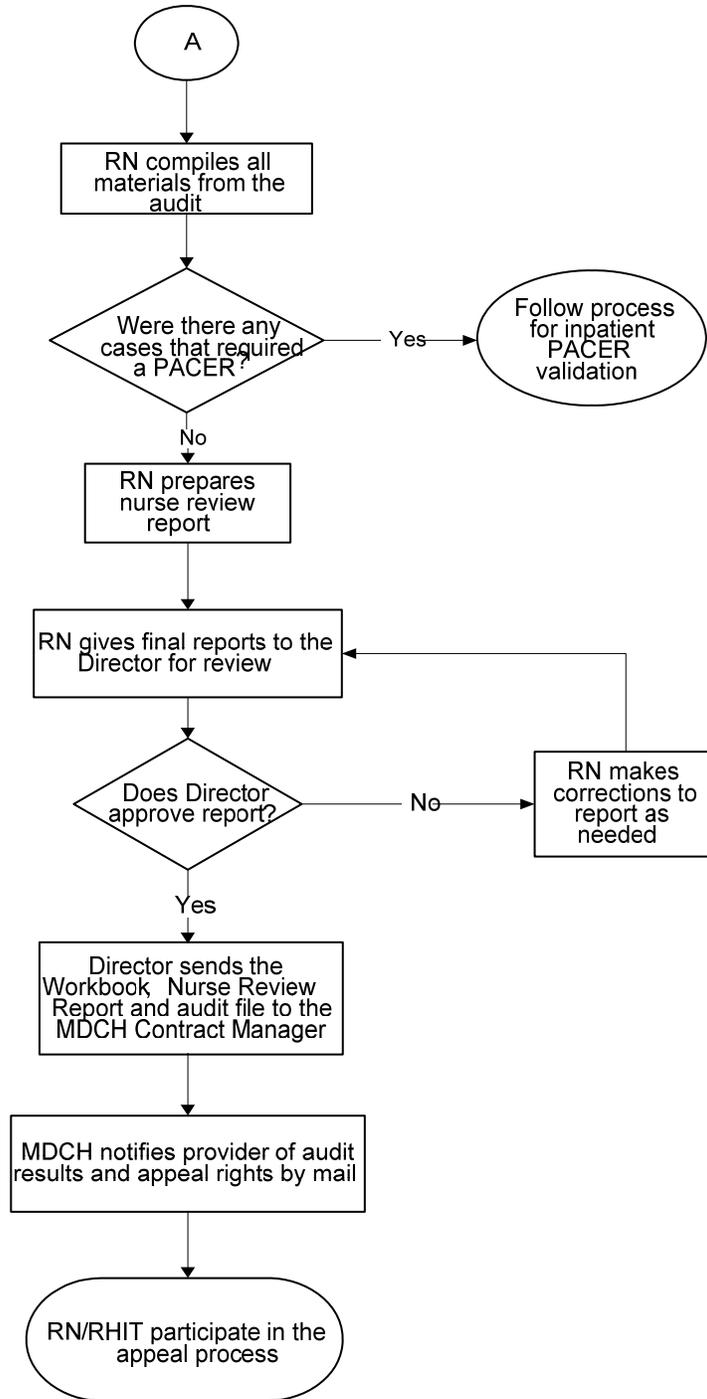




Figure 8: ER/Outpatient Audit Process





PACER VALIDATION REQUIREMENTS

MPRO will use the MDCH defined criteria outlined in Table 7 to review and validate PACER authorizations, as part of the inpatient audits. The sample size of a PACER validation will vary for each audit, based upon the number of beneficiary admissions in the inpatient sample that required a PACER authorization.

With over 70 years of cumulative experience, our nurse reviewers are very experienced with the PACER validation criteria and conduct PACER validations under MPRO's current contract with MDCH. This is accomplished by reviewing the hospital medical record and comparing clinical information contained in the medical record to the documentation provided during the initial telephone contact to obtain the PACER authorization. The MPRO computer system is currently in place and has the capability to validate the PACER authorization numbers. A detailed description of the PACER Validation process is included in Section X.

Aside from fulfilling the contract requirements, the PACER validation process provides valuable information to MPRO in our quest to improve the efficiency and effectiveness of our review processes. We will incorporate the PACER validation results into our internal quality control program.

PACER VALIDATION PROCESS

MPRO has developed a process for PACER validation that is integrated within the inpatient audit process. The initial step in the process is to determine which cases within the inpatient audit are potentially eligible for a PACER validation. The RN/Audit Coordinator will review the documentation in each case to determine if a PACER authorization was included on the claim. In addition, he/she will search MPRO's PACER system to determine whether a PACER authorization was granted by MPRO for that admission. All cases that have a PACER authorization recorded in the MDCH workbook or have a PACER authorization in MPRO's system are eligible for a PACER validation review.

Once the cases requiring PACER validation are identified, the RN/Audit Coordinator conducts a review of the validity of the PACER authorization:

Table 7: PACER Validation Review Criteria and Review Process

PACER Validation Review Criteria	Reviewer Type	Review Process
PACER number obtained for readmissions within 15 days, transfers, elective admissions, and continued stays for rehabilitative facilities	RN	For 15-day readmissions, verify same condition and determine whether the case was continuation of care. Review transfers against Medicaid guidelines for appropriateness. For elective procedures, verify that the procedure is on the InterQual® inpatient list and whether the procedure was performed on the same day as the admission. For rehabilitation continued stay reviews, determine if the patient received clinical benefit from the rehab stay or whether the patient was awaiting placement.

If the inpatient admission meets InterQual® and other required criteria, the RN/Audit Coordinator verifies that the PACER authorization number matches with the PACER authorization number in MPRO's system, and the review is complete. However, if the inpatient admission does not meet the InterQual® criteria, then additional review is required.

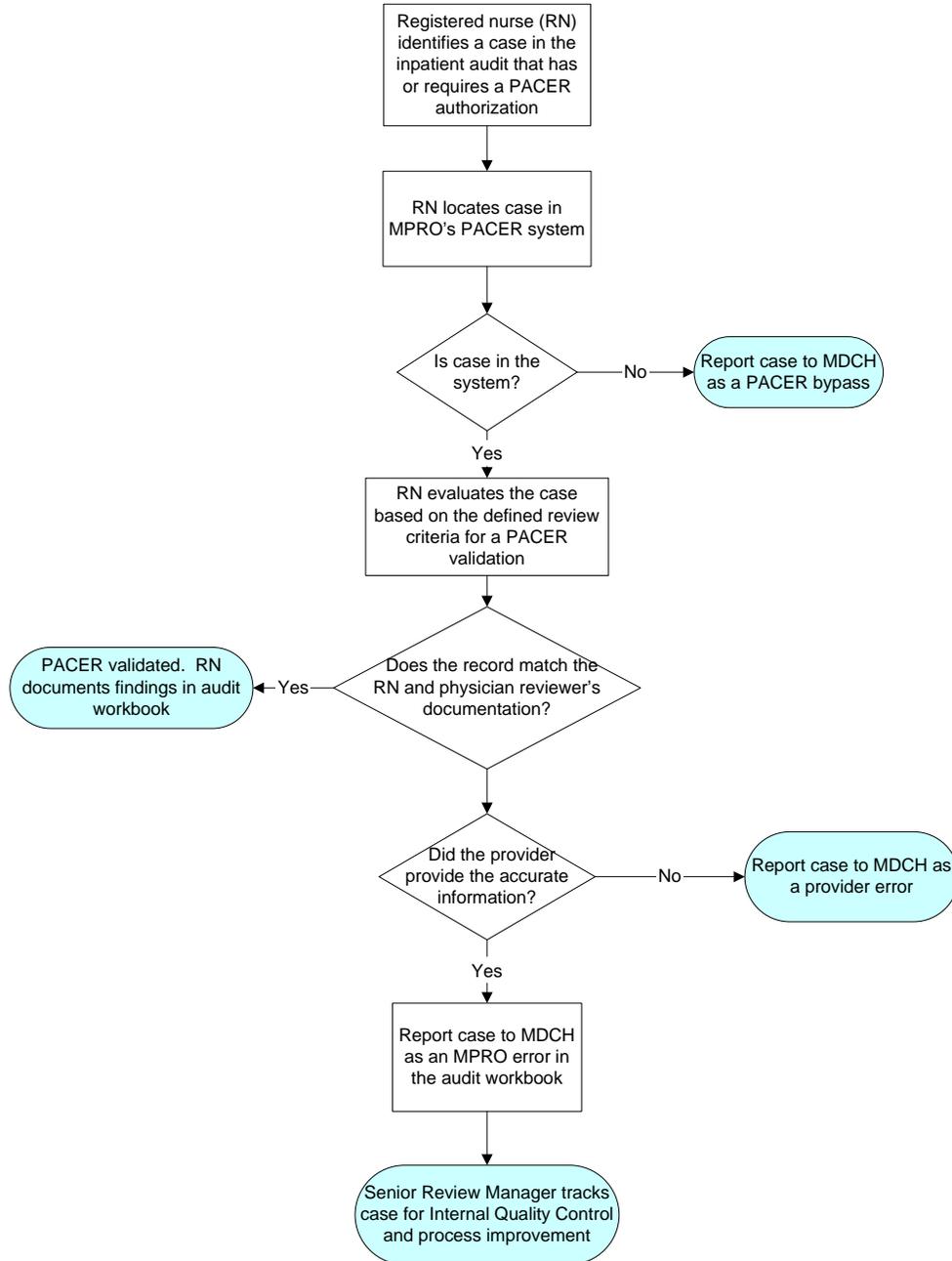
For cases where the admission is not found to be medically necessary, the RN/Audit Coordinator will obtain the documentation of the PACER Review Coordinator and the Physician Reviewer who initially approved the case. The RN/Audit Coordinator will review the documentation collected and compare it to what is present in the medical record. There are two possible types of errors as outlined below.

Scenario	Outcome
Documentation in the medical record matches the information provided during the initial telephonic review, but criteria are not met.	MPRO Error
Information in the medical record does not match the information provided during the initial telephonic review. Criteria were met on initial telephonic review, but documentation does not substantiate the admission.	Provider Error



The RN/Audit Coordinator will determine whether the case represents a provider error or an MPRO error, and will document the findings in the audit workbook. If the case is deemed an MPRO error, the information also will be provided to the Senior Medical Review Manager for internal quality control tracking. The following flow chart illustrates the process for PACER validation.

Figure 9: PACER Validation Process



**STATEWIDE UTILIZATION REVIEW**

1. Statewide Utilization Review Requirements:

For the Inpatient Utilization Review, the Contractor shall review records based on the following criteria:

- a. Medical necessity for admission, Severity of Illness/Intensity of Service (SI/IS) utilizing admission criteria approved by the MDCH per body system.
- b. Continued stay criteria utilizing admission criteria approved by the MDCH per body system for inpatient rehabilitation.
- c. Discharge criteria utilizing admission criteria approved by the MDCH per body system.
- d. Services were performed in the appropriate setting.
- e. Services performed are in compliance with Medicaid Program Policy and Federal/State Statutes.
- f. Services performed are in accordance with current professional standards of care.
- g. PACER authorization/tracking number obtained for readmissions within fifteen(15) days, transfers, elective admissions, and continued stays for rehabilitative facilities.

For the Outpatient Utilization Review, the Contractor shall review records based on the following criteria:

- a. No findings.
- b. Services were performed in the appropriate setting.
- c. Services performed are in compliance with Medicaid Program Policy and Federal/State Statutes.
- d. Services performed are in accordance with current professional standards of care.
- e. Services performed are medically necessary in appropriate scope, duration, and intensity.
- f. Incorrect procedure code/Ambulatory Payment Classification codes/revenue codes billed.
- g. Provider not in compliance with EMTALA, (for Emergency Room Services only).
- h. Quality of care issues- Gross and Flagrant.
- i. Incomplete medical record.

2. Statewide Utilization Review Process:

The Contractor is expected to complete Utilization Review of Hospital CHAMPS Specialty Code B205 that crosswalks to Legacy Provider Type 30 Inpatient Hospital and/or CHAMPS Specialty Codes B206 or B210 that crosswalks to Legacy Provider Outpatient Hospital services provided to Medicaid beneficiaries.

- a. Selection for the Statewide Utilization Review Process will include a random sample from a universe of paid claims data downloaded weekly from the MDCH CHAMPS interface by the Contractor. The Contractor will draw a random sample of twenty (20) inpatient records and twenty (20) beneficiary outpatient dates of service per facility per year. Approximately four (4) hospitals per week will be reviewed for a total of sixteen (16) hospitals per month. The sample will be drawn on a monthly basis by the Contractor for the hospitals selected for review for that month. The hospitals will be sampled individually going back one (1) year from the date drawn utilizing a past year of data for the review. EXAMPLE: Start June 2009, go back one (1) year, sampling June 1, 2008, through May 31, 2009, data. If a hospital has been selected to be audited that year, they will be exempt from the Review for that year.



b. The medical record for the Medicaid beneficiary will be requested by the Contractor from the hospital via fax/mail. A letter will be sent by the Contractor so that the provider receives the letter by the first of the month. This letter will give the provider thirty (30) days to submit the record. If no record(s) are submitted, the MDCH may decide to initiate an audit. The Contractor will have thirty (30) days from the provider deadline to review the records. For example, the letter requesting records is sent so the provider receives the letter by June 1, records are required to arrive to the Contractor by June 30, the Contractor has until July 31 to review.

c. Reporting is expected for all facilities whether there is an issue or not. Reporting to the MDCH is expected on a monthly basis utilizing the spreadsheets attached, see Attachments N, N1 and N4:

i. Spreadsheet I:

List Hospitals selected for month in Alphabetical Order by Name and ID number.

ii. Spreadsheet II:

List by Provider; Provider ID number/NPI Number/Taxonomy Code;
Time period sample pulled from; date medical records requested; total number member requested; Listed alphabetically by: Beneficiary Name; Beneficiary ID number; Dates of Service; Date Medical Record Received; Findings; Total number of Findings and Comments.

This report/spreadsheet will then be utilized for future audit selections. A cumulative report must be submitted annually within thirty (30) days of the end of the fiscal year.

The Contractor will send an educational letter to the provider if there are any findings/issues identified at the end of the monthly review.

d. A quarterly report will be reviewed by the MDCH Contract Manager.

e. The Contractor shall apply quality of care criteria/screens in all reviews- in every category undertaken and in every admission request or treated case reviewed.

i. Criteria may be the same as or similar to those required by Centers for Medicare and Medicaid (CMS). The Contractor will inform the MDCH of any quality problem that has resulted in serious patient harm as soon as it is identified. All other quality of care findings and their severity level will be reported on a regular basis to the MDCH. The Contractor will recommend to the MDCH the appropriate provider sanctions/interventions.

ii. Sanctions/interventions- may include provider participation, termination, education, or other appropriate action. The Contractor and the MDCH shall work together in determining the appropriateness of these sanctions/interventions and in applying them.

Contractor Response to Tasks:

MPRO has been performing the inpatient SWUR for approximately three years. In January of 2009, MPRO began review of SWUR for outpatient providers. The intention of this program is to educate the provider.

We will complete utilization review of hospital CHAMPS Specialty Code B205, which crosswalks to Legacy Provider Type 30 Inpatient hospital and/or CHAMPS Specialty Codes B206 or B210, which crosswalks to Legacy Provider Outpatient hospital services. We will download paid claims data weekly from the MDCH CHAMPS interface.

We will select and review a random sample of 20 inpatient records from 16 hospitals per month. In addition, we will select and review outpatient random samplings that will consist of 20 beneficiary outpatient dates of service from 16 hospitals per month. We will select cases going back one year and will select cases from the entire year. We will send a letter to the providers prior to the first of each month with a list of selected cases. The providers have 30 days to submit the records. Providers being audited during the sample year are exempt from this selection. If the provider does not send any records to MPRO, MDCH may decide to initiate an audit. Currently, we are completing reviews within 30 days from the provider deadline.



MPRO will review records based on the following criteria:

Table 8: Summary of Criteria for Each Type of Audit

Description of Review Criteria	Inpatient Audit	Outpatient/ER Audit
Medical necessity for admission, Severity of Illness/Intensity of Services (SI/IS) utilizing InterQual® criteria per body system	√	
Continued stay criteria utilizing InterQual® criteria per body system for inpatient rehabilitation	√	
Discharge criteria InterQual® per body system	√	
Services were performed in the appropriate setting	√	√
Review for correct procedure	√	√
Review for diagnosis coding via DRG assignment validation	√	
Assess for quality of care utilizing clinical knowledge and expertise and knowledge-based medicine (Gross and Flagrant)	√	√
Services performed are in compliance with Medicaid Program Policy and Federal/State statutes	√	√
Services performed are in accordance with current professional standards of care	√	√
Services performed are medically necessary in appropriate scope, duration and intensity		√
Verify procedure code billed		√
Verify procedure code/ambulatory payment classification/revenue codes billed		√
Verify adherence to EMTALA for ER services		√
PACER number obtained for readmissions within 15 days, transfers, elective admissions, and continued stays for rehabilitative facilities	√	
PACER number validated	√	
Services related to CSHCS qualifying diagnosis	√	√
No findings		√
Incomplete medical record		√

MPRO will send MDCH reports monthly using MDCH required spreadsheets that reflect the review determinations by provider. Whether a facility has an audit issue or not, we will submit a report. Spreadsheet I will list hospitals selected for that month in alphabetical order by name and ID. Spreadsheet II lists:

- Provider/provider ID number/NPI number/taxonomy code;
- Time period the sample is pulled from;
- Date medical records were requested;
- Total number of records requested (listed alphabetically by beneficiary name);
- Beneficiary ID number;
- Dates of service;
- Date medical record was received;
- Findings;
- Total number of findings; and
- Comments.

MDCH will receive this report monthly, quarterly, and then annually (within 30 days of the end of the fiscal year).

MPRO sends educational letters to providers that reflect our utilization, coding/billing view, and quality review findings. We send these letters by the fifth of the month following completion of the review month.



During review activity, MPRO will assess each case for quality. We will refer quality concerns to a physician reviewer to evaluate if the quality of care is within generally acceptable standards of care. If we identify a serious quality concern, we will notify MDCH immediately. If there is a pattern of poor quality of care, we also will report this to MDCH. MPRO and MDCH will work together to evaluate the appropriate actions indicated for the quality concern(s) identified and for any future monitoring of compliance.

LONG TERM CARE RETROSPECTIVE REVIEW

1. Long Term Care Retrospective Review Requirements:

The Contractor must maintain absolute confidentiality of providers and beneficiaries assuring that no disclosure of information that may identify provider(s) or beneficiary(s) is shared inappropriately. The Contractor must be in compliance with HIPAA. All documents and/or information obtained by the Contractor from the MDCH in connection with this Contract shall be kept confidential and shall not be provided to any third party unless disclosure is approved in writing by the MDCH.

The Contractor shall perform the Retrospective reviews from a statistically valid random sample as generated by the MDCH. The review sample will contain the following:

- a. Provider's Medicaid ID/NPI Number
- b. Beneficiary's name
- c. Beneficiary's Medicaid ID
- d. Beneficiary's date of birth
- e. Date the online Michigan Medicaid Nursing Facility Level of Care was created
- f. Door through which the beneficiary qualified

The Retrospective review sample will be given to the Contractor by the MDCH. The Contractor will inform the nursing facility or MI Choice Waiver provider of a Retrospective review by way of NOTIFICATION OF RETROSPECTIVE REVIEW letter, (See Attachment O-P). The letter shall include the Medicaid ID(s) of the beneficiary(s) who will receive a Retrospective review, the 'to' and 'from' dates that the Contractor will be reviewing, and a list of the medical records required from the provider/program by the Contractor, as well as the date by which the requested medical records must be received by the Contractor in order to conduct the Retrospective review.

The provider/program has thirty (30) calendar days from the date of the Contractor's NOTIFICATION OF RETROSPECTIVE REVIEW letter to respond by way of receipt of all requested medical records to the Contractor. The Contractor has thirty (30) calendar days from the date the full medical records are received from the provider/program to complete the Retrospective review. When an incomplete set of medical records is received by the Contractor from the provider/program, the Contractor will begin the review of the medical records submitted. Retrospective reviews will be conducted at the Contractor's place of business.

Should the provider/program not respond, or respond with an incomplete set of requested medical records, to the Contractor's NOTIFICATION OF RETROSPECTIVE REVIEW letter within thirty (30) calendar days from the date of the request, the Contractor shall issue an INCOMPLETE RETROSPECTIVE REVIEW MEDICAL RECORD REMINDER-PENDING TECHNICAL DENIAL letter, (See Attachment Q).

Should the provider/program not respond to the request in the INCOMPLETE RETROSPECTIVE REVIEW MEDICAL RECORD REMINDER-PENDING TECHNICAL DENIAL letter within fifteen (15) calendar days from the date the INCOMPLETE RETROSPECTIVE REVIEW MEDICAL RECORD REMINDER-PENDING TECHNICAL DENIAL letter was sent, the Contractor shall issue a RETROSPECTIVE REVIEW FINAL TECHNICAL DENIAL letter to the provider/program, (See Attachment R).



The Contractor shall forward to the MDCH a recommendation for RETROSPECTIVE REVIEW FINAL TECHNICAL DENIAL with the monthly reports.

The Contractor shall send to each provider for whom a Retrospective Review was conducted, a RETROSPECTIVE REVIEW DETERMINATION letter, (See Attachment S-T), informing the provider/program of the result of the Contractor's Retrospective Review for each case review.

a. Nursing Facility Retrospective Review Process:

The Contractor will request from the Nursing Facility provider copies of the beneficiary's medical records for the ninety (90) day period under Retrospective Review as follows:

- i. Copy of the Michigan Medicaid Nursing Facility Level of Care Determination
- ii. Copy of the **Signed** Computer Generated Freedom of Choice Form or a copy of the **Signed** Hard Copy of Freedom of Choice form attached to the Computer-Generated Freedom of Choice form
- iii. PASARR screen Level I
- iv. PASARR screen Level II, if indicated by PASARR screen Level I
- v. MDS documents
- vi. Nursing notes
- vii. Physician notes
- viii. Interdisciplinary Care Plan notes
- ix. Quarterly Care Planning notes
- x. Skilled therapy evaluations and progress notes
- xi. Discharge plans
- xii. Medicare Certification/Recertification form

The Contractor shall review the medical records based on the following criteria:

- i. Medical necessity for admission based on the Michigan Medicaid Nursing Facility Level of Care Determination
- ii. Continued stay criteria based on the Michigan Medicaid Nursing Facility Level of Care Determination

The Contractor shall report their findings to the MDCH LTC Contract Manager on a monthly basis. Findings shall include the number of Retrospective Reviews in which the Contractor agreed with the provider's door of eligibility, the number in which the Contractor agreed with the eligibility in general, the number in which the Contractor disagreed (denial), the number of Retrospective reviews resulting in a Retrospective Review Final Technical Denial, and the number of Retrospective Review Final Technical Denials based on the absence of PASARR documentation. The Contractor shall also report on the number of outstanding Nursing Facility Retrospective reviews, the number of Retrospective Reviews conducted to date and their findings.

b. MI Choice Waiver Retrospective Review Process:

The Contractor will request from MI Choice Waiver program providers copies of the beneficiary's medical record (case record) for the ninety (90) day period under retrospective review, as follows:

- i. Copy of the Michigan Medicaid Nursing Facility Level of Care Determination
- ii. Copy of the **Signed** Computer-Generated Freedom of Choice form or a copy of the **Signed** Hard Copy Freedom of Choice form attached to the Computer-Generated Freedom of Choice form
- iii. MDS-Home Care Assessment documents
- iv. Medical Notes
- v. Physician Notes and Orders
- vi. MI Choice Waiver contact notes from friends, family of the enrollee, or from the enrollee
- vii. MI Choice Waiver participant's Plan of Care



The Contractor shall review the records based on the following criteria:

- i. Medical necessity for enrollment based on the Michigan Medicaid Nursing Facility Level of Care Determination
- ii. Continued program participation based on the Michigan Medicaid Nursing Facility Level of Care Determination

The Contractor shall report their findings to the MDCH LTC Contract Manager on a monthly basis. Findings shall include the number of Retrospective Reviews in which the Contractor agreed with the program's door of eligibility, the number in which the Contractor agreed with eligibility in general, the number in which the Contractor disagreed (Denial), the number of Retrospective Reviews resulting in a Retrospective Review Final Technical Denial, and the number of Retrospective Review Final Technical Denials based on the absence of PASARR documentation.

Contractor Response to Tasks:

LONG TERM CARE RETROSPECTIVE REVIEW PROCESS

In the last five years, MPRO has worked closely with MDCH to design and improve reporting as it relates to long term care retrospective review. As a team, we recognized report enhancements would provide MDCH with more meaningful data. We are pleased to be a part of this work and look forward to continuing this work with MDCH. In addition, as a HIPAA-compliant organization, we will continue to maintain absolute confidentiality of providers and beneficiaries. We will keep the information obtained during this contract confidential and will not release it to any third party.

REVIEW PROCESS

MPRO utilizes a MedQuest database to enter and report information collected during the long term care retrospective review process. During the five years of our current contract, we improved this database to produce reports for MDCH that are more robust. The following provides an overview of the process for long term care (LTC) retrospective review.

Identification of Sample

MDCH generates and sends a statistically valid random sample to MPRO monthly. The review sample includes:

- Provider's Medicaid ID/NPI number;
- Beneficiary name;
- Beneficiary Medicaid ID;
- Beneficiary date of birth;
- Date the online Michigan Medicaid Nursing Facility Level of Care was created; and
- Door through which the beneficiary qualified.

Once we receive the sample from MDCH, our IT department loads the information into the MedQuest database; a mailing/selection list is generated and sorted by provider. This begins the process to obtain provider medical records.

Obtain Medical Records

MPRO sends the "Notification of Retrospective Review" letter with a case listing to each provider requesting the copy of the medical record for the MDCH-designated review period. The provider has 30 calendar days to submit the medical record to MPRO. The requirements for Nursing Facilities and MI Choice Waiver differ slightly in submission criteria. The following is a list of the requirements for each.



Table 9: Summary of Criteria for LTC Retrospective Review

Description of Provider Requirements to Submit	Nursing Facility	MI Choice Waiver
Copy of beneficiary’s medical records for the 90-day period under retrospective review	√	√
Copy of MI Medicaid Nursing Facility Level of Care Determination	√	√
Copy of signed computer generated Freedom of Choice form; or a copy of the signed Freedom of Choice hard copy form attached to the computer generated Freedom of Choice form	√	√
PASARR screen Level I	√	
PASARR screen Level II, if indicated by PASARR screen Level I	√	
MDS documents	√	
Nursing notes	√	
Physician notes	√	
Interdisciplinary Care Plan notes	√	
Quarterly Care Planning notes	√	
Skilled therapy evaluations and progress notes	√	
Discharge plans	√	
Medicare Certification/Recertification form	√	
MDS Home Care Assessment documents		√
MI Choice Waiver contact notes from friends, family of the enrollee, or from the enrollee		√
MI Choice Waiver Participants Plan of Care		√

Review Process

The LTC Review Coordinator will evaluate each case based on nursing facility level of care criteria developed by MDCH. The assessment will include the medical necessity for admission and continued stay based on the Michigan Nursing Facility Level of Care Determination. LTC Review Coordinator evaluates the documentation in the medical record for compliance with all required criteria. In addition, the LTC Review Coordinator will examine the information provided through the Nursing Facility Level of Care Determination web portal to determine whether the case was approved based upon the nursing facility level of care definition, the MDCH exception criteria for frailty, behaviors, or complex treatments.

Communication to Providers

MPRO will present the provider with the following documentation as outlined in the CONTRACT.



Table 10: Summary of Notifications for LTC Retrospective Review

Step	Notifications	Provider Timeframe	MPRO Timeframe
1	Notification of Retrospective Review: Advises the provider that the record needs to be submitted	30 days to submit	30 days to review
2	Incomplete Retrospective Review Medical Record Reminder-Pending Technical Denial: Sent when an incomplete or missing medical record is submitted.	15 days to submit	Not outlined in the CONTRACT. MPRO adheres to 15 days following receipt
3	Retrospective Review Final Technical Denial: Sent when provider does not submit the requested information		Not outlined in the CONTRACT. MPRO adheres to 5 days following provider due date
4	Retrospective Review Determination Letter		Sent to the provider upon completion of the review

Report Findings

On a monthly basis, we will send an electronic list of:

- Number of retrospective reviews MPRO agreed with the provider’s door of eligibility;
- Number MPRO, in general, agreed with provider about eligibility;
- Number MPRO disagreed with;
- Number of technical denials;
- Number of denials based on the absence of PASARR documentation;
- Number of outstanding reviews; and
- Total number of reviews conducted to date and the findings.

MPRO has enhanced its reporting to provide MDCH with a clearer picture of what occurs collectively with each provider.

APPEALS PROCESS FOR HOSPITAL AUDITS AND LONG TERM CARE RETROSPECTIVE REVIEW

1. Inpatient/Outpatient/Emergency Room Audits:

The MDCH Medicaid Integrity Program will notify the providers of the audit results, hearing dates, and appeal rights by mail.

The Contractor’s nurse reviewer and a like specialty physician (when applicable) must be available to testify as to the results of the audit review at any preliminary or bureau conference; administrative hearing or judicial proceeding. Contractor physician representation at the appeals will be at the request of the State Office of Administrative Hearings and Rules and the Office of Medical Affairs on an as needed basis for hospital audits.

2. Long Term Care Retrospective Review:

a. Provider Appeals

The Contractor shall send Retrospective Review Denial recommendations to the MDCH following the completion of the Contractor’s Retrospective review. The Contractor shall send notice of the determination of the Retrospective Review (s) to the provider/program. The provider/program must be able to request reconsideration (appeal) of any adverse/adequate determination made by the Contractor for admission or extended stay within three (3) working days of receipt of the adverse/adequate determination. The MDCH allows the provider the right of appeal through the Medicaid Provider Reviews and Hearings Administrative Rules, MAC R400.3401-400.3425 under the authority conferred on the Director of MDCH by Sections 6 and 9 of Act. No. 280 of the Public Acts of 1939.



The Contractor's nurse reviewer and a like specialty physician (when applicable) must be available to testify as to the results of the Retrospective Review at any preliminary or bureau conference; administrative hearing or judicial proceeding. The Contractor physician representation at the appeals will be at the request of the State Office of Administrative Hearings and Rules (SOAHR) for the MDCH.

b. Beneficiary Appeals

Beneficiaries as well as providers/programs have the right to appeal a denial of service. As is the case for Medicare, beneficiary appeals made during the inpatient stay must be resolved by the Contractor within three (3) working days. Appeals made to the Contractor following discharge must be resolved within thirty (30) working days.

Only after these appeals have been exhausted, may any appeal be made directly to the SOAHR/MDCH. When such an appeal is made, the Contractor will provide the written reports, and make direct testimony available to the SOAHR/MDCH as the MDCH deems necessary.

An appeals form (DCH-0092 Hearing Request) and an addressed stamped envelope provided by the State must accompany the adverse/adequate action notice. The adverse/adequate action notice and appeal form must be sent to the beneficiary the day of the adverse/adequate action. Copies of all adverse/adequate action notice shall be stored by the Audit Contractor and available upon request.

Contractor Response to Tasks:

APPEALS PROCESS

When necessary, MPRO is prepared to support all review determinations at the appeal level. Our staff is highly experienced in the appeals process and currently participates in all appeals, with the exception of long term care retrospective review. However, MPRO is prepared to make the appropriate process changes to facilitate the long term care retrospective review denials. We will send notice to the provider of the denial and inform the provider that they have three working days to request reconsideration. If we uphold any denial decision, the provider or beneficiary can appeal if all prior appeals have been utilized. We are prepared to support these determinations at the appeal level since the provider has an obligation to exhaust all appeals prior to requesting an appeal with the State Office of Hearing & Appeals.

TIMEFRAMES

The following timeframes listed in Table I-III are for the first, second, and third years of the contract. For the purposes of the table listed below, an audit/reviews is considered completed once the workbook and reports are submitted to the MDCH. The Contractor is still responsible for participating in the Appeal Process until a settlement is reached.

TABLE I

Type of Hospital Audits	Fiscal Year	Number of Audits to be completed by Quarter			
		1 st	2 nd	3 rd	4 th
Inpatient Audits	FY2010	0	3	3	3
	FY2011	3	3	3	3
	FY2012	3	3	3	3
	FY2013	3	0	0	0
Three Year Total			36		
Outpatient/Emergency Room Audits	FY2010	0	3	3	3
	FY2011	3	3	3	3
	FY2012	3	3	3	3
	FY2013	3	0	0	0
Three Year Total			36		

*Audits will average 250 beneficiaries per audit



TABLE II

Type of Long Term Care Review	Fiscal Year	Number of Reviews to be completed by Quarter			
		1 st	2 nd	3 rd	4 th
<i>Retrospective Review</i>	FY2010	0	450	450	450
	FY2011	450	450	450	450
	FY2012	450	450	450	450
	FY2013	450	0	0	0
<i>Three Year TOTAL</i>		5400			
<i>Immediate Reviews (NONC)</i>	Second Qtr FY2010 through First Qtr FY2013	100 Annual Projection			
<i>Exception Reviews (telephonic)</i>	Second Qtr FY2010 through First Qtr FY2013	160 Annual Projection			

TABLE III

Statewide Utilization Review	Fiscal Year	Number of Utilization Reviews completed by Quarter			
		1 st	2 nd	3 rd	4 th
Inpatient	FY2010	0	960	960	960
	FY2011	960	960	960	960
	FY2012	960	960	960	960
	FY2013	960	0	0	0
Total		11,520			
Outpatient	FY2010	0	960	960	960
	FY2011	960	960	960	960
	FY2012	960	960	960	960
	FY2013	960	0	0	0
Total		11,520			



Contractor Response to Task:

TIMEFRAMES

As a current contractor of the State of Michigan and CMS, we are currently in compliance with all required contract timeframes. Our proven processes and our commitment to quality improvement assures that we meet or exceed review timeline expectations. Further, we will meet the review timeframes set forth by URAC in our accreditation as a Health Utilization Management (HUM) organization (see Appendix B for a copy of our accreditation). Under our current Medicaid FFS Review contract, we complete 99.5% of all inpatient retrospective reviews within 30 days receipt of the medical record.

We will complete all inpatient and outpatient/ER audits, SWUR inpatient and outpatient, and LTC retrospective reviews in a timely manner, according to schedule in the table below.

Table 11: Audit and Review Schedule

Type of Audit/Review	Fiscal Year	Number of Audits/Reviews by Quarter				
		Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4	Total
Inpatient Audits	2010		3	3	3	9
	2011	3	3	3	3	12
	2012	3	3	3	3	12
	2013	3				
	Contract Total					36
Outpatient/ER Audits	2010		3	3	3	9
	2011	3	3	3	3	12
	2012	3	3	3	3	12
	2013	3				
	Contract Total					36
Long Term Care Retrospective Review	2010		450	450	450	1,350
	2011	450	450	450	450	1,800
	2012	450	450	450	450	1,800
	2013	450				450
	Contract Total					5,400
SWUR Inpatient	2010		960	960	960	2,880
	2011	960	960	960	960	3,840
	2012	960	960	960	960	3,840
	2013	960				960
	Contract Total					11,520
SWUR Outpatient	2010		960	960	960	2,880
	2011	960	960	960	960	3,840
	2012	960	960	960	960	3,840
	2013	960				960
	Contract Total					11,520

Each provider audit for inpatient and outpatient/ER will consist of approximately 250 beneficiaries, as defined by MDCH. The audits will include all inpatient admissions or outpatient/ER services provided to each beneficiary during the timeframe covered by the audit.



1.030 Roles and Responsibilities

1.031 Contractor Staff, Roles, and Responsibilities

QUALIFICATIONS OF CONTRACTOR'S STAFF FOR PACER AND LONG TERM CARE IMMEDIATE AND EXCEPTION REVIEW AND HOSPITAL AUDITS/STATEWIDE UTILIZATION REVIEW AND LONG TERM CARE RETROSPECTIVE REVIEW

1. Staff Requirements

a. The Contractor shall specify the number of staff dedicated to the duties explained in this contract and provide credentialing/licensure prior to the start of this Contract. Attestation of licensure will be required at the end of each year thereafter. In addition, proof of licensure will be sent to the State at time of hire for all new employees where licensure is required. The Registered Nurse Reviewer must report directly to an RN who must report directly to an RN. Necessary substitutions due to change of employment status and other unforeseen circumstances may be made with prior notification to the MDCH and for employees with the same licensure (i.e., RN replaces RN). If the replacement does not have the same licensure prior authorization is required by the MDCH.

b. The Contractor shall utilize Registered Nurse Reviewers who demonstrate knowledge of Inpatient /Outpatient Hospital/Emergency Room Services/PACER/Utilization Review. The Contractor shall utilize Registered Nurse Reviewers for Long Term Care Immediate, Exception and Retrospective Reviews who demonstrate knowledge of Long Term Care and Michigan's Medicaid criteria. The Contractor shall utilize Registered Nurse Reviewers who demonstrate knowledge of Inpatient Hospital admission criteria approved by MDCH and Nursing Facility Level of Care Exception criteria. The Registered Nurses performing the audit/Statewide Utilization Review/Long Term Care Immediate and Exception review functions cannot perform the Retrospective Review and PACER authorizations, MDCH expects the Contractor to designate separate staff for each.

c. The Contractor shall be staffed by Physician Reviewers with expertise in the areas listed above and to participate in the PACER authorization process, and to act as a resource for audits and Statewide Utilization Review and Long Term Care Retrospective Review appeal representation, when requested by the ALJ.

d. The coding review for inpatient hospital review shall be validated by a Registered Health Information Technologist, RHIT.

2. Other Requirements

a. The Contractor shall maintain all reporting requirements established by the MDCH.

b. The Contractor shall maintain a positive working relationship with Providers of medical care and Provider Organizations.

c. The Contractor shall maintain confidentiality of Provider/Beneficiary information and provide the MDCH with its confidentiality policy and procedure.

d. Should the Contractor be a vendor from a State other than Michigan, the Contractor's Project Manager and staff must have an office located in the Greater Lansing Area.

e. The Contractor must be a Peer Review Organization (PRO). However, QIO-like entities satisfies the requirements of the CONTRACT and are qualified for this CONTRACT as well.



Contractor Response to Tasks:

QUALIFICATIONS OF CONTRACTOR'S STAFF

STAFF REQUIREMENTS

MPRO's Michigan Medicaid Audit Review Team is comprised of a multidisciplinary staff of individuals with experience in Michigan Medicaid policies, utilization review, billing and coding, medical record review, use of InterQual® and long term criteria, and project management.

We have assembled an impressive and highly competent team of 17 individuals to perform the tasks required for this contract. We have the distinct advantage of capitalizing on the collective strengths of our current review staff and executive leadership, their combined experience, and knowledge of Medicare and Medicaid programs as well as long term care to execute start-up operations quickly for the Michigan FFS Review contract.

As shown in the organizational chart below, MPRO's team complies with all MDCH reporting requirements. Specifically, our RN Nurse Reviewers must report directly to an RN. In addition, RNs that work in PACER and LTC exception/immediate review will not work on audits, SWUR, or LTC retrospective review and vice versa. Our RNs will utilize MDCH approved criteria to perform all review and adhere to all Medicaid policies.

Our staffing model maximizes the strengths within our current review team and is further strengthened by the addition of highly qualified RNs and physician reviewers with acute and long term care experience.

ORGANIZATION CHART

The following organization chart shows the proposed organization structure for the Medicaid FFS contract indicating lines of authority, responsibility, communication, and accountability. Following the organizational chart is a table summarizing the relevant skills of our key project staff.



Figure 10: MPRO FFS Organizational Chart

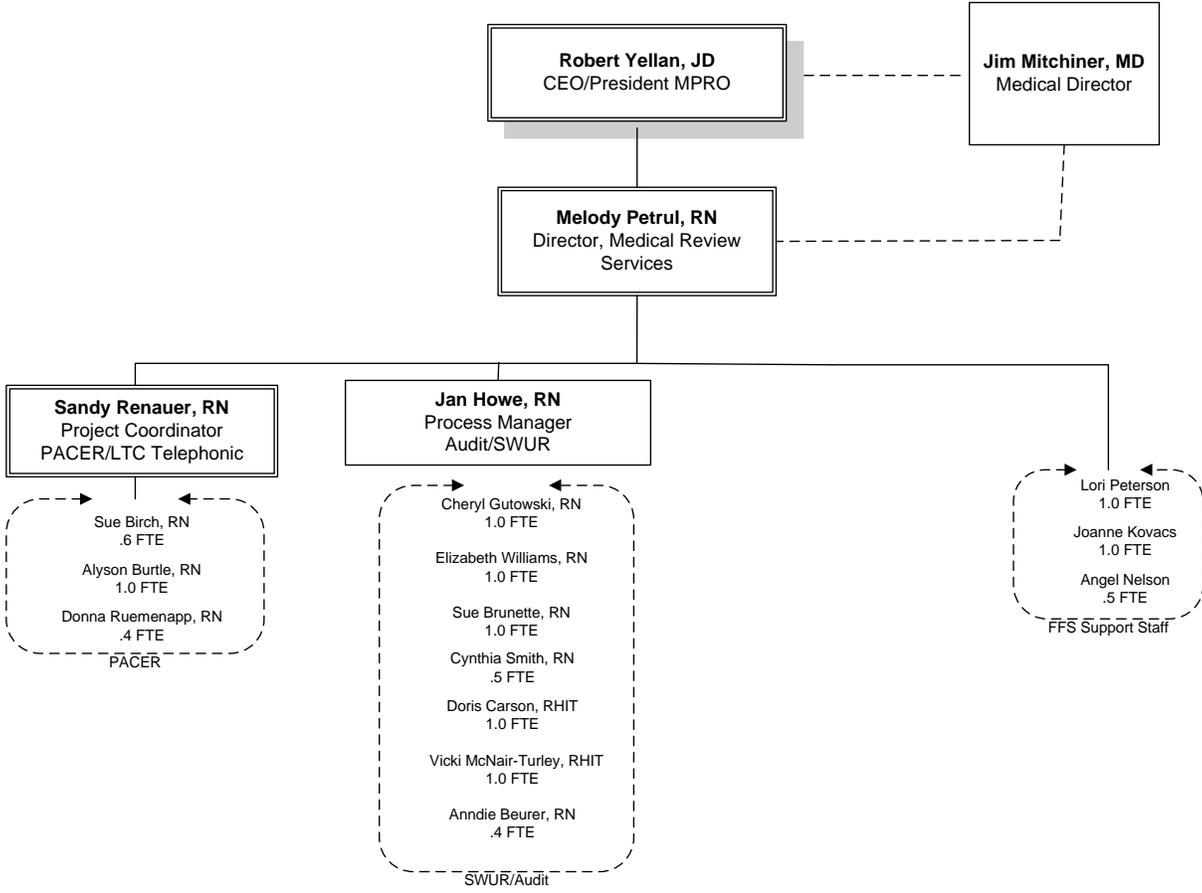




Table 12: Staff Experience

Name/Project Role	Michigan Medicaid	Knowledge of outpatient coding	Knowledge of inpatient coding	Medicare and Medicaid Population Characteristics, Policies, Data Systems	Knowledge of Inpatient Hospital® Criteria	Knowledge of Long Term Care Medicaid Exception Criteria	Research Design and Methodology, Including Statistical Analysis	Quality Assurance Methodology (Assessment and Improvement Technologies)	Knowledge of Inpatient/Outpatient Hospital/ER/PACER/Utilization Review	Knowledge of Long Term Care	Quality Assurance/Improvement Principles	Data Analysis/Reporting	Knowledge of Inpatient/Outpatient Hospital/ER/PACER/Utilization Review/Long Term Care
Melody Petrul, RN Director, Medical Review Services	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
James Mitchiner, MD, MPH, FACEP Medical Director	✓			✓	✓			✓	✓	✓	✓		✓
Jan Howe, RN Audit/Statewide Utilization Process Manager	✓	✓		✓	✓	✓	✓	✓	✓		✓	✓	✓
Sandra Renauer, RN, PACER/LTC Exception and Immediate Review Project Coordinator	✓			✓	✓	✓		✓	✓	✓	✓		✓
Cheryl Gutowski, RN Audit Reviewer Coordinator	✓	✓			✓	✓					✓		
Elizabeth Williams, RN Audit Reviewer Coordinator	✓				✓								✓
Susan Brunette, RN Audit Reviewer Coordinator	✓	✓			✓	✓					✓		
Cynthia Smith, RN Audit Review Coordinator	✓				✓	✓					✓		✓
Doris Carson, RHIT Audit/SWUR Compliance Analyst			✓										
Vicki McNair-Turley, RHIT Audit/SWUR Compliance Analyst			✓										
Anndie Beurer, RHIT, Audit/SWUR Compliance Analyst			✓										
Susan Birch, RN PACER Review Coordinator	✓			✓	✓	✓				✓			✓
Alyson Burtle, RN PACER Review Coordinator	✓			✓	✓	✓				✓			✓
Donna Ruemenapp, RN PACER Review Coordinator	✓			✓	✓	✓				✓			✓

**CONTINUITY OF STAFF**

The success of the Michigan FFS Review contract depends upon consistent and reliable project staffing. We assure MDCH that the key project staff outlined in this proposal will be dedicated and available to fulfill their assigned duties throughout the duration of this contract. To date, many have been performing this work since January 2005. However, there are instances where changes in project staff may be necessary due to illness, disability, or termination of employment. In the event a change in project staffing is necessary, MPRO will notify MDCH immediately. MDCH will also have the opportunity to review and approve any new additions to the core project team. We will support an effective transition and thorough transfer of knowledge from the outgoing project team member to his or her replacement and assure MDCH that all replacement staff will have the same licensures as the outgoing staff member (i.e., RN replaces an RN).

NURSE REVIEW STAFF

Our nurse review team has more than 70 combined years of experience in Michigan Medicaid and utilization review and quality assurance. Our nurse reviewers are licensed in the State of Michigan as Registered Nurses (RNs) and are knowledgeable of all inpatient/outpatient hospital/ER services/PACER/utilization review/long term care. Additional qualifications for our nurse reviewers include: minimum of five years experience in an acute care or outpatient clinical setting, personal computer competency, quality improvement, utilization review experience, and excellent verbal/written communication skills.

Coders who are Registered Health Information Technologists (RHIT) will support the nurse review team. A RHIT/Coder will validate all of the coding for inpatient hospital reviews.

We will provide MDCH with proof of licensure for relevant staff members at the time of award and annually each year thereafter. In addition, we will send proof of licensure (where licensure is required) for all new employees at the time of hire.

PROFESSIONAL REVIEW STAFF

Our professional review network is an integral component of our utilization review program. It is comprised of over 150 licensed, board-certified, and credentialed physicians. We have experienced physician reviewers representing the entire spectrum of medical specialties and sub-specialties. Our physician reviewers are knowledgeable of all inpatient/outpatient hospital/ER services/PACER/utilization review/long term care. For this review program, our physician reviewers will serve as a resource for audits. Through quarterly educational sessions, newsletters, and hands-on orientation, we will keep physician reviewers abreast of current trends and changes in Medicare and Medicaid principles that affect health care. In addition, our physician reviewers have current clinical knowledge and clinical experience, have no history of disciplinary action or sanctions related to quality of care, fraud, or other criminal activity and have no conflicts-of-interest with any case under review. These physicians maintain active medical practices while participating in our medical review processes and/or committee activities.

Biographies of the key staff and additional professional and technical staff that comprise our Audit Review Team follow. For detailed resumes of key staff, see Appendix C.

KEY STAFF BIOGRAPHIESDirector of Medical Review Services – Melody Petrul, RN

Role – Manages the Review Program and serves as the primary point-of-contact for MDCH related to all project activities.

Biography – Melody Petrul has worked as a RN since 1975. Through her various MPRO roles, Ms. Petrul has worked for the Medicare, Medicaid, and private review programs. Currently, she serves as MPRO's Director of Review Services, responsible for managing the Medicaid FFS review contract and ensuring compliance with federal and state regulations related to medical review activities. She also provides education and training to the nurse review, coders, and medical records staff. She is an expert resource regarding daily review and monitoring activities. She manages several committees, including URAC re-credentialing, staff education, physician credentialing, various quality improvement activities (internal and external), medical records management, and confidentiality/HIPAA compliance issues. Ms. Petrul reports to Robert Yellan, President and CEO.

Medical Director – James C. Mitchiner, MD, MPH, FACEP

Role – Serves as a physician reviewer for the inpatient and outpatient/ER audits, as needed to assist the nurse reviewers. Participates in hearings and appeals at MDCH as needed.



Biography – Dr. Mitchiner has more than 26 years of experience in the field of emergency medicine. He is a staff physician at two Ann Arbor, Michigan area emergency departments (St. Joseph Mercy and St. Joseph Mercy Saline) and is a clinical faculty member of the University of Michigan St. Joseph Mercy Hospital Emergency Medicine Residency Program.

As Medicare Medical Director for MPRO, he works with all quality improvement teams to promote 9th Scope of Work topics. In addition, he establishes and maintains relationships with executive/clinical leadership of collaborating partners and current clinical consultants. He stays informed on the literature pertaining to quality improvement and health care changes affecting care systems.

Dr. Mitchiner has been active in many professional medical associations and societies, including the American College of Emergency Physicians, Michigan College of Emergency Physicians (past president), Michigan State Medical Society, and the Society for Academic Emergency Medicine. He is Board Certified in Emergency Medicine. Dr. Mitchiner has published articles in peer-reviewed and non-peer reviewed publications, and he is a frequent lecturer at both the state and national levels. He is a clinical Assistant Professor of Emergency Medicine at the University of Michigan Medical School.

He has a Doctorate of Medicine from the University of Illinois College of Medicine and earned a Master's degree in Health Management and Policy from the University of Michigan. Dr. Mitchiner is also an Assistant Clinical Professor of Emergency Medicine at the University of Michigan Medical School.

Audit/Statewide Utilization Process Manager – Jan Howe, RN

Role – Develops and maintains review processes, acts as liaison to project managers, performs MPRO's responsibilities relative to auditing review program appeals, confirms the accuracy of SWUR program data, performs reviews, and conducts employee orientations.

Biography – Ms. Howe has served over 20 years at MPRO in various capacities. During her time at MPRO, she has also been a systems analyst. This experience has proved to be valuable in developing reports that are useful to MDCH and also serving as a liaison between MPRO's review staff, MDCH, and information technology staff both at MPRO and MDCH. Ms. Howe manages the daily operations of the audits, SWUR, and LTC reviews to assure that they are timely and with a quality that meets or exceeds the expectations of our current contract.

Prior to MPRO, she served as a Review Coordinator, Process Manager for Inpatient Retrospective Review for Medicare and Medicaid, and IT operations liaison. She also has patient care experience, working as a staff nurse in an orthopedics department for five years, and in an emergency department for more than 10 years.

PACER/LTC Exception and Immediate Review Project Coordinator – Sandra Renauer, RN

Role – Serves as the Project Coordinator for the PACER, long term care exception and immediate review team. Leads a team of RNs in performing prior authorization review and long term care exception and immediate review. Assures staffing is adequate to meet our deliverable for answering all incoming calls on average of 90 seconds or less. In addition, works closely with the physician reviewers to assure that their decisions are timely and accurate and in accordance to Medicaid policy.

Biography – Sandra Renauer has worked as an RN at MPRO for more than eight years. Her experience includes working with MPRO's Medicare, Medicaid, and private review contracts. Currently, she is Project Coordinator for the Medicaid PACER pre-authorization program. In this role, she is responsible for the day-to-day activities of the department, ensuring that there is sufficient nurse and physician reviewer staffing to meet contractual and departmental commitments. Ms. Renauer works with the nurses and physician reviewers to assure prior authorization reviews are completed accurately and on time, per contract requirements. She serves as the liaison between MPRO and the contract manager to ensure MPRO is meeting customer deliverables.

Ms. Renauer was instrumental in streamlining the internal quality improvement processes for MPRO's Medicare Beneficiary Protection program. She has been active in Emergency Medical Treatment cases, Active Labor Act (EMTALA) cases, sanctions cases, and has worked with the Office of Inspector General (OIG).

Ms. Renauer's employment history includes active nursing in Detroit-area hospitals, mainly in the medical-surgical field. Other hands-on nursing experience includes hospice and pediatric psychiatric. She also has extensive experience as a nurse consultant and medical underwriter for a private health insurance company.

Audit Review Coordinator – Cheryl Gutowski, RN

Role – Works with the RHITs and support staff to assure the audits and SWUR-inpatient are performed in accordance with state requirements.

Biography – Cheryl Gutowski oversees administrative processes and conducts clinical activities associated with the assigned fee-for-service audit of inpatient, emergency department, outpatient, and long term care exception retrospective review programs. She also serves as a customer liaison for operational functions. She assists in implementing and conducting process improvement plans, coordinating and evaluating the internal quality-monitoring program, and assists in staff education and orientation programs.

Ms. Gutowski's years as an Audit Review Coordinator has provided her with expertise in all aspects of acute inpatient and psychiatric review, including mental health managed care, peer review systems, development and use of treatment criteria and standards, and quality improvement concepts. Her expertise has continued to develop while serving as supervisor and manager. She is skilled at managing the retrospective review process in acute inpatient and mental health programs, program development and implementation, and quality monitoring.

Before coming to MPRO, Ms. Gutowski served as acting team leader and staff nurse on chemical dependency, psychiatric inpatient, and medical-surgical units. She facilitated development of a standardized review process, developed an internal quality-monitoring process, assisted in developing and implementing a chemical dependency unit, and developed didactic education groups for psychiatric inpatient programs.

Audit Review Coordinator – Elizabeth Williams, RN

Role – Works with the RHITs and support staff to assure the audits and SWUR are performed in accordance with state requirements.

Biography – As an Audit Review Coordinator Elizabeth Williams manages and coordinates inpatient, outpatient, or ER audits. She evaluates the medical necessity and appropriateness of health care services, coding assignments, and the quality of care provided. She generates reports and submits them to MDCH; she also represents MPRO at appeals requested by MDCH for audited providers. In addition, Ms. Williams is experienced at leading health care delivery teams to provide high-quality care with continuous improvement of patient services.

Audit Review Coordinator – Susan Brunette, RN

Role – Works with the RHITs and support staff to assure the audits and SWUR inpatient/outpatient are performed in accordance with state requirements.

Biography – Susan Brunette currently serves as MPRO's Audit Review Coordinator. In this capacity, she manages and coordinates inpatient and outpatient audits, serves as liaison between MPRO and providers, and evaluates medical records for medical necessity and appropriateness of health care services. Prior to coming to MPRO, she served as Case Manager for utilization review at M-CARE, where she reviewed requests submitted by medical providers to see if insurance guidelines were being met and approved requests to determine eligibility for certain types of procedures.

A range of other positions have prepared Ms. Brunette to work in many areas of health care and health care management, including providing patient care in the operating room and medical offices, as well as conducting utilization review, case management, billing review, auditing, and cost containment activities. She has extensive knowledge of the insurance industry and worker's compensation applications, InterQual® criteria, CPT coding, and ICD-9 diagnosis guidelines.

Audit Review Coordinator – Cynthia Smith, RN

Role – Performs retrospective long term care reviews and provides consistent and reliable reporting.

Biography – Cynthia Smith has 30 years of diverse experience in the medical field performing nursing, telephone-based case management, utilization review, discharge planning, and medical record analysis. In her current position as long term care Audit Review Coordinator, she is responsible for medical review of Medicaid beneficiaries in nursing facilities and Medicaid waiver cases. In addition, she works with the nursing management staff in various long term care facilities to explain and clarify denial-of-care letters.

Ms. Smith interacts effectively with patients, physicians, health care professionals, home care agencies, nursing facilities, and insurance claim representatives. She also helps maintain high productivity, a smooth workflow, and a friendly work environment.

Audit/SWUR Coding Compliance Analyst – Doris Carson, RHIT

Role – Assures review determinations for the inpatient audit and SWUR-inpatient review are accurate and in compliance with coding requirements and state and federal regulations.

Biography – Doris Carson is a Coding Compliance Analyst for MPRO with 10 years of experience in the field of coding. Current responsibilities include reviewing inpatient medical records to verify diagnosis-related group (DRG) validation for the Department of Community Health. She also represents MPRO at statewide DRG appeals. In her previous position, Ms. Carson coded and abstracted in-patient records using ICD-9-CM codes/guidelines.

Audit/SWUR Coding Compliance Analyst – Vicki McNair-Turley, RHIT

Role – Assures review determinations for the inpatient audit and SWUR-inpatient review are accurate and in compliance with coding requirements and state and federal regulations.

Biography – Ms. McNair-Turley serves as a highly skilled Coding Compliance Analyst with more than 10 years experience in diagnosis-related group (DRG) validation and coding compliance. For the last three years, she has performed DRG validation for MDCH. Other duties include corresponding with hospitals regarding audit results and representing MPRO at appeals. In addition, she has worked on the Medicare contract performing the same duties.

Prior to coming to MPRO, Ms. McNair-Turley worked for two major Ann Arbor, Michigan-based health systems, St. Joseph Mercy Health System and the University of Michigan. In both positions, she performed DRG audits, provided educational presentations, and was a liaison to the medical staff, coding staff, clinical documentation specialists, and ancillary hospital staff. She also responded to third-party DRG denials.

Audit/SWUR Coding Compliance Analyst – Anndie Beurer, RHIT

Role – Assures review determinations for the inpatient audit and SWUR-inpatient review are accurate and in compliance with coding requirements and state and federal regulations.

Biography – Ms. Beurer has 29 years combined experience in utilization review and coding. As a Medicare Coding Compliance Analyst, she reviews medical records, ensuring that diagnostic and procedural coding practices are consistent with coding rules and regulations for Medicare, Medicaid, and private review contracts. She assists nurse reviewers and physician advisors to resolve coding issues and problem cases. She also represents MPRO at statewide DRG appeals and hearing processes.

In her previous position as Outcomes Management Associate, Ms. Beurer collaborated with case management, social work, and coding staff to maximize reimbursement, while attempting to maintain reasonable length-of-stay. She performed concurrent and retrospective appeals of denied inpatient stays and was frequently consulted about sensitive issues by physicians and other health care professionals.

PACER Review Coordinator – Susan Birch, RN

Role – Assures that the care and services provided to Medicaid beneficiaries is medically necessary and performed in the appropriate setting and in accordance with state and federal guidelines.

Biography – Susan Birch has more than 20 years of medical/surgical nursing experience, including 11 years at an urban. Ms. Birch has experience in both inpatient hospice care and home care settings. Her home care experience includes field nursing, as well as establishing a quality assurance department for a local home care agency. While in the home care setting, she held a managerial position for supervision and educational training for new nurses, as well as responsibility for yearly teaching and evaluation of all nursing field and office staff. She has traveled to Honolulu, Hawaii to train staff in an independent quality assurance department and has been a Red Cross BCLS trainer. Her background includes involvement in Joint Commission on Accreditation of Healthcare Organizations certification for the acute care hospital and for the home care agency, as well as MPRO URAC accreditation.

PACER Review Coordinator – Alyson Burtle, RN

Role – Assures that the care and services provided to Medicaid beneficiaries is medically necessary and performed in the appropriate setting and in accordance with state and federal guidelines.

Biography – Alyson Burtle has worked as a RN since 1985. She has worked for MPRO both in Medicaid and in a private-review program. Currently, she serves as a PACER Review Coordinator, responsible for processing, in a courteous and professional manner, requests for preauthorization of elective admissions, transfers, re-admissions within 15 days, and rehabilitation stays. She also directs independent reviews for the Informal Deficiency Review Services for Michigan long term care facilities.

PACER Review Coordinator – Donna Ruemenapp, RN

Role – Assures that the care and services provided to Medicaid beneficiaries is medically necessary and performed in the appropriate setting and in accordance with state and federal guidelines.

Biography – Donna Ruemenapp is a goal-oriented, team-focused RN who possesses a high level of professionalism and strong commitment to excellence. She brings more than 15 years of successful experience as a medical/pharmaceutical sales representative and 12 years of clinical nursing experience to her current MPRO position. Her 5 years of utilization review and quality assurance experience allows her to have a positive impact on patient outcomes.

ADDITIONAL SUPPORT STAFF BIOGRAPHIESSupport Technician – Lori Peterson

Role – Scans inpatient/ER/outpatient records, ensuring medical record integrity and confidentiality of the records, and prepares audit and SWUR program records for review.

Biography – Lori Peterson has worked for MPRO for 14 years. At the onset of her MPRO career, she worked as a helpdesk and a data support technician for the IT department. During the last five years, she has served as a Support Technician for the Medicaid program. In her current role as Support Technician, she scans the inpatient/ER/outpatient records of audited providers and assures the scanned records are prepared and ready for the RNs and RHITs to review.

Support Technician – Joanne Kovacs

Role – Scans inpatient/ER/outpatient records, ensuring medical record integrity and confidentiality of the records, and prepares audit and SWUR program records for review.

Biography – Joanne Kovacs has worked for MPRO since 1997. She has served in various roles including Corporate Administrative Assistant where she was responsible for generating documents, proof reading and formatting documents, scheduling, filing, data entry, and many other administrative responsibilities. In 2008, Ms. Kovacs joined the Medicaid Fee For Service Team as a Support Technician. In her current role as Support Technician, she scans the inpatient/ER/outpatient records of audited providers and assures the scanned records are prepared and ready for the RNs and RHITs to review.

Administrative Assistant – Angel Nelson

Role – Manages the day-to-day responsibilities of the long term care retrospective review program and PACER. Mails correspondence generated by all programs. Responds to phone calls related to medical record requests and fields calls to the RNs or RHITs. Files and stores medical records.

Biography – In her role as part-time Administrative Assistant/Review Support Technician, Ms. Nelson provides technical and administrative support for all clinical review projects, contracts, and leadership and staff functions. She is responsible for daily maintenance of clinical review information, including medical records and other case files and data entry; she also generates case listings, types letters and reports, provides phone coverage, and supports technical activities as necessary. She also provides technical support for all clinical review activities.

OTHER REQUIREMENTS**REPORTS**

Our project team has significant experience in producing accurate and timely reports that meet or exceed MDCH's requirements.

**COLLABORATION WITH PROVIDERS**

MPRO has been operating within the State of Michigan for more than 25 years and has developed relationships with physicians, hospitals, nursing homes, and home health agencies throughout the state. We are respected as an unbiased and impartial clinical review organization. Our positive working relationship with the provider community is one of our strongest assets. By selecting us as the contractor for the Michigan Hospital Admissions Review and Certification Program, MDCH will maintain the trusted confidence of tried and true provider relations.

PRIVACY, DATA SECURITY, AND CONFIDENTIALITY

MPRO's Audit Review Team has significant experience in the proper handling of confidential information, and we have documented policies and procedures to ensure the confidentiality and security of all data we maintain.

MICHIGAN VENDOR

MPRO's corporate office is located in the State of Michigan. Our staff has easy access to the Greater Lansing Area.

PEER REVIEW ORGANIZATION STATUS

Through a competitive bid process in 1984, MPRO was designated by the Centers for Medicare & Medicaid Services as the peer review organization (PRO) for the Medicare program in Michigan. Since the initial award, our sustained performance has resulted in continuous, non-competitive contract renewal. As a result, we have accumulated more than 25 years of daily experience with the peer review process in Michigan.

MPRO is a Michigan non-profit corporation incorporated in 1984; we are qualified as a tax-exempt organization under Section 501(c)(3) of the Internal Revenue Code.

MILESTONES AND DELIVERABLES

For the Contract the following mechanisms must be in place:

1. Readiness for Implementation

- a. The Contractor must have an operational system in place no later than one (1) month from the start up of the Contract including but not limited to sufficient staff.
- b. The Contractor shall demonstrate to the MDCH's satisfaction no later than one (1) month from the start up of the Contract, that the Contractor is fully capable of performing all duties under this Contract, including demonstration of the following:
 - i. That the Contractor demonstrates a sufficient number of RN's experienced in the areas of Inpatient, Outpatient, Emergency Room, PACER and Long Term Care, and Physician's experienced in the area of Long Term Care, to perform the audit/review duties as specified herein. The Registered Nurses performing the audit/Statewide Utilization Review/LTC review functions cannot perform the PACER authorizations. The MDCH expects the Contractor to designate separate staff for each review.
 - ii. That the Contractor has thoroughly trained its staff on the specifics of the audit/Statewide Utilization Review/LTC review processes and that the Contractor's staff has sufficient knowledge to make determinations of medical services needed.
 - iii. That the Contractor has the ability to accept, process and transmit to the MDCH those audits/Statewide Utilization Review/LTC reviews that have been completed.
 - iv. That the Contractor has quality assurance procedures in place that assures it follows all State and Federal laws for confidentiality.
- c. The Contractor's inability to demonstrate to the MDCH's satisfaction and as provided herein, that the Contractor is fully capable of performing all duties under this Contract no later than February 1, 2010, shall be grounds for the immediate termination of this Contract by the MDCH in accordance with the terms specified herein.



2. Program Specification

- a. The Contractor shall complete the audit/review process within the Timeframes described under Article 1.022 and submit the required reports within the Timeframes described under Article 1.042.
- b. The Contractor shall retain all records until the audit/review is closed, (settlement is reached) or the records are requested by the Appeals Section.

Contractor Response to Tasks:

IMPLEMENTATION READINESS

As the current FFS contractor, MPRO is in a unique position to meet MDCH's contract milestones and deliverables with little or no start-up time. We have a Michigan-based facility, management infrastructure, experienced staff, phone system, MDCH-specific computer system, and audit/review processes in place for immediate start up after contract negotiations are completed. The following outlines milestones and deliverables and our compliance plan.

Table 13: Milestones/Deliverables – Readiness for Implementation

MDCH Milestone or Deliverable	Due Date	MPRO Compliance Plan
Operational system in place, including but not limited to, sufficient staff.	January 1, 2010 or as directed by MDCH	MPRO is currently in compliance with this requirement.
Sufficient number of RNs with experience in the areas of inpatient, outpatient, ER, PACER and long term care.	January 1, 2010 or as directed by MDCH	MPRO currently has a team of experienced review nurses in the areas of inpatient, outpatient, ER, PACER, and long term care.
Physicians are experienced in the all areas of review and clinical experience.	January 1, 2010 or as directed by MDCH	MPRO has physicians experienced in various clinical areas and in case/audit review.
Separate staff designated for the PACER authorization and audit/review functions.	January 1, 2010 or as directed by MDCH	To meet the terms of this contract, MPRO divides the nurses between PACER and audit/review functions. As the organizational chart shows, each staff member is designated PACER or audit/review.
Contractor has fully trained its staff on the specifics of the audit/SWUR/LTC review processes.	January 1, 2010 or as directed by MDCH	MPRO's review staff is trained in the audit and review functions for PACER authorizations and inpatient, outpatient, ER, and PACER validation reviews. RNs are trained in telephonic exception and immediate review and in retrospective LTC review.
Contractor's staff has sufficient knowledge to make determinations of medical services needed.	January 1, 2010 or as directed by MDCH	Our review staff has the knowledge of Michigan-specific policies and review criteria to make determinations regarding medical services needed.
Contractor has the ability in place to accept, process, and transmit to MDCH those audits that have been completed.	January 1, 2010 or as directed by MDCH	MPRO has a system in place to accept, process, and transmit completed audits, SWUR, and LTC. The system/process that we use is MDCH's design.



Contractor has quality assurance procedures in place to assure it follows all state and federal laws for Confidentiality.	January 1, 2010 or as directed by MDCH	As a longstanding contractor of CMS and the State of Michigan, MPRO has always had a solid infrastructure to preserve confidentiality of information in compliance with all applicable state and federal laws. Our confidentiality and security procedures comply with HIPAA and other applicable regulations.
The contractor is fully capable of performing all duties under this contract no later than Feb. 2010.	January 1, 2010	MPRO is able to perform all the requested requirements outlined in this CONTRACT.

PROGRAM SPECIFICATIONS

Table 14: Milestones/Deliverables – Program Specifications

MDCH Milestone or Deliverable	Due Date	MPRO Compliance Plan
Contractor will complete the audit/review process within the timeframes described in the CONTRACT.	January 1, 2010	MPRO complies with all the timeframes for our current contract with MDCH.
Contractor will submit the required reports within the timeframes specified in the CONTRACT.	January 1, 2010	MPRO currently submits all reports to MDCH within the timeframes specified by our current contract. We are prepared to meet all reporting timeframes requested in the CONTRACT.
Contractor shall retain all records until the audit/review is closed (settlement is reached) or the records are requested by the Appeals section.	January 1, 2010	MPRO maintains all contract records at our office in Farmington Hills, Michigan. We have a medical records room where paper copies of documents or CDs are stored. We secure archived records at an off-site storage facility. We store all audit/review case documents until the audit/review is closed (settlement reached) or the records are requested by the appeals section.

As outlined in the tables above, MPRO currently complies with all of MDCH's requirements, and we are ready to start work on this contract upon its award.

FRAUD AND ABUSE

The Contractor shall report suspected fraud, and/or abuse by Medicaid beneficiaries and/or providers to the MDCH Medicaid Integrity Program. The report shall detail the provider, beneficiary and all information on the situation. The link to information regarding fraud and abuse and how to report it is located on the MDCH website www.michigan.gov/mdch, click on the links to inside Community Health, and Fraud and Abuse.



Contractor Response to Task:

FRAUD AND ABUSE

MPRO trains its review staff on the importance of identifying and reporting suspected fraud and abuse. In providing these services, we will use the following definitions of fraud and abuse that were provided on the web site, Michigan.gov/mdch.

Fraud – Intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law (42 CFR §455.2).

Abuse – 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 professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program (42 CFR §455.2).

Our Director of Medical Review Services is the contact for all staff who suspect Medicaid fraud or abuse. She will coordinate the preparation of the necessary documentation, including provider and beneficiary identifying information and a full description of the situation, along with reports and other documentation that is available. The Director will download and complete the fraud and abuse form from MDCH's web site and submit it to MDCH's Contract Manager within 48 hours of identification of the situation.

1.040 Project Plan

1.041 Project Plan Management CONTRACT MONITORING

The Contractor shall permit the MDCH or its designee to visit and to make an evaluation of the project as determined by the Contract Manager. At least once (1) per contract year the MDCH will complete a site visit of the Contractor to monitor work in progress. If the Contractor is in/out of the State of Michigan, the monitoring will occur at the Audit Contractor site. All travel, lodging and meal expenses for up to three (3) State of Michigan employees shall be paid by the Contractor for this yearly review should the Contractor be in/out of the State of Michigan.

The Contractor shall meet/teleconference with the MDCH contract management at least weekly during the first month of the contract and at least monthly for the remainder of the contract to review all Nurse Review Reports, etc.

The Contract Manager shall monitor that the Contractor complete work within the timeframes listed under Articles 1.022 and 1.042.

Contractor Response to Tasks:

CONTRACT MONITORING

As a current contractor of MDCH, we are committed to ensuring exceptional performance and full compliance with all contract terms and requirements. We will provide all necessary documentation and access, so the MDCH Contract Manager is able to monitor MPRO's contract performance effectively. This includes, but is not limited to, the following activities:

- Offering the Director of Medical Review Services as the primary point-of-contact to facilitate requests from MDCH;
- Submitting all reports electronically and in compliance with HIPAA transaction standards;
- Providing documents, reports, and financial statements to the MDCH Contract Manager within the required timeframes;
- Transmitting HIPAA-compliant reports electronically to MDCH;
- Participating in weekly meetings or teleconferences with the MDCH Contract Manager during the first month of the contract and at least monthly for the remainder of the contract;
- Allowing access to MDCH or its designee to complete a site visit at MPRO's office at least once per year to monitor work in progress under the contract (we will reimburse all travel, lodging and meal expenses for up to three State of Michigan representatives for this annual review); and
- Providing reporting to MDCH on reviewer response for PACER and LTC exception and immediate review programs.

**1. PACER:**

The MDCH PACER Contract Manager will review the following reports: number of cases reviewed; number review coordinator approved, number referred, and number denied; number physician approved, and denied; number reconsideration cases; number reconsideration overturned and upheld; net denials number and percent of denials; number of abandoned calls, number of PACER calls, number of informational calls. The Contract Manager shall also review that the date and time of the request, approval, or denial was within the timeframes mentioned under Article 1.022.

2. Long Term Care Exception and Immediate Reviews:

The MDCH LTC Contract Manager will review the following data submitted by the Contractor in the Immediate/Exception Review Report: number of Immediate and Exception Reviews performed per month, the number denied, number approved and the approval code.

The Contract Manager shall also review that the date and time of the request, approval, or denial was within the timeframes mentioned under Article 1.022.

3. Hospital Audits/Statewide Utilization Review:

The MDCH Contract Manager through reports and financial statements shall monitor the audit progress as listed in Article 1.022 Hospital Audits/Utilization and Statewide Utilization Review Sections. Reports shall be electronically transmitted to the MDCH in compliance with HIPAA transactions.

For this Contract, each phase of the Hospital Audit/Statewide Utilization Review process will be monitored by the MDCH Contract Manager. At a maximum, five (5) percent of audit total (or a number determined by the MDCH) will be submitted to the MDCH for validation. At a maximum, five (5) records per provider for the Statewide Utilization Review Process (or a number determined by the MDCH) will be submitted to the MDCH for validation.

There is a 5% validation on each audit. For Statewide Utilization Review there is a maximum of 5 records per provider on a monthly basis.

4. Long Term Care Retrospective Review:

The MDCH LTC Contract Manager will also review the following data submitted by the Contractor in the Retrospective Review reports: the number or retrospective reviews performed per month: the number upheld, the number overturned (final denial), the number of technical denials: the number of technical denials based on an incomplete medical record/case record, the number of technical denials based on the absence of PASARR documentation: the number of abandoned calls.

The MDCH LTC Contract Manager shall review long term care reports as defined under Article 1.042. Reports shall be transmitted electronically or by mail to the MDCH in compliance with HIPAA transactions.



Contractor Response to Tasks:

MPRO will provide MDCH with the HIPAA-compliant reports needed to perform contract monitoring. The table below describes the contents of each report by program.

Table 15: Report Contents by Program

Program	MPRO Reporting
PACER	<ul style="list-style-type: none"> ▪ Number of cases reviewed ▪ Number approved by RN ▪ Number referred ▪ Number approved ▪ Number denied by physician ▪ Number approved by physician ▪ Number of reconsiderations ▪ Number of reconsiderations overturned ▪ Number of reconsiderations upheld ▪ Number of net denials ▪ Number and percentage of denials ▪ Number of PACER calls ▪ Number of abandoned calls ▪ Number of informational calls ▪ Average time to answer calls ▪ Percentage of time calls answered within 90 seconds or less ▪ Management review of date/time of request
Long Term Care Exception and Immediate Reviews	<ul style="list-style-type: none"> ▪ Number of immediate reviews ▪ Number of exception reviews ▪ Number denied each month ▪ Number approved each month ▪ Approval code ▪ Management review of date/time of request
Hospital Audits	<ul style="list-style-type: none"> ▪ Nurse review report ▪ Financial statements ▪ Maximum 5% of audit total (or number determined by MDCH) submitted to MDCH for validation
Statewide Utilization Review	<ul style="list-style-type: none"> ▪ Review report ▪ Financial statements ▪ Maximum five records per provider (or number determined by MDCH) submitted to MDCH for validation
Long Term Care Review Retrospective	<ul style="list-style-type: none"> ▪ Number of retrospective reviews performed per month ▪ Number upheld ▪ Number overturned (final denial) ▪ Number of denials based on incomplete medical/case record ▪ Number of technical denials ▪ Number based on absence of PASARR documentation

SANCTIONS

PACER:

Sanctions will be imposed based on the results of the monthly billing validation conducted by the MDCH Contract Manager and the PACER validation performance review conducted as part of the Inpatient Audit process. The penalty will be determined by the number of incorrect authorizations; authorizations by telephone/electronic computer system not completed in a timely manner; telephone response time with an average time to answer greater than ninety (90) seconds.



The MDCH Contract Manager reserves the right to change the PACER validation process with a thirty (30) day notice to the Contractor. The MDCH Contract Manager also reserves the right to change the PACER review process or cancel the Contract with a thirty (30) day notice to the Contractor.

Monetary sanctions imposed pursuant to this section may be collected by deducting the amount of the sanction from any payments due the Contractor or by demanding immediate payment by the Contractor. The MDCH, at its sole discretion, may establish an installment payment plan for payment of any sanction. The determination of the amount of any sanction shall be at the sole discretion of the MDCH, within the ranges set forth below. Self-reporting by the Contractor will be taken into consideration in determining the sanction amount. Upon determination of substantial noncompliance, the MDCH shall give written notice to the Contractor describing the non-compliance, the opportunity to cure the non-compliance where a cure is allowed under this Contract and the sanction which the MDCH will impose here under. The MDCH, at its sole discretion, may waive the imposition of sanctions.

1. Number of Incorrect Authorizations. With the beginning of this Contract, if the Contractor inappropriately authorizes inpatient admissions, transfers, readmissions within fifteen (15) days, and continued stay for rehabilitative facilities, then the MDCH will give written notice to the Contractor of the number of Incorrect Admissions by fax, (hardcopy to follow by overnight mail through request of proof of delivery). The Contractor shall have ten (10) calendar days following the notice in which to submit a corrective action plan. If the corrective action plan has not been submitted within ten (10) calendar days following the notice, the MDCH, without further notice, may impose a sanction of no less than \$10,000. At the end of each subsequent ten (10) day period in which the corrective action plan has not been submitted, the MDCH may, without further notice, impose further sanctions of \$10,000.

In addition to the above, beginning April 1, 2010, additional sanctions will begin. If greater than ten (10) PACER authorizations per audit are determined to be inappropriately authorized during the PACER validation conducted by Contractor during the audit process, the Contractor will be sanctioned the amount of the hospitalizations approved in error.

2. Authorization Process not completed in a timely manner. Upon review by the MDCH Contract Manager, if authorizations from the previous month are not completed in a timely manner, the MDCH will withhold twenty five percent (25%) of the monthly future payments until the Contractor achieves the schedule and demonstrates adherence to the Contract.
3. Telephone response time. If telephone response time is greater than ninety (90) seconds for two (2) consecutive months, the MDCH will withhold twenty five percent (25%) of the monthly future payments until the Contractor achieves the schedule and demonstrates adherence to the Contract.
4. Based on the monthly billing validation performed by the MDCH Contract Manager, (part of the PACER validation that MDCH reviews monthly via the complete listing of all PACER activity the previous month), if ten percent (10%) of the PACER determinations for inpatient elective admissions, transfers, and readmissions within fifteen (15) days are incorrect, \$10,000 or the amount of the dollars for the hospitalization, whichever is less, will be taken back from the Contractor. The MDCH selects a random sample of PACER validations of the previous month PACER activity. The selection by the MDCH is random, i.e., if the number for validation was forty (40) PACER cases then ten percent (10%) would be four (4). The number of cases to be selected on a monthly basis is determined by the MDCH.



Contractor Response to Tasks:

SANCTIONS

MPRO will abide by the requirements set forth by MDCH regarding timeframes and review accuracy. We recognize that MDCH may impose monetary sanctions. We hereby acknowledge the following terms and conditions under which MDCH may impose sanctions beginning the second year of the contract. The potential sanctions represent the maximum amount that MDCH may enforce. MDCH will use its sole discretion to determine the actual amount of any sanctions after taking into account all factors related to the situation, including but not limited to, MPRO's efforts to notify MDCH regarding any contract violations or failures.

PACER

Table 16: Sanctions – PACER

Contract Violation	Notification	Opportunity to Cure	Potential Sanction Imposed
Number of incorrect authorizations (inappropriate authorizations of admissions, transfers, readmissions within 15 days and continued stay for rehab facilities)	MDCH gives written notice by fax and sends hard copy notification via overnight mail.	MPRO has 10 calendar days following notice to submit a corrective action plan (CAP).	MDCH will charge MPRO \$10,000 per each 10-day period for which the CAP is not submitted. Additional sanctions after 4/1/2010: If > 10 PACER authorizations approved in error, MPRO is sanctioned the amount of the incorrect hospitalizations.
Authorization process not completed in a timely manner	MDCH gives written notice. CONTRACT does not specify details.	MPRO must achieve monthly schedule and demonstrate contract adherence.	MDCH will withhold 25% of monthly future payments until MPRO demonstrates contract adherence.
Telephone response time > 90 seconds for two consecutive months	MDCH gives written notice. CONTRACT does not specify details.	MPRO must achieve monthly schedule and demonstrate contract adherence.	MDCH will withhold 25% of monthly future payments until MPRO achieves schedule and demonstrates contract adherence.
Monthly billing validation – 10% incorrect determinations for inpatient elective admissions, transfers, and readmissions within 15 days	MDCH gives written notice. CONTRACT does not specify details.	CONTRACT does not specify.	MPRO will pay back \$10,000 or the cost of the hospitalization, whichever is less.

Our internal quality control process will ensure our review processes comply with MDCH requirements and proactively address any potential areas of non-compliance. Our commitment to quality monitoring and improvement recognizes the need to measure and report areas of non-compliance, so that appropriate action is taken to rectify the situation. All review staff are encouraged to notify the Director of Medical Review Services as soon as they become aware of any situation that might jeopardize our ability to meet a timeframe or contract requirement.

We acknowledge that MDCH may elect to adjust the number of audits/review conducted per provider type within 30 days notice to MPRO. MDCH may also change the audit/review process or cancel the contract with 30 days notice to MPRO.

**Long Term Care Immediate and Exception Review:**

Sanctions will be imposed based on the results of the monthly billing validation conducted by the MDCH LTC Contract Manager. The penalty will be determined by the number of incorrect Immediate and Exception Review determinations; determinations not completed in a timely manner; telephone response time with an average time to answer greater than ninety (90) seconds.

The MDCH Contract Manager reserves the right to change the LTC validation process with a thirty (30) day notice to the Contractor. The MDCH Contract Manager also reserves the right to change the LTC review process or cancel the Contract with a thirty (30) day notice to the Contractor.

Monetary sanctions imposed pursuant to this section may be collected by deducting the amount of the sanction from any payments due the Contractor or by demanding immediate payment by the Contractor. The MDCH, at its sole discretion, may establish an installment payment plan for payment of any sanction. The determination of the amount of any sanction shall be at the sole discretion of the MDCH, within the ranges set forth below. Self-reporting by the Contractor will be taken into consideration in determining the sanction amount. Upon determination of substantial noncompliance, the MDCH shall give written notice to the Contractor describing the non-compliance, the opportunity to cure the non-compliance where a cure is allowed under this Contract and the sanction which the MDCH will impose here under. The MDCH, at its sole discretion, may waive the imposition of sanctions.

1. Number of Incorrect Immediate and Exception Review determinations. With the beginning of this Contract, if the Contractor inappropriately determines LTC admission or enrollment, then the MDCH will give written notice to the Contractor of the number of incorrect admissions by fax, (hardcopy to follow by overnight mail through request of proof of delivery). The Contractor shall have ten (10) calendar days following the notice in which to submit a corrective action plan. If the corrective action plan has not been submitted within ten (10) calendar days following the notice, the MDCH, without further notice, may impose a sanction of no less than \$10,000. At the end of each subsequent ten (10) day period in which the corrective action plan has not been submitted, the MDCH may, without further notice, impose further sanctions of \$10,000.
2. Immediate and Exception Review process not completed in a timely manner. Upon review by the MDCH LTC Contract Manager, if authorizations from the previous month are not completed in a timely manner, the MDCH will withhold twenty five percent (25%) of the monthly future payments until the Contractor achieves the schedule and demonstrates adherence to the Contract.
3. Telephone response time. If telephone response time is greater than ninety (90) seconds for two (2) consecutive months, the MDCH will withhold twenty five percent (25%) of the monthly future payments until the Contractor achieves the schedule and demonstrates adherence to the Contract.

s should confirm that the Contractor will provide all requirements listed above and provide detail regarding how the Contractor will accomplish these requirements.



Contractor Response to Tasks:

SANCTIONS

MPRO will abide by the requirements set forth by MDCH regarding timeframes and review accuracy. We recognize that MDCH may impose monetary sanctions. We hereby acknowledge the following terms and conditions under which MDCH may impose sanctions beginning the second year of the contract. The potential sanctions represent the maximum amount that MDCH may enforce. MDCH will use its sole discretion to determine the actual amount of any sanctions after taking into account all factors related to the situation, including but not limited to, MPRO's efforts to notify MDCH regarding any contract violations or failures.

LONG TERM CARE IMMEDIATE AND EXCEPTION REVIEW

Table 17: Sanctions – Long Term Care Immediate and Exception Review

Contract Violation	Notification	Opportunity To Cure	Potential Sanction Imposed
Number of incorrect immediate and exception review determinations	MDCH gives written notice by fax and sends hard copy notification via overnight mail.	MPRO has 10 calendar days following notice to submit a CAP.	MDCH will charge MPRO \$10,000 per each 10-day period for which the CAP is not submitted.
Immediate and exception review process not completed in a timely manner	MDCH gives written notice. CONTRACT does not specify details.	MPRO must achieve previous month's schedule.	MDCH will withhold 25% of monthly future payments until MPRO achieves the schedule and demonstrates contract adherence.
Telephone response time > 90 seconds for two consecutive months	MDCH gives written notice. CONTRACT does not specify details.	MPRO must achieve previous month's schedule.	MDCH will withhold 25% of monthly future payments until MPRO achieves the schedule and demonstrates contract adherence.

MPRO will use our internal quality control process to ensure that our review processes comply with MDCH requirements and proactively address any potential areas of non-compliance. Our commitment to quality monitoring and improvement recognizes the need to measure and report areas of non-compliance, so that appropriate action is taken to rectify the situation. All review staff are encouraged to notify the Director of Medical Review Services as soon as they become aware of any situation that might jeopardize our ability to meet a timeframe or contract requirement.

We acknowledge that MDCH may elect to adjust the number of audits/review conducted per provider type within 30 days notice to MPRO. MDCH may also change the audit/review process or cancel the contract with 30 days notice to MPRO.

Hospital Audits/Statewide Utilization Review/LTC Retrospective Reviews:

For the first year of the Contract, the Contractor is expected to correct any inability to meet Timeframes. The MDCH reserves the right to adjust the number of Hospital Audits/Statewide Utilization Review/LTC Retrospective Reviews conducted per provider type with a thirty (30) day notice to the Contractor. The MDCH also reserves the right to change the audit/review process or cancel the Contract with a thirty (30) day notice to the Contractor.

In the second year, monetary sanctions imposed pursuant to this section may be collected by deducting the amount of the sanction from any payments due the Contractor or by demanding immediate payment by the Contractor. The MDCH, at its sole discretion, may establish an installment payment plan for payment of any sanction. The determination of the amount of any sanction shall be at the sole discretion of the MDCH, within the ranges set forth below. Self-reporting by the Contractor will be taken into consideration in determining the sanction amount. Upon determination of substantial noncompliance, the MDCH shall give written notice to the Contractor describing the non-compliance, the opportunity to cure the non-compliance where a cure is allowed under this Contract and the sanction which the MDCH will impose here under. The MDCH, at its sole discretion, may waive the imposition of sanctions. Sanctions will be imposed based on the following:



1. Failure to Report. If the Contractor fails to submit, by the due date, any report or other material required by this Contract to be submitted to the MDCH, the MDCH will give written notice to the Contractor of the late report or material by fax (hardcopy to follow by overnight mail through request of proof of delivery). The Contractor shall have ten (10) calendar days following the notice in which to cure the failure by submitting the complete and accurate report or material. If the report or other material has not been submitted within ten (10) calendar days following the notice, the MDCH, without further notice, may impose a sanction of no less than \$10,000. At the end of each subsequent ten (10) day period in which the complete and accurate report has not been submitted, the MDCH may, without further notice, impose further sanction of \$10,000.

2. Audits/Statewide Utilization Review/LTC Retrospective Reviews. The number of Hospital Audits/ Statewide Utilization Review/LTC Retrospective Reviews to be completed are outlined under Article 1.021. Upon review by the MDCH Contract Manager, if the Hospital Audit/ Statewide Utilization Review/LTC Retrospective Reviews from the previous month are not completed correctly or in a timely manner, the MDCH will withhold twenty five percent (25%) of the monthly future payments until the Contractor achieves the schedule and demonstrates adherence to the Contract.

Contractor Response to Task:

SANCTIONS

MPRO will abide by the requirements set forth by MDCH regarding timeframes. If MDCH finds us non-compliant with any aspect of the contract during the first contract year, we will take immediate steps to correct the situation. These steps may include development of a CAP, staff re-training, or changes to program operations. We will document and report all of our efforts to MDCH during our monthly project status meetings.

In the second contract year, MDCH may impose monetary sanctions, and we hereby acknowledge the following terms and conditions under which sanctions may be imposed, beginning the second year of the contract. The potential sanctions represent the maximum amount that MDCH may enforce. MDCH will use its sole discretion to determine the actual amount of any sanctions after taking into account all factors related to the situation, including but not limited to, MPRO's efforts to notify MDCH regarding any contract violations or failures.

HOSPITAL AUDITS/SWUR

Table 18: Sanctions – Hospital Audits/SWUR/LTC Retrospective Reviews

Contract Violation	Notification	Opportunity to Cure	Potential Sanction Imposed
Failure to report by due date	MDCH gives written notice by fax and sends hard copy notification via overnight mail.	MPRO has 10 calendar days following notice to submit the report or material.	MDCH will charge MPRO \$10,000 per each 10-day period for which a complete and accurate report is not submitted.
Audits/SWUR/LTC retrospective reviews not completed in timely manner	MDCH gives written notice. CONTRACT does not specify details.	MPRO must achieve previous month's schedule of deliverables.	MDCH will withhold 25% of monthly future payments until MPRO's reviews from the previous month are completed correctly or according to schedule.

MPRO acknowledges that MDCH may elect to adjust the number of audits/review conducted per provider type within 30 days notice to MPRO. MDCH may also change the audit/review process or cancel the contract with 30 days notice to MPRO.

Our internal quality control process will ensure our review processes comply with MDCH requirements and proactively address any potential areas of non-compliance. Our commitment to quality monitoring and improvement recognizes the need to measure and report areas of non-compliance, so that appropriate action is taken to rectify the situation. All review staff are encouraged to notify the Director of Medical Review Services as soon as they become aware of any situation that might jeopardize our ability to meet a timeframe or contract requirement.



1.042 Reports

The MDCH reserves the right to adjust the number of audits conducted per provider type, (inpatient/outpatient hospital/emergency room services), the number of Statewide Utilization Review records and the number of Long Term Care Retrospective Reviews with a thirty (30) day notice to the Contractor. The MDCH reserves the right to change/cancel the audit/review process or cancel the contract with a thirty (30) day notice to the Contractor.

Reports and information shall be submitted to the MDCH Contract Manager at the address listed in the front of this contract. The Contract Manager shall evaluate the reports submitted as described in this section for their completeness and adequacy.

The Contractor shall provide Inter-rater Reliability reports to the MDCH on a quarterly basis. The Inter-rater Reliability Rater is a validation of work by the Contractor. Inter-rater instructions as well as the process for the review are required. One actual example of a report de-identified for each part of the Program is requested (PACER, Inpatient Audits, Outpatient Audits).

PACER Reports:

Reports shall be provided electronically to the Contract Manager weekly, monthly, quarterly, and annually. They shall include: number of cases reviewed; number review coordinator approved, number referred, and number of cases denied; number of cases physician approved, and denied; number of reconsideration cases; number of reconsideration cases overturned and upheld; number of net denials and percent of denials; number of cases appealed, number of appealed cases overturned and upheld.

The Contractor shall report by percentage and whole numbers all telephone calls where the provider remains on hold greater than ninety (90) seconds. The Contractor shall report, by percentage, the numbers of calls not completed in a timely manner.

The Contractor shall provide Inter-rater Reliability Reports to the MDCH of Community Health on a quarterly basis. The Inter-rater Reliability Report is a validation of employee internal monitoring performed by the Contractor. Inter-rater instructions as well as the process for the review are required. One actual example of a report de-identified for each part of the Program is requested (PACER, Inpatient Audits, Outpatient Audits).

Long Term Care Immediate and Exception Review Reports:

Reports shall be provided electronically or by mail to the LTC Contract Manager monthly, quarterly and annually. For Immediate and Exception Reviews, they shall include:

- a. number of Exception Reviews and Immediate Reviews performed
- b. the following information for each Immediate and Exception Review:
 - i. the telephone contact date from the provider/beneficiary/representative
 - ii. the review determination date
 - iii. the beneficiary's first and last name and Medicaid ID
 - iv. the providers NPI and setting type (nursing facility, waiver, PACE)
 - v. the Review Nurse's initials
 - vi. the number approved and the approval code
 - vii. the number denied
 - v. copies of Immediate and Exception Review Adverse and Adequate actions
 - ix. copies of the documentation reviewed in Immediate Reviews
 - x. the number of Immediate and Exception Reviews appealed

The Contractor shall report by percentage and whole numbers all telephone calls where the provider remains on hold greater than ninety (90) seconds. The Contractor shall report, by percentage, the numbers of calls not completed in a timely manner.

**Hospital Audits/Statewide Utilization Review Reports:**

The reporting mechanisms are listed below under 1-3.

A “work plan” for the first quarter of the contract will be submitted electronically to the MDCH by January 31, 2010, describing proposed audit/review activities. An “updated work plan” shall be provided electronically by the last day of the preceding quarter beginning with the April quarter describing proposed audit activities.

The Contractor shall report the following information to the MDCH at the designated time frames in a format agreed upon by the MDCH and the Contractor. The MDCH reserves the right to modify the reporting requirements. Proposals for alternative reporting requirements will be considered by the MDCH.

1. A “monthly report” shall be provided electronically to the MDCH by close of business on the 5th calendar day of each month. The report will list newly initiated audits/reviews and activities on audits/reviews initiated during previous months. Activities shall include:
 - a. Name and date of audit(s)/reviews initiated.
 - b. Name and date of audit(s)/reviews completed.
 - c. Number Retrospective Reviews of PACER authorization not meeting criteria.
 - i. number of authorizations given in error
 - ii. number of provider errors
 - d. For Statewide Utilization Review, a summary of review findings to include provider name alphabetically and ID number, time period sample pulled from, date medical record requested, beneficiary name alphabetically and ID number, and findings.
2. A “quarterly report” shall be provided electronically to the MDCH by the last calendar day of the month following the reporting quarter detailing year-to-date totals for all activities.
3. An “annual report” shall be provided electronically by the Contractor to the MDCH by the last calendar day of the month following the annual reporting period that is an accumulation of the quarterly reports.

Long Term Care Retrospective Review Reports:

Reports shall be provided electronically or by mail to the LTC Contract Manager monthly, quarterly and annually. LTC Retrospective Review reports shall include:

- a. the number of Retrospective Reviews performed for the review period
- b. the following information for each Retrospective Review:
 - i. the number of Retrospective Reviews completed
 - ii. the number of Retrospective Reviews approved (door validation)
 - iii. the number of Retrospective Reviews approved (in general)
 - iv. the number of Retrospective Reviews denied (final denial)
 - v. the number of Retrospective Reviews denied (final technical denial)
 - vi. the number of Retrospective Reviews denied (absence of PASARR)
 - vii. the number of Retrospective Reviews voided
 - viii. the number of Retrospective Reviews de-selected
 - ix. the number of Retrospective Reviews not open
- c. the following information for the approved (door validation) Retrospective Reviews:



- i. the provider's name
 - ii. the provider's NPI
 - iii. the beneficiary's Medicaid ID
 - iv. the reviewed door and the validation door
 - v. the Retrospective Review selection date and review period (from date/to date)
- d. the following information for denied (final denial, final technical denial, absence of PASARR) Retrospective Reviews:
- i. the provider's name
 - ii. the provider's NPI
 - iii. the beneficiary's Medicaid ID
 - iv. the Retrospective Review selection date and review period (from date/to date)
- e. the number of Retrospective Reviews denials appealed
- f. the number of Retrospective Review appeals upheld and overturned

Contractor Response to Tasks:

REPORTS

MPRO will submit electronic reports to MDCH's Contract Manager that document the progress and results of the audits and retrospective reviews conducted for inpatient, outpatient, ER and long term care admissions, and SWUR. Based upon our activities with the current Medicaid FFS review contract, we are equipped to provide the required reports and can easily adapt our process to accommodate new reports. At the onset of the contract, we will coordinate with MDCH to develop a reporting format that best meets the needs of both parties, and we will be flexible to respond to any changes requested by MDCH throughout the term of the contract.

PACER REPORTS

MPRO will submit reports to MDCH that document the progress and results of PACER reviews. Based on our activities with the current PACER review, we are equipped to provide the required reports and can adapt our process to accommodate new reports. At the onset of the contract, we will coordinate with MDCH to develop a reporting format that best meets the needs of both parties, and we will be flexible to respond to any changes requested by MDCH throughout the term of the contract.

The reports we provide to MDCH will track the progress in meeting contract requirements. We will develop and produce existing reports and ad-hoc reports using the system and process that has provided accurate and timely report generation for more than 21 years. We use rigorous internal controls in the development, production, and verification of reports prior to submission to MDCH.

In addition, MPRO will provide MDCH with a phone report that includes the percentage and whole numbers of all calls where the provider remains on hold for greater than 90 seconds.

Monthly Reports

We will produce monthly reports that provide the information requested by MDCH for PACER authorizations, phone statistics, and long term care exception reviews. We currently produce several reports that fulfill MDCH's requirements. The existing Pacer Review Summary Report contains the state-required data elements with the exception of appeals data for the inpatient PACER activities. We will add data columns to this report for number of cases appealed, number of appealed cases overturned, and number of appealed cases upheld to meet MDCH's requirements. We will complete this report modification prior to the start of the contract, provided MDCH has a system in place to notify MPRO of all appeals. We will also produce a similar report with information for the long term care exception process.



In addition, MPRO will provide reports for our telephone responsiveness. The purpose of this report is to monitor our responsiveness to telephone intake and to ensure compliance with contract requirements regarding speed of answer. The existing report titled Performance Indicators consists of four separate sections: phone statistics, review timeliness, reconsideration timeliness, and appeal results.

The mandatory components of each report include the following:

1. Inpatient PACER Review Summary Report:
 - a. Number of cases reviewed,
 - b. Number of cases approved by the Review Coordinator,
 - c. Number of cases referred,
 - d. Number of cases denied,
 - e. Number of cases approved by physician reviewer,
 - f. Number of cases denied by physician reviewer,
 - g. Number of reconsiderations,
 - h. Number of reconsiderations upheld,
 - i. Number of reconsiderations overturned,
 - j. Number of net denials,
 - k. Percentage denied,
 - l. Number of cases appealed,
 - m. Number of appeals overturned, and
 - n. Number of appeals cases upheld.
2. Performance Indicators – PACER Phone Statistics:
 - a. Total number of calls,
 - b. Total number of telephonic reviews,
 - c. Number of informational calls,
 - d. Number of calls answered within 90 seconds,
 - e. Percentage of calls answered within 90 seconds,
 - f. Average time to answer,
 - g. Number of calls abandoned, and
 - h. Percentage of abandoned calls.

We will work with MDCH to review and interpret these reports to ensure the highest level of performance and provide insight into new program development. In addition, we will create any ad-hoc reports requested by MDCH. See Appendix D for sample reports.

Weekly Reports

MPRO has the capability to produce weekly reports. Currently, we collect and give the information from the weekly report to MDCH when the monthly report is due. In the event MDCH requires these reports on a more frequent basis, we will comply.

Quarterly Reports

The quarterly reports will contain the information from the monthly report with the totals incorporating the entire quarter's activity.



Annual Report

The annual report will contain the information from the monthly and quarterly reports with the totals incorporating the entire year's activity.

REPORTING SCHEDULE

MPRO will submit all reports to the MDCH Contract Manager electronically and in hard copy according to the following reporting time line. This time line covers year one of the contract.

Table 19: PACER Report Schedule

Report Name	Time Period	Due Date
Monthly Report	January 2010	February 5, 2010
	February 2010	March 5, 2010
	March 2010	April 5, 2010
Quarterly Report	January 1, 2010 through March 30, 2010	April 30, 2010
Monthly Report	April 2010	May 5, 2010
	May 2010	June 5, 2010
	June 2010	July 5, 2010
Quarterly Report	April 1, 2010 through June 30, 2010	July 31, 2010
Monthly Report	July 2010	August 5, 2010
	August 2010	September 5, 2010
	September 2010	October 5, 2010
Quarterly Report	July 1, 2010 through September 30, 2010	October 30, 2010
Monthly Report	October 2010	November 5, 2010
	November 2010	December 5, 2010
	December 2010	January 5, 2011
Quarterly Report	September 1, 2010 through December 31, 2010	January 31, 2011
Annual Report	October 1, 2010 through September 30, 2011	October 31, 2011

LONG TERM CARE IMMEDIATE AND EXCEPTION REVIEW REPORTS

MPRO will submit reports to MDCH that document the progress and results of the LTC immediate and exception reviews. Based on our activities in the current LTC immediate and exception review, we are equipped to provide the required reports. We currently report monthly on the number of exception and immediate reviews performed and the following case specifics for each review:

- Telephone contract date from the provider/beneficiary/or representative
- The review determination date
- The beneficiary's first and last name
- The beneficiary's Medicaid ID
- The provider's NPI and setting (nursing facility, waiver, or PACE)
- The RN's initials
- Decision (denied or approved-if approved the approval code)

In addition to providing the report by the fifth day of every month, MPRO sends a copy of all the Adverse Action Notices issued and for immediate reviews we send copies of all information submitted by the provider.

We will also provide reports for our telephone responsiveness. The purpose of this report is to monitor our responsiveness to telephone intake and to ensure compliance with contract requirements regarding speed of answer. The existing report titled Performance Indicators consists of: phone statistics, review timeliness, reconsideration timeliness, and appeal results. Due to HIPAA compliance regulations, we currently fax this information to MDCH, and we send a copy of all documentation each month on immediate reviews.



HOSPITAL AUDITS AND STATEWIDE UTILIZATION REVIEW REPORTS

To track anticipated audit activities, we will develop a quarterly audit work plan that describes our proposed audit/review activities. We will present the work plan for the first quarter of the contract to MDCH on January 31, 2010. We will provide all subsequent work plans to MDCH by the last day of the preceding quarter. The submission of this work plan starts with the last day of the preceding quarter of April 2010.

We will also provide information on updates and status during the monthly meeting and include the performance indicators submitted each month. We will submit this to MDCH on the fifth day of every month. Each report will contain a summary of audit activities including:

- Newly initiated audits/reviews
- Activities on audits/reviews initiated during previous months

Activities will include:

- Name and date of audits/reviews initiated
- Name and date of audits/reviews completed
- Number of retrospective reviews of PACER authorization not meeting criteria
 - Number of authorizations given in error
 - Number of provider errors

SWUR reports include:

- Summary of review findings arranged alphabetically by provider
- Provider ID number
- Time period
- Sample pulled from
- Date medical record was requested
- Beneficiary name alphabetically
- Beneficiary ID number
- Findings

MPRO will provide a monthly, quarterly, and annual report of all SWUR.

LONG TERM CARE RETROSPECTIVE REVIEW REPORTS

Monthly, MPRO faxes or mails MDCH a report that includes:

- The number of retrospective reviews performed for the period
- The number completed
- The number approved; door was validated
- The number approved; through another door
- Number denied (final denial)
- Number of technical denials
- Number denied due to absence of PASARR
- Number voided
- Number de-selected
- Number not open

We generate a Door Validation Report each month also. This report shows whether MPRO can approve the beneficiary through the same door as the provider. It includes the following:



- Provider name
- Provider NPI
- Beneficiary ID
- Reviewed door
- Validation door
- Retrospective review selection date and review period
- Denials

The PASARR Report shows whether a PASARR was necessary. A PASARR is necessary if the patient resides in a nursing home; however, it is not necessary if the patient is in a waiver program. There are two types of PASARR reports – PASARR 1 and PASARR 2. A PASARR 2 is only necessary when a PASARR 1 identifies that the patient has some mental health concerns. The reported information assists MDCH in identifying if providers are completing these as required and if there is appropriate follow up when mental health concerns are noted. This report provides the following:

- Provider name
- Provider NPI
- Beneficiary ID
- Retrospective review selection date and review period

Finally, the report will show the number of retrospective denials appealed and the number upheld and overturned. MPRO is excited to work with MDCH on developing this appeal process further.

1.050 Acceptance

1.051 Criteria—Deleted/Not Applicable

1.052 Final Acceptance—Deleted/Not Applicable

1.060 Proposal Pricing

1.061 Proposal Pricing

PAYMENT SCHEDULE-PACER/LONG TERM CARE IMMEDIATE AND EXCEPTION REVIEWS, PACER AND LONG TERM CARE IMMEDIATE AND EXCEPTION REVIEW APPEAL PROCESS

The payment schedule will be based on the number of PACER reviews, LTC Immediate and Exception reviews, LTC Immediate and Exception Review Appeal Process with an RN and PACER Appeal Process with RN and Physician (telephonic/electronic) completed the previous month. The Contractor is required to be available at all appeal levels. The Contractor's nurse reviewer/physician reviewer, (if applicable), must be available to testify as to the results of the PACER or LTC review at any preliminary or bureau conference; administrative hearing or judicial proceeding

PAYMENT SCHEDULE-HOSPITAL AUDITS/STATEWIDE UTILIZATION REVIEWS/LONG TERM CARE RETROSPECTIVE REVIEWS AND LONG TERM CARE RETROSPECTIVE APPEAL PROCESS

The payment schedule will be based on the number of audits/Statewide Utilization Reviews/LTC Retrospective Reviews completed. The per audit payment will include both the medical record review and the appeal process through settlement. The LTC Retrospective Review payment will include the medical/case record review. The Appeal Process for Long Term Care Retrospective Review will be paid separately. Although the Contractor will receive payment upon completion of the audit or LTC Retrospective Review, the Contractor is still required to participate in the Appeal process even though payment has been received. The Statewide Utilization Review payment includes medical record review only as there is no appeal process.



For Inpatient Statewide Utilization Review payment will occur if the medical record is received and reviewed.

For Outpatient Statewide Utilization Review payment will occur if seventy five percent (75%) of the services paid for date of service selected are received and reviewed.

The Contractor will be paid monthly based on the number of hospital audits completed the previous month of the contract.

The Contractor will be paid monthly based on the number of Statewide Utilization Reviews completed the previous month of the contract.

The Contractor will be paid monthly based on the number of Long Term Care Immediate (NONC), Exception (Telephonic) and LTC Retrospective Reviews completed the previous month of the contract.

For authorized Services and Price List, see Attachment A.

Quick Payment Term - 1% off invoice if paid within 15 days.

Contractor's out-of-pocket expenses are not separately reimbursable by the State unless, on a case-by-case basis for unusual expenses, the State has agreed in advance and in writing to reimburse Contractor for the expense at the State's current travel reimbursement rates. See www.michigan.gov/dmb for current rates.

1.062 Price Term

Prices quoted are firm for the entire length of the Contract.

1.063 Tax Excluded from Price

(a) Sales Tax: For purchases made directly by the State, the State is exempt from State and Local Sales Tax. Prices must not include the taxes. Exemption Certificates for State Sales Tax will be furnished upon request.

(b) Federal Excise Tax: The State may be exempt from Federal Excise Tax, or the taxes may be reimbursable, if articles purchased under any resulting Contract are used for the State's exclusive use. Certificates showing exclusive use for the purposes of substantiating a tax-free or tax-reimbursable sale will be sent upon request. If a sale is tax exempt or tax reimbursable under the Internal Revenue Code, prices must not include the Federal Excise Tax.

Contractor Response:

PROPOSAL PRICING

MPRO is pleased to submit this price proposal to MDCH for the Medicaid Fee-For-Service Review contract. We have based our pricing model on the contract activities and projected volumes as described in the CONTRACT. We have developed a specific cost model for each activity in order to offer MDCH a pricing structure that is compliant with the payment terms outlined in both the CONTRACT and the Contractor's Questions and Answers.

MPRO understands that Michigan is facing budget constraints unlike any seen in recent history. We believe that the review programs in place save the State significant dollars, and we have suggestions that could save the State significantly more. We estimate the PACER program alone has saved the State of Michigan 12 million dollars in the past four years. The audit program saves the State money; however, if the State considered changing some of the methodology behind the selection process and the actual audit itself, we could save the State even more money. Additionally, from our review activities, the area of long term care appears to have admissions that are not medically indicated. Further development in this area could prove beneficial to the State in terms of dollars saved. MPRO wants to be a part of this continued effort to improve quality care within our State without spending money unnecessarily and we look forward to discussing our ideas with the State.

MPRO's pricing model is based on the contract activities and projected volumes as described in the CONTRACT. To the extent that the projected volumes do not materialize, the total contract price will be less than the contract price stated below. We have significant experience in managing this contract as efficiently and cost effectively as possible. The substantial difference in this CONTRACT is the addition of reconsideration and appeal rights in long term care. This change adds a significant layer to the long term care retrospective review program as history tells us that providers appeal most denials.



The total contract price for the three-year term of the contract is \$7,451,400 (see details in Price Proposal table below). We believe through staffing excellence, efficient and effective processes, and our long term relationship with the State of Michigan, we offer a reasonable and fair proposal price.

Table 20: Price Proposal (Attachment A)

Program		Projected Volume/Month	Total Annual Volume	Unit Price	One Year Pricing	Three Year Pricing
PACER	FFS Reviews	900/month	10,800	\$56.75	\$ 612,900	\$1,838,700
	FFS Appeals	RN=6.25 hours	75 hours	\$27.00/per half hour	\$ 4,050	\$ 12,150
		MD=6.25 hours	75 hours	\$77.00/per half hour	\$ 11,550	\$ 34,650
Audits	Inpatient	1 audit	15	\$43,250	\$ 648,750	\$1,946,250
	Outpatient	1 audit	15	\$28,000	\$ 420,000	\$1,260,000
SWUR	Inpatient	320 reviews/month	3,840	\$80.00	\$ 307,200	\$ 921,600
	Outpatient	320 reviews/month	3,840	\$80.00	\$ 307,200	\$ 921,600
LTC	Immediate Reviews	8.33/month	100	\$124.50	\$ 12,450	\$ 37,350
	Exception Reviews	13.33/month	160	\$65.00	\$ 10,400	\$ 31,200
	Immediate & Exception Appeals	RN=8.33 hours/month	100 hours	\$27.00/per half hour	\$ 5,400	\$ 16,200
		MD=8.33 hours/month	100 hours	\$77.00/per half hour	\$ 15,400	\$ 46,200
	Retrospective Reviews	150/month	1,800	\$35.00	\$ 63,000	\$ 189,000
	Retrospective Appeals	RN=41.66 hours/month	500 hours	\$27.00/per half hour	\$ 27,000	\$ 81,000
		MD=20.83hours/month	250 hours	\$77.00/per half hour	\$ 38,500	\$ 115,500
	Grand Total				\$2,483,800	\$7,451,400

**ISSUES AFFECTING PROPOSED RATES**

There are several factors that impact our price determinations for each of the activities. These issues are summarized below.

INCREASED LABOR COSTS

Due to the highly competitive health care labor market, as well as the continuing escalation of health care benefit costs for employees, we have experienced increased labor costs. This price proposal reflects an increase to the labor rates for both the RNs and the coders. We believe that this rate increase will assist us in recruiting and retaining highly qualified and experienced staff to perform the duties under this contract.

INCREASED STAFFING NEEDS FOR LONG TERM CARE REVIEW

Based on the information in the CONTRACT, we are anticipating that the long term care retrospective reviews will be a more labor intensive effort than in previous years because Medicaid policy appears to be catching up to this process and denials may be issued (reference Medicaid Provider Manual, Nursing Facility, Section 4.2B Provider Appeals). In the past five years, the review decisions have been more educational and monetary recovery was not associated with retrospective long term care review results.

PRICING ASSUMPTIONS

MPRO has made the following assumptions related to our pricing model. If MDCH provides information in conflict with any of these core assumptions, we would be open to further discussions with MDCH regarding our pricing model.

1. With respect to the labor for the appeals process, we assume that appeals hearings for the PACER reviews, long term care exception reviews, and long term care retrospective reviews will take place via conference call and will not require a trip to Lansing for a face-to-face hearing.
2. With respect to the labor for the inpatient and outpatient/ER appeals, we assume that the bureau and administrative hearings will be held in Lansing and our RNs and physicians will be required to drive to Lansing to participate.
3. With respect to pricing for the PACER appeals, we assume that MDCH would like us to propose a separate rate for each appeal case. With respect to the PACER authorization telephonic reviews, we assume that the contract does not include medical necessity reviews at the procedure level. We have priced the PACER authorizations to include medical necessity of the admission, but not the procedures. Under our current contract, we perform reviews at the procedure level for laminectomies, hysterectomies, and spinal fusion. If MDCH desires for MPRO to continue with these three procedure-level reviews, the costs can be absorbed in our proposed rates. However, if procedure-level reviews are requested for additional procedures, then we would need to adjust our proposed rates.

**PRICING ASSURANCES**

We provide the following pricing assurances, as outlined in the CONTRACT:

All rates/prices quoted in this proposal are firm for the duration of the contract ending December 31, 2012 unless modified to the State's benefit by the mutual agreement of the parties to the contract.

INDEPENDENT PRICE DETERMINATION

MPRO hereby attests that this price analysis is submitted in full compliance with the provisions stated in Section 3.033 – Independent Price Determination of the CONTRACT. By submission of this proposal, MPRO certifies that:

- a. The prices in this proposal have been arrived at independently, without consultation, communication, or agreement, for the purpose of restricting competition as to any matter relating to such prices with any other Contractor or with any competitor; and
- b. Unless otherwise required by law, the prices which have been quoted in this proposal have not been knowingly disclosed by MPRO and will not knowingly be disclosed by MPRO prior to award directly or indirectly to any other Contractor or to any competitor; and
- c. No attempt has been made or will be made by MPRO to induce any other person or firm to submit or not submit a proposal for the purpose of restricting competition.

Robert J, Yellan, JD, MPH, MPRO's President and Chief Executive Officer, certifies that he is the person responsible for the decision as to the prices being offered in the proposal and has not participated (and will not participate) in any action contrary to a., b., and c. above.

PAYMENT SCHEDULE

MPRO acknowledges and agrees to the terms of payment as outlined in the CONTRACT and will work with MDCH to develop a payment and billing schedule. In addition, MPRO will provide expert testimony and assistance for any audits or reviews that are appealed, even if the appeal takes place after full payment has been rendered.

MPRO is willing to offer quick payment terms of 1% off invoice if paid within 15 days.

1.064 Holdback—Deleted/Not Applicable**1.070 Additional Requirements****1.071 Additional Terms and Conditions specific to this CONTRACT—Deleted/Not Applicable**



Article 2, Terms and Conditions

2.000 Contract Structure and Term

2.001 Contract Term

The Contract is for a period of 3 years beginning 01/01/2010 through 12/31/2012. All outstanding Purchase Orders must also expire upon the termination (cancellation for any of the reasons listed in **Section 2.150**) of the Contract, unless otherwise extended under the Contract. Absent an early termination for any reason, Purchase Orders issued but not expired, by the end of the Contract's stated term, will remain in effect for the balance of the fiscal year for which they were issued.

2.002 Options to Renew

The Contract may be renewed in writing by mutual agreement of the parties not less than 30 days before its expiration. The Contract may be renewed for up to two (2) additional one year periods.

2.003 Legal Effect

Contractor must show acceptance of the Contract by signing two copies of the Contract and returning them to the Contract Administrator. The Contractor must not proceed with the performance of the work to be done under the Contract, including the purchase of necessary materials, until both parties have signed the Contract to show acceptance of its terms, and the Contractor receives a Contract release/purchase order that authorizes and defines specific performance requirements.

Except as otherwise agreed in writing by the parties, the State assumes no liability for costs incurred by Contractor or payment under the Contract, until Contractor is notified in writing that the Contract (or Change Order) has been approved by the State Administrative Board (if required), approved and signed by all the parties, and a Purchase Order against the Contract has been issued.

2.004 Attachments & Exhibits

All Attachments and Exhibits affixed to any and all Statement(s) of Work, or appended to or referencing the Contract, are incorporated in their entirety and form part of the Contract.

2.005 Ordering

The State will issue a written Purchase Order, Blanket Purchase Order, Direct Voucher or Procurement Card Order, which must be approved by the Contract Administrator or the Contract Administrator's designee, to order any Services/Deliverables under the Contract. All orders are subject to the terms and conditions of the Contract. No additional terms and conditions contained on either a Purchase Order or Blanket Purchase Order apply unless they are also specifically contained in that Purchase Order's or Blanket Purchase Order's accompanying Statement of Work. Exact quantities to be purchased are unknown, however, the Contractor must furnish all such materials and services as may be ordered during the CONTRACT period. Quantities specified, if any, are estimates based on prior purchases, and the State is not obligated to purchase in these or any other quantities.

2.006 Order of Precedence

(a) The Contract, including any Statements of Work and Exhibits, to the extent not contrary to the Contract, each of which is incorporated for all purposes, constitutes the entire agreement between the parties with respect to the subject matter and supersedes all prior agreements, whether written or oral, with respect to the subject matter and as additional terms and conditions on the purchase order must apply as limited by **Section 2.005**.

(b) In the event of any inconsistency between the terms of the Contract and a Statement of Work, the terms of the Statement of Work will take precedence (as to that Statement of Work only); provided, however, that a Statement of Work may not modify or amend the terms of the Contract, which may be modified or amended only by a formal Contract amendment.

2.007 Headings

Captions and headings used in the Contract are for information and organization purposes. Captions and headings, including inaccurate references, do not, in any way, define or limit the requirements or terms and conditions of the Contract.

**2.008 Form, Function & Utility**

If the Contract is for use of more than one State agency and if the Deliverable/Service does not meet the form, function, and utility required by that State agency, that agency may, subject to State purchasing policies, procure the Deliverable/Service from another source.

2.009 Reformation and Severability

Each provision of the Contract is severable from all other provisions of the Contract and, if one or more of the provisions of the Contract is declared invalid, the remaining provisions of the Contract remain in full force and effect.

2.010 Consents and Approvals

Except as expressly provided otherwise in the Contract, if either party requires the consent or approval of the other party for the taking of any action under the Contract, the consent or approval must be in writing and must not be unreasonably withheld or delayed.

2.011 No Waiver of Default

If a party fails to insist upon strict adherence to any term of the Contract then the party has not waived the right to later insist upon strict adherence to that term, or any other term, of the Contract.

2.012 Survival

Any provisions of the Contract that impose continuing obligations on the parties, including without limitation the parties' respective warranty, indemnity and confidentiality obligations, survive the expiration or termination of the Contract for any reason. Specific references to survival in the Contract are solely for identification purposes and not meant to limit or prevent the survival of any other section.

2.020 Contract Administration**2.021 Issuing Office**

The Contract is issued by the Department of Management and Budget, Purchasing Operations and MDCH (collectively, including all other relevant State of Michigan departments and agencies, the "State"). Purchasing Operations is the sole point of contact in the State with regard to all procurement and contractual matters relating to the Contract. Purchasing Operations **is the only State office authorized to change, modify, amend, alter or clarify the prices, specifications, terms and conditions of the Contract.** The Contractor Administrator within Purchasing Operations for the Contract is:

Andy Ghosh, CPPB, Contract Administrator
Purchasing Operations
Department of Management and Budget
Mason Bldg, 2nd Floor
PO Box 30026
Lansing, MI 48909
Email: ghosha@michigan.gov
Phone: 517-373-7396

2.022 Contract Compliance Inspector

After DMB-Purchasing Operations receives the properly executed Contract, it is anticipated that the Director of Purchasing Operations, in consultation with MDCH, will direct the person named below, or any other person so designated, to monitor and coordinate the activities for the Contract on a day-to-day basis during its term. However, monitoring of the Contract implies **no authority to change, modify, clarify, amend, or otherwise alter the prices, terms, conditions and specifications of the Contract as that authority is retained by DMB Purchasing Operations.** The CCI for the Contract is:

Laura Dotson
Michigan Department of Community Health
320 S. Walnut, Lansing MI 48933
Email: DotsonL1@michigan.gov
Phone: 517-241-4686

**2.023 Project Manager**

The following individuals will oversee the project:

Donna O'Shesky, Inpatient Hospital Contract Manager
Michigan Department of Community Health
400 S. Pine St., Lansing MI 48909
OSheskyD@michigan.gov
517-335-5204
517-241-9087

Elizabeth Aastad, Long Term Care Contract Manager
Michigan Department of Community Health
400 S. Pine St., Lansing MI 48909
AastadL@michigan.gov
517-241-2115
517-241-8969

Renate Rademacher, Outpatient Hospital Contract Manager
Michigan Department of Community Health
400 S. Pine St., Lansing MI 48909
RademacherR@michigan.gov
517-335-5070
517-241-9087

2.024 Change Requests

The State reserves the right to request, from time to time, any changes to the requirements and specifications of the Contract and the work to be performed by the Contractor under the Contract. During the course of ordinary business, it may become necessary for the State to discontinue certain business practices or create Additional Services/Deliverables. At a minimum, to the extent applicable, the State would like the Contractor to provide a detailed outline of all work to be done, including tasks necessary to accomplish the services/deliverables, timeframes, listing of key personnel assigned, estimated hours for each individual per task, and a complete and detailed cost justification.

If the Contractor does not so notify the State, the Contractor has no right to claim thereafter that it is entitled to additional compensation for performing that service or providing that deliverable.

Change Requests:

- (a) By giving Contractor written notice within a reasonable time, the State must be entitled to accept a Contractor proposal for Change, to reject it, or to reach another agreement with Contractor. Should the parties agree on carrying out a Change, a written Contract Change Notice must be prepared and issued under the Contract, describing the Change and its effects on the Services and any affected components of the Contract (a "Contract Change Notice").
- (b) No proposed Change may be performed until the proposed Change has been specified in a duly executed Contract Change Notice issued by the Department of Management and Budget, Purchasing Operations.
- (c) If the State requests or directs the Contractor to perform any activities that Contractor believes constitute a Change, the Contractor must notify the State that it believes the requested activities are a Change before beginning to work on the requested activities. If the Contractor fails to notify the State before beginning to work on the requested activities, then the Contractor waives any right to assert any claim for additional compensation or time for performing the requested activities. If the Contractor commences performing work outside the scope of the Contract and then ceases performing that work, the Contractor must, at the request of the State, retract any out-of-scope work that would adversely affect the Contract.

2.025 Notices

Any notice given to a party under the Contract must be deemed effective, if addressed to the State contact as noted in Section 2.021 and the Contractor's contact as noted on the cover page of the contract, upon: (i) delivery, if hand delivered; (ii) receipt of a confirmed transmission by facsimile if a copy of the notice is sent by another means specified in this Section; (iii) the third Business Day after being sent by U.S. mail, postage pre-paid, return receipt requested; or (iv) the next Business Day after being sent by a nationally recognized overnight express courier with a reliable tracking system.



Either party may change its address where notices are to be sent by giving notice according to this Section.

2.026 Binding Commitments

Representatives of Contractor must have the authority to make binding commitments on Contractor's behalf within the bounds set forth in the Contract. Contractor may change the representatives from time to time upon written notice.

2.027 Relationship of the Parties

The relationship between the State and Contractor is that of client and independent contractor. No agent, employee, or servant of Contractor or any of its Subcontractors must be deemed to be an employee, agent or servant of the State for any reason. Contractor is solely and entirely responsible for its acts and the acts of its agents, employees, servants and Subcontractors during the performance of the Contract.

2.028 Covenant of Good Faith

Each party must act reasonably and in good faith. Unless stated otherwise in the Contract, the parties must not unreasonably delay, condition, or withhold the giving of any consent, decision, or approval that is either requested or reasonably required of them in order for the other party to perform its responsibilities under the Contract.

2.029 Assignments

(a) Neither party may assign the Contract, or assign or delegate any of its duties or obligations under the Contract, to any other party (whether by operation of law or otherwise), without the prior written consent of the other party; provided, however, that the State may assign the Contract to any other State agency, department, division or department without the prior consent of Contractor and Contractor may assign the Contract to an affiliate so long as the affiliate is adequately capitalized and can provide adequate assurances that the affiliate can perform the requirements of the Contract. The State may withhold consent from proposed assignments, subcontracts, or novations when the transfer of responsibility would operate to decrease the State's likelihood of receiving performance on the Contract or the State's ability to recover damages.

(b) Contractor may not, without the prior written approval of the State, assign its right to receive payments due under the Contract. If the State permits an assignment, the Contractor is not relieved of its responsibility to perform any of its contractual duties, and the requirement under the Contract that all payments must be made to one entity continues.

(c) If the Contractor intends to assign the Contract or any of the Contractor's rights or duties under the Contract, the Contractor must notify the State in writing at least 90 days before the assignment. The Contractor also must provide the State with adequate information about the assignee within a reasonable amount of time before the assignment for the State to determine whether to approve the assignment.

2.030 General Provisions

2.031 Media Releases

News releases (including promotional literature and commercial advertisements) pertaining to the CONTRACT and Contract or project to which it relates must not be made without prior written State approval, and then only in accordance with the explicit written instructions from the State. No results of the activities associated with the CONTRACT and Contract are to be released without prior written approval of the State and then only to persons designated.

2.032 Contract Distribution

Purchasing Operations retains the sole right of Contract distribution to all State agencies and local units of government unless other arrangements are authorized by Purchasing Operations.

2.033 Permits

Contractor must obtain and pay any associated costs for all required governmental permits, licenses and approvals for the delivery, installation and performance of the Services. The State must pay for all costs and expenses incurred in obtaining and maintaining any necessary easements or right of way.

2.034 Website Incorporation

The State is not bound by any content on the Contractor's website, even if the Contractor's documentation specifically referenced that content and attempts to incorporate it into any other communication, unless the State has actual knowledge of the content and has expressly agreed to be bound by it in a writing that has been manually signed by an authorized representative of the State.

**2.035 Future Bidding Preclusion**

Contractor acknowledges that, to the extent the Contract involves the creation, research, investigation or generation of a future CONTRACT, it may be precluded from bidding on the subsequent CONTRACT. The State reserves the right to disqualify any Contractor if the State determines that the Contractor has used its position (whether as an incumbent Contractor, or as a Contractor hired to assist with the CONTRACT development, or as a Vendor offering free assistance) to gain a competitive advantage on the CONTRACT

2.036 Freedom of Information

All information in any proposal submitted to the State by Contractor and the Contract is subject to the provisions of the Michigan Freedom of Information Act, 1976 PA 442, MCL 15.231, et seq (the "FOIA").

2.037 Disaster Recovery

Contractor and the State recognize that the State provides essential services in times of natural or man-made disasters. Therefore, except as so mandated by Federal disaster response requirements, Contractor personnel dedicated to providing Services/Deliverables under the Contract must provide the State with priority service for repair and work around in the event of a natural or man-made disaster.

2.040 Financial Provisions**2.041 Fixed Prices for Services/Deliverables**

Each Statement of Work or Purchase Order issued under the Contract must specify (or indicate by reference to the appropriate Contract Exhibit) the firm, fixed prices for all Services/Deliverables, and the associated payment milestones and payment amounts. The State may make progress payments to the Contractor when requested as work progresses, but not more frequently than monthly, in amounts approved by the Contract Administrator, after negotiation. Contractor must show verification of measurable progress at the time of requesting progress payments.

2.042 Adjustments for Reductions in Scope of Services/Deliverables

If the scope of the Services/Deliverables under any Statement of Work issued under the Contract is subsequently reduced by the State, the parties must negotiate an equitable reduction in Contractor's charges under such Statement of Work commensurate with the reduction in scope.

2.043 Services/Deliverables Covered

For all Services/Deliverables to be provided by Contractor (and its Subcontractors, if any) under the Contract, the State must not be obligated to pay any amounts in addition to the charges specified in the Contract.

2.044 Invoicing and Payment – In General

- (a) Each Statement of Work issued under the Contract must list (or indicate by reference to the appropriate Contract Exhibit) the prices for all Services/Deliverables, equipment and commodities to be provided, and the associated payment milestones and payment amounts.
- (b) Each Contractor invoice must show details as to charges by Service/Deliverable component and location at a level of detail reasonably necessary to satisfy the State's accounting and charge-back requirements. Invoices for Services performed on a time and materials basis must show, for each individual, the number of hours of Services performed during the billing period, the billable skill/labor category for such person and the applicable hourly billing rate. Prompt payment by the State is contingent on the Contractor's invoices showing the amount owed by the State minus any holdback amount to be retained by the State in accordance with **Section 1.064**.
- (c) Correct invoices will be due and payable by the State, in accordance with the State's standard payment procedure as specified in 1984 PA 279, MCL 17.51 et seq., within 45 days after receipt, provided the State determines that the invoice was properly rendered.
- (d) All invoices should reflect actual work done. Specific details of invoices and payments will be agreed upon between the CCI and the Contractor.

The specific payment schedule for any Contract(s) entered into, as the State and the Contractor(s) must mutually agree upon. The schedule must show payment amount and must reflect actual work done by the payment dates, less any penalty cost charges accrued by those dates. As a general policy, statements must be forwarded to the designated representative by the 5th day of the following month.

**PAYMENT SCHEDULE-PACER/LONG TERM CARE IMMEDIATE AND EXCEPTION REVIEWS, PACER AND LONG TERM CARE IMMEDIATE AND EXCEPTION REVIEW APPEAL PROCESS**

The payment schedule will be based on the number of PACER reviews, LTC Immediate and Exception reviews, LTC Immediate and Exception Review Appeal Process with an RN and PACER Appeal Process with RN and Physician (telephonic/electronic) completed the previous month. The Contractor is required to be available at all appeal levels. The Contractor's nurse reviewer/physician reviewer, (if applicable), must be available to testify as to the results of the PACER or LTC review at any preliminary or bureau conference; administrative hearing or judicial proceeding

PAYMENT SCHEDULE-HOSPITAL AUDITS/STATEWIDE UTILIZATION REVIEWS/LONG TERM CARE RETROSPECTIVE REVIEW AND LONG TERM CARE RETROSPECTIVE APPEALS PROCESS

The payment schedule will be based on the number of audits/Statewide Utilization Reviews/LTC reviews completed. The per audit payment will include both the medical record review and the appeal process through settlement. The Long Term Care retrospective review payment will include the medical/case record review. The Appeal Process for LTC retrospective review will be paid separately. Although the Contractor will receive payment upon completion of the audit or Retrospective Review, the Contractor is still required to participate in the Appeal process even though payment has been received. The Statewide Utilization Review payment includes medical record review only as there is no appeal process.

For Inpatient Statewide Utilization Review payment will occur if the medical record is received and reviewed.

For Outpatient Statewide Utilization Review payment will occur if 75% of the services paid for date of service selected are received and reviewed.

The Contractor will be paid monthly based on the number of hospital audits completed the previous month of the contract.

The Contractor will be paid monthly based on the number of Statewide Utilization Reviews completed the previous month of the contract.

The Contractor will be paid monthly based on the number of Long Term Care Immediate (NONC), Exception (Telephonic) and Retrospective Reviews completed the previous month of the contract.

All invoices should reflect actual work done. Specific details of invoices and payments will be agreed upon between the CCI and the Contractor.

The specific payment schedule for any Contract(s) entered into, as the State and the Contractor(s) must mutually agree upon. The schedule must show payment amount and must reflect actual work done by the payment dates, less any penalty cost charges accrued by those dates. As a general policy, statements must be forwarded to the designated representative by the 15th day of the following month.

2.045 Pro-ration

To the extent there are any Services that are to be paid for on a monthly basis, the cost of such Services must be pro-rated for any partial month.

2.046 Antitrust Assignment

The Contractor assigns to the State any claim for overcharges resulting from antitrust violations to the extent that those violations concern materials or services supplied by third parties to the Contractor, toward fulfillment of the Contract.

2.047 Final Payment

The making of final payment by the State to Contractor does not constitute a waiver by either party of any rights or other claims as to the other party's continuing obligations under the Contract, nor will it constitute a waiver of any claims by one party against the other arising from unsettled claims or failure by a party to comply with the Contract, including claims for Services and Deliverables not reasonably known until after acceptance to be defective or substandard. Contractor's acceptance of final payment by the State under the Contract must constitute a waiver of all claims by Contractor against the State for payment under the Contract, other than those claims previously filed in writing on a timely basis and still unsettled.

**2.048 Electronic Payment Requirement**

Electronic transfer of funds is required for payments on State contracts. The Contractor must register with the State electronically at <http://www.cpexpress.state.mi.us>. As stated in 1984 PA 431, all contracts that the State enters into for the purchase of goods and services must provide that payment will be made by Electronic Fund Transfer (EFT).

2.050 Taxes**2.051 Employment Taxes**

Contractors are expected to collect and pay all applicable federal, state, and local employment taxes.

2.052 Sales and Use Taxes

Contractors are required to be registered and to remit sales and use taxes on taxable sales of tangible personal property or services delivered into the State. Contractors that lack sufficient presence in Michigan to be required to register and pay tax must do so as a volunteer. This requirement extends to: (1) all members of any controlled group as defined in § 1563(a) of the Internal Revenue Code and applicable regulations of which the company is a member, and (2) all organizations under common control as defined in § 414(c) of the Internal Revenue Code and applicable regulations of which the company is a member that make sales at retail for delivery into the State are registered with the State for the collection and remittance of sales and use taxes. In applying treasury regulations defining "two or more trades or businesses under common control" the term "organization" means sole proprietorship, a partnership (as defined in § 701(a)(2) of the Internal Revenue Code), a trust, an estate, a corporation, or a limited liability company.

2.060 Contract Management**2.061 Contractor Personnel Qualifications**

All persons assigned by Contractor to the performance of Services under the Contract must be employees of Contractor or its majority-owned (directly or indirectly, at any tier) subsidiaries (or a State-approved Subcontractor) and must be fully qualified to perform the work assigned to them. Contractor must include a similar provision in any subcontract entered into with a Subcontractor. For the purposes of the Contract, independent contractors engaged by Contractor solely in a staff augmentation role must be treated by the State as if they were employees of Contractor for the Contract only; however, the State understands that the relationship between Contractor and Subcontractor is an independent contractor relationship.

2.062 Contractor Key Personnel

- (a) The Contractor must provide the CCI with the names of the Key Personnel.
- (b) Key Personnel must be dedicated as defined in the Statement of Work to the Project for its duration in the applicable Statement of Work with respect to other individuals designated as Key Personnel for that Statement of Work.
- (c) The State reserves the right to recommend and approve in writing the initial assignment, as well as any proposed reassignment or replacement, of any Key Personnel. Before assigning an individual to any Key Personnel position, Contractor must notify the State of the proposed assignment, must introduce the individual to the appropriate State representatives, and must provide the State with a resume and any other information about the individual reasonably requested by the State. The State reserves the right to interview the individual before granting written approval. In the event the State finds a proposed individual unacceptable, the State must provide a written explanation including reasonable detail outlining the reasons for the rejection.
- (d) Contractor must not remove any Key Personnel from their assigned roles on the Contract without the prior written consent of the State. The Contractor's removal of Key Personnel without the prior written consent of the State is an unauthorized removal ("Unauthorized Removal"). Unauthorized Removals does not include replacing Key Personnel for reasons beyond the reasonable control of Contractor, including illness, disability, leave of absence, personal emergency circumstances, resignation or for cause termination of the Key Personnel's employment. Unauthorized Removals does not include replacing Key Personnel because of promotions or other job movements allowed by Contractor personnel policies or Collective Bargaining Agreement(s) as long as the State receives prior written notice before shadowing occurs and Contractor provides 30 days of shadowing unless parties agree to a different time period. The Contractor with the State must review any Key Personnel replacements and appropriate transition planning must be established. Any Unauthorized Removal may be considered by the State to be a material breach of the Contract, in respect of which the State may elect to exercise its termination and cancellation rights.



(e) The Contractor must notify the Contract Compliance Inspector and the Contract Administrator at least 10 business days before redeploying non-Key Personnel, who are dedicated to primarily to the Project, to other projects. If the State does not object to the redeployment by its scheduled date, the Contractor may then redeploy the non-Key Personnel.

2.063 Re-assignment of Personnel at the State's Request

The State reserves the right to require the removal from the Project of Contractor personnel found, in the judgment of the State, to be unacceptable. The State's request must be written with reasonable detail outlining the reasons for the removal request. Additionally, the State's request must be based on legitimate, good-faith reasons. Replacement personnel for the removed person must be fully qualified for the position. If the State exercises this right, and the Contractor cannot immediately replace the removed personnel, the State agrees to an equitable adjustment in schedule or other terms that may be affected by the State's required removal. If any incident with removed personnel results in delay not reasonably anticipatable under the circumstances and which is attributable to the State, the applicable SLAs for the affected Service will not be counted for a time as agreed to by the parties.

2.064 Contractor Personnel Location

All staff assigned by Contractor to work on the Contract must perform their duties either primarily at Contractor's offices and facilities or at State facilities. Without limiting the generality of the foregoing, Key Personnel must, at a minimum, spend at least the amount of time on-site at State facilities as indicated in the applicable Statement of Work. Subject to availability, selected Contractor personnel may be assigned office space to be shared with State personnel.

2.065 Contractor Identification

Contractor employees must be clearly identifiable while on State property by wearing a State-issued badge, as required. Contractor employees are required to clearly identify themselves and the company they work for whenever making contact with State personnel by telephone or other means.

2.066 Cooperation with Third Parties

Contractor must cause its personnel and the personnel of any Subcontractors to cooperate with the State and its agents and other contractors including the State's Quality Assurance personnel. As reasonably requested by the State in writing, the Contractor must provide to the State's agents and other contractors reasonable access to Contractor's Project personnel, systems and facilities to the extent the access relates to activities specifically associated with the Contract and will not interfere or jeopardize the safety or operation of the systems or facilities. The State acknowledges that Contractor's time schedule for the Contract is very specific and must not unnecessarily or unreasonably interfere with, delay, or otherwise impede Contractor's performance under the Contract with the requests for access.

2.067 Contractor Return of State Equipment/Resources

The Contractor must return to the State any State-furnished equipment, facilities, and other resources when no longer required for the Contract in the same condition as when provided by the State, reasonable wear and tear excepted.

2.068 Contract Management Responsibilities

The Contractor must assume responsibility for all contractual activities, whether or not that Contractor performs them. Further, the State considers the Contractor to be the sole point of contact with regard to contractual matters, including payment of any and all charges resulting from the anticipated Contract. If any part of the work is to be subcontracted, the Contract must include a list of Subcontractors, including firm name and address, contact person and a complete description of work to be subcontracted. The State reserves the right to approve Subcontractors and to require the Contractor to replace Subcontractors found to be unacceptable. The Contractor is totally responsible for adherence by the Subcontractor to all provisions of the Contract. Any change in Subcontractors must be approved by the State, in writing, prior to such change.

2.070 Subcontracting by Contractor

2.071 Contractor Full Responsibility

Contractor has full responsibility for the successful performance and completion of all of the Services and Deliverables. The State will consider Contractor to be the sole point of contact with regard to all contractual matters under the Contract, including payment of any and all charges for Services and Deliverables.

**2.072 State Consent to Delegation**

Contractor must not delegate any duties under the Contract to a Subcontractor unless the Department of Management and Budget, Purchasing Operations has given written consent to such delegation. The State reserves the right of prior written approval of all Subcontractors and to require Contractor to replace any Subcontractors found, in the reasonable judgment of the State, to be unacceptable. The State's request must be written with reasonable detail outlining the reasons for the removal request. Additionally, the State's request must be based on legitimate, good-faith reasons. Replacement Subcontractor(s) for the removed Subcontractor must be fully qualified for the position. If the State exercises this right, and the Contractor cannot immediately replace the removed Subcontractor, the State will agree to an equitable adjustment in schedule or other terms that may be affected by the State's required removal. If any such incident with a removed Subcontractor results in delay not reasonable anticipatable under the circumstances and which is attributable to the State, the applicable SLA for the affected Work will not be counted for a time agreed upon by the parties.

2.073 Subcontractor Bound to Contract

In any subcontracts entered into by Contractor for the performance of the Services, Contractor must require the Subcontractor, to the extent of the Services to be performed by the Subcontractor, to be bound to Contractor by the terms of the Contract and to assume toward Contractor all of the obligations and responsibilities that Contractor, by the Contract, assumes toward the State. The State reserves the right to receive copies of and review all subcontracts, although Contractor may delete or mask any proprietary information, including pricing, contained in such contracts before providing them to the State. The management of any Subcontractor is the responsibility of Contractor, and Contractor must remain responsible for the performance of its Subcontractors to the same extent as if Contractor had not subcontracted such performance. Contractor must make all payments to Subcontractors or suppliers of Contractor. Except as otherwise agreed in writing by the State and Contractor, the State will not be obligated to direct payments for the Services other than to Contractor. The State's written approval of any Subcontractor engaged by Contractor to perform any obligation under the Contract will not relieve Contractor of any obligations or performance required under the Contract.

2.074 Flow Down

Except where specifically approved in writing by the State on a case-by-case basis, Contractor must flow down the obligations in **Sections 2.031, 2.060, 2.100, 2.110, 2.120, 2.130, 2.200** in all of its agreements with any Subcontractors.

2.075 Competitive Selection

The Contractor must select Subcontractors (including suppliers) on a competitive basis to the maximum practical extent consistent with the objectives and requirements of the Contract.

2.080 State Responsibilities**2.081 Equipment**

The State must provide only the equipment and resources identified in the Statements of Work and other Contract Exhibits.

2.082 Facilities

The State must designate space as long as it is available and as provided in the Statement of Work, to house the Contractor's personnel whom the parties agree will perform the Services/Deliverables at State facilities (collectively, the "State Facilities"). The Contractor must have reasonable access to, and, unless agreed otherwise by the parties in writing, must observe and comply with all rules and regulations relating to each of the State Facilities (including hours of operation) used by the Contractor in the course of providing the Services. Contractor must not, without the prior written consent of the State, use any State Facilities or access any State information systems provided for the Contractor's use, or to which the Contractor otherwise gains access in the course of performing the Services, for any purpose other than providing the Services to the State.

**2.090 Security****2.091 Background Checks**

On a case-by-case basis, the State may investigate the Contractor's personnel before they may have access to State facilities and systems. The scope of the background check is at the discretion of the State and the results will be used to determine Contractor personnel eligibility for working within State facilities and systems. The investigations will include Michigan State Police Background checks (ICHAT) and may include the National Crime Information Center (NCIC) Finger Prints. Proposed Contractor personnel may be required to complete and submit an RI-8 Fingerprint Card for the NCIC Finger Print Check. Any request for background checks will be initiated by the State and will be reasonably related to the type of work requested.

All Contractor personnel must comply with the State's security and acceptable use policies for State IT equipment and resources. See <http://www.michigan.gov/dit>. Furthermore, Contractor personnel must agree to the State's security and acceptable use policies before the Contractor personnel will be accepted as a resource to perform work for the State. The Contractor must present these documents to the prospective employee before the Contractor presents the individual to the State as a proposed resource. Contractor staff must comply with all Physical Security procedures in place within the facilities where they are working.

2.092 Security Breach Notification

If the Contractor breaches this Section, the Contractor must (i) promptly cure any deficiencies and (ii) comply with any applicable federal and state laws and regulations pertaining to unauthorized disclosures. Contractor and the State will cooperate to mitigate, to the extent practicable, the effects of any breach, intrusion, or unauthorized use or disclosure. Contractor must report to the State, in writing, any use or disclosure of Confidential Information, whether suspected or actual, other than as provided for by the Contract within 10 days of becoming aware of the use or disclosure or the shorter time period as is reasonable under the circumstances.

2.093 PCI Data Security Requirements--Deleted/Not Applicable**2.100 Confidentiality****2.101 Confidentiality**

Contractor and the State each acknowledge that the other possesses, and will continue to possess, confidential information that has been developed or received by it. As used in this Section, "Confidential Information" of Contractor must mean all non-public proprietary information of Contractor (other than Confidential Information of the State as defined below) which is marked confidential, restricted, proprietary, or with a similar designation. "Confidential Information" of the State must mean any information which is retained in confidence by the State (or otherwise required to be held in confidence by the State under applicable federal, state and local laws and regulations) or which, in the case of tangible materials provided to Contractor by the State under its performance under the Contract, is marked as confidential, proprietary, or with a similar designation by the State. "Confidential Information" excludes any information (including the Contract) that is publicly available under the Michigan FOIA.

2.102 Protection and Destruction of Confidential Information

The State and Contractor must each use at least the same degree of care to prevent disclosing to third parties the Confidential Information of the other as it employs to avoid unauthorized disclosure, publication, or dissemination of its own confidential information of like character, but in no event less than reasonable care. Neither Contractor nor the State will (i) make any use of the Confidential Information of the other except as contemplated by the Contract, (ii) acquire any right in or assert any lien against the Confidential Information of the other, or (iii) if requested to do so, refuse for any reason to promptly return the other party's Confidential Information to the other party. Each party must limit disclosure of the other party's Confidential Information to employees and Subcontractors who must have access to fulfill the purposes of the Contract. Disclosure to, and use by, a Subcontractor is permissible where (A) use of a Subcontractor is authorized under the Contract, (B) the disclosure is necessary or otherwise naturally occurs in connection with work that is within the Subcontractor's scope of responsibility, and (C) Contractor obligates the Subcontractor in a written Contract to maintain the State's Confidential Information in confidence. At the State's request, any employee of Contractor and of any Subcontractor having access or continued access to the State's Confidential Information may be required to execute an acknowledgment that the employee has been advised of Contractor's and the Subcontractor's obligations under this Section and of the employee's obligation to Contractor or Subcontractor, as the case may be, to protect the Confidential Information from unauthorized use or disclosure.



Promptly upon termination or cancellation of the Contract for any reason, Contractor must certify to the State that Contractor has destroyed all State Confidential Information.

2.103 Exclusions

Notwithstanding the foregoing, the provisions of **Section 2.100** will not apply to any particular information which the State or Contractor can demonstrate (i) was, at the time of disclosure to it, in the public domain; (ii) after disclosure to it, is published or otherwise becomes part of the public domain through no fault of the receiving party; (iii) was in the possession of the receiving party at the time of disclosure to it without an obligation of confidentiality; (iv) was received after disclosure to it from a third party who had a lawful right to disclose the information to it without any obligation to restrict its further disclosure; or (v) was independently developed by the receiving party without reference to Confidential Information of the furnishing party. Further, the provisions of **Section 2.100** will not apply to any particular Confidential Information to the extent the receiving party is required by law to disclose the Confidential Information, provided that the receiving party (i) promptly provides the furnishing party with notice of the legal request, and (ii) assists the furnishing party in resisting or limiting the scope of the disclosure as reasonably requested by the furnishing party.

2.104 No Implied Rights

Nothing contained in this Section must be construed as obligating a party to disclose any particular Confidential Information to the other party, or as granting to or conferring on a party, expressly or impliedly, any right or license to the Confidential Information of the other party.

2.105 Respective Obligations

The parties' respective obligations under this Section must survive the termination or expiration of the Contract for any reason.

2.110 Records and Inspections

2.111 Inspection of Work Performed

The State's authorized representatives must at all reasonable times and with 10 days prior written request, have the right to enter Contractor's premises, or any other places, where the Services are being performed, and must have access, upon reasonable request, to interim drafts of Deliverables or work-in-progress. Upon 10 Days prior written notice and at all reasonable times, the State's representatives must be allowed to inspect, monitor, or otherwise evaluate the work being performed and to the extent that the access will not reasonably interfere or jeopardize the safety or operation of the systems or facilities. Contractor must provide all reasonable facilities and assistance for the State's representatives.

2.112 Examination of Records

For seven years after the Contractor provides any work under the Contract (the "Audit Period"), the State may examine and copy any of Contractor's books, records, documents and papers pertinent to establishing Contractor's compliance with the Contract and with applicable laws and rules. The State must notify the Contractor 20 days before examining the Contractor's books and records. The State does not have the right to review any information deemed confidential by the Contractor to the extent access would require the confidential information to become publicly available. This provision also applies to the books, records, accounts, documents and papers, in print or electronic form, of any parent, affiliated or subsidiary organization of Contractor, or any Subcontractor of Contractor performing services in connection with the Contract.

2.113 Retention of Records

Contractor must maintain at least until the end of the Audit Period, all pertinent financial and accounting records (including time sheets and payroll records, information pertaining to the Contract, and to the Services, equipment, and commodities provided under the Contract) pertaining to the Contract according to generally accepted accounting principles and other procedures specified in this Section. Financial and accounting records must be made available, upon request, to the State at any time during the Audit Period. If an audit, litigation, or other action involving Contractor's records is initiated before the end of the Audit Period, the records must be retained until all issues arising out of the audit, litigation, or other action are resolved or until the end of the Audit Period, whichever is later.

2.114 Audit Resolution

If necessary, the Contractor and the State will meet to review each audit report promptly after issuance. The Contractor must respond to each audit report in writing within 30 days from receipt of the report, unless a shorter response time is specified in the report. The Contractor and the State must develop, agree upon and monitor an action plan to promptly address and resolve any deficiencies, concerns, and/or recommendations in the audit report.

**2.115 Errors**

(a) If the audit demonstrates any errors in the documents provided to the State, then the amount in error must be reflected as a credit or debit on the next invoice and in subsequent invoices until the amount is paid or refunded in full. However, a credit or debit may not be carried for more than four invoices. If a balance remains after four invoices, then the remaining amount will be due as a payment or refund within 45 days of the last quarterly invoice that the balance appeared on or termination of the Contract, whichever is earlier.

(b) In addition to other available remedies, the difference between the payment received and the correct payment amount is greater than 10%, then the Contractor must pay all of the reasonable costs of the audit.

2.120 Warranties**2.121 Warranties and Representations**

The Contractor represents and warrants:

(a) It is capable in all respects of fulfilling and must fulfill all of its obligations under the Contract. The performance of all obligations under the Contract must be provided in a timely, professional, and workman-like manner and must meet the performance and operational standards required under the Contract.

(b) The Contract Appendices, Attachments and Exhibits identify the equipment and software and services necessary for the Deliverable(s) to perform and Services to operate in compliance with the Contract's requirements and other standards of performance.

(c) It is the lawful owner or licensee of any Deliverable licensed or sold to the State by Contractor or developed by Contractor under the Contract, and Contractor has all of the rights necessary to convey to the State the ownership rights or licensed use, as applicable, of any and all Deliverables. None of the Deliverables provided by Contractor to the State under the Contract, nor their use by the State, will infringe the patent, copyright, trade secret, or other proprietary rights of any third party.

(d) If, under the Contract, Contractor procures any equipment, software or other Deliverable for the State (including equipment, software and other Deliverables manufactured, re-marketed or otherwise sold by Contractor under Contractor's name), then in addition to Contractor's other responsibilities with respect to the items in the Contract, Contractor must assign or otherwise transfer to the State or its designees, or afford the State the benefits of, any manufacturer's warranty for the Deliverable.

(e) The Contract signatory has the power and authority, including any necessary corporate authorizations, necessary to enter into the Contract, on behalf of Contractor.

(f) It is qualified and registered to transact business in all locations where required.

(g) Neither the Contractor nor any affiliates, nor any employee of either, has, must have, or must acquire, any contractual, financial, business, or other interest, direct or indirect, that would conflict in any manner or degree with Contractor's performance of its duties and responsibilities to the State under the Contract or otherwise create an appearance of impropriety with respect to the award or performance of this Agreement. Contractor must notify the State about the nature of the conflict or appearance of impropriety within two days of learning about it.

(h) If any of the certifications, representations, or disclosures made in the Contractor's original bid response change after the Contract start date, the Contractor must report those changes immediately to the Department of Management and Budget, Purchasing Operations.

2.122 Warranty of Merchantability—Deleted/Not Applicable**2.123 Warranty of Fitness for a Particular Purpose—Deleted/Not Applicable****2.124 Warranty of Title—Deleted/Not Applicable**

**2.125 Equipment Warranty—Deleted/Not Applicable****2.126 Equipment to be New—Deleted/Not Applicable****2.127 Prohibited Products—Deleted/Not Applicable****2.128 Consequences For Breach**

In addition to any remedies available in law, if the Contractor breaches any of the warranties contained in this section, the breach may be considered as a default in the performance of a material obligation of the Contract.

2.130 Insurance**2.131 Liability Insurance**

The Contractor must provide proof of the minimum levels of insurance coverage as indicated below. The insurance must protect the State from claims which may arise out of or result from the Contractor's performance of Services under the terms of the Contract, whether the Services are performed by the Contractor, or by any Subcontractor, or by anyone directly or indirectly employed by any of them, or by anyone for whose acts they may be liable.

The Contractor waives all rights against the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees and agents for recovery of damages to the extent these damages are covered by the insurance policies the Contractor is required to maintain under the Contract.

All insurance coverage's provided relative to the Contract/Purchase Order are PRIMARY and NON-CONTRIBUTING to any comparable liability insurance (including self-insurances) carried by the State.

The insurance must be written for not less than any minimum coverage specified in the Contract or required by law, whichever is greater.

The insurers selected by Contractor must have an A.M. Best rating of A or better, or as otherwise approved in writing by the State, or if the ratings are no longer available, with a comparable rating from a recognized insurance rating agency. All policies of insurance required in the Contract must be issued by companies that have been approved to do business in the State. See www.michigan.gov/deleg.

Where specific limits are shown, they are the minimum acceptable limits. If Contractor's policy contains higher limits, the State must be entitled to coverage to the extent of the higher limits.

The Contractor is required to pay for and provide the type and amount of insurance checked below:

1. Commercial General Liability with the following minimum coverage:
- \$2,000,000 General Aggregate Limit other than Products/Completed Operations
 - \$2,000,000 Products/Completed Operations Aggregate Limit
 - \$1,000,000 Personal & Advertising Injury Limit
 - \$1,000,000 Each Occurrence Limit

The Contractor must list the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees and agents as ADDITIONAL INSUREDS on the Commercial General Liability certificate. The Contractor also agrees to provide evidence that insurance policies contain a waiver of subrogation by the insurance company.

2. If a motor vehicle is used to provide services or products under the Contract, the Contractor must have vehicle liability insurance on any auto including owned, hired and non-owned vehicles used in Contractor's business for bodily injury and property damage as required by law.

The Contractor must list the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees and agents as ADDITIONAL INSUREDS on the vehicle liability certificate. The Contractor also agrees to provide evidence that insurance policies contain a waiver of subrogation by the insurance company.



3. Workers' compensation coverage must be provided according to applicable laws governing the employees and employers work activities in the state of the Contractor's domicile. If the applicable coverage is provided by a self-insurer, proof must be provided of approved self-insured authority by the jurisdiction of domicile. For employees working outside of the state of qualification, Contractor must provide appropriate certificates of insurance proving mandated coverage levels for the jurisdictions where the employees' activities occur.

Any certificates of insurance received must also provide a list of states where the coverage is applicable.

The Contractor also agrees to provide evidence that insurance policies contain a waiver of subrogation by the insurance company. This provision must not be applicable where prohibited or limited by the laws of the jurisdiction in which the work is to be performed.

4. Employers liability insurance with the following minimum limits:

\$100,000 each accident
\$100,000 each employee by disease
\$500,000 aggregate disease

5. Employee Fidelity, including Computer Crimes, insurance naming the State as a loss payee, providing coverage for direct loss to the State and any legal liability of the State arising out of or related to fraudulent or dishonest acts committed by the employees of Contractor or its Subcontractors, acting alone or in collusion with others, in a minimum amount of \$1,000,000.00 with a maximum deductible of \$50,000.00.

6. Umbrella or Excess Liability Insurance in a minimum amount of ten million dollars (\$5,000,000.00), which must apply, at a minimum, to the insurance required in Subsection 1 (Commercial General Liability) above.

7. Professional Liability (Errors and Omissions) Insurance with the following minimum coverage: \$3,000,000.00 each occurrence and \$3,000,000.00 annual aggregate.

8. Fire and Personal Property Insurance covering against any loss or damage to the office space used by Contractor for any reason under the Contract, and the equipment, software and other contents of the office space, including without limitation, those contents used by Contractor to provide the Services to the State, up to its replacement value, where the office space and its contents are under the care, custody and control of Contractor. The policy must cover all risks of direct physical loss or damage, including without limitation, flood and earthquake coverage and coverage for computer hardware and software. The State must be endorsed on the policy as a loss payee as its interests appear.

2.132 Subcontractor Insurance Coverage

Except where the State has approved in writing a Contractor subcontract with other insurance provisions, Contractor must require all of its Subcontractors under the Contract to purchase and maintain the insurance coverage as described in this Section for the Contractor in connection with the performance of work by those Subcontractors. Alternatively, Contractor may include any Subcontractors under Contractor's insurance on the coverage required in this Section. Subcontractor must fully comply with the insurance coverage required in this Section. Failure of Subcontractor to comply with insurance requirements does not limit Contractor's liability or responsibility.

2.133 Certificates of Insurance and Other Requirements

Contractor must furnish to DMB-Purchasing Operations, certificate(s) of insurance verifying insurance coverage or providing satisfactory evidence of self-insurance as required in this Section (the "Certificates"). The Certificate must be on the standard "accord" form or equivalent. **THE CONTRACT OR PURCHASE ORDER NO. MUST BE SHOWN ON THE CERTIFICATE OF INSURANCE TO ASSURE CORRECT FILING.** All Certificate(s) are to be prepared and submitted by the Insurance Provider. All Certificate(s) must contain a provision indicating that coverages afforded under the policies **MUST NOT BE CANCELLED, MATERIALLY CHANGED, OR NOT RENEWED** without 30 days prior written notice, except for 10 days for non-payment of premium, having been given to the Director of Purchasing Operations, Department of Management and Budget. The notice must include the Contract or Purchase Order number affected. Before the Contract is signed, and not less than 20 days before the insurance expiration date every year thereafter, the Contractor must provide evidence that the State and its agents, officers and employees are listed as additional insureds under each commercial general liability and commercial automobile liability policy. In the event the State approves the representation of the State by the insurer's attorney, the attorney may be required to be designated as a Special Assistant Attorney General by the Attorney General of the State of Michigan.



The Contractor must maintain all required insurance coverage throughout the term of the Contract and any extensions and, in the case of claims-made Commercial General Liability policies, must secure tail coverage for at least three years following the expiration or termination for any reason of the Contract. The minimum limits of coverage specified above are not intended, and must not be construed, to limit any liability or indemnity of Contractor under the Contract to any indemnified party or other persons. Contractor is responsible for all deductibles with regard to the insurance. If the Contractor fails to pay any premium for required insurance as specified in the Contract, or if any insurer cancels or significantly reduces any required insurance as specified in the Contract without the State's written consent, then the State may, after the State has given the Contractor at least 30 days written notice, pay the premium or procure similar insurance coverage from another company or companies. The State may deduct any part of the cost from any payment due the Contractor, or the Contractor must pay that cost upon demand by the State.

2.140 Indemnification

2.141 General Indemnification

To the extent permitted by law, the Contractor must indemnify, defend and hold harmless the State from liability, including all claims and losses, and all related costs and expenses (including reasonable attorneys' fees and costs of investigation, litigation, settlement, judgments, interest and penalties), accruing or resulting to any person, firm or corporation that may be injured or damaged by the Contractor in the performance of the Contract and that are attributable to the negligence or tortious acts of the Contractor or any of its Subcontractors, or by anyone else for whose acts any of them may be liable.

2.142 Code Indemnification

To the extent permitted by law, the Contractor must indemnify, defend and hold harmless the State from any claim, loss, or expense arising from Contractor's breach of the No Surreptitious Code Warranty.

2.143 Employee Indemnification

In any claims against the State of Michigan, its departments, divisions, agencies, sections, commissions, officers, employees and agents, by any employee of the Contractor or any of its Subcontractors, the indemnification obligation under the Contract must not be limited in any way by the amount or type of damages, compensation or benefits payable by or for the Contractor or any of its Subcontractors under worker's disability compensation acts, disability benefit acts or other employee benefit acts. This indemnification clause is intended to be comprehensive. Any overlap in provisions, or the fact that greater specificity is provided as to some categories of risk, is not intended to limit the scope of indemnification under any other provisions.

2.144 Patent/Copyright Infringement Indemnification

To the extent permitted by law, the Contractor must indemnify, defend and hold harmless the State from and against all losses, liabilities, damages (including taxes), and all related costs and expenses (including reasonable attorneys' fees and costs of investigation, litigation, settlement, judgments, interest and penalties) incurred in connection with any action or proceeding threatened or brought against the State to the extent that the action or proceeding is based on a claim that any piece of equipment, software, commodity or service supplied by the Contractor or its Subcontractors, or the operation of the equipment, software, commodity or service, or the use or reproduction of any documentation provided with the equipment, software, commodity or service infringes any United States patent, copyright, trademark or trade secret of any person or entity, which is enforceable under the laws of the United States.

In addition, should the equipment, software, commodity, or service, or its operation, become or in the State's or Contractor's opinion be likely to become the subject of a claim of infringement, the Contractor must at the Contractor's sole expense (i) procure for the State the right to continue using the equipment, software, commodity or service or, if the option is not reasonably available to the Contractor, (ii) replace or modify to the State's satisfaction the same with equipment, software, commodity or service of equivalent function and performance so that it becomes non-infringing, or, if the option is not reasonably available to Contractor, (iii) accept its return by the State with appropriate credits to the State against the Contractor's charges and reimburse the State for any losses or costs incurred as a consequence of the State ceasing its use and returning it.

Notwithstanding the foregoing, the Contractor has no obligation to indemnify or defend the State for, or to pay any costs, damages or attorneys' fees related to, any claim based upon (i) equipment developed based on written specifications of the State; (ii) use of the equipment in a configuration other than implemented or approved in writing by the Contractor, including, but not limited to, any modification of the equipment by the State; or (iii) the combination, operation, or use of the equipment with equipment or software not supplied by the Contractor under the Contract.

**2.145 Continuation of Indemnification Obligations**

The Contractor's duty to indemnify under this Section continues in full force and effect, notwithstanding the expiration or early cancellation of the Contract, with respect to any claims based on facts or conditions that occurred before expiration or cancellation.

2.146 Indemnification Procedures

The procedures set forth below must apply to all indemnity obligations under the Contract.

(a) After the State receives notice of the action or proceeding involving a claim for which it will seek indemnification, the State must promptly notify Contractor of the claim in writing and take or assist Contractor in taking, as the case may be, any reasonable action to avoid the imposition of a default judgment against Contractor. No failure to notify the Contractor relieves the Contractor of its indemnification obligations except to the extent that the Contractor can prove damages attributable to the failure. Within 10 days following receipt of written notice from the State relating to any claim, the Contractor must notify the State in writing whether Contractor agrees to assume control of the defense and settlement of that claim (a "Notice of Election"). After notifying Contractor of a claim and before the State receiving Contractor's Notice of Election, the State is entitled to defend against the claim, at the Contractor's expense, and the Contractor will be responsible for any reasonable costs incurred by the State in defending against the claim during that period.

(b) If Contractor delivers a Notice of Election relating to any claim: (i) the State is entitled to participate in the defense of the claim and to employ counsel at its own expense to assist in the handling of the claim and to monitor and advise the State about the status and progress of the defense; (ii) the Contractor must, at the request of the State, demonstrate to the reasonable satisfaction of the State, the Contractor's financial ability to carry out its defense and indemnity obligations under the Contract; (iii) the Contractor must periodically advise the State about the status and progress of the defense and must obtain the prior written approval of the State before entering into any settlement of the claim or ceasing to defend against the claim and (iv) to the extent that any principles of Michigan governmental or public law may be involved or challenged, the State has the right, at its own expense, to control the defense of that portion of the claim involving the principles of Michigan governmental or public law. But the State may retain control of the defense and settlement of a claim by notifying the Contractor in writing within 10 days after the State's receipt of Contractor's information requested by the State under clause (ii) of this paragraph if the State determines that the Contractor has failed to demonstrate to the reasonable satisfaction of the State the Contractor's financial ability to carry out its defense and indemnity obligations under this Section. Any litigation activity on behalf of the State, or any of its subdivisions under this Section, must be coordinated with the Department of Attorney General. In the event the insurer's attorney represents the State under this Section, the insurer's attorney may be required to be designated as a Special Assistant Attorney General by the Attorney General of the State of Michigan.

(c) If Contractor does not deliver a Notice of Election relating to any claim of which it is notified by the State as provided above, the State may defend the claim in the manner as it may deem appropriate, at the cost and expense of Contractor. If it is determined that the claim was one against which Contractor was required to indemnify the State, upon request of the State, Contractor must promptly reimburse the State for all the reasonable costs and expenses.

2.150 Termination/Cancellation**2.151 Notice and Right to Cure**

If the Contractor breaches the Contract, and the State, in its sole discretion, determines that the breach is curable, then the State must provide the Contractor with written notice of the breach and a time period (not less than 30 days) to cure the Breach. The notice of breach and opportunity to cure is inapplicable for successive or repeated breaches or if the State determines in its sole discretion that the breach poses a serious and imminent threat to the health or safety of any person or the imminent loss, damage, or destruction of any real or tangible personal property.

2.152 Termination for Cause

(a) The State may terminate the Contract, for cause, by notifying the Contractor in writing, if the Contractor (i) breaches any of its material duties or obligations under the Contract (including a Chronic Failure to meet any particular SLA), or (ii) fails to cure a breach within the time period specified in the written notice of breach provided by the State



(b) If the Contract is terminated for cause, the Contractor must pay all costs incurred by the State in terminating the Contract, including but not limited to, State administrative costs, reasonable attorneys' fees and court costs, and any reasonable additional costs the State may incur to procure the Services/Deliverables required by the Contract from other sources. Re-procurement costs are not consequential, indirect or incidental damages, and cannot be excluded by any other terms otherwise included in the Contract, provided the costs are not in excess of 50% more than the prices for the Service/Deliverables provided under the Contract.

(c) If the State chooses to partially terminate the Contract for cause, charges payable under the Contract will be equitably adjusted to reflect those Services/Deliverables that are terminated and the State must pay for all Services/Deliverables for which Final Acceptance has been granted provided up to the termination date. Services and related provisions of the Contract that are terminated for cause must cease on the effective date of the termination.

(d) If the State terminates the Contract for cause under this Section, and it is determined, for any reason, that Contractor was not in breach of contract under the provisions of this section, that termination for cause must be deemed to have been a termination for convenience, effective as of the same date, and the rights and obligations of the parties must be limited to that otherwise provided in the Contract for a termination for convenience.

2.153 Termination for Convenience

The State may terminate the Contract for its convenience, in whole or part, if the State determines that a termination is in the State's best interest. Reasons for the termination must be left to the sole discretion of the State and may include, but not necessarily be limited to (a) the State no longer needs the Services or products specified in the Contract, (b) relocation of office, program changes, changes in laws, rules, or regulations make implementation of the Services no longer practical or feasible, (c) unacceptable prices for Additional Services or New Work requested by the State, or (d) falsification or misrepresentation, by inclusion or non-inclusion, of information material to a response to any CONTRACT issued by the State. The State may terminate the Contract for its convenience, in whole or in part, by giving Contractor written notice at least 30 days before the date of termination. If the State chooses to terminate the Contract in part, the charges payable under the Contract must be equitably adjusted to reflect those Services/Deliverables that are terminated. Services and related provisions of the Contract that are terminated for cause must cease on the effective date of the termination.

2.154 Termination for Non-Appropriation

(a) Contractor acknowledges that, if the Contract extends for several fiscal years, continuation of the Contract is subject to appropriation or availability of funds for the Contract. If funds to enable the State to effect continued payment under the Contract are not appropriated or otherwise made available, the State must terminate the Contract and all affected Statements of Work, in whole or in part, at the end of the last period for which funds have been appropriated or otherwise made available by giving written notice of termination to Contractor. The State must give Contractor at least 30 days advance written notice of termination for non-appropriation or unavailability (or the time as is available if the State receives notice of the final decision less than 30 days before the funding cutoff).

(b) If funding for the Contract is reduced by law, or funds to pay Contractor for the agreed-to level of the Services or production of Deliverables to be provided by Contractor are not appropriated or otherwise unavailable, the State may, upon 30 days written notice to Contractor, reduce the level of the Services or the change the production of Deliverables in the manner and for the periods of time as the State may elect. The charges payable under the Contract will be equitably adjusted to reflect any equipment, services or commodities not provided by reason of the reduction.

(c) If the State terminates the Contract, eliminates certain Deliverables, or reduces the level of Services to be provided by Contractor under this Section, the State must pay Contractor for all Work-in-Process performed through the effective date of the termination or reduction in level, as the case may be and as determined by the State, to the extent funds are available. This Section will not preclude Contractor from reducing or stopping Services/Deliverables or raising against the State in a court of competent jurisdiction, any claim for a shortfall in payment for Services performed or Deliverables finally accepted before the effective date of termination.

2.155 Termination for Criminal Conviction

The State may terminate the Contract immediately and without further liability or penalty in the event Contractor, an officer of Contractor, or an owner of a 25% or greater share of Contractor is convicted of a criminal offense related to a State, public or private Contract or subcontract.

**2.156 Termination for Approvals Rescinded**

The State may terminate the Contract if any final administrative or judicial decision or adjudication disapproves a previously approved request for purchase of personal services under Constitution 1963, Article 11, § 5, and Civil Service Rule 7-1. In that case, the State must pay the Contractor for only the work completed to that point under the Contract. Termination may be in whole or in part and may be immediate as of the date of the written notice to Contractor or may be effective as of the date stated in the written notice.

2.157 Rights and Obligations upon Termination

(a) If the State terminates the Contract for any reason, the Contractor must (a) stop all work as specified in the notice of termination, (b) take any action that may be necessary, or that the State may direct, for preservation and protection of Deliverables or other property derived or resulting from the Contract that may be in Contractor's possession, (c) return all materials and property provided directly or indirectly to Contractor by any entity, agent or employee of the State, (d) transfer title in, and deliver to, the State, unless otherwise directed, all Deliverables intended to be transferred to the State at the termination of the Contract and which are resulting from the Contract (which must be provided to the State on an "As-Is" basis except to the extent the amounts paid by the State in respect of the items included compensation to Contractor for the provision of warranty services in respect of the materials), and (e) take any action to mitigate and limit any potential damages, or requests for Contractor adjustment or termination settlement costs, to the maximum practical extent, including terminating or limiting as otherwise applicable those subcontracts and outstanding orders for material and supplies resulting from the terminated Contract.

(b) If the State terminates the Contract before its expiration for its own convenience, the State must pay Contractor for all charges due for Services provided before the date of termination and, if applicable, as a separate item of payment under the Contract, for Work In Process, on a percentage of completion basis at the level of completion determined by the State. All completed or partially completed Deliverables prepared by Contractor under the Contract, at the option of the State, becomes the State's property, and Contractor is entitled to receive equitable fair compensation for the Deliverables. Regardless of the basis for the termination, the State is not obligated to pay, or otherwise compensate, Contractor for any lost expected future profits, costs or expenses incurred with respect to Services not actually performed for the State.

(c) Upon a good faith termination, the State may assume, at its option, any subcontracts and agreements for Services and Deliverables provided under the Contract, and may further pursue completion of the Services/Deliverables under the Contract by replacement contract or otherwise as the State may in its sole judgment deem expedient.

2.158 Reservation of Rights

Any termination of the Contract or any Statement of Work issued under it by a party must be with full reservation of, and without prejudice to, any rights or remedies otherwise available to the party with respect to any claims arising before or as a result of the termination.

2.160 Termination by Contractor**2.161 Termination by Contractor—Deleted/Not Applicable****2.170 Transition Responsibilities****2.171 Contractor Transition Responsibilities**

If the State terminates the Contract, for convenience or cause, or if the Contract is otherwise dissolved, voided, rescinded, nullified, expires or rendered unenforceable, the Contractor agrees to comply with direction provided by the State to assist in the orderly transition of equipment, services, software, leases, etc. to the State or a third party designated by the State. If the Contract expires or terminates, the Contractor agrees to make all reasonable efforts to effect an orderly transition of services within a reasonable period of time that in no event will exceed thirty (30) days. These efforts must include, but are not limited to, those listed in **Sections 2.171, 2.172, 2.173, 2.174, and 2.175.**

**2.172 Contractor Personnel Transition**

The Contractor must work with the State, or a specified third party, to develop a transition plan setting forth the specific tasks and schedule to be accomplished by the parties to effect an orderly transition. The Contractor must allow as many personnel as practicable to remain on the job to help the State, or a specified third party, maintain the continuity and consistency of the services required by the Contract. In addition, during or following the transition period, in the event the State requires the Services of the Contractor's Subcontractors or vendors, as necessary to meet its needs, Contractor agrees to reasonably, and with good-faith, work with the State to use the Services of Contractor's Subcontractors or vendors. Contractor must notify all of Contractor's subcontractors of procedures to be followed during transition.

2.173 Contractor Information Transition

The Contractor agrees to provide reasonable detailed specifications for all Services/Deliverables needed by the State, or specified third party, to properly provide the Services/Deliverables required under the Contract. The Contractor must provide the State with asset management data generated from the inception of the Contract through the date on which the Contractor is terminated in a comma-delineated format unless otherwise requested by the State. The Contractor must deliver to the State any remaining owed reports and documentation still in Contractor's possession subject to appropriate payment by the State.

2.174 Contractor Software Transition

The Contractor must reasonably assist the State in the acquisition of any Contractor software required to perform the Services/use the Deliverables under the Contract. This must include any documentation being used by the Contractor to perform the Services under the Contract. If the State transfers any software licenses to the Contractor, those licenses must, upon expiration of the Contract, transfer back to the State at their current revision level. Upon notification by the State, Contractor may be required to freeze all non-critical changes to Deliverables/Services.

2.175 Transition Payments

If the transition results from a termination for any reason, reimbursement must be governed by the termination provisions of the Contract. If the transition results from expiration, the Contractor will be reimbursed for all reasonable transition costs (i.e. costs incurred within the agreed period after contract expiration that result from transition operations) at the rates agreed upon by the State. The Contractor must prepare an accurate accounting from which the State and Contractor may reconcile all outstanding accounts.

2.176 State Transition Responsibilities

In the event that the Contract is terminated, dissolved, voided, rescinded, nullified, or otherwise rendered unenforceable, the State agrees to perform the following obligations, and any others upon which the State and the Contractor agree:

- (a) Reconciling all accounts between the State and the Contractor;
- (b) Completing any pending post-project reviews.

2.180 Stop Work**2.181 Stop Work Orders**

The State may, at any time, by written stop work order to Contractor, require that Contractor stop all, or any part, of the work called for by the Contract for a period of up to 90 calendar days after the stop work order is delivered to Contractor, and for any further period to which the parties may agree. The stop work order must be identified as a stop work order and must indicate that it is issued under this **Section 2.180**. Upon receipt of the stop work order, Contractor must immediately comply with its terms and take all reasonable steps to minimize incurring costs allocable to the work covered by the stop work order during the period of work stoppage. Within the period of the stop work order, the State must either: (a) cancel the stop work order; or (b) terminate the work covered by the stop work order as provided in **Section 2.150**.

2.182 Cancellation or Expiration of Stop Work Order

The Contractor must resume work if the State cancels a Stop Work Order or if it expires. The parties will agree upon an equitable adjustment in the delivery schedule, the Contract price, or both, and the Contract must be modified, in writing, accordingly, if: (a) the stop work order results in an increase in the time required for, or in Contractor's costs properly allocable to, the performance of any part of the Contract; and (b) Contractor asserts its right to an equitable adjustment within 30 calendar days after the end of the period of work stoppage; provided that, if the State decides the facts justify the action, the State may receive and act upon a Contractor proposal submitted at any time before final payment under the Contract. Any adjustment must conform to the requirements of **Section 2.024**.

**2.183 Allowance of Contractor Costs**

If the stop work order is not canceled and the work covered by the stop work order is terminated for reasons other than material breach, the termination must be deemed to be a termination for convenience under **Section 2.150**, and the State will pay reasonable costs resulting from the stop work order in arriving at the termination settlement. For the avoidance of doubt, the State is not liable to Contractor for loss of profits because of a stop work order issued under this **Section 2.180**.

2.190 Dispute Resolution**2.191 In General**

Any claim, counterclaim, or dispute between the State and Contractor arising out of or relating to the Contract or any Statement of Work must be resolved as follows. For all Contractor claims seeking an increase in the amounts payable to Contractor under the Contract, or the time for Contractor's performance, Contractor must submit a letter, together with all data supporting the claims, executed by Contractor's Contract Administrator or the Contract Administrator's designee certifying that (a) the claim is made in good faith, (b) the amount claimed accurately reflects the adjustments in the amounts payable to Contractor or the time for Contractor's performance for which Contractor believes the State is liable and covers all costs of every type to which Contractor is entitled from the occurrence of the claimed event, and (c) the claim and the supporting data are current and complete to Contractor's best knowledge and belief.

2.192 Informal Dispute Resolution

(a) All disputes between the parties must be resolved under the Contract Management procedures in the Contract. If the parties are unable to resolve any disputes after compliance with the processes, the parties must meet with the Director of Purchasing Operations, DMB, or designee, for the purpose of attempting to resolve the dispute without the need for formal legal proceedings, as follows:

- (i) The representatives of Contractor and the State must meet as often as the parties reasonably deem necessary to gather and furnish to each other all information with respect to the matter in issue which the parties believe to be appropriate and germane in connection with its resolution. The representatives must discuss the problem and negotiate in good faith in an effort to resolve the dispute without the necessity of any formal proceeding.
- (ii) During the course of negotiations, all reasonable requests made by one party to another for non-privileged information reasonably related to the Contract must be honored in order that each of the parties may be fully advised of the other's position.
- (iii) The specific format for the discussions will be left to the discretion of the designated State and Contractor representatives, but may include the preparation of agreed upon statements of fact or written statements of position.
- (iv) Following the completion of this process within 60 calendar days, the Director of Purchasing Operations, DMB, or designee, must issue a written opinion regarding the issue(s) in dispute within 30 calendar days. The opinion regarding the dispute must be considered the State's final action and the exhaustion of administrative remedies.

(b) This Section must not be construed to prevent either party from instituting, and a party is authorized to institute, formal proceedings earlier to avoid the expiration of any applicable limitations period, to preserve a superior position with respect to other creditors, or under **Section 2.193**.

(c) The State will not mediate disputes between the Contractor and any other entity, except state agencies, concerning responsibility for performance of work under the Contract.

2.193 Injunctive Relief

The only circumstance in which disputes between the State and Contractor will not be subject to the provisions of **Section 2.192** is where a party makes a good faith determination that a breach of the terms of the Contract by the other party is the that the damages to the party resulting from the breach will be so immediate, so large or severe and so incapable of adequate redress after the fact that a temporary restraining order or other immediate injunctive relief is the only adequate remedy.

2.194 Continued Performance

Each party agrees to continue performing its obligations under the Contract while a dispute is being resolved except to the extent the issue in dispute precludes performance (dispute over payment must not be deemed to preclude performance) and without limiting either party's right to terminate the Contract as provided in **Section 2.150**, as the case may be.



2.200 Federal and State Contract Requirements

2.201 Nondiscrimination

In the performance of the Contract, Contractor agrees not to discriminate against any employee or applicant for employment, with respect to his or her hire, tenure, terms, conditions or privileges of employment, or any matter directly or indirectly related to employment, because of race, color, religion, national origin, ancestry, age, sex, height, weight, marital status, or physical or mental disability. Contractor further agrees that every subcontract entered into for the performance of the Contract or any purchase order resulting from the Contract must contain a provision requiring non-discrimination in employment, as specified here, binding upon each Subcontractor. This covenant is required under the Elliot Larsen Civil Rights Act, 1976 PA 453, MCL 37.2101, et seq., and the Persons with Disabilities Civil Rights Act, 1976 PA 220, MCL 37.1101, et seq., and any breach of this provision may be regarded as a material breach of the Contract.

2.202 Unfair Labor Practices

Under 1980 PA 278, MCL 423.321, et seq., the State must not award a Contract or subcontract to an employer whose name appears in the current register of employers failing to correct an unfair labor practice compiled under Section 2 of the Act. This information is compiled by the United States National Labor Relations Board. A Contractor of the State, in relation to the Contract, must not enter into a contract with a Subcontractor, manufacturer, or supplier whose name appears in this register. Under Section 4 of 1980 PA 278, MCL 423.324, the State may void any Contract if, after award of the Contract, the name of Contractor as an employer or the name of the Subcontractor, manufacturer or supplier of Contractor appears in the register.

2.203 Workplace Safety and Discriminatory Harassment

In performing Services for the State, the Contractor must comply with the Department of Civil Services Rule 2-20 regarding Workplace Safety and Rule 1-8.3 regarding Discriminatory Harassment. In addition, the Contractor must comply with Civil Service regulations and any applicable agency rules provided to the Contractor. For Civil Service Rules, see <http://www.mi.gov/mdcs/0,1607,7-147-6877---,00.html>.

2.204 Prevailing Wage

The rates of wages and fringe benefits to be paid each class of individuals employed by the Contractor, its subcontractors, their subcontractors, and all persons involved with the performance of the Contract in privity of contract with the Contractor must not be less than the wage rates and fringe benefits established by the Michigan Department of Energy, Labor and Economic Development, Wage and Hour Bureau, schedule of occupational classification and wage rates and fringe benefits for the local where the work is to be performed. The term Contractor must include all general contractors, prime contractors, project managers, trade contractors, and all of their contractors or subcontractors and persons in privity of contract with them.

The Contractor, its subcontractors, their subcontractors and all persons involved with the performance of the Contract in privity of contract with the Contractor must keep posted on the work site, in a conspicuous place, a copy of all wage rates and fringe benefits as prescribed in the contract. You must also post, in a conspicuous place, the address and telephone number of the Michigan Department of Energy, Labor and Economic Development, the office responsible for enforcement of the wage rates and fringe benefits. The Contractor must keep an accurate record showing the name and occupation of the actual wage and benefits paid to each individual employed in connection with the Contract. This record must be available to the State upon request for reasonable inspection.

If any trade is omitted from the list of wage rates and fringe benefits to be paid to each class of individuals by the Contractor, it is understood that the trades omitted must also be paid not less than the wage rate and fringe benefits prevailing in the local where the work is to be performed.

2.210 Governing Law

2.211 Governing Law

The Contract must in all respects be governed by, and construed according to, the substantive laws of the State of Michigan without regard to any Michigan choice of law rules that would apply the substantive law of any other jurisdiction to the extent not inconsistent with, or pre-empted by federal law.

2.212 Compliance with Laws

Contractor must comply with all applicable state, federal and local laws and ordinances in providing the Services/Deliverables.

**2.213 Jurisdiction**

Any dispute arising from the Contract must be resolved in the State of Michigan. With respect to any claim between the parties, Contractor consents to venue in Ingham County, Michigan, and irrevocably waives any objections it may have to the jurisdiction on the grounds of lack of personal jurisdiction of the court or the laying of venue of the court or on the basis of forum non conveniens or otherwise. Contractor agrees to appoint agents in the State of Michigan to receive service of process.

2.220 Limitation of Liability**2.221 Limitation of Liability**

Neither the Contractor nor the State is liable to each other, regardless of the form of action, for consequential, incidental, indirect, or special damages. This limitation of liability does not apply to claims for infringement of United States patent, copyright, trademark or trade secrets; to claims for personal injury or damage to property caused by the gross negligence or willful misconduct of the Contractor; to claims covered by other specific provisions of the Contract calling for liquidated damages; or to court costs or attorney's fees awarded by a court in addition to damages after litigation based on the Contract.

The Contractor and the State's liability for damages is limited to the value of the Contract.

The foregoing limitation of liability does not apply to claims for infringement of United States patent, copyright, trademarks or trade secrets; to claims for personal injury or damage to property caused by the gross negligence or willful misconduct of the Contractor; to claims covered by other specific provisions of the Contract calling for liquidated damages; or to court costs or attorney's fees awarded by a court in addition to damages after litigation based on the Contract.

2.230 Disclosure Responsibilities**2.231 Disclosure of Litigation**

(a) Disclosure. Contractor must disclose any material criminal litigation, investigations or proceedings involving the Contractor (and each Subcontractor) or any of its officers or directors or any litigation, investigations or proceedings under the Sarbanes-Oxley Act. In addition, each Contractor (and each Subcontractor) must notify the State of any material civil litigation, arbitration or proceeding which arises during the term of the Contract and extensions, to which Contractor (or, to the extent Contractor is aware, any Subcontractor) is a party, and which involves: (i) disputes that might reasonably be expected to adversely affect the viability or financial stability of Contractor or any Subcontractor; or (ii) a claim or written allegation of fraud against Contractor or, to the extent Contractor is aware, any Subcontractor by a governmental or public entity arising out of their business dealings with governmental or public entities. The Contractor must disclose in writing to the Contract Administrator any litigation, investigation, arbitration or other proceeding (collectively, "Proceeding") within 30 days of its occurrence. Details of settlements which are prevented from disclosure by the terms of the settlement may be annotated. Information provided to the State from Contractor's publicly filed documents referencing its material litigation will be deemed to satisfy the requirements of this Section.

(b) Assurances. If any Proceeding disclosed to the State under this Section, or of which the State otherwise becomes aware, during the term of the Contract would cause a reasonable party to be concerned about:

- (i) the ability of Contractor (or a Subcontractor) to continue to perform the Contract according to its terms and conditions, or
- (ii) whether Contractor (or a Subcontractor) in performing Services for the State is engaged in conduct which is similar in nature to conduct alleged in the Proceeding, which conduct would constitute a breach of the Contract or a violation of Michigan law, regulations or public policy, then the Contractor must provide the State all reasonable assurances requested by the State to demonstrate that:
 - (a) Contractor and its Subcontractors must be able to continue to perform the Contract and any Statements of Work according to its terms and conditions, and
 - (b) Contractor and its Subcontractors have not and will not engage in conduct in performing the Services which is similar in nature to the conduct alleged in the Proceeding.



- (c) Contractor must make the following notifications in writing:
- (1) Within 30 days of Contractor becoming aware that a change in its ownership or officers has occurred, or is certain to occur, or a change that could result in changes in the valuation of its capitalized assets in the accounting records, Contractor must notify DMB Purchasing Operations.
 - (2) Contractor must also notify DMB Purchasing Operations within 30 days whenever changes to asset valuations or any other cost changes have occurred or are certain to occur as a result of a change in ownership or officers.
 - (3) Contractor must also notify DMB Purchasing Operations within 30 days whenever changes to company affiliations occur.

2.232 Call Center Disclosure—Deleted/Not Applicable

2.233 Bankruptcy

The State may, without prejudice to any other right or remedy, terminate the Contract, in whole or in part, and, at its option, may take possession of the "Work in Process" and finish the Works in Process by whatever appropriate method the State may deem expedient if:

- (a) the Contractor files for protection under the bankruptcy laws;
- (b) an involuntary petition is filed against the Contractor and not removed within 30 days;
- (c) the Contractor becomes insolvent or if a receiver is appointed due to the Contractor's insolvency;
- (d) the Contractor makes a general assignment for the benefit of creditors; or
- (e) the Contractor or its affiliates are unable to provide reasonable assurances that the Contractor or its affiliates can deliver the services under the Contract.

Contractor will fix appropriate notices or labels on the Work in Process to indicate ownership by the State. To the extent reasonably possible, materials and Work in Process must be stored separately from other stock and marked conspicuously with labels indicating ownership by the State.

2.240 Performance

2.241 Time of Performance

- (a) Contractor must use commercially reasonable efforts to provide the resources necessary to complete all Services and Deliverables according to the time schedules contained in the Statements of Work and other Exhibits governing the work, and with professional quality.
- (b) Without limiting the generality of **Section 2.241(a)**, Contractor must notify the State in a timely manner upon becoming aware of any circumstances that may reasonably be expected to jeopardize the timely and successful completion of any Deliverables/Services on the scheduled due dates in the latest State-approved delivery schedule and must inform the State of the projected actual delivery date.
- (c) If the Contractor believes that a delay in performance by the State has caused or will cause the Contractor to be unable to perform its obligations according to specified Contract time periods, the Contractor must notify the State in a timely manner and must use commercially reasonable efforts to perform its obligations according to the Contract time periods notwithstanding the State's failure. Contractor will not be in default for a delay in performance to the extent the delay is caused by the State.

2.242 Service Level Agreements (SLAs)—Deleted/Not Applicable

2.243 Liquidated Damages—Deleted/Not Applicable

2.244 Excusable Failure

Neither party will be liable for any default, damage, or delay in the performance of its obligations under the Contract to the extent the default, damage or delay is caused by government regulations or requirements (executive, legislative, judicial, military, or otherwise), power failure, lightning, earthquake, war, water or other forces of nature or acts of God, delays or failures of transportation, equipment shortages, suppliers' failures, or acts or omissions of common carriers, fire; riots, civil disorders; strikes or other labor disputes, embargoes; injunctions (provided the injunction was not issued as a result of any fault or negligence of the party seeking to have its default or delay excused);



or any other cause beyond the reasonable control of a party; provided the non-performing party and its Subcontractors are without fault in causing the default or delay, and the default or delay could not have been prevented by reasonable precautions and cannot reasonably be circumvented by the non-performing party through the use of alternate sources, workaround plans or other means, including disaster recovery plans.

If a party does not perform its contractual obligations for any of the reasons listed above, the non-performing party will be excused from any further performance of its affected obligation(s) for as long as the circumstances prevail. but the party must use commercially reasonable efforts to recommence performance whenever and to whatever extent possible without delay. A party must promptly notify the other party in writing immediately after the excusable failure occurs, and also when it abates or ends.

If any of the above-enumerated circumstances substantially prevent, hinder, or delay the Contractor's performance of the Services/provision of Deliverables for more than 10 Business Days, and the State determines that performance is not likely to be resumed within a period of time that is satisfactory to the State in its reasonable discretion, then at the State's option: (a) the State may procure the affected Services/Deliverables from an alternate source, and the State is not be liable for payment for the unperformed Services/ Deliverables not provided under the Contract for so long as the delay in performance continues; (b) the State may terminate any portion of the Contract so affected and the charges payable will be equitably adjusted to reflect those Services/Deliverables terminated; or (c) the State may terminate the affected Statement of Work without liability to Contractor as of a date specified by the State in a written notice of termination to the Contractor, except to the extent that the State must pay for Services/Deliverables provided through the date of termination.

The Contractor will not have the right to any additional payments from the State as a result of any Excusable Failure occurrence or to payments for Services not rendered/Deliverables not provided as a result of the Excusable Failure condition. Defaults or delays in performance by Contractor which are caused by acts or omissions of its Subcontractors will not relieve Contractor of its obligations under the Contract except to the extent that a Subcontractor is itself subject to an Excusable Failure condition described above and Contractor cannot reasonably circumvent the effect of the Subcontractor's default or delay in performance through the use of alternate sources, workaround plans or other means.

2.250 Approval of Deliverables

2.251 Delivery Responsibilities

Unless otherwise specified by the State within an individual order, the following must be applicable to all orders issued under the Contract.

- (a) Shipment responsibilities - Services performed/Deliverables provided under the Contract must be delivered "F.O.B. Destination, within Government Premises." The Contractor must have complete responsibility for providing all Services/Deliverables to all site(s) unless otherwise stated. Actual delivery dates must be specified on the individual purchase order.
- (b) Delivery locations - Services must be performed/Deliverables must be provided at every State of Michigan location within Michigan unless otherwise stated in the SOW. Specific locations will be provided by the State or upon issuance of individual purchase orders.
- (c) Damage Disputes - At the time of delivery to State Locations, the State must examine all packages. The quantity of packages delivered must be recorded and any obvious visible or suspected damage must be noted at time of delivery using the shipper's delivery document(s) and appropriate procedures to record the damage. Where there is no obvious or suspected damage, all deliveries to a State Location must be opened by the State and the contents inspected for possible internal damage not visible externally within 14 days of receipt. Any damage must be reported to the Contractor within five days of inspection

2.252 Delivery of Deliverables

Where applicable, the Statements of Work/POs contain lists of the Deliverables to be prepared and delivered by Contractor including, for each Deliverable, the scheduled delivery date and a designation of whether the Deliverable is a document ("Written Deliverable"), a good ("Physical Deliverable") or a Service. All Deliverables must be completed and delivered for State review and written approval and, where applicable, installed according to the State-approved delivery schedule and any other applicable terms and conditions of the Contract.

**2.253 Testing**

(a) Before delivering any of the above-mentioned Statement of Work Physical Deliverables or Services to the State, Contractor must first perform all required quality assurance activities to verify that the Physical Deliverable or Service is complete and conforms with its specifications listed in the applicable Statement of Work or Purchase Order. Before delivering a Physical Deliverable or Service to the State, Contractor must certify to the State that (1) it has performed the quality assurance activities, (2) it has performed any applicable testing, (3) it has corrected all material deficiencies discovered during the quality assurance activities and testing, (4) the Deliverable or Service is in a suitable state of readiness for the State's review and approval, and (5) the Deliverable/Service has all Critical Security patches/updates applied.

(b) If a Deliverable includes installation at a State Location, then Contractor must (1) perform any applicable testing, (2) correct all material deficiencies discovered during the quality assurance activities and testing, and (3) inform the State that the Deliverable is in a suitable state of readiness for the State's review and approval. To the extent that testing occurs at State Locations, the State is entitled to observe or otherwise participate in testing.

2.254 Approval of Deliverables, In General

(a) All Deliverables (Physical Deliverables and Written Deliverables) and Services require formal written approval by the State, according to the following procedures. Formal approval by the State requires the State to confirm in writing that the Deliverable meets its specifications. Formal approval may include the successful completion of Testing as applicable in **Section 2.253**, to be led by the State with the support and assistance of Contractor. The approval process will be facilitated by ongoing consultation between the parties, inspection of interim and intermediate Deliverables and collaboration on key decisions.

(b) The State's obligation to comply with any State Review Period is conditioned on the timely delivery of Deliverables/Services being reviewed.

(c) Before commencement of its review or testing of a Deliverable/Service, the State may inspect the Deliverable/Service to confirm that all components of the Deliverable/Service have been delivered without material deficiencies. If the State determines that the Deliverable/Service has material deficiencies, the State may refuse delivery of the Deliverable/Service without performing any further inspection or testing of the Deliverable/Service. Otherwise, the review period will be deemed to have started on the day the State receives the Deliverable or the Service begins, and the State and Contractor agree that the Deliverable/Service is ready for use and, where applicable, certification by Contractor according to **Section 2.253**.

(d) The State must approve in writing a Deliverable/Service after confirming that it conforms to and performs according to its specifications without material deficiency. The State may, but is not be required to, conditionally approve in writing a Deliverable/Service that contains material deficiencies if the State elects to permit Contractor to rectify them post-approval. In any case, Contractor will be responsible for working diligently to correct within a reasonable time at Contractor's expense all deficiencies in the Deliverable/Service that remain outstanding at the time of State approval.

(e) If, after three opportunities (the original and two repeat efforts), the Contractor is unable to correct all deficiencies preventing Final Acceptance of a Deliverable/Service, the State may: (i) demand that the Contractor cure the failure and give the Contractor additional time to cure the failure at the sole expense of the Contractor; or (ii) keep the Contract in force and do, either itself or through other parties, whatever the Contractor has failed to do, and recover the difference between the cost to cure the deficiency and the contract price plus an additional sum equal to 10% of the cost to cure the deficiency to cover the State's general expenses provided the State can furnish proof of the general expenses; or (iii) terminate the particular Statement of Work for default, either in whole or in part by notice to Contractor provided Contractor is unable to cure the breach. Notwithstanding the foregoing, the State cannot use, as a basis for exercising its termination rights under this Section, deficiencies discovered in a repeat State Review Period that could reasonably have been discovered during a prior State Review Period.

(f) The State, at any time and in its reasonable discretion, may halt the testing or approval process if the process reveals deficiencies in or problems with a Deliverable/Service in a sufficient quantity or of a sufficient severity that renders continuing the process unproductive or unworkable. If that happens, the State may stop using the Service or return the applicable Deliverable to Contractor for correction and re-delivery before resuming the testing or approval process.

**2.255 Process For Approval of Written Deliverables**

The State Review Period for Written Deliverables will be the number of days set forth in the applicable Statement of Work following delivery of the final version of the Deliverable (and if the Statement of Work does not state the State Review Period, it is by default five Business Days for Written Deliverables of 100 pages or less and 10 Business Days for Written Deliverables of more than 100 pages). The duration of the State Review Periods will be doubled if the State has not had an opportunity to review an interim draft of the Written Deliverable before its submission to the State. The State agrees to notify Contractor in writing by the end of the State Review Period either stating that the Deliverable is approved in the form delivered by Contractor or describing any deficiencies that must be corrected before approval of the Deliverable (or at the State's election, after approval of the Deliverable). If the State notifies the Contractor about deficiencies, the Contractor must correct the described deficiencies and within 30 Business Days resubmit the Deliverable in a form that shows all revisions made to the original version delivered to the State. Contractor's correction efforts must be made at no additional charge. Upon receipt of a corrected Deliverable from Contractor, the State must have a reasonable additional period of time, not to exceed the length of the original State Review Period, to review the corrected Deliverable to confirm that the identified deficiencies have been corrected.

2.256 Process for Approval of Services

The State Review Period for approval of Services is governed by the applicable Statement of Work (and if the Statement of Work does not state the State Review Period, it is by default 30 Business Days for Services). The State agrees to notify the Contractor in writing by the end of the State Review Period either stating that the Service is approved in the form delivered by the Contractor or describing any deficiencies that must be corrected before approval of the Services (or at the State's election, after approval of the Service). If the State delivers to the Contractor a notice of deficiencies, the Contractor must correct the described deficiencies and within 30 Business Days resubmit the Service in a form that shows all revisions made to the original version delivered to the State. The Contractor's correction efforts must be made at no additional charge. Upon implementation of a corrected Service from Contractor, the State must have a reasonable additional period of time, not to exceed the length of the original State Review Period, to review the corrected Service for conformity and that the identified deficiencies have been corrected.

2.257 Process for Approval of Physical Deliverables

The State Review Period for approval of Physical Deliverables is governed by the applicable Statement of Work (and if the Statement of Work does not state the State Review Period, it is by default 30 continuous Business Days for a Physical Deliverable). The State agrees to notify the Contractor in writing by the end of the State Review Period either stating that the Deliverable is approved in the form delivered by the Contractor or describing any deficiencies that must be corrected before approval of the Deliverable (or at the State's election, after approval of the Deliverable). If the State delivers to the Contractor a notice of deficiencies, the Contractor must correct the described deficiencies and within 30 Business Days resubmit the Deliverable in a form that shows all revisions made to the original version delivered to the State. The Contractor's correction efforts must be made at no additional charge. Upon receipt of a corrected Deliverable from the Contractor, the State must have a reasonable additional period of time, not to exceed the length of the original State Review Period, to review the corrected Deliverable to confirm that the identified deficiencies have been corrected.

2.258 Final Acceptance

Unless otherwise stated in the Article 1, Statement of Work or Purchase Order, "Final Acceptance" of each Deliverable must occur when each Deliverable/Service has been approved by the State following the State Review Periods identified in **Sections 2.251-2.257**. Payment will be made for Deliverables installed and accepted. Upon acceptance of a Service, the State will pay for all Services provided during the State Review Period that conformed to the acceptance criteria.

2.260 Ownership**2.261 Ownership of Work Product by State**

The State owns all Deliverables as they are works made for hire by the Contractor for the State. The State owns all United States and international copyrights, trademarks, patents, or other proprietary rights in the Deliverables.

**2.262 Vesting of Rights**

With the sole exception of any preexisting licensed works identified in the SOW, the Contractor assigns, and upon creation of each Deliverable automatically assigns, to the State, ownership of all United States and international copyrights, trademarks, patents, or other proprietary rights in each and every Deliverable, whether or not registered by the Contractor, insofar as any the Deliverable, by operation of law, may not be considered work made for hire by the Contractor for the State. From time to time upon the State's request, the Contractor must confirm the assignment by execution and delivery of the assignments, confirmations of assignment, or other written instruments as the State may request. The State may obtain and hold in its own name all copyright, trademark, and patent registrations and other evidence of rights that may be available for Deliverables.

2.263 Rights in Data

(a) The State is the owner of all data made available by the State to the Contractor or its agents, Subcontractors or representatives under the Contract. The Contractor must not use the State's data for any purpose other than providing the Services, 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 the Contractor. No employees of the Contractor, other than those on a strictly need-to-know basis, have access to the State's data. Contractor must not possess or assert any lien or other right against the State's data. Without limiting the generality of this Section, the Contractor must only use personally identifiable information as strictly necessary to provide the Services and must disclose the information only to its employees who have a strict need-to-know the information. The Contractor must comply at all times with all laws and regulations applicable to the personally identifiable information.

(b) The State is the owner of all State-specific data under the Contract. The State may use the data provided by the Contractor for any purpose. The State must not possess or assert any lien or other right against the Contractor's data. Without limiting the generality of this Section, the State may use personally identifiable information only as strictly necessary to utilize the Services and must disclose the information only to its employees who have a strict need to know the information, except as provided by law. The State must comply at all times with all laws and regulations applicable to the personally identifiable information. Other material developed and provided to the State remains the State's sole and exclusive property.

2.264 Ownership of Materials

The State and the Contractor will continue to own their respective proprietary technologies developed before entering into the Contract. Any hardware bought through the Contractor by the State, and paid for by the State, will be owned by the State. Any software licensed through the Contractor and sold to the State, will be licensed directly to the State.

2.270 State Standards**2.271 Existing Technology Standards**

The Contractor must adhere to all existing standards as described within the comprehensive listing of the State's existing technology standards at <http://www.michigan.gov/dit>.

2.272 Acceptable Use Policy

To the extent that Contractor has access to the State computer system, Contractor must comply with the State's Acceptable Use Policy, see <http://www.michigan.gov/ditservice>. All Contractor employees must be required, in writing, to agree to the State's Acceptable Use Policy before accessing the State system. The State reserves the right to terminate Contractor's access to the State system if a violation occurs.

2.273 Systems Changes

Contractor is not responsible for and not authorized to make changes to any State systems without written authorization from the Project Manager. Any changes Contractor makes to State systems with the State's approval must be done according to applicable State procedures, including security, access, and configuration management procedures.

2.280 Extended Purchasing**2.281 MIDEAL—Deleted/Not Applicable****2.282 State Employee Purchases—Deleted/Not Applicable**



2.290 Environmental Provision

2.291 Environmental Provision

Hazardous Materials:

For the purposes of this Section, "Hazardous Materials" is a generic term used to describe asbestos, ACBMs, PCBs, petroleum products, construction materials including paint thinners, solvents, gasoline, oil, and any other material the manufacture, use, treatment, storage, transportation, or disposal of which is regulated by the federal, State, or local laws governing the protection of the public health, natural resources, or the environment. This includes, but is not limited to, materials such as batteries and circuit packs, and other materials that are regulated as (1) "Hazardous Materials" under the Hazardous Materials Transportation Act, (2) "chemical hazards" under the Occupational Safety and Health Administration standards, (3) "chemical substances or mixtures" under the Toxic Substances Control Act, (4) "pesticides" under the Federal Insecticide Fungicide and Rodenticide Act, and (5) "hazardous wastes" as defined or listed under the Resource Conservation and Recovery Act.

(a) The Contractor must use, handle, store, dispose of, process, transport and transfer any material considered a Hazardous Material according to all federal, State, and local laws. The State must provide a safe and suitable environment for performance of Contractor's Work. Before the commencement of Work, the State must advise the Contractor of the presence at the work site of any Hazardous Material to the extent that the State is aware of the Hazardous Material. If the Contractor encounters material reasonably believed to be a Hazardous Material and which may present a substantial danger, the Contractor must immediately stop all affected Work, notify the State in writing about the conditions encountered, and take appropriate health and safety precautions.

(b) Upon receipt of a written notice, the State will investigate the conditions. If (a) the material is a Hazardous Material that may present a substantial danger, and (b) the Hazardous Material was not brought to the site by the Contractor, or does not result in whole or in part from any violation by the Contractor of any laws covering the use, handling, storage, disposal of, processing, transport and transfer of Hazardous Materials, the State must order a suspension of Work in writing. The State must proceed to have the Hazardous Material removed or rendered harmless. In the alternative, the State must terminate the affected Work for the State's convenience.

(c) Once the Hazardous Material has been removed or rendered harmless by the State, the Contractor must resume Work as directed in writing by the State. Any determination by the Michigan Department of Community Health or the Michigan Department of Environmental Quality that the Hazardous Material has either been removed or rendered harmless is binding upon the State and Contractor for the purposes of resuming the Work. If any incident with Hazardous Material results in delay not reasonable anticipatable under the circumstances and which is attributable to the State, the applicable SLAs for the affected Work will not be counted in **Section 2.242** for a time as mutually agreed by the parties.

(d) If the Hazardous Material was brought to the site by the Contractor, or results in whole or in part from any violation by the Contractor of any laws covering the use, handling, storage, disposal of, processing, transport and transfer of Hazardous Material, or from any other act or omission within the control of the Contractor, the Contractor must bear its proportionate share of the delay and costs involved in cleaning up the site and removing and rendering harmless the Hazardous Material according to Applicable Laws to the condition approved by applicable regulatory agency(ies).

Michigan has a Consumer Products Rule pertaining to labeling of certain products containing volatile organic compounds. For specific details visit http://www.michigan.gov/deq/0,1607,7-135-3310_4108-173523--,00.html

Refrigeration and Air Conditioning:

The Contractor must comply with the applicable requirements of Sections 608 and 609 of the Clean Air Act (42 U.S.C. 7671g and 7671h) as each or both apply to the Contract.

Environmental Performance:

Waste Reduction Program: Contractor must establish a program to promote cost-effective waste reduction in all operations and facilities covered by the Contract. The Contractor's programs must comply with applicable Federal, State, and local requirements, specifically including Section 6002 of the Resource Conservation and Recovery Act (42 U.S.C. 6962, et seq.).

**2.300 Other Provisions**

2.311 Forced Labor, Convict Labor, Forced or Indentured Child Labor, or Indentured Servitude Made Materials
Equipment, materials, or supplies, that will be furnished to the State under the Contract must not be produced in whole or in part by forced labor, convict labor, forced or indentured child labor, or indentured servitude.

“Forced or indentured child labor” means all work or service: exacted from any person under the age of 18 under the menace of any penalty for its nonperformance and for which the worker does not offer himself voluntarily; or performed by any person under the age of 18 under a contract the enforcement of which can be accomplished by process or penalties.

2.400 Acceptance of terms and conditions stipulated in Article 2 of this CONTRACT:

Contractor Response:

MPRO agrees to the terms and conditions defined in Article 2 – Terms and conditions, including the HIPAA Business Associate Addendum (Addendum 1), of the State of Michigan Department of Management and Budget Purchasing Operations’ Request for Proposal No. 071I9200277. In addition, upon contract award, we will provide MDCH with a Certificate of Liability Insurance.



HOSPITAL ADMISSIONS REVIEW & CERTIFICATION FOR DEPARTMENT OF COMMUNITY HEALTH
Attachment A (Price Proposal)
Contract NO. 071B0200072

Program		Projected Volume/Month (estimated)	Total Annual Per Program (estimated)	Unit Price	One Year Pricing	Three Year Pricing
PACER	FFS Reviews	900/month	10,800	\$56.75	\$ 612,900	\$1,838,700
	FFS Appeals	RN=6.25 hours	75 hours	\$27.00/per half hour	\$ 4,050	\$ 12,150
		MD=6.25 hours	75 hours	\$77.00/per half hour	\$ 11,550	\$ 34,650
Audits	Inpatient	1 audit	15	\$43,250	\$ 648,750	\$1,946,250
	Outpatient	1 audit	15	\$28,000	\$ 420,000	\$1,260,000
SWUR	Inpatient	320 reviews/month	3,840	\$80.00	\$ 307,200	\$ 921,600
	Outpatient	320 reviews/month	3,840	\$80.00	\$ 307,200	\$ 921,600
LTC	Immediate Reviews	8.33/month	100	\$124.50	\$ 12,450	\$ 37,350
	Exception Reviews	13.33/month	160	\$65.00	\$ 10,400	\$ 31,200
	Immediate & Exc Appeals	RN=8.33/month	100 hours	\$27.00/per half hour	\$ 5,400	\$ 16,200
		MD=8.33/month	100 hours	\$77.00/per half hour	\$ 15,400	\$ 46,200
	Retrospective Reviews	150/month	1,800	\$35.00	\$ 63,000	\$ 189,000
	Retrospective Appeals	RN=41.66/month	500 hours	\$27.00/per half hour	\$ 27,000	\$ 81,000
		MD=20.83/month	250 hours	\$77.00/per half hour	\$ 38,500	\$ 115,500
	Grand Total				\$2,483,800	\$7,451,400

The task for Long Term Care is Immediate and Exception Appeals. The total is 8.33 hours per month for RN, Annual total of 100 hours. The total is 8.33 hrs per month for MD, Annual total of 100 hours. The task for Long Term Care is Retrospective Appeals. The total is 41.66 hrs per month for RN, Annual total of 500 hours. The Total is 20.83 hrs per month for MD, Annual total of 250 hours. InterQual® Criteria is currently utilized for Inpatient and Outpatient review.



**ATTACHMENT B
HIPAA BUSINESS ASSOCIATE ADDENDUM**

The parties to this Business Associate Addendum (“Addendum”) are the State of Michigan, acting by and through the Department of Management and Budget, on behalf of the Department of _____ (“State”) and _____, (“Contractor”). This Addendum supplements and is made a part of the existing contract(s) or agreement(s) between the parties including the following Contract(s): _____ (“Contract”).

For purposes of this Addendum, the State is (check one):

- Covered Entity (“CE”)
- Business Associate (“Associate”)

and Contractor is (check one):

- Covered Entity (“CE”)
- Business Associate (“Associate”)

RECITALS

- A. Pursuant to the terms of the Contract, CE wishes to disclose certain information to Associate, some of which may constitute Protected Health Information (“PHI”) (defined below). In consideration of the receipt of PHI, Associate agrees to protect the privacy and security of the information as set forth in this Addendum.
- B. CE and Associate intend to protect the privacy and provide for the security of PHI disclosed to Associate pursuant to the Contract in compliance with the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 (“HIPAA”) and regulations promulgated thereunder by the U.S. Department of Health and Human Services (the “HIPAA Regulations”) and other applicable laws, as amended.
- C. As part of the HIPAA Regulations, the Privacy Rule and the Security Rule (defined below) requires CE to enter into a contract containing specific requirements with Associate prior to the disclosure of PHI, as set forth in, but not limited to, 45 CFR §§ 160.103, 164.502(e), 164.504(e), and 164.314 and contained in this Addendum.



In consideration of the mutual promises below and the exchange of information pursuant to this Addendum, the parties agree as follows:

1. Definitions.

a. Except as otherwise defined herein, capitalized terms in this Addendum shall have the definitions set forth in the HIPAA Regulations at 45 CFR Parts 160, 162 and 164, as amended, including, but not limited to, subpart A, subpart C (“Security Rule”) and subpart E (“Privacy Rule”).

b. “Agreement” means both the Contract and this Addendum.

c. “Contract” means the underlying written agreement or purchase order between the parties for the goods or services to which this Addendum is added.

d. “Protected Health Information” or “PHI” means any information, whether oral or recorded in any form or medium: (i) that relates to the past, present or future physical or mental condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and (ii) that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual, and shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 CFR § 164.501.

e. “Protected Information” shall mean PHI provided by CE to Associate or created or received by Associate on CE’s behalf.

2. Obligations of Associate.

a. Permitted Uses. Associate shall not use Protected Information except for the purpose of performing Associate’s obligations under the Contract and as permitted under this Agreement. Further, Associate shall not use Protected Information in any manner that would constitute a violation of the HIPAA Regulations if so used by CE, except that Associate may use Protected Information: (i) for the proper management and administration of Associate; (ii) to carry out the legal responsibilities of Associate; or (iii) for Data Aggregation purposes for the Health Care Operations of CE. Additional provisions, if any, governing permitted uses of Protected Information are set forth in Attachment A to this Addendum.

b. Permitted Disclosures. Associate shall not disclose Protected Information in any manner that would constitute a violation of the HIPAA Regulations if disclosed by CE, except that Associate may disclose Protected Information: (i) in a manner permitted pursuant to the Contract and this Addendum; (ii) for the proper management and administration of Associate; (iii) as required by law; (iv) for Data Aggregation purposes for the Health Care Operations of CE; or (v) to report violations of law to appropriate federal or state authorities, consistent with 45 CFR § 164.502(j)(1). To the extent that Associate discloses Protected Information to a third party, Associate must obtain, prior to making any such disclosure: (i) reasonable assurances from such third party that such Protected Information will be held confidential as provided pursuant to this Addendum and only disclosed as required by law or for the purposes for which it was disclosed to such third party; and (ii) an agreement to implement reasonable and appropriate safeguards to protect the Protected Information; and (iii) an agreement from such third party to immediately notify Associate of any breaches of confidentiality of the Protected Information or any Security Incident, to the extent it has obtained knowledge of such breach. Additional provisions, if any, governing permitted disclosures of Protected Information are set forth in Attachment A.



c. Appropriate Safeguards. Associate shall implement appropriate Security Measures as are necessary to protect against the use or disclosure of Protected Information other than as permitted by the Contract or this Addendum. Associate shall maintain a comprehensive written information privacy and security program that includes Security Measures that reasonably and appropriately protect the Confidentiality, Integrity, and Availability of Protected Information relative to the size and complexity of the Associate's operations and the nature and scope of its activities.

d. Reporting of Improper Use or Disclosure. Associate shall report to CE in writing any use or disclosure of Protected Information, whether suspected or actual, other than as provided for by the Contract and this Addendum within ten (10) days of becoming aware of such use or disclosure. If the disclosure is a Major Disclosure, then the improper use or disclosure shall be reported within three (3) days. A Major Disclosure means any improper use or disclosure of over twenty-five percent (25%) of the Protected Information held by the Associate. CE and Associate will cooperate to mitigate the effects of any unauthorized use or disclosure and document the outcome.

e. Associate's Agents. If Associate uses one or more subcontractors or agents to provide services under this Agreement, and such subcontractors or agents receive or have access to Protected Information, each subcontractor or agent shall sign an agreement with Associate containing substantially the same provisions as this Addendum and further identifying CE as a third party beneficiary of the agreement with such subcontractors or agents in the event of any violation of such subcontractor or agent agreement. Associate shall implement and maintain sanctions against agents and subcontractors that violate such restrictions and conditions and shall mitigate the effects of any such violation.

f. Access to Protected Information. Associate shall make Protected Information maintained by Associate or its agents or subcontractors in Designated Record Sets available to CE for inspection and copying within ten (10) days of a request by CE to enable CE to fulfill its obligations to permit individual access to PHI under the Privacy Rule, including, but not limited to, 45 CFR § 164.524.

g. Amendment of PHI. Within ten (10) days of receipt of a request from CE for an amendment of Protected Information or a record about an individual contained in a Designated Record Set, Associate or its agents or subcontractors shall make such Protected Information available to CE for amendment and incorporate any such amendment to enable CE to fulfill its obligations with respect to requests by individuals to amend their PHI under the Privacy Rule, including, but not limited to, 45 CFR § 164.526. If any individual requests an amendment of Protected Information directly from Associate or its agents or subcontractors, Associate must notify CE in writing within ten (10) days of receipt of the request. Any denial of amendment of Protected Information maintained by Associate or its agents or subcontractors shall be the responsibility of CE.

h. Accounting Rights. Within ten (10) days of notice by CE of a request for an accounting of disclosures of Protected Information, Associate and its agents or subcontractors shall make available to CE the information required to provide an accounting of disclosures to enable CE to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 CFR § 164.528. As set forth in, and as limited by, 45 CFR § 164.528, Associate shall not provide an accounting to CE of disclosures made: (i) to carry out treatment, payment or health care operations, as set forth in 45 CFR § 164.506; (ii) to individuals of Protected Information about them as set forth in 45 CFR § 164.502; (iii) pursuant to 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); or (vi) to correctional institutions or law enforcement officials as set forth in 45 CFR § 164.512(k)(5).



Associate agrees to implement a process that allows for an accounting to be collected and maintained by Associate and its agents or subcontractors for at least six (6) years prior to the request, but not before the compliance date of the Privacy Rule. At a minimum, such information shall include: (i) the date of disclosure; (ii) the name of the entity or person who received Protected Information and, if known, the address of the entity or person; (iii) a brief description of Protected Information 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 individual's authorization, or a copy of the written request for disclosure. In the event that the request for an accounting is delivered directly to Associate or its agents or subcontractors, Associate shall within ten (10) days of the receipt of the request forward it to CE in writing. It shall be CE's responsibility to prepare and deliver any such accounting requested. Associate shall not disclose any Protected Information except as set forth in Section 2(b) of this Addendum.

i. Governmental Access to Records. Associate shall make its internal practices, books and records relating to the use and disclosure of Protected Information available to the Secretary of the U.S. Department of Health and Human Services (the "Secretary"), in a time and manner designated by the Secretary, for purposes of determining CE's compliance with the HIPAA Regulations. Associate shall provide to CE a copy of any Protected Information that Associate provides to the Secretary concurrently with providing such Protected Information to the Secretary.

j. Minimum Necessary. Associate (and its agents or subcontractors) shall only request, use and disclose the minimum amount of Protected Information necessary to accomplish the purpose of the request, use or disclosure, in accordance with the Minimum Necessary requirements of the Privacy Rule, including, but not limited to 45 CFR §§ 164.502(b) and 164.514(d).

k. Data Ownership. Unless otherwise specified in the Contract, Associate acknowledges that Associate has no ownership rights with respect to the Protected Information. The CE retains all rights with respect to ownership of the Protected Information.

l. Retention of Protected Information. Notwithstanding Section 5(d) of this Addendum, Associate and its subcontractors or agents shall retain all Protected Information throughout the term of the Contract and shall continue to maintain the information required under Section 2(h) of this Addendum for a period of six (6) 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 shall survive the termination of the Contract.

m. Destruction of Protected Information. Associate agrees to implement policies and procedures for the final disposition of electronic Protected Information and/or the hardware and equipment on which it is stored, including but not limited to, removal before re-use.

n. Notification of Breach. During the term of the Contract or this Addendum, Associate shall notify CE within twenty-four (24) hours of any suspected or actual breach of security, intrusion, or unauthorized use or disclosure of PHI and/or any actual or suspected use or disclosure of data in violation of any applicable federal or state laws or regulations. Associate shall take (i) prompt corrective action to cure any such deficiencies and (ii) any action pertaining to such unauthorized disclosure required by applicable federal and state laws and regulations. CE and Associate will cooperate to mitigate the effects on any breach, Security Incident, intrusion, or unauthorized use and document the Security Incident and its outcome.



o. Audits, Inspection and Enforcement. Within ten (10) days of a written request by CE, Associate and its agents or subcontractors shall allow CE to conduct a reasonable inspection of the facilities, systems, books, records, agreements, policies and procedures relating to the use or disclosure of Protected Information pursuant to this Addendum for the purpose of determining whether Associate has complied with this Addendum; provided, however, that: (i) Associate and CE shall mutually agree in advance upon the scope, timing and location of such an inspection; (ii) CE shall protect the confidentiality of all confidential and proprietary information of Associate to which CE has access during the course of such inspection; and (iii) CE or Associate shall execute a nondisclosure agreement, if requested by Associate or CE. The fact that CE inspects, or fails to inspect, or has the right to inspect, Associate's facilities, systems, books, records, agreements, policies and procedures does not relieve Associate of its responsibility to comply with this Addendum, nor does CE's (i) failure to detect or (ii) detection, but failure to notify Associate or require Associate's remediation of any unsatisfactory practices, constitute acceptance of such practice or a waiver of CE's enforcement rights under this Agreement.

p. Safeguards During Transmission. Associate shall be responsible for using Security Measures to reasonably and appropriately maintain and ensure the Confidentiality, Integrity, and Availability of Protected Information transmitted to CE pursuant to this Agreement, in accordance with the standards and requirements of the HIPAA Regulations, until such Protected Information is received by CE, and in accordance with any specifications set forth in Attachment A.



3. Obligations of CE.

a. Safeguards During Transmission. CE shall be responsible for using Security Measures to reasonably and appropriately maintain and ensure the Confidentiality, Integrity, and Availability of Protected Information transmitted to Associate pursuant to this Agreement, in accordance with the standards and requirements of the HIPAA Regulations, until such Protected Information is received by Associate, and in accordance with any specifications set forth in Attachment A.

b. Notice of Changes. CE shall provide Associate with a copy of its notice of privacy practices produced in accordance with 45 CFR § 164.520, as well as any subsequent changes or limitation(s) to such notice, to the extent such changes or limitations may effect Associate's use or disclosure of Protected Information. CE shall provide Associate with any changes in, or revocation of, permission to use or disclose Protected Information, to the extent it may affect Associate's permitted or required uses or disclosures. To the extent that it may affect Associate's permitted use or disclosure of Protected Information, CE shall notify Associate of any restriction on the use or disclosure of Protected Information that CE has agreed to in accordance with 45 CFR § 164.522.

4. Term. This Addendum shall continue in effect as to each Contract to which it applies until such Contract is terminated or is replaced with a new contract between the parties containing provisions meeting the requirements of the HIPAA Regulations, whichever first occurs. However, certain obligations will continue as specified in this Addendum.

5. Termination.

a. Material Breach. In addition to any other provisions in the Contract regarding breach, a breach by Associate of any provision of this Addendum, as determined by CE, shall constitute a material breach of the Agreement and shall provide grounds for termination of the Contract by CE pursuant to the provisions of the Contract covering termination for cause. If the Contract contains no express provisions regarding termination for cause, the following shall apply to termination for breach of this Addendum, subject to 5.b.:

(1) Default. If Associate refuses or fails to timely perform any of the provisions of this Addendum, CE may notify Associate in writing of the non-performance, and if not corrected within thirty (30) days, CE may immediately terminate the Agreement. Associate shall continue performance of the Agreement to the extent it is not terminated.

(2) Associate's Duties. Notwithstanding termination of the Agreement, and subject to any directions from CE, Associate shall take timely, reasonable and necessary action to protect and preserve property in the possession of Associate in which CE has an interest.

(3) Compensation. Payment for completed performance delivered and accepted by CE shall be at the Contract price.



(4) Erroneous Termination for Default. If after such termination it is determined, for any reason, that Associate was not in default, or that Associate's action/inaction was excusable, such termination shall be treated as a termination for convenience, and the rights and obligations of the parties shall be the same as if the contract had been terminated for convenience, as described in this Addendum or in the Contract.

b. Reasonable Steps to Cure Breach. If CE knows of a pattern of activity or practice of Associate that constitutes a material breach or violation of the Associate's obligations under the provisions of this Addendum or another arrangement and does not terminate this Agreement pursuant to Section 5(a), then CE shall take reasonable steps to cure such breach or end such violation, as applicable. If CE's efforts to cure such breach or end such violation are unsuccessful, CE shall either (i) terminate this Agreement, if feasible or (ii) if termination of this Agreement is not feasible, CE shall report Associate's breach or violation to the Secretary of the Department of Health and Human Services.

c. Reserved.

d. Effect of Termination.

(1) Except as provided in paragraph (2) of this subsection, upon termination of this Agreement, for any reason, Associate shall return or destroy all Protected Information that Associate or its agents or subcontractors still maintain in any form, and shall retain no copies of such Protected Information. If Associate elects to destroy the Protected Information, Associate shall certify in writing to CE that such Protected Information has been destroyed.

(2) If Associate believes that returning or destroying the Protected Information is not feasible, including but not limited to, a finding that record retention requirements provided by law make return or destruction infeasible, Associate shall promptly provide CE notice of the conditions making return or destruction infeasible. Upon mutual agreement of CE and Associate that return or destruction of Protected Information is infeasible, Associate shall continue to extend the protections of Sections 2(a), 2(b), 2(c), 2(d) and 2(e) of this Addendum to such information, and shall limit further use of such Protected Information to those purposes that make the return or destruction of such Protected Information infeasible.

6. Reserved.

7. No Waiver of Immunity. No term or condition of this Agreement shall be construed or interpreted as a waiver, express or implied, of 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, as applicable, as now in effect or hereafter amended.

8. Reserved.



9. Disclaimer. CE makes no warranty or representation that compliance by Associate with this Addendum, HIPAA or the HIPAA Regulations will be adequate or satisfactory for Associate's own purposes. Associate is solely responsible for all decisions made by Associate regarding the safeguarding of Protected Information.

10. Certification. To the extent that CE determines an examination is necessary in order to comply with CE's legal obligations pursuant to HIPAA relating to certification of its security practices, CE or its authorized agents or contractors, may, at CE's expense, examine Associate's facilities, systems, procedures and records as may be necessary for such agents or contractors to certify to CE the extent to which Associate's security safeguards comply with HIPAA, the HIPAA Regulations or this Addendum.

11. Amendment.

a. Amendment to Comply with Law. The parties acknowledge that state and federal laws relating to data security and privacy are rapidly evolving and that amendment of this Addendum 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, the Privacy Rule, the Security Rule and other applicable laws relating to the security or privacy of Protected Information. The parties understand and agree that CE must receive satisfactory written assurance from Associate that Associate will adequately safeguard all Protected Information. Upon the request of either party, the other party agrees to promptly enter into negotiations concerning the terms of an amendment to this Addendum embodying written assurances consistent with the standards and requirements of HIPAA, the Privacy Rule, the Security Rule or other applicable laws. CE may terminate the Agreement upon thirty (30) days written notice in the event (i) Associate does not promptly enter into negotiations to amend this Agreement when requested by CE pursuant to this Section or (ii) Associate does not enter into an amendment to this Agreement providing assurances regarding the safeguarding of PHI that CE, in its sole discretion, deems sufficient to satisfy the standards and requirements of HIPAA, the HIPAA Regulations and other applicable laws.

b. Amendment of Attachment A. Attachment A may be modified or amended by mutual agreement of the parties in writing from time to time without formal amendment of this Addendum.

12. Assistance in Litigation or Administrative Proceedings. Associate shall make itself, and any subcontractors, employees or agents assisting Associate in the performance of its obligations under this Agreement, available to CE, at no cost to CE, to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against CE, its directors, officers or employees, departments, agencies, or divisions based upon a claimed violation of HIPAA, the HIPAA Regulations or other laws relating to security and privacy of Protected Information, except where Associate or its subcontractor, employee or agent is a named adverse party.

13. No Third Party Beneficiaries. Nothing express or implied in this Agreement is intended to confer, nor shall anything herein confer, upon any person other than CE, Associate and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

14. Effect on Contract. Except as specifically required to implement the purposes of this Addendum, or to the extent inconsistent with this Addendum, all other terms of the Contract shall remain in force and effect. This Addendum is incorporated into the Contract as if set forth in full therein. The parties expressly acknowledge and agree that sufficient mutual consideration exists to make this Addendum legally binding in accordance with its terms. Associate and CE expressly waives any claim or defense that this Addendum is not part of the Agreement between the parties under the Contract.



15. Interpretation and Order of Precedence. This Addendum is incorporated into and becomes part of each Contract identified herein. Together, this Addendum and each separate Contract constitute the “Agreement” of the parties with respect to their Business Associate relationship under HIPAA and the HIPAA Regulations. The provisions of this Addendum shall prevail over any provisions in the Contract that may conflict or appear inconsistent with any provision in this Addendum. This Addendum and the Contract shall be interpreted as broadly as necessary to implement and comply with HIPAA and the HIPAA Regulations. The parties agree that any ambiguity in this Addendum shall be resolved in favor of a meaning that complies and is consistent with HIPAA and the HIPAA Regulations. This Addendum supercedes and replaces any previous separately executed HIPAA addendum between the parties. In the event of any conflict between the mandatory provisions of the HIPAA Regulations and the provisions of this Addendum, the HIPAA Regulations shall control. Where the provisions of this Addendum differ from those mandated by the HIPAA Regulations, but are nonetheless permitted by the HIPAA Regulations, the provisions of this Addendum shall control.

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

17. Survival of Certain Contract Terms. Notwithstanding anything herein to the contrary, Associate’s obligations under Section 5(d) and record retention laws (“Effect of Termination”) and Section 13 (“No Third Party Beneficiaries”) shall survive termination of this Agreement and shall be enforceable by CE as provided herein in the event of such failure to perform or comply by the Associate.

18. Representatives and Notice.

a. Representatives. For the purpose of this Agreement, the individuals identified in the Contract shall be the representatives of the respective parties. If no representatives are identified in the Contract, the individuals listed below are hereby 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.

b. Notices. All required notices shall be in writing and shall be hand delivered or given by certified or registered mail to the representatives at the addresses set forth below.

Covered Entity Representative:

Name: _____
Title: _____
Department and Division: _____
Address: _____

Business Associate Representative:

Name: _____
Title: _____
Department and Division: _____
Address: _____



Any notice given to a party under this Addendum shall be deemed effective, if addressed to such party, upon: (i) delivery, if hand delivered; or (ii) the third (3rd) Business Day after being sent by certified or registered mail.

IN WITNESS WHEREOF, the parties hereto have duly executed this Addendum as of the Addendum Effective Date.

Associate

Covered Entity

[INSERT NAME]

[INSERT NAME]

By: _____

By: _____

Date: _____

Date: _____

Print Name: _____

Print Name: _____

Title: _____

Title: _____



ATTACHMENT A (HIPAA)

This Attachment sets forth additional terms to the HIPAA Business Associate Addendum dated _____, between _____ and _____ (“Addendum”) and is effective as of _____ (the “Attachment Effective Date”). This Attachment applies to the specific contracts listed below covered by the Addendum. This Attachment may be amended from time to time as provided in Section 11(b) of the Addendum.

1. Specific Contract Covered. This Attachment applies to the following specific contract covered by the Addendum: _____

2. Additional Permitted Uses. In addition to those purposes set forth in Section 2(a) of the Addendum, Associate may use Protected Information as follows:

3. Additional Permitted Disclosures. In addition to those purposes set forth in Section 2(b) of the Addendum, Associate may disclose Protected Information as follows:

4. Subcontractor(s). The parties acknowledge that the following subcontractors or agents of Associate shall receive Protected Information in the course of assisting Associate in the performance of its obligations under the Contract and the Addendum:

5. Receipt. Associate’s receipt of Protected Information pursuant to the Contract and Addendum shall be deemed to occur as follows, and Associate’s obligations under the Addendum shall commence with respect to such PHI upon such receipt:

6. Additional Restrictions on Use of Data. CE is a Business Associate of certain other Covered Entities and, pursuant to such obligations of CE, Associate shall comply with the following restrictions on the use and disclosure of Protected Information:



7. Additional Terms. *[This section may include specifications for disclosure format, method of transmission, use of an intermediary, use of digital signatures or PKI, authentication, additional security of privacy specifications, de-identification or re-identification of data and other additional terms.]*

Associate

Covered Entity

[INSERT NAME]

[INSERT NAME]

By: _____

By: _____

Print Name: _____

Print Name: _____

Title: _____

Title: _____

Date: _____

Date: _____

s:sa/ac/ga/2002 2002017913A HIPAA Michigan Model BA Addendum



REFERENCED ATTACHMENTS

**ATTACHMENT B
HOSPITAL ADEQUATE ACTION NOTICE
Denial of Service**

Date

Beneficiary Name
Beneficiary AddressRE: Beneficiary Name
Beneficiary Medicaid ID #

Dear (Beneficiary Name):

(Contractor Name), the contractor for the State of Michigan's Prior Authorization Certification Evaluation Review Program, has received a request from your physician for services for Medicaid or Medicaid/CSHCS dually enrolled coverage under this contract. Following a review of the services for which you have applied, it has been determined that the following service(s) shall not be authorized. The reason for this action is the physician reviewer determined that the admission and procedure are not medically necessary. The documentation did not support symptomatology that would warrant an acute care admission/procedure. Therefore, authorization for the admission has been denied. The legal basis for this decision is 42CFR440.230(d).

Service(s)**Effective Date**

If you do not agree with this action, you may request a Michigan Department of Community Health (department) hearing within 90 days of the date of this notice. Hearing requests must be made in writing and signed by you or your authorized representative.

To request a departmental hearing, complete the "Request for Hearing" form, and return it in the enclosed envelope, or mail to:

State Office of Administrative Hearings and Rules
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
P.O. BOX 30763
LANSING, MI 48909-7695

If you have any questions about this denial, you may call the Contractor Manager for the (Contractor Name) Contract at (phone number).

If you want to know more about how a departmental hearing works, call (877) 833-0870.

Enclosures:

REFERENCED ATTACHMENTS (continued)Hearing Request Form
Return Envelope



ATTACHMENT C

HOSPITAL ADVANCE ACTION NOTICE
Suspension, Reduction or Termination

Date

Name

Address

City, State, Zip

RE: Beneficiary's Name

Beneficiary's Medicaid ID Number

Dear _____:

(Contractor name), the contractor for the State of Michigan's Prior Authorization Certification Evaluation Review Program, has received a request from your physician for services for Medicaid, or Medicaid/CSHCS dually enrolled coverage under this contract. Following a review of the services that you are currently receiving, it has been determined that the following service(s) shall not be authorized. The reason for this action is _____

_____. The legal basis for this decision is 42CFR440.230(d).

Service(s)

Effective Date

If you do not agree with this action, you may request a Michigan Department of Community Health (department) hearing within 90 days of the date of this notice. Hearing requests must be made in writing and signed by you or your authorized representative.

To request a departmental hearing, complete the "Request for Hearing" form, and return it in the enclosed envelope, or mail to:

State Office of Administrative Hearings and Rules
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
P.O. BOX 30763
LANSING, MI 48909-7695

You will continue to receive the affected services in most circumstances until the hearing decision is rendered if your request for a department hearing is received prior to the effective date of action.

If you continue to receive benefits because you requested a department hearing you may be required to repay the benefits. This will occur if:

- The proposed termination or denial of benefits is upheld in the hearing decision.
You withdraw your hearing request.
You or the person you asked to represent you does not attend the hearing.

If you have any questions about this denial, you may call the Contractor Manager for the (Contractor Name) Contract at (phone number).

If you want to know more about how a departmental hearing works, call (877) 833-0870.

Enclosures:

Hearing Request Form

Return Envelope

**REFERENCED ATTACHMENTS (Continued)****ATTACHMENT D****LONG TERM CARE
Adequate Action Notice**

Date:
Name:
Address:
City, State, Zip Code

Dear _____:

Following a review of your long term care needs, it has been determined that you do not qualify for nursing facility level services based on the Michigan Medicaid Nursing Facility Level of Care Determination. You did not qualify under any of the following eligibility categories: Activities of Daily Living, Cognition, Physician Involvement, Treatments and Conditions, Skilled Rehabilitative Therapies, Behavior, or Service Dependencies. The legal basis for this decision is 42 CFR 440.230 (d).

If you do not agree with this action, you may request all or any of the following:

Medicaid Fair Hearing: to request a Medicaid Fair Hearing, complete a "Request for an Administrative Hearing" (DCH-0092) form and mail it to:

**State Office of Administrative Hearings and Rules
Michigan Department of Community Health
P.O. Box 30763
Lansing, Michigan 48909**

The Medicaid Fair Hearing Request **must** be

- **Received within 90 calendar days of the date of this notice**
- In writing, and
- Signed by you or a person authorized to sign for you

Sincerely,
(provider representative)

**REFERENCED ATTACHMENTS (CONTINUED)****ATTACHMENT E****LONG TERM CARE
Advance Action Notice**

Date:
Name:
Address:
City, State, Zip Code

Dear _____:

Following a review of your long term care needs, it has been determined that you no longer qualify for nursing facility level services based on the Michigan Medicaid Nursing Facility Level of Care Determination. You did not qualify under any of the following eligibility categories: Activities of Daily Living, Cognition, Physician Involvement, Treatments and Conditions, Skilled Rehabilitative Therapies, Behavior, or Service Dependencies. Nursing facility level services will be terminated 90 days from the date of this notice. The final date of nursing facility level services will be _____. The legal basis for this decision is 42 CFR 440.230 (d).

If you do not agree with this action, you may request all or any of the following:

Medicaid Fair Hearing: to request a Medicaid Fair Hearing, complete a "Request for an Administrative Hearing" (DCH-0092) form and mail it to:

**State Office of Administrative Hearings and Rules
Michigan Department of Community Health
P.O. Box 30763
Lansing, Michigan 48909**

The Medicaid Fair Hearing Request **must** be"

- **Received within 90 calendar days of the date of this notice**
- In writing, and
- Signed by you or a person authorized to sign for you

You will continue to receive the affected services until the hearing decision is rendered **if** your request for a fair hearing is received prior to the effective date of action as stated above.

Sincerely,
(provider representative)



REFERENCED ATTACHMENTS (Continued)

ATTACHMENT F

REQUEST for HEARING

INSTRUCTIONS

You may use this form to request a hearing. You may also submit your hearing request in writing on any paper.

A hearing is an impartial review of a decision made by the Michigan Department of Community Health or one of its contract agencies that client believes is wrong.

GENERAL INSTRUCTIONS:

- Read ALL instructions FIRST, then remove this instruction sheet before completing the form.
- Complete **Section 1**.
- Complete **Section 2** only if you want someone to represent you at the hearing.
- **Do NOT** complete Section 4.
- Please use a PEN and PRINT FIRMLY.
- If you have any questions, please call toll free: **1 (877) 833 - 0870**.
- Remove the BOTTOM (**Yellow**) copy and save with the instruction sheet for your records.
- After you complete this form, mail it in the enclosed self addressed, postage paid envelope or mail to:

STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES

FOR THE DEPARTMENT OF COMMUNITY HEALTH

PO BOX 30763

LANSING MI 48909

- You may choose to have another person represent you at a hearing.
 - This person can be anyone you choose but he/she must be at least 18 years of age.
 - You **MUST** give this person written permission to represent you. You may give written permission by checking **YES** in **SECTION 2** and **having the person who is representing you complete SECTION 3. You MUST still complete and sign SECTION 1.**
 - Your guardian or conservator may represent you. A copy of the Court Order naming the guardian/conservator must be included with this request.

- *The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, marital status, political beliefs or disability.*
- *If you need help with reading, writing, or hearing, you are invited to make your needs known to the Department of Community Health.*

If you do not understand this, call the Department of Community Health at (877) 833-0870.

Si Ud. no entiende esto, llame a la oficina del Departamento de Salud Comunitaria.

إذا لم تفهم هذا، اتصل بإدارة الصحة المحلية التابعة لولاية ميتشيجن.

1 (877) 833 - 0870

Completion: Is Voluntary



REFERENCED ATTACHMENTS (Continued)

REQUEST FOR HEARING
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES FOR THE DEPARTMENT OF COMMUNITY HEALTH
PO BOX 30763
LANSING, MI 48909
1 (877) 833-0870

SECTION 1 – To be completed by PERSON REQUESTING A HEARING:

Your Name			Your Telephone Number ()	Your Social Security Number	
Your Address (No. & Street, Apt. No.)			Your Signature		Date Signed
City	State	ZIP Code			
What Agency took the action or made the decision that you are appealing.				Case Number	
I WANT TO REQUEST A HEARING: The following are my reasons for requesting a hearing. Use Additional Sheets if Needed. <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>					
Do you have physical or other conditions requiring special arrangements for you to attend or participate in a hearing? <input type="checkbox"/> NO <input type="checkbox"/> YES (Please Explain in Here):					

SECTION 2 – Have you chosen someone to represent you at the hearing?

Has someone agreed to represent you at a hearing? <input type="checkbox"/> NO <input type="checkbox"/> YES (If YES, have the individual complete section 3)
--

SECTION 3 – Authorized Hearing Representative Information:

Name of Representative			Representative Telephone Number ()		
Address (No. & Street, Apt. No.)			Representative Signature		Date Signed
City	State	ZIP Code			

SECTION 4 – To be completed by the AGENCY distributing this form to the client

Name of Agency			AGENCY Contact Person Name		
AGENCY Address (No. & Street, Apt. No.)			AGENCY Telephone Number ()		
City	State	ZIP Code	State Program or Service being provided to this appellant		

DCH-0092 (SOAHR) (Rev 3/06)

DISTRIBUTION: WHITE (2nd page) Administrative Tribunal, YELLOW - Person Requesting Hearing

**REFERENCED ATTACHMENTS (Continued)****ATTACHMENT G****Annotations**

DOC (documented), meaning the service conformed to Program regulations, policies and procedures.

NF (not found), meaning the provider did not provide any record substantiating that the service was performed.

NS-1 (not supported), meaning the service was improperly billed.

NS-2, meaning the service is not a covered benefit of the Program.

NS-3, meaning the service was not medically necessary.

NS-4, meaning the record(s) was insufficient to support the service paid by the Program.

NS-7, meaning the record(s) was illegible.

RC, meaning that the record did not support the service paid but supported another service. The procedure code for the appropriate service will be annotated beneath the printed procedure code.

RC/UP (recoded underpayment), meaning that the record did not support the service paid but supported another service. The procedure code for the appropriate service will be annotated beneath the printed procedure code. If this results in an underpayment to the provider the annotation will be reflected by RC/UP (recoded underpayment).



REFERENCED ATTACHMENTS (Continued)

ATTACHMENT H

[Outpatient Letter]

DATE

Jane Doe
Utilization Review Specialist
Sample Road
Anywhere, MI xxxxx

Dear Ms. Doe:

The (Contractor Name) as a contracted agent of the Michigan Department of Community Health, is currently performing a audit of your Provider Type 40 (Outpatient Hospital) facility. As I explained during my telephone conversation, this post payment medical record review is being conducted to determine compliance with Medicaid policy and guidelines.

This letter is to confirm our appointment scheduled for _____ and _____ at _____ a.m. in your facility. These visits are to copy records for approximately two hundred fifty (250) Medicaid beneficiaries for whom you provided services for the review period of 1/1/200_ thru 12/31/200_. All Outpatient Services for the beneficiaries included in the sample, for the review period are needed. Examples of some of the Outpatient Hospital services that may be included are: laboratory, radiology, Emergency Room visits, physical therapy etc. Some of the services may include items that are series billed such as physical therapy visits. An itemized bill is needed for the following Revenue Center Codes 250, 251, 252, 257, 258, 259, 260, 262, 270, 271, 272, and 370. The dates of service that require the itemized bill are highlighted on the case listing.

In addition to myself there will be another nurse reviewer. We will require a room with an electrical outlet and will be bringing equipment to your facility. You will be furnished with a beneficiary list thirty (30) calendar days prior to our arrival. It is estimated we will need _____ days at your facility to copy the records.

If you have any questions regarding this correspondence or if there is difficulty locating a record and you need assistance identifying the Outpatient Hospital service provided please call. I can be reached at (---) --- - ----.

Thank-you again for your cooperation and continued participation in the Medicaid Program.

Sincerely,

_____ RN, _____
ADDRESS

Cc: CEO

**REFERENCED ATTACHMENTS (Continued)****ATTACHMENT H1
[Inpatient Letter]****DATE**

Jane Doe
Utilization Review Specialist
Sample Road
Anywhere, MI xxxxx

Dear Ms. Doe:

The (Contractor Name) as a contracted agent of the Michigan Department of Community Health is currently performing an audit of your Provider Type 30 (Inpatient Hospital) facility. As I explained during my telephone conversation, this post payment medical record review is being conducted to determine compliance with Medicaid policy and guidelines.

This letter is to confirm our appointment scheduled for _____ and _____ at _____ a.m. in your facility. These visits are to copy records for approximately two hundred fifty (250) Medicaid beneficiaries for whom you provided services for the review period of 1/1/200_ thru 12/31/200_. The beneficiaries may have more than one (1) Inpatient Hospital admission during the audit review period. All admissions for the beneficiaries included in the sample for the audit timeframe are needed.

In addition to myself there will be another nurse reviewer. We will require a room with an electrical outlet and will be bringing equipment to your facility. You will be furnished with a beneficiary list thirty (30) calendar days prior to our arrival. It is estimated we will need _____ days at your facility to copy the records.

If you have any questions regarding this correspondence or if there is difficulty locating a record and you need assistance identifying the Inpatient Hospital admission please call. I can be reached at (---) --- - ----.

Thank-you again for your cooperation and continued participation in the Medicaid Program.

Sincerely,

_____ RN, _____

ADDRESS

Cc: CEO

**REFERENCED ATTACHMENTS (Continued)****ATTACHMENT I
DATE**

Jane Doe
Utilization Review Specialist
Sample Road
Anywhere, MI xxxxx

Dear Ms. Doe:

Attached you will find a list of the records that are missing from the audit sample. As per our telephone conversation this afternoon, please send me all records you are able to locate within ten (10) business days of the date of this letter. Any record not found for this audit will be considered Not Found (NF) and monies will be recouped accordingly.

If you have any questions regarding this correspondence please call. I can be reached at (---) -----.

Thank-you again for your cooperation and continued participation in the Medicaid Program.

Sincerely,

____RN, _____
Contractor Name
Contractor Address

CC:CEO



Attachment I cont'

BENEFICIARY NAME	MEDICAID ID NUMBER	DATE OF BIRTH	DATES OF SERVICE	SERVICE PROVIDED
Xxxx xxxxx	#####	D/M/YY	1/15/98-1/16/98	Newborn care
Xxxx xxxxx	#####	D/M/YY	3/20/98-5/8/98	Newborn care
Xxxx xxxxx	#####	D/M/YY	6/30/98-9/15/98	Newborn care, circumcision
Xxxx xxxxx	#####	D/M/YY	7/12/98-7/27/98	Newborn care, circumcision



REFERENCED ATTACHMENTS (Continued)

ATTACHMENT J

Nurse Review Report

For

Case Number:

ID Number:

Review Period: **thru**

Sample Size: Stratum
Stratum

Missing Records:

Review By: _____
(Signature)

Date:

(Organization Name)
(Organization Address)

**Provider Name**

Nurse Review Report

Reason For Review:

This review was conducted to determine compliance with Medicaid Policy and guidelines.

Sample Statistics:

Review Period:

Run Date:

I.D. Number:

Total Payments:

Sample Payments:

Total Beneficiaries:

Sample Beneficiaries:

Total Claims:

Sample Claims:

Summary of Field Activities:

The on-site visits were conducted on _____ at _____.
_____ was our contact person. All available medical records were copied. _____ assisted in the copying of records.

Nurse Review Findings:

(This section summarizes the results of the audit review. Policy and Procedure, as well as Procedure and Revenue Codes should be referenced where applicable. Examples stating the stratum and beneficiary number should be listed with each finding. In addition to the above, every finding should include an attachment which contains a copy of the policy, procedure and revenue code supporting the finding.)



REFERENCED ATTACHMENTS (Continued)

ATTACHMENT K

ADEQUATE ACTION NOTICE

Denial of Service

Date

Beneficiary Name

Beneficiary Address

RE: Beneficiary Name

Beneficiary Medicaid ID #

Dear (Beneficiary Name):

(Contractor Name), the contractor for the State of Michigan's Prior Authorization Certification Evaluation Review Program, has received a request from your physician for services for Medicaid Long Term Care Services. Following a review of the services for which you have applied, it has been determined that the following service(s) shall not be authorized. It has been determined that you do not meet the functional/medical eligibility requirements for this program. Therefore, authorization for the admission has been denied. The legal basis for this decision is the 42CFR 440.230(d).

Service(s)

Effective Date

If you do not agree with this action, you may request a Michigan Department of Community Health (department) hearing within 90 days of the date of this notice. Hearing requests must be made in writing and signed by you or your authorized representative.

To request a departmental hearing, complete the "Request for Hearing" form, and return it in the enclosed envelope, or mail to:

State Office of Administrative Hearings and Rules
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
P.O. BOX 30763
LANSING, MI 48909-7695

If you have any questions about this denial, you may call the Contractor Manager for the (Contractor Name) Contract at (phone number).

If you want to know more about how a departmental hearing works, call (877) 833-0870.

Enclosures:
Hearing Request Form
Return Envelope



REFERENCED ATTACHMENTS (Continued)

ATTACHMENT L

ADVANCE ACTION NOTICE
Suspension, Reduction or Termination

Date

Name

Address

City, State, Zip

RE: Beneficiary's Name
Beneficiary's Medicaid ID Number

Dear _____:

(Contractor name), the contractor for the State of Michigan's Prior Authorization Certification Evaluation Review Program, has received a request from your physician for Medicaid Long Term Care Services. Following a review of the services that you are currently receiving, it has been determined that the following service(s) shall not be authorized. The reason for this action is _____. The legal basis for this decision is 42CFR 440.230(d).

Service(s) Effective Date

If you do not agree with this action, you may request a Michigan Department of Community Health (department) hearing within 90 days of the date of this notice. Hearing requests must be made in writing and signed by you or your authorized representative.

To request a departmental hearing, complete the "Request for Hearing" form, and return it in the enclosed envelope, or mail to:

State Office of Administrative Hearings and Rules
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
P.O. BOX 30763
LANSING, MI 48909-7695

You will continue to receive the affected services in most circumstances until the hearing decision is rendered if your request for a department hearing is received prior to the effective date of action.

If you continue to receive benefits because you requested a department hearing you may be required to repay the benefits. This will occur if:

- The proposed termination or denial of benefits is upheld in the hearing decision.
You withdraw your hearing request.
You or the person you asked to represent you does not attend the hearing.

If you have questions about this denial, you may call the Contract Manager for the Contract at (517)-----. If you want to know more about how a departmental hearing works, call (877) 833-0870.

Enclosures:
Hearing Request Form
Return Envelope



REFERENCED ATTACHMENTS (Continued)

ATTACHMENT N5 (Outpatient Education Letter)

(Contractor Name)

Address

{ insert phone number }

Addressee: {CEO }

Date:

Beneficiary Name:

Beneficiary ID:

<Provider name>

Birth Date:

<Pro Address 1>

Hospital:

<Pro Address 2>

Provider ID:

<Pro city, state zip>

Date of Service:

CRN:

Line Item:

Dear <Contact person>:

Under a contract with the Michigan Department of Community Health (MDCH), the (Contractor) has the legal responsibility to conduct review of health care provided to Michigan Medicaid beneficiaries. As a part of this contract, (Contractor) conducts post-payment review with validation of the medical record and the outpatient claim to verify that services were performed in the appropriate setting; services are performed in compliance with Medicaid Program Policy and Federal State Statutes; services performed are in compliance with current professional standards of care; services performed are medically necessary in scope, duration, and intensity; that the correct procedure/revenue center/APC codes were utilized; services performed show adherence to EMTALA; that quality of care will be reviewed; the amount billed e.g., quantity, units were appropriate.

Recently (Contractor) requested the medical record to validate the services provided to the above beneficiary for the date of service listed above. The information sent to (Contractor) was reviewed and the following issue(s) was/were identified:

Billed by Facility:

Line	Code	Description	Service Date	Quantity	APC Code

Recommended Adjustment:

Line	Code	Description	Service Date	Quantity	APC Code



Comments:

This letter is being provided to you for educational purposes and should be utilized to prevent further reoccurrences of the issue described above. This review will not result in any financial recoveries.

If you have any questions concerning this letter, please contact *{insert name}* at *{insert phone number}*.

Sincerely,

{Name of person doing review}

{Title}

**REFERENCED ATTACHMENTS (Continued)****ATTACHMENT O****NURSING FACILITY RETROSPECTIVE REVIEW NOTIFICATION****DATE:****NAME:****ADDRESS:****CITY, STATE, ZIP****Dear Administrator/Director of Nursing:**

In accordance with the Medicaid Provider Manual, Nursing Facility Coverages Chapter, Section 4.1.D.5, Retrospective Review and Medicaid Recovery, the Michigan Department of Community Health (MDCH) will perform Retrospective Reviews of the Michigan Medicaid Nursing Facility Level of Care Determination (LOC Determination), randomly and whenever indicated. The (Contractor) is the contractor for MDCH's Retrospective Reviews.

Attached are the case listing and label(s) for the nursing facility resident's(s') medical records that must be submitted by the provider, and received by (Contractor), within thirty (30) calendar days from the date of this letter.

The enclosed case listings include selections based on completion of the LOC Determination for a specific review period. The beginning and end dates of the review period may or may not correspond directly with the admission and/or discharge dates for this beneficiary. The submitted record must include all required documentation for any care provided during this period that will be billed to Medicaid, including, but not limited to, the following:

1. Copy of the LOC Determination
2. Copy of the **Signed Computer-Generated** Freedom of Choice Form or **Signed Hard Copy** Freedom of Choice form **attached to the Computer-Generated** Freedom of Choice form
3. PASARR evaluation-level 1, and level 2 when indicated (Form-DCH-3877 and 3878)
4. All Minimum Data Set documents for the period under review
5. Face sheet
6. Original History and Physical
7. Physician Orders for the period under review
8. All nursing notes, rehabilitation notes, physician progress notes, or interdisciplinary team notes for the period under review
9. Skilled therapy evaluations and progress notes for the period under review



10. Discharge plans
11. Medicare Recertification/Certification form

Again, copies of the above mentioned resident's (s') medical records for this review must be submitted to, and received by, (Contractor) within thirty (30) calendar days from the date of this letter, therefore, the due date for the above medical records is_____.

Failure to provide (Contractor) with the requested medical records will result in a technical denial, which imposes a monetary penalty. Please attach the enclosed label to the medical record file and mail it to:

LTC Medicaid Medical Review
Contractor Name
Address

If you have any questions, please contact (*Contract Representative*) at (---).

Sincerely,

Director, Medical Review Services
Enclosures: Label(s) and Case Listing

**REFERENCED ATTACHMENTS (Continued)****ATTACHMENT P****MI CHOICE WAIVER RETROSPECTIVE REVIEW NOTIFICATION****DATE:****NAME:****ADDRESS:****CITY, STATE, ZIP****Dear Administrator/Director of Nursing:**

In accordance with the Medicaid Provider Manual, Nursing Facility Coverages Chapter, Section 4.1.D.5, Retrospective Review and Medicaid Recovery, the Michigan Department of Community Health (MDCH) will perform Retrospective Reviews of the Michigan Medicaid Nursing Facility Level of Care Determination (LOC Determination), randomly and whenever indicated. The (Contractor) is the contractor for MDCH's Retrospective Reviews.

Attached are the case listing and label(s) for the MI Choice Waiver participant's(s') medical records that must be submitted by the provider, and received by (Contractor), within thirty (30) calendar days from the date of this letter.

The enclosed case listings include selections based on completion of the LOC Determination for a specific review period. The beginning and end dates of the review period may or may not correspond directly with the admission and/or discharge dates for this beneficiary. The submitted record must include all required documentation for any care provided to the participant(s) during this period that will be billed to Medicaid, including, but not limited to, the following:

1. Copy of the LOC Determination
2. Copy of the **Signed Computer-Generated** Freedom of Choice Form or copy of the **Signed Hard Copy** Freedom of Choice form **attached to the Computer-Generated** Freedom of Choice form.
3. Minimum Data Set –Home Care Assessment documents for the period under review
4. All available medical records for the period under review
5. All physician notes and orders for the period under review
6. All MI Choice Program contact notes from the family, friends or the participant for the period under review
7. MI Choice Program's Plan of Care for the participant during the period of review

Again, copies of the above medical records for the participant's (s') review must be submitted to, and received by, (Contractor) within thirty (30) calendar days from the date of this letter, therefore, the due date for the above medical records is **(Date)**.



Failure to provide (Contractor) with the requested medical record will result in a technical denial, which imposes a monetary penalty. Please attach the enclosed label to the medical record file and mail it to:

LTC Medicaid Medical Review
Contractor
Address

If you have any questions, please contact (name) at (phone number).

Sincerely,

Director, Medical Review Services
Enclosures: Label(s) and Case Listing

**REFERENCED ATTACHMENTS (Continued)****ATTACHMENT Q****INCOMPLETE RETROSPECTIVE REVIEW MEDICAL RECORD REMINDER-PENDING
TECHNICAL DENIAL****DATE:****NAME:****ADDRESS:****CITY, STATE, ZIP**

RE: (Beneficiary's Name)

Dear Administrator/Director of Nursing/MI Choice Program Director:

In accordance with the Medicaid Provider Manual, Nursing Facility Coverages Chapter, Section 4.1.D.5, Retrospective Review and Medicaid Recovery, the Michigan Department of Community Health (MDCH) will perform Retrospective Reviews of the Michigan Medicaid Nursing Facility Level of Care Determination (LOC Determination), randomly and whenever indicated. The (Contractor) is the contractor for MDCH's Retrospective Reviews.

On (DATE) the following medical records were requested from your facility for the review period from (DATE) to (DATE) Beneficiary Medicaid ID: (Medicaid ID)

The medical records listed below, as requested in the previous notice, must be received by the Contractor within **fourteen (14) calendar** days from the date of this letter. Should the requested documentation not be received by (date), a notice of Retrospective Review Final Technical Denial will be forwarded to MDCH for further action by the Department.

1. (List Item)
2. (List Item)
3. (List Item)

If you have any questions, please contact (name) at (phone number).

LTC Medicaid Medical Review
Contractor
Address

Sincerely,

Director, Medical Review Services
Enclosures: Label(s) and Case Listing

**REFERENCED ATTACHMENTS (Continued)****ATTACHMENT R****FINAL TECHNICAL DENIAL****DATE:****NAME:****ADDRESS:****CITY, STATE, ZIP****RE:** Notice of Final Denial

In accordance with the Medicaid Provider Manual, Nursing Facility Coverages Chapter, Section 4.1.D.5, Retrospective Review and Medicaid Recovery, the Michigan Department of Community Health (MDCH) will perform Retrospective Reviews of the Michigan Medicaid Nursing Facility Level of Care Determination (LOC Determination), randomly and whenever indicated. The (Contractor) is the contractor for MDCH's Retrospective Reviews.

On (date) Contractor sent a INCOMPLETE RETROSPECTIVE REVIEW MEDICAL RECORD-PENDING TECHNICAL DENIAL letter to your (facility/agency) based upon non-compliance to the request of medical records to conduct Retrospective Reviews on behalf of MDCH, in compliance with state policy. Medical records as requested in the INCOMPLETE RETROSPECTIVE REVIEW MEDICAL RECORD-PENDING TECHNICAL DENIAL letter were not forwarded to (Contractor) as requested in that notice.

Notice of RETROSPECTIVE REVIEW FINAL TECHNICAL DENIAL will be forwarded to MDCH as notice of inaction by you (facility/agency) to the requests made by (Contractor).

Sincerely,

(*Contract Representative*), RN
Director, Medical Review Services

**REFERENCED ATTACHMENTS (Continued)****ATTACHMENT S****NURSING FACILITY RETROSPECTIVE REVIEW DETERMINATION****DATE:****NAME:****ADDRESS:****CITY, STATE, ZIP**

RE: (beneficiary's name)

Dear Administrator/Director of Nursing,

In accordance with the Medicaid Provider Manual, Nursing Facility Coverages Chapter, Section 4.1.D.5, Retrospective Review and Medicaid Recovery, the Michigan Department of Community Health (MDCH) will perform Retrospective Reviews of the Michigan Medicaid Nursing Facility Level of Care Determination (LOC Determination), randomly and whenever indicated. The (Contractor) is the contractor for MDCH's Retrospective Reviews.

The Contractor nurse reviewer has conducted a Retrospective Review by evaluating the case record documentation submitted by your facility for the above beneficiary for the review period beginning (date) through (date). Based upon the Retrospective Review conducted by (Contractor), it has been determined that:

This is an informational letter to assist your facility in understanding and implementing MDCH policy, in particular, regarding Informed Choice, Preadmission Screening and Quarterly and Annual Resident Review requirements. Data from these reviews have been forwarded to MDCH for further evaluation and trending as needed. Continued non-adherence to policy may result in further action by MDCH.

Questions may be forwarded to (name) at:

LTC Medicaid Medical Review
Contractor
Address

Sincerely,

(Contract Representative), RN
Director, Medical Review Services

**REFERENCED ATTACHMENTS (Continued)****ATTACHMENT T****MI CHOICE WAIVER RETROSPECTIVE REVIEW REMINDER****DATE:****NAME:****ADDRESS:****CITY, STATE, ZIP**

RE: (beneficiary's name)

Dear Administrator/Director of Nursing:

In accordance with the Medicaid Provider Manual, Nursing Facility Coverages Chapter, Section 4.1.D.5, Retrospective Review and Medicaid Recovery, the Michigan Department of Community Health (MDCH) will perform Retrospective Reviews of the Michigan Medicaid Nursing Facility Level of Care Determination (LOC Determination), randomly and whenever indicated. The (Contractor) is the contractor for MDCH's Retrospective Reviews.

The Contractor nurse reviewer has conducted a Retrospective Review by evaluating the case record documentation submitted by your agency for the above beneficiary for the review period beginning (date) through (date). Based upon the Retrospective Review conducted by (Contractor), it has been determined that:

This is an informational letter to assist your agency in understanding and implementing MDCH policy, in particular, regarding Informed Choice, and Annual MDS-HC Assessments requirements. Data from these reviews have been forwarded to MDCH for further evaluation and trending as needed. Continued non-adherence to policy may result in further action by MDCH.

Questions may be forwarded to (name) at:

LTC Medicaid Medical Review
Contractor
Address

Sincerely,

(*Contract Representative*), RN
Director, Medical Review Services

