Form No. DTMB-3522 (Rev. 4/2012)
AUTHORITY: Act 431 of 1984
COMPLETION: Required
PENALTY: Contract will not be executed unless form is filed

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

CONTRACT NO. 071B5500015

between

THE STATE OF MICHIGAN

and

NAME & ADDRESS OF CONTRACTOR:	PRIMARY CONTACT	EMAIL
Meridian Health Plan of Michigan, Inc.	Vijay Kotte	vijay.kotte@mhplan.com
777 Woodward Ave., Suite 600	TELEPHONE	CONTRACTOR #, MAIL CODE
Detroit, MI 48226	313-324-3700	

STATE CONTACTS	AGENCY	NAME	PHONE	EMAIL
CONTRACT COMPLIANCE INSPECTOR:	MDCH	Kevin Dunn	517-335-5096	Dunnk3@michigan.gov
BUYER:	DTMB	Lance Kingsbury	517-284-7017	kingsburyl@michigan.gov

CONTRACT SUMMARY:

DESCRIPTION: Demonstration Program to Integrate Care for Persons Eligible for Medicare and Medicaid

INITIAL TERM	EFFECTIVE DATE	INITIAL EXPIRATION DATE	AVAILABLE OPTIONS
1 Year; 3 months	October 1, 2014	December 31, 2015	2, 1 Year Options
PAYMENT TERMS	**F.O.B**	**SHIPPED**	**SHIPPED FROM**
N/A	N/A	N/A	N/A

ALTERNATE PAYMENT OPTIONS:			AVAILABLE TO MiDEAL PARTICIPANTS	
☐ P-card	☐ Direct Voucher (DV)	☐ Other	☐ YES	☒ NO

MINIMUM DELIVERY REQUIREMENTS:

MISCELLANEOUS INFORMATION:

ESTIMATED CONTRACT VALUE AT TIME OF EXECUTION:	$125,000,000.00

THIS IS NOT AN ORDER: This Contract Agreement is awarded on the basis of our inquiry bearing the solicitation #0071141113B0000292. Orders for delivery will be issued directly by the Department of Technology, Management & Budget through the issuance of a Purchase Order Form.

Notice of Contract #: 071B5500015

FOR THE CONTRACTOR:	**FOR THE STATE:**
Meridian Health Plan of Michigan, Inc.	
Firm Name	Signature
Authorized Agent Signature	Name/Title
	DTMB Procurement
Authorized Agent (Print or Type)	Enter Name of Agency
Date	Date

Contract

Between

United States Department of Health and Human Services

Centers for Medicare & Medicaid Services

In Partnership with

The State of

Michigan

and

Meridian Health Plan of Michigan, Inc.

Issued:

September 25, 2014

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This Contract, made on September 25, 2014, is between the United States Department of Health and Human Services, acting by and through the Centers for Medicare & Medicaid Services (CMS), the State of Michigan, acting by and through The Michigan Department of Community Health (MDCH), and the Michigan Department of Technology, Management and Budget (DTMB), and Meridian Health Plan of Michigan, Inc. the Integrated Care Organization (ICO). The ICO's principal place of business is 777 Woodward Avenue, Suite 600, Detroit, MI 48226.

WHEREAS, CMS is an agency of the United States, Department of Health and Human Services, responsible for the administration of the Medicare, Medicaid, and State Children's Health Insurance Programs under Title XVIII, Title XIX, Title IX, Title XI, and Title XXI of the Social Security Act;

WHEREAS, Section 1115A of the Social Security Act provides CMS the authority to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care furnished to individuals under such titles, including allowing states to test and evaluate fully integrating care for dual eligible individuals in the State;

WHEREAS, MDCH is an agency responsible for operating a program of medical assistance under 42 U.S.C. § 1396 et seq., and the Social Welfare Act, MCL 400.1 et seq., designed to pay for medical, behavioral health, and Long Term Supports and Services (LTSS) for eligible beneficiaries (Enrollee, or Enrollees);

WHEREAS, the ICO is in the business of providing medical services, and CMS and MDCH desire to purchase such services from the ICO;

WHEREAS, the ICO agrees to furnish these services in accordance with the terms and conditions of this Contract and in compliance with all federal and State laws and regulations;

NOW, THEREFORE, in consideration of the mutual promises set forth in this Contract, the Parties agree as follows:

Section 1. Definition of Terms

1.1. **Abuse -** Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the 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 enrollee practices that result in unnecessary cost to the program.

1.2. **Adverse Action** - (i) The denial or limited authorization of a service authorization request, including the type or level of service; (ii) the reduction, suspension, or termination of a previously authorized service; (iii) the failure to provide services in a timely manner; or denial in whole or in part of a payment for a covered service for Enrollee; (iv) the failure by the ICO to render a decision within the required timeframes; or (v) solely with respect to an ICO that is the only ICO serving a rural area, the denial of Enrollee's request to obtain services outside of the Contracting Area.

1.3. **Adverse Action Notice** – A written notification of an Adverse Action provided to the Enrollee.

1.4. **Alternative Format –** Provision of Enrollee information in a format that takes into consideration the special needs of those who, for example, are visually impaired or have limited reading proficiency. Examples of Alternative Formats shall include, but not be limited to, Braille, large font, audio tape, video tape, and information read aloud to the Enrollee.

1.5. **Alternative Payment Methodologies --** Payment methods used by a payer to reimburse heath care providers that are not solely based on the fee-for-service (FFS) basis.

1.6. **Appeal —** As defined in 42 CFR 438.400(3)(b). A request for review of a ICO or PIHP's decision that results in any of the following actions: (1)The denial or limited authorization of a requested service, including the type or level of service; (2) The reduction, suspension, or termination of a previously authorized service; (3) The denial, in whole or in part, of payment for a properly authorized and covered service; (4) The failure to provide services in a timely manner, as defined by the State; (5) The failure of an Entity to act within the established timeframes for grievance and appeal disposition; (6) For a resident of a rural area with only one Integrated Care Organization, the denial of an enrollee's request to exercise his or her right, under 42 CFR 438.52(b)(2)(ii), to obtain services outside the network.

1.7. **Behavioral Health Inpatient Services** – Services provided in a hospital setting to include inpatient medical/surgical/psychiatric.

1.8. **Behavioral Health Outpatient Services** – Services that are provided in the home or community setting and to Enrollees who are able to return home after care without an overnight stay in a hospital or other inpatient facility.

1.9. **Capitated Financial Alignment Model (Demonstration)** — A model where a State, CMS, and a health plan enter into a three-way contract, and the health plan receives a prospective blended payment to provide comprehensive, coordinated care.

1.10. **Capitation Payment** – A payment CMS and the State make periodically to an ICO on behalf of each Enrollee under this Contract for the provision of services within this Demonstration, regardless of whether the Enrollees receive services during the period covered by the payment. Any and all costs incurred by the ICO in excess of a Capitation Payment shall be borne in full by the ICO, except as described in Section 4.3.1 and in the application of rules related to Medicare Part D.

1.11. **Care Bridge** – The Care Coordination framework for Michigan's integrated care program. Through the Care Bridge, the members of an Enrollee's Integrated Care Team (ICT) facilitate formal and informal services and supports in an Enrollee's person-centered care plan. The Care Bridge includes an electronic Care Coordination platform which will support an Integrated Care Bridge Record to facilitate timely and effective information flow between the members of the ICT.

1.12. **CareConnect360 -** A web portal to support care coordination of Enrollees' physical health and behavioral health conditions. The portal provides Integrated Care Organizations (ICOs) and Prepaid Inpatient Health Plans (PIHPs) access to Medicaid and limited Medicare claims information in the MDCH Data Warehouse related to both physical and behavioral health care. Due to federal confidentiality requirements, Substance Use Disorder information is not included in the claim data.

1.13. **Care Coordination** – A process used by a person or team to assist Enrollees in accessing Medicare and Medicaid services, as well as social, educational, and other support services, regardless of the funding source for the services. It is characterized by advocacy, communication, and resource management to promote quality, cost effectiveness and positive outcomes.

1.14. **Care Coordination Platform** – An electronic platform supported by web-based technology that will manage communication and information flow regarding referrals, care transitions, and care delivery; facilitate timely and thorough coordination and communication among the Enrollee, ICO, PIHP, the primary care provider, LTSS Supports Coordinators and other providers; provide prior authorization information for services; and house the Integrated Care Bridge Record.

1.15. **Center for Medicare and Medicaid Innovation (CMMI)** – Established by Section 3021 of the Affordable Care Act, CMMI was established to test innovative payment and service delivery models to reduce program expenditures under Medicare and Medicaid while preserving or enhancing the quality of care furnished to individuals under such titles.

1.16. **Centers for Medicare & Medicaid Services (CMS)** — The federal agency under Department of Health and Human Services responsible for administering the Medicare and Medicaid programs, among other programs.

1.17. **Claim -** An itemized statement of services rendered by health care providers (such as hospitals, physicians, dentists, etc.), billed electronically or on the CMS-1500 or UB-04, or their successor forms.

1.18. **CMS -** See Centers for Medicare & Medicaid Services (CMS).

1.19. **Community Health Automated Medicaid Processing System (CHAMPS) -** See Michigan's Medicaid Management Information System (MMIS).

1.20. **Community Supports** – Supports or services that are non-reimbursed or are provided through entities such as churches, senior centers, or community resources.

1.21. **Confidential Information -** All information and documentation of a party to this Contract that: has been marked "confidential" or with words of similar meaning, at the time of disclosure by such party; if disclosed orally or not marked "confidential" or with words of similar meaning, was subsequently summarized in writing by the disclosing party and marked "confidential" or with words of similar meaning; and, should reasonably be recognized as confidential information of the disclosing party. The term "Confidential Information" does not include any information or documentation that was: subject to disclosure under the Michigan Freedom of Information Act (FOIA); already in the possession of the receiving party without an obligation of confidentiality; developed independently by the receiving party, as demonstrated by the receiving party, without violating the disclosing party's proprietary rights; obtained from a source other than the disclosing party without an obligation of confidentiality; or, publicly available when received, or thereafter became publicly available (other than through any unauthorized disclosure by, through, or on behalf of, the receiving party).

1.22. **Consumer Assessment of Healthcare Providers and Systems (CAHPS) -**Enrollee survey tool developed and maintained by the Agency for Healthcare Research and Quality to support and promote the assessment of consumers' experiences with health care.

1.23. **Contract-** The three-way agreement that CMS and MDCH enter into with an ICO specifying the terms and conditions pursuant to which the ICO may participate in this Demonstration.

1.24. **Contract Management Team (CMT)** — A group of CMS and MDCH representatives responsible for overseeing the contract management functions outlined in Section 2.2 of the Contract.

1.25. **Contract Operational Start Date** — The first date on which any Enrollment into the ICO's plan is effective.

1.26. **Covered Services** — The set of supports and services to be offered by the ICO as defined in Appendix A.

1.27. **Cultural Competence –** Understanding and being able to respond appropriately to values, beliefs, and needs that are associated with the Enrollees' age, gender identity, sexual orientation, and/or racial, ethnic, or religious backgrounds. Cultural Competence also includes a set of competencies which are required to ensure appropriate, culturally sensitive health care and supports and services to persons with congenital or acquired disabilities. A competency based on the premise of respect for Enrollee and cultural differences, and an implementation of a trust-promoting method of inquiry and assistance.

1.28. **Demonstration –** See Capitated Financial Alignment Model.

1.29. **Emergency Medical Condition -** A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body functions, or serious dysfunction of any bodily organ or part.

1.30. **Emergency Services –**Inpatient and outpatient services covered under this Contract that are furnished by a provider qualified to furnish such services and that are needed to evaluate or stabilize an Enrollee's Emergency Medical Condition.

1.31. **Encounter Data -** The record of Claims for health care supports and services for which the ICO pays.

1.32. **Enrollee** – An individual enrolled in an ICO participating in the Demonstration, including the duration of any month in which his/her eligibility for the Demonstration ends.

1.33. **Enrollee Communications -** Materials designed to communicate plan benefits, policies, processes and Enrollee rights to Enrollees. This includes pre-enrollment, post-enrollment, and operational materials.

1.34. **Enrollee Medical Record -** Documentation containing medical history, including information relevant to maintaining and promoting each Enrollee's general health and well-being, as well as any clinical information concerning illnesses and chronic medical conditions.

1.35. **Enrollment -** The processes by which a Potential Enrollee is enrolled into the ICO's Medicare-Medicaid Plan.

1.36. **Enrollment Broker** - An entity contracted by the Michigan Department of Technology Management and Budget (DTMB) to contact, educate and perform general Enrollment, disenrollment, and changes of Enrollment functions for Medicaid and Medicare Beneficiaries eligible for the Demonstration.

1.37. **Excluded Parties List System (EPLS) -** The General Services Administration (GSA) maintains the EPLS, which includes information regarding parties debarred, suspended, proposed for debarment, excluded, or otherwise disqualified from receiving Federal funds. All Federal agencies are required to send information to the EPLS on parties they have debarred or suspended as described above; OIG sends monthly updates of the List of Excluded Individuals and Entities (LEIE) to GSA for inclusion in the EPLS. The EPLS does not include any unique identifiers; it provides only the name and address of excluded entities. If EPLS users believe that they have identified an excluded entity, they should confirm the information with the Federal agency that made the exclusion.

1.38. **Expedited Appeal –**The accelerated process by which an ICO must respond to an appeal by an Enrollee if a denial of care decision by an ICO may jeopardize life, health or ability to attain, maintain or regain maximum function.

1.39. **External Appeal –** An Appeal, subsequent to the ICO Appeal decision, to the State Fair Hearing process for Medicaid-based Adverse Action or the Medicare process for Medicare-based Adverse Action.

1.40. **External Quality Review Organization (EQRO)** – An independent entity that contracts with the State and evaluates the access, timeliness, and quality of care delivered by ICOs to their Enrollees.

1.41. **Federally-Qualified Health Center (FQHC)** — an entity that satisfies the criteria set forth in 42 U.S.C. § 1396d(l)(2)(B).

1.42. **First Tier, Downstream and Related Entity —** An individual or entity that enters into a written arrangement with the ICO, acceptable to CMS, to provide administrative or health care services of the ICO under this Contract.

1.43. **Fraud -** Knowing and willful deception, or a reckless disregard of the facts, with the intent to receive an unauthorized benefit. Includes any act that constitutes fraud under federal or State law.

1.44. **Grievance -** Any dispute, other than one that constitutes an organization determination under 42 C.F.R. § 422.566 or an Appeal of an Adverse Action, expressing dissatisfaction with any aspect of the ICO's or provider's operations, activities, or behavior, regardless of whether remedial action is requested pursuant to 42 C.F.R. § 422.561. Possible subjects for Grievances include, but are not limited to, quality of care or services provided, aspects of interpersonal relationships such as rudeness of a primary care provider (PCP) or employee of the ICO, or failure to respect the Enrollee's rights, as provided for in 42 C.F.R. § 438.400.

1.45. **Habilitation and Supports Waiver -** 1915 (c) home and community based services waiver that provides intensive habilitation and support services to assist individuals with intellectual/developmental disabilities to live independently in the community.

1.46. **Health Insuring Corporation (HIC) –** A corporation licensed by the State that, pursuant to a policy, contract, certificate, or agreement, pays for, reimburses, or provides, delivers, arranges for, or otherwise makes available, basic health care services, supplemental health care services, or specialty health care services, or a combination of basic health care services and either supplemental health care services or specialty health care services, through either an open panel plan or a closed panel plan.

1.47. **Health Outcomes Survey (HOS)** – Enrollee survey used by the Centers for Medicare and Medicaid Services to gather valid and reliable health status data in Medicare managed care for use in quality improvement activities, plan accountability, public reporting, and improving health.

1.48. **Health Plan Management System (HPMS)** — A system that supports contract management for Medicare health plans and prescription drug plans and supports data and information exchanges between CMS and health plans. Current and prospective Medicare health plans submit applications, information about Provider Networks, plan benefit packages, formularies, and other information via HPMS.

1.49. **Health Risk Assessment (HRA) –** A comprehensive assessment of an Enrollee's medical, psychosocial, cognitive, and functional status in order to determine their medical, behavioral health, LTSS, and social needs.

1.50. **Healthcare Effectiveness Data and Information Set (HEDIS)** — Tool developed and maintained by the National Committee for Quality Assurance that is used by health plans to measure performance on dimensions of care and service in order to maintain and/or improve quality.

1.51. **Home and Community-Based Services (HCBS) Waiver –** A variety of Medicaid home and community-based services as authorized under a §1915(c) waiver designed to offer an alternative to institutionalization. Individuals may be preauthorized to receive one or more of these services either solely or in combination, based on the documented need for the service or services to avoid institutionalization (nursing facility) placement.

1.52. **Hospital Access Agreement (HAA) --** An agreement between MDCH and the hospital that applies when a hospital provides services to Medicaid beneficiaries who are enrolled in an ICO with which the hospital does not have a contract. Where a hospital and the ICO have a contract, the terms of that contract govern each relationship, and the HAA does not apply. When a hospital and an ICO have a limited services contract, the HAA applies for all covered services outside the scope of the limited services contract. Since the HAA is not a contract between a hospital and ICO, it is expected that health plans will continue to use network-contracted providers where appropriate.

1.53. **ICO Advisory Council** - To obtain meaningful enrollee and community input on issues related to MI Health Link management, quality, and Enrollee services and supports, each ICO has at least one consumer advisory council and a process for that council to provide input to the governing board of the parent organization. The ICO Advisory Council composition reflects the diversity of the MI Health Link Enrollees. At least one half of the ICO Advisory Council includes a mix of Enrollees, caregivers, and local representation from key community stakeholders such as advocacy organizations, faith-based organizations, and other community-based organizations, with one third of the ICO Advisory Council composed of Enrollees.

1.54. **ICO Care Coordinator –** A Michigan licensed registered nurse, nurse practitioner, physician's assistant, or Bachelor's or Master's prepared social worker employed or contracted with the ICO who is accountable for providing Care Coordination services and trained in person-centered planning techniques. Qualifications of the ICO Care Coordinator and ICO Care Coordinator responsibilities are outlined in Section 2.5.3.2.

1.55. **Independent Living Philosophy –** A philosophy that emphasizes consumer control, the idea that people with disabilities are the best experts on their own needs, having crucial and valuable perspective to contribute and deserving of equal opportunity to decide how to live, work, and take part in their communities, particularly in reference to services that powerfully affect their day-to-day lives and access to independence.

1.56. **Indian Enrollee –** An individual who is an Indian (as defined in section 4(c) of the Indian Health Care Improvement Act of 1976 (25 U.S.C. 1603(c)).

1.57. **Individual Integrated Care and Supports Plan (IICSP) –** The plan of care developed by an Enrollee, the Enrollee's ICO Care Coordinator and the Enrollee's Integrated Care Team which incorporates the following elements: assessment results; summary of the Enrollee's health; the Enrollee's preferences for care, supports and services; the Enrollee's prioritized list of concerns, goals and objectives, and strengths; specific services including amount, scope and duration, providers and benefits; the plan for addressing concerns or goals; the person(s) responsible for specific interventions, monitoring and Reassessment; and the due date for the intervention and Reassessment. The IICSP is also referred to as person-centered plan or plan of care. The IICSP will be maintained in the Integrated Care Bridge Record.

1.58. **Integrated Care Bridge Record (ICBR)** – An individualized Enrollee record generated and maintained within the electronic Care Coordination platform. It allows secure access for Enrollees and the ICT to use and (where appropriate) update information.

1.59. **Integrated Care Organization (ICO) –** A HIC contracted with MDCH and CMS to comprehensively manage the full continuum of Medicare and Medicaid benefits for Medicare-Medicaid Enrollees including Long Term Supports and Services as needed and desired by the enrollee.

1.60. **Integrated Care Team (ICT)** – A team including the Enrollee, Enrollee's chosen allies or legal representative, Primary Care Physician, ICO Care Coordinator, LTSS Coordinator or PIHP Supports Coordinator (as applicable) and others as needed. The ICT works with the Enrollee to develop, implement, and maintain the IICSP and to coordinate the delivery of services and benefits as needed for the Enrollee.

1.61. **Involuntary Disenrollment –** Disenrollments under Sections 2.3.7.4 or 2.3.7.5 of this Contract

1.62. **Level I Assessment –** A broad assessment tool that will be used to assess the Enrollee's current health and functional needs within 45 calendar days of Enrollment. This assessment will serve as the basis for further assessment needs that may include Long Term Supports and Services (LTSS), Behavioral Health (BH), Intellectual or Developmental Disability (I/DD) and/or Substance Use Disorder (SUD).

1.63. **Level II Assessment –** Based on the findings from the Level I Assessment, for Enrollees identified with BH, I/DD, SUD, or LTSS the ICO will collaborate with the PIHP or the regional LTSS providers to conduct the Level II Assessment based on the Enrollee's needs and preferences.

1.64. **List of Excluded Individuals and Entities (LEIE) -** When the Office of Inspector General (OIG) excludes a provider from participation in federally funded health care programs; it enters information about the provider into the LEIE, a database that houses information about all excluded providers. This information includes the provider's name, address, provider type, and the basis of the exclusion. The LEIE is available to search or download on the OIG Web site and is updated monthly. To protect sensitive information, the downloadable information does not include unique identifiers such as Social Security numbers (SSN), Employer Identification numbers (EIN), or National Provider Identifiers (NPI).

1.65. **Long Term Care Reimbursement and Rate Setting Section -** The organizational area within MDCH responsible for rate setting and reimbursement for Michigan's nursing facilities.

1.66. **Long Term Supports and Services (LTSS) -** A variety of supports and services that help elderly individuals and/or individuals with disabilities meet their daily needs for assistance and improve the quality of their lives. Examples include assistance with bathing, dressing and other basic activities of daily life and self-care, as well as support for everyday tasks such as laundry, shopping, and transportation. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities.

1.67. **Marketing, Outreach, and Enrollee Communications** — Any informational materials targeted to Enrollees that are consistent with the definition of marketing materials at 42 CFR 422.2260.

1.68. **MDCH –** Michigan Department of Community Health.

1.69. **Medicaid -** The program of medical assistance benefits under Title XIX of the Social Security Act, Michigan Social Welfare Act, MCL 400.1 et seq., and other applicable laws, and regulations, and various Demonstrations and Waivers.

1.70. **Medicaid Management Information System (MMIS) -** The medical assistance and payment information system of the Michigan Department of Community Health (Community Health Automated Medicaid Processing System - CHAMPS)

1.71. **Medically Necessary Services** – Services must be provided in a way that provides all protections to covered individuals provided by Medicare and Michigan Medicaid. Per Medicare, services must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. 1395y. Per Medicaid, determination that a specific service is medically (clinically) appropriate, necessary to meet needs, consistent with the person's diagnosis, symptomatology and functional impairments, is the most cost-effective option in the most integrated setting, and is consistent with clinical standards of care. Medical necessity includes, but is not limited to, those supports and services designed to assist the person to attain or maintain a sufficient level of functioning to enable the person to live in his or her community.

1.72. **Medicare —** Title XVIII of the Social Security Act, the federal health insurance program for people age 65 or older, people under 65 with certain disabilities, and people with End Stage Renal Disease (ESRD) or Amyotrophic Lateral Sclerosis. Medicare Part A provides coverage of inpatient hospital services and services of other institutional providers, such as skilled nursing facilities and home health agencies. Medicare Part B provides supplementary medical insurance that covers physician services, outpatient services, some home health care, durable medical equipment, and laboratory services and supplies, generally for the diagnosis and treatment of illness or injury. Medicare Part C provides Medicare beneficiaries with the option of receiving Part A and Part B services through a private health plan. Medicare Part D provides outpatient prescription drug benefits.

1.73. **Medicare Advantage -** The Medicare managed care options that are authorized under Part C of Title XVIII of the Social Security Act and implementing regulations at C.F.R. part 422.

1.74. **Medicare Exclusion Database (MED) -** Online application provides the ability to download the monthly provider sanctions/reinstatements files, perform an inquiry on the excluded providers, and perform monthly matching process and administration. Users access the site and files with IACS IDs; the files are available for download from the site.

1.75. **Medicare Medicaid Assistance Program (MMAP) –** MMAP is Michigan's State Health Insurance Program (SHIP) that assists individuals in understanding the Medicare and Medicaid programs and provides Enrollment assistance to persons seeking guidance on health care options.

1.76. **Medicare-Medicaid Coordination Office (MMCO) -** Formally the Federal Coordinated Health Care Office, established by Section 2602 of the Affordable Care Act.

1.77. **Medication Review and Reconciliation –** The review of a medication regimen (including prescribed medication, over-the-counter medications, and herbal supplements) to ensure it is appropriate for the individual, determine appropriate use, identify potential medication interactions, protect the individual against over-medication, and possibly educate and train family members or caretakers.

1.78. **MI Choice** – Michigan's existing Medicaid 1915 (c) Home and Community-Based Services Waiver for individuals who are elderly or physically disabled. Individuals enrolled in MI Choice must Opt Out of their existing program to participate in the Demonstration and do not qualify for Passive Enrollment.

1.79. **MI Health Link Program Liaison (or Program Liaison)** – An individual, employed by the ICO, who is located in an operations/business office in Michigan, and represents the ICO in all matters pertaining to the ICO's participation in the Demonstration, and acts as a link between the ICO, CMS, and MDCH. This individual has the responsibilities as set forth in this contract.

1.80. **Michigan Compiled Laws (MCL) –** Contains all Michigan statutes of a general and permanent nature passed by the Michigan Legislature and signed by the governor.

1.81. **Michigan Department of Insurance and Financial Services (DIFS)** – The agency responsible for regulation of all insurers operating in the state of Michigan.

1.82. **Michigan Medicaid** – The Medicaid program operated by the Medical Services Administration (MSA) within MDCH.

1.83. **Minimum Data Set (MDS) —** Part of the federally-mandated process for assessing individuals receiving care in certified skilled nursing facilities in order to record their overall health status regardless of payer source. The process provides a comprehensive assessment of individuals' current health conditions, treatments, abilities, and plans for discharge. The MDS is administered to all residents upon admission, quarterly, yearly, and whenever there is a significant change in an individual's condition. Section Q is the part of the MDS designed to explore meaningful opportunities for nursing facility residents to return to community settings.

1.84. **Notice --** Communication provided to the Enrollee in written form.

1.85. **Nursing Facility -** Any facility licensed by the State of Michigan, in accordance with the Public Health Code, 1978 PA 368, as amended, MCL 333.1101 – 333.25211, and certified by Medicare in accordance with section 42 CFR 483 et seq. to provide skilled and non-skilled nursing care.

1.86. **Nursing Facility Care –** Long term, skilled nursing or rehabilitation services provided in a facility licensed in accordance with MCL 333.1101 – 333.25211 and certified in accordance with section 42 CFR 483 et seq. designed to meet an Enrollee's needs.

1.87. **Nursing Facility Level of Care Determination (NFLOCD) -** The assessment tool utilized in determining if an Enrollee meets medical and functional eligibility for Medicaid-reimbursed Nursing Facility Care, or Enrollment in the MI Choice Program or Program of All-Inclusive Care for the Elderly (PACE). The NFLOCD is an electronic web-based system accessed through Michigan's Single Sign-On System.

1.88. **Ombudsman -** The entity designated by the State, and independent of the Department, that advocates and investigates on behalf of Enrollees to safeguard due process and to serve as an early and consistent means of identifying systematic problems with the Demonstration as provided for in State administrative rules and in accordance with the Older Americans Act of 1965.

1.89. **Opt In –** A process by which a Potential Enrollee can choose to participate in the Demonstration.

1.90. **Opt Out –** A process by which a Potential Enrollee can choose not to participate in the Demonstration.

1.91. **Passive Enrollment —** An Enrollment process through which an eligible individual is enrolled by the MDCH (or its vendor) into an ICO's plan, following a minimum 60 calendar day advance notification that includes the plan selection and the opportunity to select a different plan, make another Enrollment decision, or decline Enrollment into an ICO, or opt-out of the Demonstration prior to the effective date.

1.92. **Patient Pay Amount (PPA) -** When an Enrollee's income exceeds an allowable amount, he or she must contribute toward the cost of Medicaid covered Nursing Facility Care to maintain Medicaid eligibility. This contribution, known as the Patient Pay Amount (PPA), is determined by the local Michigan Department of Human Services.

1.93. **Patient's Right to Independent Review Act (PRIRA) -** A Michigan law that provides patients with appeal rights due to adverse decisions made by health carriers regarding a denial, reduction, or termination of health care services. The PRIRA external review process applies after the patient has exhausted the health carrier's internal grievance process.

1.94. **Person-Centered Planning Process –** A process for planning and supporting a person receiving services that builds on the individual's desire to engage in activities that promote community life and that honor the individual's preferences, choices, and abilities. The Person-Centered Planning Process is led by the person and involves families, friends, legal representative, and professionals as he/she desires or requires.

1.95. **Post-Stabilization Care Services -** Covered Services related to an Emergency Medical Condition that are provided after the Enrollee's Emergency Medical Condition has been Stabilized to maintain the stabilized condition and/or under the circumstances described in 42 CFR 438.114(e).

1.96. **Potential Enrollee** — An individual who is eligible to enroll in the Demonstration but has not yet done so. This includes individuals who are enrolled in Medicare Part A and B and are receiving full Medicaid benefits, have no other comprehensive private or public health coverage, and who meet all other Demonstration eligibility criteria.

1.97. **Pre-paid Inpatient Health Plan (PIHP) –** PIHPs manage the Medicaid specialty services under the 1915(b)(c) Waiver Program, consistent with the requirements of 42 C.F.R. Part 401. This benefit plan covers mental health and substance use services for people eligible for Medicaid who have a need for behavioral health, intellectual/developmental disabilities services and supports, or substance use services.

1.98. **Prevalent Languages —**When 5 percent of the ICO's enrolled population is non-English speaking and speaks a common language other than English.

1.99. **Primary Care Provider (PCP)** – Practitioner of primary care selected by the Enrollee or assigned to the Enrollee by the ICO and responsible for providing and coordinating the Enrollee's health care needs, including the initiation and monitoring of referrals for specialty services when required. Primary Care Providers may be nurse practitioners, physician assistants or physicians who are board certified, or a specialist selected by an Enrollee.

1.100. **Privacy Rules -** Requirements established in the Privacy Act of 1974, Health Insurance Portability and Accountability Act of 1996, and implementing regulations, Medicaid regulations, including 42 CFR §431.300 through 431.307, as well as relevant Michigan privacy laws.

1.101. **Program of All-Inclusive Care for the Elderly (PACE) —** A capitated benefit for frail elderly authorized by the Balanced Budget Act of 1997 (BBA) that features a comprehensive service delivery system and integrated Medicare and Medicaid financing. PACE is a three-way partnership between the Federal government, Michigan, and the PACE organization. PACE participants must Opt Out of their existing program to participate in the Demonstration and do not qualify for Passive Enrollment.

1.102. **Provider Network –** A network of health care and social support providers, including but not limited to primary care physicians, nurses, nurse practitioners, physician assistants, care managers, specialty providers, behavioral health/substance use providers, nursing home providers, LTSS providers, pharmacy providers, and other acute care providers employed by or under subcontract with the ICO.

1.103. **Provider Preventable Condition -** A hospital acquired condition or a condition occurring in any health care setting that has been found by the State, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines, has a negative consequence for the Enrollee, and is auditable.

1.104. **Quality Assurance Supplement (QAS) -** Supplemental payment made to nursing facilities that incorporates funds from the quality assurance assessment tax as approved in the Michigan state plan.

1.105. **Quality Improvement Organization (QIO) –** As set forth in Section 1152 of the Social Security Act and 42 CFR Part 476, an organization under contract with CMS to perform utilization and quality control peer review in the Medicare program or an organization designated as QIO-like by CMS. The QIO or QIO-like entity provides quality assurance and utilization review.

1.106. **Rapid Dispute Resolution Process** - The process implemented by MDCH to administer and resolve claim disputes.

1.107. **Readiness Review** – A process that will evaluate each ICO's ability to comply with the Demonstration requirements, including but not limited to, the ability to quickly and accurately process Claims and Enrollment information, accept and transition new Enrollees, and provide adequate access to all Medicare- and Medicaid-covered Medically Necessary Services. CMS and MDCH will use the results to inform the decision of whether the ICO is ready to participate in the Demonstration. At a minimum, the Readiness Review will include a desk review and a site visit to the ICO's Michigan offices.

1.108. **Reassessment –** A detailed assessment of the Enrollee at specified intervals, after a change in health status or at the Enrollee's request.

1.109. **Self-Determination –** Provision of the opportunity for an Enrollee to exercise choice and control in identifying, accessing, and managing supports and services in accordance with his or her needs and personal preferences. Arrangements that support Self-Determination means that the Enrollee has the authority to exercise decision making over LTSS and accepts the responsibility for taking a direct role in managing them. Arrangements that support Self-Determination are an alternative to provider management of services wherein a service provider has the responsibility for managing all aspects of service delivery in accordance with the service plan developed through the Person-Centered Planning Process. Self-Determination promotes personal choice and control over the delivery of LTSS, including who provides services, how they are delivered, and hiring and firing personal attendants and/or home care workers.

1.110. **Service Area** - The specific geographic area of Michigan designated in the CMS HPMS, and as referenced in Appendix H, for which the ICO agrees to provide Covered Services to all Enrollees who select or are passively enrolled with the ICO.

1.111. **Single Case Agreement** – An agreement between the ICO and a non-network provider to treat an Enrollee at the applicable Medicaid or Medicare fee for service (FFS) rates.

1.112. **Solvency** – Standards for requirements on cash flow, net worth, cash reserves, working capital requirements, insolvency protection and reserves established by MDCH and agreed to by CMS.

1.113. **Specialty Services Supports Program -** The approved 1915 (b) waiver through which all Medicaid covered behavioral health services are provided.

1.114. **Stabilized -** As defined in 42 C.F.R. § 489.24(b), means, with respect to an Emergency Medical Condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer (including discharge) of the individual from a hospital or, in the case of a pregnant woman who is having contractions, that the woman has delivered the child and the placenta.

1.115. **State** – The State of Michigan.

1.116. **State Data** – includes: (a) the State's data collected, used, processed, stored, or generated as the result of the Contract activities; (b) personally identifiable information ("PII") collected, used, processed, stored, or generated as the result of the Contract activities, including, without limitation, any information that identifies an Enrollee, such as an Enrollee's social security number or other government-issued identification number, date of birth, address, telephone number, biometric data, mother's maiden name, email address, credit card information, or an individual's name in combination with any other of the elements here listed; and, (c) PHI collected, used, processed, stored, or generated as the result of the Contract activities, which is defined under HIPAA and its related rules and regulations. State data is further defined in Section 5.2.7.1

1.117. **State Fair Hearing** – An impartial review of a decision made by the MDCH or one of its contract agencies which is conducted by a Michigan Administrative Hearings System (MAHS) Administrative Law Judge under the oversight, supervision, and authority of MDCH so as to provide due process rights required by applicable law.

1.118. **State Plan Personal Care -** Services provided for in the Michigan State Plan that address physical assistance needs and enable individuals to live in their homes. Personal care services include hands-on assistance with activities of daily living (ADLs): eating, toileting, bathing, grooming, dressing, ambulation and, transferring and instrumental activities of daily living (IADLs): personal laundry, light housekeeping, shopping, meal preparation and medical administration.

1.119. **Supports Coordinator –** The Supports Coordinator (the LTSS Supports Coordinator or PIHP Supports Coordinator) is a member of the ICT who is available to Enrollees who have identified LTSS, behavioral health, intellectual/developmental disabilities, or substance use needs. The Supports Coordinator collaborates with the Enrollee and the ICO Care Coordinator to assure all necessary supports and services are provided to enable the Enrollee to achieve desired outcomes. Refer to Section 2.5.4 of this Contract for additional details specific to the LTSS Supports Coordinator.

1.120. **Teletypewriter (TTY)/Telecommunications Device for the Deaf (TDD) –** TDD is a teleprinter, an electronic device for text communication over a telephone line, that is designed for use by persons with hearing or speech difficulties. Another name for the device is teletypewriter (TTY).

1.121. **Treating Provider** – Someone who provides or has provided clinical treatment or evaluation to the Enrollee and who has, or has had, an ongoing treatment relationship with the Enrollee within the past (twelve) 12 months. Generally, an ongoing treatment relationship is considered to be when the clinical evidence establishes that the Enrollee sees, or has seen, the provider with a frequency consistent with accepted clinical practice for the type of treatment, evaluation and/or service required for clinical need(s). Treating Providers include primary care physicians, specialists, physician assistants, nurse practitioners, psychiatrists, counselors, and therapists. Treating Providers are not those who provide services that are non-clinical in nature or provide only routine preventative care.

1.122. **Urgent Care** — Medical services required promptly to prevent impairment of health due to symptoms that do not constitute an Emergency Medical Condition, but that are the result of an unforeseen illness, injury, or condition for which medical services are immediately required. Urgent Care is appropriately provided in a clinic, physician's office, or in a hospital emergency department if a clinic or physician's office is inaccessible. Urgent Care does not include primary care services or services provided to treat an Emergency Medical Condition.

1.123. **Utilization Management (UM) -** The process of evaluating the necessity, appropriateness and efficiency of health care services against established guidelines and criteria.

Section 2. ICO Responsibilities

2.1. Compliance

2.1.1. ICO Requirements for State Operations

2.1.1.1. Through the Capitated Financial Alignment Model initiative, CMS and MDCH will work in partnership to offer Potential Enrollees the option of enrolling in an ICO's participating plan, which consists of a comprehensive network of health service and supports providers. The ICO will deliver and coordinate all components of Medicare and Medicaid Covered Services for Enrollees.

2.1.1.2. Licensure

2.1.1.2.1. The ICO shall obtain and retain at all times during the period of this Contract a valid license or certificate of authority issued by the DIFS and comply with all terms and conditions set forth in MCL 500.3505, and any and all other applicable laws of the State of Michigan, as amended.

2.1.1.3. Certification

2.1.1.3.1. Pursuant to MCL 500.3505 and 500.3509, all managed care health insurance plan licensees must obtain Service Area approval certification and remain certified by the Michigan Department of Insurance and Financial Services.

2.1.1.4. Accreditation

2.1.1.4.1. If the ICO is accredited through the National Committee for Quality Assurance (NCQA), the ICO must report to MDCH any deficiencies noted by NCQA for the ICO's Medicare and/or Medicaid product lines within thirty (30) calendar days of being notified of the deficiencies, or on the earliest date permitted by NCQA, whichever is earliest.

2.1.1.5. Mergers, Acquisitions and Changes of Control

2.1.1.5.1. If the ICO is accredited through the National Committee for Quality Assurance (NCQA), in addition to the requirements at 42 C.F.R. § 422 Subpart L, the ICO must adhere to the NCQA notification requirements with regards to mergers and acquisitions and must notify MDCH and CMS of any action by NCQA that is prompted by a merger or acquisition (including, but not limited to change in accreditation status, loss of accreditation, etc.).

2.1.1.5.2. The ICO will notify, at least ninety (90) calendar days before the effective date, the State of a change in the ICO's organizational structure or ownership. For purposes of this ICO, a change in control means any of the following:

2.1.1.5.2.1. A sale of more than fifty (50%) of the ICO's stock;

2.1.1.5.2.2. A sale of substantially all of the ICO's assets;

2.1.1.5.2.3. A change in a majority of the ICO's board members;

2.1.1.5.2.4. Consummation of a merger or consolidation of ICO with any other entity;

2.1.1.5.2.5. A change in ownership through a transaction or series of transactions;

2.1.1.5.2.6. Or the board (or the stockholders) approves a plan of complete liquidation.

2.1.1.5.3. A change of control does not include any consolidation or merger effected exclusively to change the domicile of ICO, or any transaction or series of transactions principally for bona fide equity financing purposes.

2.1.1.5.4. In the event of a change of control, the ICO must require the successor to assume this Contract and all of its obligations under this Contract.

2.1.2. Compliance with Contract Provisions and Applicable Laws

2.1.2.1. The ICO must, to the satisfaction of CMS and MDCH:

2.1.2.1.1. Comply with all provisions set forth in this Contract; and

2.1.2.1.2. Comply with all applicable provisions of federal and State laws, policies, regulations, guidance, waivers and standards, and Demonstration terms and conditions, including the implementation of a compliance plan. The ICO must comply with the Medicare Advantage requirements in Part C of Title XVIII, and 42 C.F.R. Part 422 and Part 423, except to the extent that waivers from these requirements are provided in the MOU signed by CMS and MDCH for this initiative.

2.1.2.1.3. Comply with Other Laws.

2.1.2.1.3.1. No obligation imposed herein on the ICO shall relieve the ICO of any other obligation imposed by law or regulation, including, but not limited to the federal Balanced Budget Act of 1997 (Public Law 105-33), and regulations promulgated by MDCH or CMS.

2.1.2.1.3.2. MDCH and CMS shall report to the appropriate agency any information it receives that indicates a violation of a law or regulation.

2.1.2.1.3.3. MDCH or CMS will inform the ICO of any such report unless the appropriate agency to which MDCH or CMS has reported requests that MDCH or CMS not inform the ICO.

2.1.2.1.4. Adopt and implement an effective compliance program to prevent, detect and correct fraud, waste, and abuse. The compliance program must, at a minimum, include written policies, procedures, and standards of conduct that:

2.1.2.1.4.1. Articulate the ICO's commitment to comply with all applicable Federal and State standards, including but not limited to:

2.1.2.1.4.1.1. Fraud detection and investigation;

2.1.2.1.4.1.2. Procedures to guard against Fraud and Abuse;

2.1.2.1.4.1.3. Prohibitions on certain relationships as required by 42 C.F.R. § 438.610;

2.1.2.1.4.1.4. Obligation to suspend payments to providers;

2.1.2.1.4.1.5. Disclosure of ownership and control of ICO;

2.1.2.1.4.1.6. Disclosure of business transactions;

2.1.2.1.4.1.7. Disclosure of information on persons convicted of health care crimes;

2.1.2.1.4.1.8. Reporting adverse actions taken for Fraud, integrity, and quality;

2.1.2.1.4.2. Describe compliance expectations as embodied in the ICO’s standards of conduct;

2.1.2.1.4.3. Implement the operation of the compliance program;

2.1.2.1.4.4. Provide guidance to employees and others on dealing with potential compliance issues;

2.1.2.1.4.5. Identify how to communicate compliance issues to appropriate compliance personnel;

2.1.2.1.5. Develop and implement an effective compliance program that applies to its operations, consistent with 42 C.F.R. § 420, et seq., 42 C.F.R. § 422.503, and 42 C.F.R. §§ 438.600-610, 42 C.F.R. 455.

2.1.2.1.6. The ICO must report all employees, providers, and Enrollees suspected of Fraud, waste, and/or abuse that warrant investigation to MDCH – Office of Inspector General (DCH-OIG) and CMS. The ICO must provide the number of complaints warranting a preliminary investigation each year. Further, for each complaint warranting full investigation, the ICO must provide MDCH-OIG the following information:

2.1.2.1.6.1. The name of the provider, individuals, and/or entity, including their address, phone number and Medicaid identification number, and any other identifying information.

2.1.2.1.6.2. Source of the complaint.

2.1.2.1.6.3. Type of provider (if applicable).

2.1.2.1.6.4. Nature of the complaint.

2.1.2.1.6.5. Approximate range of dollars involved.

2.1.2.1.6.6. Legal and administrative disposition of the case, including actions taken by law enforcement officials to whom the case has been referred.

2.1.2.1.7. Include a policy of non-intimidation and non-retaliation for good faith participation in the compliance program, including but not limited to reporting potential issues, investigating issues, conducting self-evaluations, audits and remedial actions, and reporting to appropriate officials.

2.1.2.1.8. The ICO must inform MDCH of actions taken to investigate or resolve the reported suspicion, knowledge, or action. The ICO must also cooperate fully in any investigation by MDCH and any subsequent legal action that may result from such investigation.

2.1.2.1.9. In some circumstances, the ICO is permitted to disclose protected health information, (PHI) as defined by 42 C.F.R. § 160.103 to MDCH without first obtaining authorization from the Enrollee to disclose such information. MDCH must ensure that such disclosures meet the requirements for disclosures made as part of the ICO's treatment, payment, or health care operations as defined in 45 C.F.R. § 164.50, or any other exceptions provided for under 45 C.F.R. § 164 et. seq.1.

2.1.2.1.10. Disclosure of Litigation, or Other Proceeding.

2.1.2.1.10.1. The ICO must notify MDCH and CMS within fourteen (14) calendar days of receiving notice of the following types of litigation, investigation, arbitration, or other proceeding (collectively, "Proceeding") involving the ICO, a First Tier, Downstream, or Related Entity, or an officer or director of the ICO or First Tier, Downstream, or Related Entity, that arises during the term of the ICO, including:

2.1.2.1.10.2. A criminal Proceeding;

2.1.2.1.10.3. A parole or probation Proceeding;

2.1.2.1.10.4. A Proceeding under the Sarbanes-Oxley Act;

2.1.2.1.10.5. A civil Proceeding involving:

2.1.2.1.10.5.1. A Claim that might reasonably be expected to adversely affect the ICO's viability or financial stability; or

2.1.2.1.10.5.2. A governmental or public entity's claim or written allegation of Fraud; or

2.1.2.1.10.5.3. A Proceeding involving any license that the ICO is required to possess in order to perform under this Contract.

2.2. Contract Management and Readiness Review Requirements

2.2.1. Contract Readiness Review Requirements

2.2.1.1. CMS and MDCH, or their designee, will conduct a Readiness Review of each ICO, which must be completed successfully, as determined by CMS and MDCH, prior to the Contract Operational Start Date.

2.2.1.2. CMS and MDCH Readiness Review Responsibilities

2.2.1.2.1. CMS and MDCH or its designee will conduct a Readiness Review of each ICO that will include, at a minimum, one on-site review. This review shall be conducted prior to marketing to and Enrollment of Potential Enrollees into the ICO's plan. CMS and MDCH or its designee will conduct the Readiness Review to verify the ICO's assurances that the ICO is ready and able to meet its obligations under the Contract.

2.2.1.2.2. The scope of the Readiness Review will include, but is not limited to, a review of the following elements:

2.2.1.2.2.1. Network provider composition and access, in accordance with Section 2.7;

2.2.1.2.2.2. Staffing, including key personnel and functions directly impacting Enrollees (e.g., adequacy of enrollee services staffing, in accordance with Section 2.9);

2.2.1.2.2.3. Capabilities of First Tier, Downstream and Related Entities, in accordance with Appendix C;

2.2.1.2.2.4. Care management capabilities, in accordance with Section 2.5;

2.2.1.2.2.5. Content of provider contracts, including any provider performance incentives, in accordance with Section 5.1.7;

2.2.1.2.2.6. Enrollee Services capability (materials, processes and infrastructure, e.g., call center capabilities), in accordance with Section 2.9;

2.2.1.2.2.7. Comprehensiveness of quality management/quality improvement and Utilization Management strategies, in accordance with Section 2.8.6

2.2.1.2.2.8. Internal Grievance and Appeal policies and procedures, in accordance with Section 2.10 and Section 2.11;

2.2.1.2.2.9. Fraud and Abuse and program integrity policies and procedures, in accordance with Section 2.1.2.1.4;

2.2.1.2.2.10. Financial solvency, in accordance with Section 2.15;

2.2.1.2.2.11. Information systems, including Claims payment system performance, interfacing and reporting capabilities and validity testing of Encounter Data, in accordance with Section 2.17, including IT testing and security assurances.

2.2.1.2.3. No individual shall be enrolled into the ICO unless and until CMS and MDCH determine that the ICO is ready and able to perform its obligations under the Contract as demonstrated during the Readiness Review.

2.2.1.2.4. CMS and MDCH or its designee will identify to the ICO all areas where the ICO is not ready and able to meet its obligations under the Contract and provide an opportunity for the ICO to correct such areas to remedy all identified deficiencies prior to the Contract Operational Start Date.

2.2.1.2.5. CMS or MDCH may, at its discretion, postpone the Contract Operational Start Date for the ICO that fails to satisfy all Readiness Review requirements. If, for any reason, the ICO does not fully satisfy CMS or MDCH that it is ready and able to perform its obligations under the Contract prior to the Contract Operational Start Date, and CMS or MDCH do not agree to postpone the Contract Operational Start Date, or extend the date for full compliance with the applicable Contract requirement, then CMS or MDCH may terminate the Contract.

2.2.1.3. ICO Readiness Review Responsibilities

2.2.1.3.1. The ICO must demonstrate to CMS' and MDCH's satisfaction that the ICO is ready and able to meet all Contract requirements identified in the Readiness Review prior to the Contract Operational Start Date, and prior to the ICO engaging in marketing of its Demonstration product;

2.2.1.3.2. The ICO must provide CMS and MDCH, or their designee, with corrections requested by the Readiness Review.

2.2.2. Contract Management

2.2.2.1. The ICO shall employ a qualified individual to serve as the MI Health Link Program Liaison (Program Liaison) of its Capitated Financial Alignment Model. The Program Liaison shall be dedicated to the ICO's participation in the Demonstration and be authorized and empowered to represent the ICO in all matters pertaining to the ICO's program, such as rate negotiations for the ICO program, Claims payment, and provider relations/contracting. The Program Liaison may serve as the Compliance Officer but the ICO may select a separate individual to serve in such a role. In no instance, do the roles of the Program Liaison circumvent the requirements of a Compliance Officer under 42 C.F.R. §§ 422.503(b)(4)(vi)(B), 423.504(b)(4)(vi)(B), and 438.608(b)(2). The Program Liaison shall be able to make decisions about the program and policy issues. The Program Liaison or the Medicare Compliance Officer shall act as liaison between the ICO, CMS, and MDCH, and has responsibilities that include but, are not limited to, the following:

2.2.2.1.1. Ensure the ICO's compliance with the terms of the Contract, including securing and coordinating resources necessary for such compliance;

2.2.2.1.2. Oversee all activities by the ICO and its First Tier, Downstream and Related Entities, including but not limited to coordinating with the ICO's quality management director, medical director, and behavioral health clinician;

2.2.2.1.3. Ensure that Enrollees receive written notice of any significant change in the manner in which services are rendered to Enrollees at least 30 calendar days before the intended effective date of the change, such as a retail pharmacy chain leaving the Provider Network;

2.2.2.1.4. Receive and respond to all inquiries and requests made by CMS, MDCH or both in time frames and formats specified by CMS and MDCH;

2.2.2.1.5. Meet with representatives of CMS or MDCH, or both, on a periodic or as-needed basis to resolve issues within specified timeframes;

2.2.2.1.6. Ensure the availability to CMS and MDCH, upon their request, of those members of the ICO's staff who have appropriate expertise in administration, operations, finance, management information systems, Claims processing and payment, clinical service provision, quality management, Enrollee services, Utilization Management, Provider Network management, and benefit coordination;

2.2.2.1.7. Represent the ICO at MDCH and CMS meetings;

2.2.2.1.8. Coordinate requests and activities among the ICO, the PIHP, all other First Tier, Downstream and Related Entities, CMS, and MDCH;

2.2.2.1.9. Make best efforts to promptly resolve any issues related to the Contract identified either by the ICO, CMS, or MDCH; and

2.2.2.1.10. Meet with CMS and MDCH at the time and place requested by CMS and MDCH if either CMS or MDCH or both, determine that the ICO is not in compliance with the requirements of the Contract.

2.2.2.1.11. Implement all action plans, strategies, and timelines, including but not limited to those described in the ICO's response to the Request for Proposal (RFP) to the extent such responses do not conflict with the MOU or this Contract.

2.2.3. Organizational Structure

2.2.3.1. The ICO shall establish and maintain the interdepartmental structures and processes to support the operation and management of its Demonstration line of business in a manner that fosters integration of physical health, behavioral health, and community-based and facility-based LTSS service provisions. The provision of all services shall be based on prevailing clinical knowledge and the study of data on the efficacy of treatment, when such data is available. The ICO shall describe the interdepartmental structures and processes to support the operation and management of its Demonstration line of business.

2.2.3.2. On an annual basis, and on an ad hoc basis, when changes occur or as directed by MDCH, CMS or both, the ICO shall submit to the CMT an overall organizational chart that includes senior and mid-level managers.

2.2.3.3. For all employees, by functional area, the ICO shall establish and maintain policies and procedures for managing staff retention and employee turnover. Such policies and procedures shall be provided to the CMT upon request.

2.2.3.4. If any Demonstration specific services and activities are provided by a First Tier, Downstream or Related Entity, the ICO shall submit the organizational chart of the First Tier, Downstream or Related Entity which clearly demonstrates the relationship with the First Tier, Downstream or Related Entity and the ICO's oversight of the First Tier, Downstream or Related Entity.

2.2.3.5. The ICO shall immediately notify the CMT whenever positions held by key personnel become vacant and shall notify the CMT when the position is filled and by whom.

2.2.3.5.1. Key personnel positions include, but are not limited to

2.2.3.5.1.1. The ICO's Executive with oversight of the Demonstration,

2.2.3.5.1.2. MI Health Link Program Liaison.

2.2.3.5.1.3. Chief executive officer, if applicable,

2.2.3.5.1.4. Chief financial officer,

2.2.3.5.1.5. Chief operating officer or director of Operations,

2.2.3.5.1.6. Chief medical officer/medical director,

2.2.3.5.1.7. Pharmacy director,

2.2.3.5.1.8. Quality improvement director,

2.2.3.5.1.9. Utilization Management director,

2.2.3.5.1.10. Care coordination/care management/disease management program manager,

2.2.3.5.1.11. Director of LTSS,

2.2.3.5.1.12. Community liaison,

2.2.3.5.1.13. ADA compliance director or point of contact for reasonable accommodations,

2.2.3.5.1.14. Claims director,

2.2.3.5.1.15. Management information system (MIS) director,

2.2.3.5.1.16. IT director, if different from MIS director,

2.2.3.5.1.17. Medicare/Medicaid compliance officer,

2.2.3.5.1.18. Grievance/Appeals coordinator, and

2.2.3.5.1.19. Privacy and security officer.

2.2.3.6. If MDCH or CMS is concerned that any of the key personnel are not performing the responsibilities, including but not limited to, those provided for in the person's position under Section 2.2.3.5.1MDCH shall inform the ICO of this concern. The ICO shall investigate said concerns promptly, take any actions the ICO reasonably determines necessary to ensure full compliance with the terms of this Contract, and notify MDCH of such actions. If the ICO's actions fail to ensure full compliance with the terms of this Contract, as determined by MDCH, the Corrective Action Provisions in Section 5.3.13 may be invoked by MDCH.

2.3. Eligibility and Enrollment Responsibilities

2.3.1. Eligibility Determinations

2.3.1.1. CMS and MDCH shall have sole responsibility for determining the eligibility of individuals for Medicare- and Medicaid- funded services. CMS and MDCH shall have sole responsibility for determining Enrollment in the ICO.

2.3.1.2. All Enrollment and disenrollment transactions, including Enrollments from one ICO to a different ICO, will be processed through the Michigan Enrollment Broker, except those transactions related to non-Demonstration plans participating in Medicare Advantage. Per § 30.1.4. of the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance, individuals who call 1-800-MEDICARE to Opt Out may have their requests accepted and processed by CMS.

2.3.2. Eligible Populations

2.3.2.1. The Demonstration will be available to individuals who meet all of the following criteria:

2.3.2.1.1. Age 21 or older at the time of enrollment;

2.3.2.1.2. Eligible for full benefits under Medicare Part A, and enrolled under Parts B and D, and receiving full Medicaid benefits. (This includes individuals who are eligible for Medicaid through expanded financial eligibility limits under a 1915(c) waiver or who reside in a nursing facility and have a monthly PPA); and

2.3.2.1.3. Reside in a Demonstration region.

2.3.2.2. The following populations will be excluded from enrollment in the Demonstration:

2.3.2.2.1. Individuals under the age of 21

2.3.2.2.2. Individuals previously disenrolled due to special disenrollment from Medicaid managed care as defined in 42 CFR 438.56

2.3.2.2.3. Individuals not living in a Demonstration region

2.3.2.2.4. Individuals with Additional Low Income Medicare Beneficiary/Qualified Individual (ALMB/QI) program coverage

2.3.2.2.5. Individuals without full Medicaid coverage (spend downs or deductibles)

2.3.2.2.6. Individuals with Medicaid who reside in a State psychiatric hospital

2.3.2.2.7. Individuals with commercial HMO coverage

2.3.2.2.8. Individuals with elected hospice services

2.3.3. General Enrollment

2.3.3.1. All Enrollment effective dates are prospective. Enrollee -elected Enrollment is effective the first calendar day of the month following the initial receipt of an Enrollee's request to enroll, or the first day of the month following the month in which the Enrollee is eligible, as applicable for an individual Enrollee. MDCH will conduct phased in periods for Opt In and Passive Enrollment.

2.3.3.2. The Enrollment Broker will provide customer service, including mechanisms to counsel Enrollees notified of Passive Enrollment and to receive and communicate Enrollee choice of Opt Out to CMS on a daily basis via transactions to CMS' Medicare Advantage Prescription Drug (MARx) Enrollment system.

2.3.3.3. Enrollees will also be provided a notice upon the completion of the Opt Out process.

2.3.3.4. In addition to the Enrollment Broker, the Michigan Medicare-Medicaid Assistance Program (MMAP) will provide eligible individuals, family members, and other stakeholders' direct outreach and education presentations, and maintain on-going capacity for outreach, education and individualized plan counseling.

2.3.3.4.1. The MMAP will build upon its partnership with Michigan's Area Agencies on Aging and work with other information and assistance providers, such as senior centers, and Centers for Independent Living.

2.3.3.4.2. Medicare resources, including 1-800-Medicare, will remain a resource for Medicare beneficiaries; calls related to Demonstration Enrollment will be referred to the Michigan Enrollment Broker for customer service and Enrollment support.

2.3.3.4.3. Aging and Disability Resource Collaboratives (ADRCs) will provide outreach and options counseling when they are deemed ready in the Demonstration Service Areas.

2.3.4. Opt In Enrollment

2.3.4.1. MDCH will initially conduct two phased Opt In periods. During these Opt In Enrollment periods, Potential Enrollees may choose to enroll into a particular ICO. Potential Enrollees who do not select an ICO or who do not Opt Out of the Demonstration will be assigned to an ICO during Passive Enrollment.

2.3.4.2. The ICO will be required to accept Opt In Enrollments no earlier than thirty (30) calendar days prior to the initial effective date as outlined below. Opt In Enrollments will be phased in prior to Passive Enrollment.

2.3.4.2.1. Phase 1: Potential Enrollees in Region 1 (Alger, Baraga, Chippewa, Delta, Dickinson, Gogebic, Houghton, Iron, Keweenaw, Luce, Mackinac, Marquette, Menominee, Ontonagon, and Schoolcraft counties) and Region 4 (Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, Saint Joseph, and Van Buren counties) will be able to Opt In beginning no earlier than November 1, 2014 with an Enrollment effective date of January 1, 2015

2.3.4.2.2. Phase 2: Potential Enrollees in Region 7 (Wayne County) and Region 9 (Macomb County) will be able to Opt In no earlier than March 1, 2015 with an Enrollment effective date of May 1, 2015.

2.3.4.3. The Enrollment Broker will provide notice of the opportunity to select an ICO at least thirty (30) calendar days prior to the effective date of an Opt In Enrollment period. This notice will explain the Enrollee's options, including the option to Opt Out of the Demonstration at any time.

2.3.5. Passive Enrollment

2.3.5.1. MDCH will initially conduct two Passive Enrollment phase-in periods for those Potential Enrollees who have not made a plan selection and are not excluded from Passive Enrollment.

2.3.5.1.1. Individuals excluded from Passive Enrollment include:

2.3.5.1.1.1. Individuals participating in the Program for All-Inclusive Care for the Elderly (PACE);

2.3.5.1.1.2. Individuals participating in the MI Choice Home and Community-Based Services Waiver; and

2.3.5.1.1.3. Individuals with Medicare health or drug coverage from an employer or union sponsored plan.

2.3.5.2. Passive Enrollment is effective no sooner than sixty (60) calendar days after Enrollee notification of the right to select an ICO. The start dates for the first two of these periods are tentatively as follows:

2.3.5.2.1. Phase 1: Potential Enrollees in Regions 1 and 4 will have a Passive Enrollment effective date of no earlier than April 1, 2015.

2.3.5.2.2. Phase 2: Potential Enrollees in Regions 7 and 9 will have a Passive Enrollment effective date of no earlier than July 1, 2015.

2.3.5.3. MDCH or the Enrollment Broker will provide notice of the opportunity to select an ICO at least sixty (60) calendar days prior to the effective date of a Passive Enrollment period, and will accept Opt Out requests through the last day of the month prior to the effective date of Enrollment. The sixty (60) calendar day notice will explain the Potential Enrollee's options, including the option to Opt Out of or disenroll from the Demonstration. The notice will include the name of the ICO in which the Potential Enrollee would be enrolled unless he/she selects another plan or chooses to Opt Out of the Demonstration.

2.3.5.3.1. As permitted by guidance, when a Potential Enrollee becomes eligible for the Demonstration after the phase-in is complete (e.g., ages in, moves into one of the Demonstration regions, etc.) he or she will receive a letter detailing Enrollment options.

2.3.5.3.2. If the Potential Enrollee is also eligible for passive Enrollment, he or she will have a minimum of sixty (60) calendar days to make a choice to enroll or disenroll or be passively enrolled.

2.3.5.4. Thirty (30) days prior to the Passive Enrollment effective dates above, a second notice will be provided to Potential Enrollees who have not responded to the initial notice. MDCH will proceed with Passive Enrollment into the identified ICO for Potential Enrollees who do not make a different choice, with an effective date of the first day of the month referenced in Sections 2.3.4.2.1or 2.3.4.2.2 above, as applicable.

2.3.5.5. Potential Enrollees subject to Medicare reassignment effective January 1, 2015, either from their Medicare Prescription Drug Plan (PDP) or from Medicare Advantage Drug Plan (MA-PD) to another PDP, will not be eligible for Passive Enrollment during CY 2015.

2.3.5.5.1. However, those individuals eligible to be reassigned to a new PDP effective January 1, 2016 and meeting all eligibility criteria for the Demonstration will be eligible for Passive Enrollment into an ICO effective no earlier than January 1, 2016.

2.3.5.6. MDCH will apply an intelligent methodology to assign Potential Enrollees to an ICO, which will include at minimum:

2.3.5.6.1. Potential Enrollees' current managed care Enrollment, in either MA-PDs or Medicaid managed care,

2.3.5.6.2. Enrollments of people who share a common case number for Medicaid eligibility,

2.3.5.6.3. MDCH will include additional ICO measures for quality, administration, and capacity in the algorithm as data becomes available. The algorithm will assign plans into one of three bands which will determine the number of Passive Enrollments an ICO will receive, with higher performing ICOs receiving more Passive Enrollments. Band 1 ICOs will receive more Passive Enrollments than band 2 ICOs. Band 2 ICOs will receive more Passive Enrollments than band 3 ICOs.

2.3.5.7. CMS and MDCH may stop Passive Enrollment to an ICO if the ICO does not meet reporting requirements necessary to maintain Passive Enrollment as set forth by CMS and MDCH.

2.3.5.7.1. The effective dates above are subject to the ICO meeting CMS and MDCH State requirements including the ICO's capacity to accept new Enrollees.

2.3.5.7.2. ICOs designated by CMS as a past performance outlier or identified as "consistently low performing" based on the performance of the parent and/or sibling organizations, will not receive Passive Enrollments.

2.3.5.7.3. In addition, if an ICO is not meeting certain standards, then Passive Enrollments may be stopped by either CMS or MDCH.

2.3.5.8. Enrollment Transactions

2.3.5.8.1. Enrollments and disenrollments will be processed through MDCH or its authorized agent. MDCH or its authorized agent will then submit Passive Enrollment transactions sixty (60) calendar days in advance of the effective date, to the CMS (MARx) Enrollment system directly or via a third-party CMS designates to receive such transactions, and MDCH or its authorized agent will receive notification on the next daily transaction reply report. The ICO will then receive Enrollment transactions from MDCH or its authorized agent. The ICO will also use the third-party CMS designates to submit additional Enrollment-related information to MARx, and receive files from CMS.

2.3.5.8.2. The ICO must have a mechanism for receiving timely information about all Enrollments in the ICO's plan, including the effective Enrollment date, from CMS and MDCH systems.

2.3.5.8.3. The ICO shall accept for Enrollment all Potential Enrollees, as described in Section 3.2. The ICO shall accept for Enrollment all Potential Enrollees identified by MDCH at any time without regard to income status, physical or mental condition, age, gender, sexual orientation, religion, creed, race, color, physical or mental disability, national origin, ancestry, pre-existing conditions, expected health status, or need for health care services.

2.3.5.8.4. Upon instruction by MDCH, its authorized agent may not provide new Enrollments within six (6) months (or less) of the end date of the Demonstration, unless the Demonstration is renewed or extended.

2.3.5.8.5. MDCH and CMS will monitor Enrollments and Passive Enrollment auto-assignments to all ICOs and may make adjustments to the volume and spacing of Passive Enrollment periods based on the capacity of the ICO, and of ICOs in aggregate, to accept projected Passive Enrollments. Adjustments to the volume of Passive Enrollment based on the capacity of the ICO will be subject to any capacity determinations, including but not limited to, those documented in the CMS and MDCH final Readiness Review report and ongoing monitoring by CMS and MDCH.

2.3.5.9. MDCH will share Enrollment, disenrollment and Opt Out transactions with the contracted ICO and regional Prepaid Inpatient Health Plan (PIHP).

2.3.6. Enrollee Materials

2.3.6.1. For Passive Enrollments, the ICO shall send the following materials thirty (30) calendar days prior to the Enrollee's effective date of coverage as described in the State-specific demonstration marketing guidance:

2.3.6.1.1. An ICO-specific summary of benefits for those offered Passive Enrollment (this document is not required for Opt In Enrollments). Providing the Summary of Benefits, which is considered marketing material normally provided prior to the individual making an Enrollment request, ensures that those who are offered Passive Enrollment have a similar scope of information as those who Opt In.

2.3.6.1.2. A comprehensive integrated formulary that includes Medicare and Medicaid outpatient prescription drugs and pharmacy products provided under the ICO.

2.3.6.1.3. A combined provider and pharmacy directory that includes all providers of Medicare, Medicaid, and flexible benefits as described in 2.14.5.

2.3.6.1.4. Proof of health insurance coverage so that the Enrollee may begin using ICO services as of the effective date. This proof must include the 4Rx prescription drug data necessary to access benefits.

2.3.6.1.4.1. NOTE: This proof of coverage is not the same as the Evidence of Coverage document described in the State-specific Demonstration Marketing Guidelines. The proof of coverage may be in the form of an Enrollee ID card or a welcome letter. As of the effective date of Enrollment, the ICO's systems should indicate active membership.

2.3.6.1.5. A welcome letter

2.3.6.2. For Passive Enrollment, the ICO must send the following no later than the last calendar day of the month prior to the effective date of coverage:

2.3.6.2.1. A single ID card for accessing all Covered Services under the ICO.

2.3.6.2.2. An Enrollee Handbook (Evidence of Coverage) to ensure that the individual has sufficient information about ICO benefits to make an informed decision prior to the Enrollment effective date.

2.3.6.3. For the individuals who Opt In to the Demonstration the ICO shall provide the following materials (as described in the State-specific Demonstration

Marketing Guidelines) no later than ten (10) calendar days from receipt of CMS confirmation of Enrollment or by the last calendar day of the month prior to the effective date of coverage, whichever occurs later:

2.3.6.3.1. A comprehensive integrated formulary

2.3.6.3.2. A combined Provider and Pharmacy Directory

2.3.6.3.3. A single ID card

2.3.6.3.4. A Enrollee Handbook (Evidence of Coverage)

2.3.6.3.5. NOTE: For Opt In requests received late in the month, see §30.4.2 of the Enrollment Guidance (After the Effective Date of Coverage) for more information.

2.3.6.3.6. A welcome letter.

2.3.6.4. For all Enrollments, regardless of how the Enrollment request is made, the ICO must explain:

2.3.6.4.1. The charges for which the Enrollee will be liable for (e.g., Patient Pay Amount for Nursing Facility Care, or payments for non-authorized or non-covered services) in the welcome letter.

2.3.6.4.2. The Enrollee's authorization for the disclosure and exchange of necessary information between the ICO, State, and CMS.

2.3.6.4.3. The requirements for use of the ICO's network providers. The ICO must obtain an acknowledgment (oral or written) during the assessment process by the Enrollee that he/she understands that care will be received through designated providers except for Emergency Services and urgently needed care.

2.3.6.4.4. The effective date of coverage and how to obtain services prior to the receipt of an ID card (if the ICO has not yet provided the ID card).

2.3.6.5. After the Effective Date of Coverage

2.3.6.5.1. CMS recognizes that in some instances the ICO will be unable to provide the materials and required notifications to new Enrollees prior to the effective date of coverage, as required in §30.4.1 of the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance. These cases will generally occur when an Opt In Enrollment request is received late in a month (within five (5) calendar days of the last calendar day of the month) with an effective date of the first calendar day of the next month. In these cases, the ICO still must provide the Enrollee all materials described in §30.4.1 of the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance no later than ten (10) calendar days after receipt of the completed Enrollment request. The Enrollee's coverage will be active on the effective date regardless of whether or not the Enrollee has received all the information by the effective date.

2.3.7. Disenrollment

2.3.7.1. The ICO shall have a mechanism for receiving timely information about all disenrollments from the ICO, including the effective date of disenrollment, from CMS and MDCH or its authorized agent. All disenrollment-related transactions will be performed by CMS, MDCH or its authorized agent. Enrollees can elect to disenroll from the ICO or the Demonstration at any time and enroll in another ICO, a MA-PD plan, PACE (if eligible and the program has capacity); or may elect to receive services through Medicare FFS and a prescription drug plan and to receive Medicaid FFS and any waiver programs (if eligible). A disenrollment received by CMS, MDCH or its authorized agent, either orally or in writing, by the last calendar day of the month will be effective on the first calendar day of the following month.

2.3.7.2. The ICO shall be responsible for ceasing the provision of Covered Services to an Enrollee upon the effective date of disenrollment.

2.3.7.3. The ICO shall notify MDCH of any individual who is no longer eligible to remain enrolled in the ICO per Medicare-Medicaid Plan Enrollment and Disenrollment Guidance, in order for MDCH to disenroll the Enrollee. This includes where an Enrollee remains out of the Service Area or for whom residence in the ICO's Service Area cannot be confirmed for more than six (6) consecutive months.

2.3.7.3.1. Requests to disenroll from an ICO, Opt Out, or enroll in a different ICO will be accepted at any point after an Enrollee's initial Enrollment occurs and are effective on the first calendar day of the month following receipt of request.

2.3.7.3.2. Any time an Enrollee requests to Opt Out of Passive Enrollment or disenrolls from the Demonstration, MDCH or the Enrollment Broker will send a letter confirming the Opt Out and providing information on the benefits available to the Enrollee once he or she has Opted Out or disenrolled.

2.3.7.3.3. The ICO will notify the Enrollee when the Enrollee no longer meets eligibility requirements for the ICO.

2.3.7.4. Required Involuntary Disenrollments. MDCH and CMS shall terminate an Enrollee's coverage upon the occurrence of any of the conditions enumerated in Section 40.2 of the 2013 Medicare-Medicaid Plan Enrollment and Disenrollment Guidance or upon the occurrence of any of the conditions described in this section. Except for the CMT's role in reviewing documentation related to an Enrollee's alleged material misrepresentation of information regarding third-party reimbursement coverage, as described in this section, the CMT shall not be responsible for processing disenrollments under this section. Further, nothing in this section alters the obligations of the parties for administering disenrollment transactions described elsewhere in this Contract.

2.3.7.4.1. Upon the Enrollee's death. Termination of coverage shall take effect at 11:59 p.m. on the last day of the month in which the Enrollee dies. Termination may be retroactive to this date.

2.3.7.4.2. When an Enrollee remains out of the Service Area or for whom residence in the ICO Service Area cannot be confirmed for more than six (6) consecutive months.

2.3.7.4.3. When an Enrollee no longer resides in the Service Area (except for an Enrollee living in the Service Area who is admitted to a Nursing Facility outside the Service Area and placement is not based on the family or social situation of the Enrollee).

2.3.7.4.3.1. If an Enrollee's street address on the Enrollment file is outside of the ICO's Service Area but the county code does not reflect the new address, the ICO is responsible for requesting disenrollment within fifteen (15) calendar days of the Enrollment effective date. When requesting disenrollment, the ICO must submit verifiable information that an Enrollee has moved out of the Service Area. MDCH will expedite prospective disenrollments of Enrollees and process all such disenrollments effective the next available month after notification from MDHS that the Enrollee has left the ICO's Service Area.

2.3.7.4.3.2. If the county code on the Enrollment file is outside of the ICO's Service Area, the ICO is responsible for requesting disenrollment within fifteen (15) calendar days of the Enrollment effective date. MDCH will automatically disenroll the Enrollee for the next available month.

2.3.7.4.3.3. Until the Enrollee is disenrolled from the ICO, the ICO will receive a Capitation Payment for the Enrollee. The ICO is responsible for all Medically Necessary Services for the Enrollee until he/she is disenrolled. The ICO may use it's UM protocols for hospital admissions and specialty referrals for Enrollees in this situation. The ICO may require the Enrollee to return to the Service Area to use network providers and provide transportation or the ICO may authorize out-of-network providers to provide Medically Necessary Services.

2.3.7.4.3.4. Enrollment of an Enrollee who resides out of the Service Area of the ICO before the effective date of Enrollment will be considered an "enrollment error". The ICO is responsible for requesting disenrollment within fifteen (15) calendar days of the Enrollment effective date for such enrollment errors. MDCH will retroactively disenroll the Enrollee associated with such enrollment errors effective on the date of Enrollment.

2.3.7.4.4. When CMS or MDCH is made aware that an Enrollee is incarcerated in a county jail, Michigan Department of Corrections facility, or Federal penal institution. Termination of coverage shall take effect on the first of the month of the month following the State's confirmation of a current incarceration if the start date is not known, or the first of the month following the start date of incarceration if the start date is known.

2.3.7.4.5. The termination or expiration of this Contract terminates coverage for all Enrollees with the ICO. Termination will take effect at 11:59 p.m. on the last day of the month in which this Contract terminates or expires, unless otherwise agreed to, in writing, by the Parties.

2.3.7.4.6. When the CMT approves a request based on information sent from any party to the Demonstration showing that an Enrollee has materially misrepresented information regarding third-party reimbursement coverage according to Section 40.2.6 of the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance.

2.3.7.4.7. Unless otherwise outlined in sections2.3.7.4.1 and 2.3.7.4.4, termination of an Enrollee's coverage shall take effect at 11:59 p.m. on the last day of the month following the month the Disenrollment is processed.

2.3.7.5. Optional Involuntary Disenrollments: The ICO shall not seek to terminate Enrollment because of an adverse change in an Enrollee's health status or because of the Enrollee's utilization of Covered Items and Services, diminished mental capacity, uncooperative or disruptive behavior resulting from such Enrollee's special needs (except to the extent such Enrollee's continued Enrollment with the ICO seriously impairs the ICO's ability to furnish Covered Items and Services to the Enrollee or other Enrollees as defined in Section 2.4), or take an Adverse Action in connection with a Enrollee who attempts to exercise, or is exercising, his or her Appeal or Grievance rights. Any attempts to seek to terminate Enrollment in violation of this Section 2.3.7.5 will be considered a breach of this Contract.

2.3.7.5.1. The ICO, however, following requirements in the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance, may submit a written request, accompanied by supporting documentation, to MDCH and CMS, via the CMT, to disenroll a Enrollee, for cause, if despite efforts by the ICO to, where appropriate, resolve and provide an opportunity for the Enrollee to cure the problems, the following exist:

2.3.7.5.1.1. The Enrollee engages in conduct or behavior that seriously impairs the ICO's ability to furnish Covered Items and Services to either this Enrollee or other Enrollees and provided the ICO made and documented reasonable efforts to resolve the problems presented by the Enrollee.

2.3.7.5.1.2. The Enrollee provides fraudulent information on an Enrollment form or the Enrollee willfully misuses or permits another person to misuse the Enrollee's ID card.

2.3.7.5.1.3. The Enrollee knowingly fails to complete and submit any necessary consent or release allowing the ICO and/or Providers to access necessary health care and service information for the purpose of compliance with the care delivery system requirements in Section 2.5 of this Contract.

2.3.7.5.2. As outlined in the notice requirements of Section 40.3.1 of the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance, the ICO must make a reasonable effort to identify for the Enrollee, both verbally and in writing, those actions of the Enrollee that have interfered with the effective provision of Covered Items and Services as well as explain what actions or procedures are acceptable. These efforts must include informing the individual of his or her right to use the Grievance procedures described in Section 2.12 of this Contract.

2.3.7.5.3. The ICO shall give prior verbal and written notice to the Enrollee, as required in the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance, with a copy to the CMT, of its intent to request Disenrollment. The written notice shall advise the Enrollee that the request has been forwarded to the CMT for review and approval. The written notice must include the mailing address and telephone number of the CMT.

2.3.7.5.4. To support MDCH's and CMS' evaluation of the ICOs request for Involuntary Disenrollment, the ICO shall submit all documentation required by Sections 40.3 and 40.4 of the 2013 Medicare-Medicaid Plan Enrollment and Disenrollment Guidance and the following:

2.3.7.5.4.1. In all cases, document what steps the ICO has taken to locate and engage the Enrollee, and the impact of or response to each attempt in accordance with the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance;

2.3.7.5.5. MDCH and CMS will determine when and if an ICO's request to terminate the Enrollment of an Enrollee will be granted based on the criteria in Section 2.3.2 above and in Sections 40.3 and 40.4 of the 2013 Medicare-Medicaid Plan Enrollment and Disenrollment Guidance. In the event that an ICO's request for Involuntary Disenrollment for cause is approved, the CMT will notify the ICO and the Enrollment Broker; and will instruct the Enrollment Broker to send the Enrollee an Involuntary Disenrollment Form, with a copy to the CMT. The notice will include information about the Enrollee's right to appeal the involuntary disenrollment.

2.3.7.5.6. Termination of an Enrollee's coverage shall take effect the first day of the calendar month in which the State gives the member a written notice of the disenrollment, or as provided by CMS, consistent with section 40.3.1 of the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance.

2.3.7.5.7. The CMT will develop a process to evaluate optional Involuntary Disenrollment requests. If the CMT determines that the ICO too frequently requests optional Involuntary Disenrollments for Enrollees, the CMT reserves the right to deny such requests and require the ICO to initiate steps to improve the ICO's ability to serve such Enrollees

2.4. Covered Services

2.4.1. General

2.4.1.1. The ICO must authorize, arrange, integrate, and coordinate the provision of all Covered Services for its Enrollees. (See Covered Services in Appendix A.) Covered Services must be available to all Enrollees, as authorized by the ICO and as determined Medically Necessary pursuant to section 2.4.2.2. Covered Services will be managed and coordinated by the ICO through the Integrated Care Team (ICT) (see Section 2.5.2).

2.4.1.2. For Enrollees without a current primary care provider (PCP) identified at the time of Enrollment, the ICO shall assist the Enrollee to identify and choose a new in-network PCP. The ICO shall assist the Enrollee in choosing an in-network PCP when the Enrollee's current PCP is not in network and refuses to become a network provider. The Enrollee must be allowed to choose his or her health professional to the extent possible and appropriate and the Enrollee must also be allowed to change to a different in-network PCP at any time.

2.4.1.3. The ICO will have discretion to use the Capitation Payment to offer flexible benefits, as specified in the Enrollee's IICSP, as appropriate to address the Enrollee's needs.

2.4.1.4. Under the Demonstration, skilled nursing level of care may be provided in a long term care facility without a preceding acute care inpatient stay for Enrollees, when the provision of this level of care is clinically appropriate and can avert the need for an inpatient stay.

2.4.1.5. The ICO must provide the full range of Covered Services. If either Medicare or Michigan Medicaid provides more expansive services than the other program does for a particular condition, type of illness, or diagnosis, the ICO must provide the most expansive set of services required by either program. The ICO may not limit or deny services to Enrollees based on Medicare or Michigan Medicaid providing a more limited range of services than the other program.

2.4.1.6. The State will continue to contract directly with PIHPs for delivery of Medicaid behavioral health services. PIHP Coordinators will be responsible for coordination of the Medicaid behavioral health services with other services as outlined in the IICSP through participation in the ICT

2.4.1.7. The ICO must offer the PIHP(s) operating in each Demonstration region the first opportunity to serve as the entity contracted to jointly coordinate and manage care for Enrollees with BH, SUD, and/or I/DD needs.

2.4.1.8. In addition to all Medicare Parts A, B, and D, and Medicaid State-plan services (except those covered through contracts between the State and the PIHPs), the ICO will be required to provide supplemental benefits and other supports and services as defined in the approved 1915(b) and 1915(c) waivers and other supporting documentation, rules, policy, or guidance provided by CMS or MDCH.

2.4.1.8.1. The 1915(c) services described in Table A.1 in Appendix A would be available to Enrollees who meet NFLOCD and for whom these services are included in the IICSP. Additional descriptions of these services are available in the approved 1915 (b)(c) waiver as well as other policy and supporting documents.

2.4.1.8.2. The supplemental benefits described in Table A.2 in Appendix A would be provided to Enrollees who meet established criteria and for whom the benefits are included in the IICSP.

2.4.1.9. Out-of-Network Reimbursement Rules – In an emergent or urgent situation, the ICO must reimburse an out-of-network provider of Emergency Services or urgent care, as defined by 42 C.F.R. § 424.101 and 42 C.F.R.§ 405.400, and this contract, at the Medicare or Medicaid FFS

payment amount applicable for that service, or as otherwise required under Medicare Advantage rules for Medicare services. The ICO may authorize other out-of-network services to promote access to and continuity of care. When out-of-network services are authorized and where the service would traditionally be covered under Medicare FFS, the ICO will pay out-of-network providers at least the lesser of the providers' charges or the Medicare FFS payment amount. When out-of-network services are authorized and where the service would traditionally be covered under Medicaid, the ICO will pay out-of-network providers at established Medicaid fees in effect on the date of service. Enrollees maintain Balance Billing protections. If Michigan Medicaid has not established a specific rate for the covered service, the ICO must follow Medicaid policy for the determination of the correct payment amount.

2.4.1.10. Nursing Facility Payment Rules – For traditional Medicaid nursing home days of care, the ICO shall reimburse nursing facility providers equivalent to their Medicaid FFS rate, including the Quality Assurance Supplement (QAS), as established by the Long Term Care Reimbursement and Rate Setting Section of MDCH. Nursing Facility reimbursement is further discussed in Section 4.

2.4.1.11. The ICO will contract with the PIHP, as described in 2.4.1.7 to provide Medicare Behavioral Health Inpatient Services and Behavioral Health Outpatient Services through FFS or a sub-capitated payment agreement.

2.4.2. Excluded Services

2.4.2.1. Elective abortions and related services

2.4.2.2. Elective cosmetic surgery

2.4.2.3. Services for treatment of infertility

2.4.2.4. Hospice benefits

2.4.2.5. Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies

2.4.2.6. Acupuncture

2.4.2.7. Naturopath services (the use of natural or alternative treatments)

2.4.2.8. Experimental medical and surgical treatments, items, and drugs, unless covered by Medicare or under a Medicare-approved clinical research study or the ICO

2.5. Care Delivery Model

2.5.1. General

2.5.1.1. The ICO shall offer Care Coordination services to all Enrollees to ensure effective integration and coordination between providers of medical services and supplies, behavioral health, substance use disorder and/or intellectual/developmental disabilities (BH, SUD, and/or I/DD), pharmacy, and LTSS.

2.5.1.2. The ICO shall ensure that the Enrollee has a PCP appropriate to meet his or her needs.

2.5.1.3. The ICO will develop and implement a strategy that uses a combination of initial screenings, assessments, referrals, administrative Claims data, etc. to help prioritize and determine the Care Coordination needs of each Enrollee.

2.5.1.4. The ICO-PIHP contract will be monitored by MDCH to ensure the ICO meets all delivery system requirements of the Demonstration and all Enrollees receive the appropriate Care Coordination services. The ICO will focus on providing services in the most integrated and least restrictive setting. The ICO will have significant flexibility to use innovative care delivery models and to provide a range of community-based services as a way to promote independent living and alternatives to high-cost institutionally based services. The ICO must exhaust the use of community-based services before utilizing institutional settings for LTSS.

2.5.1.5. Wherever possible, the ICO must include a person familiar with the needs, circumstances and preferences of the Enrollee when the Enrollee is unable to participate fully in or report accurately to the ICT.

2.5.1.6. The ICO will be required to employ the Care Bridge, the Care Coordination framework for the Demonstration. The Care Bridge includes a Care Coordination platform supported by web-based technology.

2.5.1.6.1. The Care Bridge allows secure access to information and enables all Enrollees and members of the ICT to use and (where appropriate) update information.

2.5.1.6.2. Through the Care Bridge, the members of the Enrollee's ICT facilitate access to formal and informal supports and services identified in the Enrollee's IISCP developed through a Person-Centered Planning Process.

2.5.1.6.3. The approved electronic Care Coordination platform will include a mechanism to alert ICT members of emergency department use or inpatient admissions.

2.5.1.6.4. The approved electronic Care Coordination platform will be compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and provide for the exchange of data in a standard format.

2.5.1.6.5. The Care Bridge includes an electronic Care Coordination Platform which will support an Integrated Care Bridge Record (ICBR) to facilitate timely and effective information flow between the members of the ICT.

2.5.1.6.6. The ICBR will include the information required in section 2.5.5.1.6 and allows ICO Care Coordinators and providers to post key updates and notify ICT members.

2.5.1.7. Care Coordination services will provide for:

2.5.1.7.1. A person-centered, outcome-based approach, consistent with the CMS model of care and Medicare and Medicaid requirements and guidance.

2.5.1.7.2. The opportunity for the Enrollee to choose arrangements that support self-determination.

2.5.1.7.3. Appropriate access and sharing of information. The Enrollee and Treating Providers will have access to all the information in the ICBR for the applicable Enrollee in accordance with the confidentiality requirements set forth in Section 5.2 of this Contract and all applicable information privacy and security rules.

2.5.1.7.4. It is the Enrollee's right to determine the appropriate involvement of other members of the ICT in accordance with applicable privacy standards.

2.5.1.7.5. Medication Review and Reconciliation conducted at least annually and when there is a change in condition or transition between settings.

2.5.2. Integrated Care Team (ICT)

2.5.2.1. Every Enrollee shall have access to and input in the development of an Integrated Care Team (ICT) to ensure the integration of the Enrollee's medical, behavioral health, and psychosocial care, and LTSS.

2.5.2.2. The ICT will be person-centered, built on the Enrollee's specific preferences and needs, and deliver services with transparency, individualization, accessibility, respect, linguistic and Cultural Competence, and dignity.

2.5.2.3. The ICT will honor the Enrollee's choice about his or her level of participation. This choice will be revisited periodically by the ICO Care Coordinator as it may change.

2.5.2.4. Integrated Care Team Members

2.5.2.4.1. The ICO Care Coordinator will lead the ICT. It will be the responsibility of the ICO Care Coordinator to set and lead ICT meetings as well as facilitate communication among ICT members. LTSS and PIHP Supports Coordinators will be members of ICTs (as applicable) to encourage communication and collaboration between ICOs, PIHPs and other providers. While the ICO Care Coordinator will be the lead of the ICT, the Enrollee may request his or her LTSS or PIHP Supports Coordinator to remain his or her main point of contact regarding the ICT.

2.5.2.4.2. Membership will include the Enrollee and the Enrollee's chosen allies, ICO Care Coordinator, PCP, and LTSS Supports Coordinator and/or PIHP Supports Coordinator (as applicable). Additional membership on the ICT may vary depending on the changing needs of the Enrollee. The team may also include the following persons as needed and available:

2.5.2.4.2.1. Family caregivers and natural supports

2.5.2.4.2.2. Primary care nurse care manager

2.5.2.4.2.3. Specialty providers

2.5.2.4.2.4. Personal care providers

2.5.2.4.2.5. Hospital discharge planner

2.5.2.4.2.6. Nursing facility representative

2.5.2.4.2.7. Others as appropriate

2.5.2.5. Integrated Care Team Responsibilities.

2.5.2.5.1. The role of ICT is to work collaboratively with the Enrollee and other team members. The ICO Care Coordinator is responsible to assure the completion of these tasks. ICT members will:

2.5.2.5.1.1. Ensure the IICSP is developed, implemented, and revised according to the Person-Centered Planning Process and the Enrollee's stated goals including making whatever accommodations are appropriate for individuals whose disabilities create obstacles to full participation with the ICT.

2.5.2.5.1.1.1. Participate in the Person-Centered Planning Process at the Enrollee's discretion to develop the IICSP;

2.5.2.5.1.1.2. Collaborate with other ICT members to ensure the Person-Centered Planning Process is maintained;

2.5.2.5.1.1.3. Assist the Enrollee in meeting his/her goals;

2.5.2.5.1.1.4. Monitor and ensure that their part of the IICSP is implemented in order to meet the Enrollee's goals;

2.5.2.5.1.2. Update the ICBR as needed pertinent to the ICT member's role on the ICT;

2.5.2.5.1.3. Review assessment, test results and other pertinent information in the ICBR;

2.5.2.5.1.4. Address transitions of care when a change between care settings occur;

2.5.2.5.1.5. Ensure continuity of care requirements are met; and

2.5.2.5.1.6. Monitor for issues related to quality of care and quality of life.

2.5.2.5.2. The operations of ICTs will vary depending on the needs and preferences of the Enrollee. An Enrollee with extensive service needs may warrant periodic meetings with all ICT members. An Enrollee with less intense needs may warrant fewer meetings with selected members of the ICT. Communication among the ICT members will be maintained by the ICO Care Coordinator and other direct communication with ICT members.

2.5.2.5.3. The ICT will adhere to an Enrollee's determination about the appropriate involvement of his or her medical providers and caregivers, according to HIPAA and, for individuals in substance use disorder treatment, C.F.R. 42, Part 2.

2.5.3. ICO Care Coordinators

2.5.3.1. ICO Care Coordinator Qualifications

2.5.3.1.1. ICO Care Coordinators must have the experience, qualifications and training including MDCH required training appropriate to the needs of the Enrollee, and the ICO must establish policies for appropriate assignment of ICO Care Coordinators.

2.5.3.1.2. ICO Care Coordinators must have knowledge of physical health, aging and loss, appropriate support services in the community, frequently used medications and their potential negative side-effects, depression, challenging behaviors, Alzheimer's disease and other disease-related dementias, behavioral health, substance use disorder, physical and developmental disabilities, issues related to accessing and using durable medical equipment as appropriate, available community services and public benefits, quality ratings and information about available options such as nursing facilities, applicable legal non-discrimination requirements such as the ADA, person centered planning, cultural competency, and elder abuse and neglect.

2.5.3.1.3. The ICO Care Coordinator must be either a Michigan:

2.5.3.1.3.1. Licensed registered nurse;

2.5.3.1.3.2. Licensed nurse practitioner;

2.5.3.1.3.3. Licensed physician's assistant;

2.5.3.1.3.4. Licensed Bachelor's prepared social worker;

2.5.3.1.3.5. Limited license Master's prepared social worker; or

2.5.3.1.3.6. Licensed Master's prepared social worker.

2.5.3.1.4. ICO Care Coordinator Training:

2.5.3.1.4.1. The ICO Care Coordinator will participate in train-the-trainer Person-Centered Planning educational opportunities offered by MDCH. The ICO will be responsible for training ICO Care Coordinator staff. The ICO will report participation of its ICO Care Coordinators in the MDCH and ICO trainings as required.

2.5.3.1.4.2. The ICO Care Coordinators will participate in train-the-trainer Self-Determination education opportunities offered by MDCH. The ICO will be responsible for training ICO Care Coordinator staff. The ICO will report participation of its ICO Care Coordinators in the MDCH and ICO trainings as required.

2.5.3.1.4.3. The ICO will participate, train and report on any other training required or offered by MDCH or its designee.

2.5.3.2. ICO Care Coordinator Responsibilities:

2.5.3.2.1. The ICO Care Coordinator will be responsible for Care Coordination for each Enrollee. The ICO Care Coordinator will conduct the Level I Assessment as described in Section 2.6.1.2.6, assure the Person-Centered Planning Process is complete, prepare the IICSP, coordinate care transitions, and lead the ICT.

2.5.3.2.2. The ICO Care Coordinator will be responsible to:

2.5.3.2.2.1. Support an on-going Person-Centered Planning Process;

2.5.3.2.2.2. Assess clinical risk and needs by conducting an assessment process that includes an Initial Screening, a Level I Assessment, and completion of or referral for a Level II Assessment (as appropriate);

2.5.3.2.2.3. Facilitate timely access to primary care, specialty care, LTSS, BH, SUD, and I/DD services, medications, and other health services needed by the Enrollee, including referrals to address any physical or cognitive barriers or referrals to the PIHP;

2.5.3.2.2.4. Create and maintain an ICBR for each Enrollee to manage communication and information regarding referrals, transitions, and care delivery;

2.5.3.2.2.5. Facilitate communication among the Enrollee's providers through the use of the Care Coordination Platform and other methods of communication including secure e-mail, fax, telephone, and written correspondence;

2.5.3.2.2.6. Notify ICT of the Enrollee's hospitalization (psychiatric or acute), and coordinate a discharge plan if applicable;

2.5.3.2.2.7. Facilitate face-to-face meetings, conference calls, and other activities of the ICT as needed or requested by the Enrollee;

2.5.3.2.2.8. Facilitate direct communication between the provider and the Enrollee or the Enrollee's authorized representative and/or family or informal supports as appropriate;

2.5.3.2.2.9. Facilitate Enrollee and family education;

2.5.3.2.2.10. Coordinate and communicate, as applicable, with the PIHP Supports Coordinator and/or the LTSS Supports Coordinator to ensure timely, non-duplicative supports and services are provided;

2.5.3.2.2.11. Develop, with the Enrollee and ICT, following the Person-Centered Planning Process, an IICSP specific to individual needs and preferences, and monitor and update the plan at least annually or following a significant change in needs or other factors;

2.5.3.2.2.12. Coordinate and make referrals to community resources (e.g. housing, home delivered meals, energy assistance programs) to meet IICSP goals;

2.5.3.2.2.13. Perform ongoing Care Coordination;

2.5.3.2.2.14. Monitor the implementation of the IICSP with the Enrollee, including facilitating the Enrollee's evaluation of the process, progress and outcomes and identifying barriers and facilitate problem resolution and follow-up;

2.5.3.2.2.15. Advocate with or on behalf of the Enrollee as needed, to ensure successful implementation of the IICSP;

2.5.3.2.2.16. Support transitions in care when the Enrollee moves between care settings including:

2.5.3.2.2.16.1. The ICO Care Coordinator will contact the Enrollee once notified of an emergency room visit to review discharge orders, schedule follow-up appoints, review any medication changes, and evaluate the need for revising the IICSP to include additional supports and services to remain in or return to the community;

2.5.3.2.2.16.2. The ICO Care Coordinator will ensure immediate and continuous discharge planning including electronic and verbal communication with the Enrollee and ICT members following an Enrollee's admission to a hospital or nursing facility. Discharge planning will ensure that necessary care, supports and services are in place in the community for the Enrollee when discharged. This includes scheduling an outpatient appointment, ensuring the Enrollee has all necessary medications or prescriptions upon discharge, and conducting follow-up with the Enrollee and/or caregiver.

2.5.3.2.2.16.3. The Care Coordinator shall make every effort to ensure that HCBS are in place upon hospital discharge to avoid unnecessary nursing facility placements. The Care Coordinator shall be able to arrange for expedited assessments and other mechanisms to assure prompt initiation of appropriate HCBS. If the Enrollee is being discharged from a Nursing Facility or hospital, the Care Coordinator shall coordinate efforts with the nursing facility social worker, discharge planner, or other staff to ensure a smooth transition.

2.5.3.2.2.16.4. Evaluating Section Q of the Minimum Data Set (MDS) for Enrollees currently in a nursing facility and discussing options for returning to the community, revising the IICSP and transitioning the Enrollee to the most integrated setting.

2.5.3.2.2.16.5. The ICO Care Coordinator will inform the Enrollee of his or her right to live in the most integrated setting, inform the Enrollee of the availability of services necessary to support his or her choices, and record the home and community-based options and settings considered by the Enrollee.

2.5.3.2.2.17. Engage in other activities or services needed to assist the Enrollee in optimizing his or her health status, including assisting with self-management skills or techniques; health education; referrals to support groups, services, and advocacy agencies, as appropriate; and other modalities to improve health status;

2.5.3.2.2.18. Assure the Medicaid eligibility redetermination process is completed timely to prevent the loss of benefits; and

2.5.3.2.2.19. If the Enrollee is receiving services that require meeting the NFLOCD standards, assure that the Enrollee continues to meet the criteria or transitions to services that do not require NFLOCD standards. The ICO Care Coordinator is required to conduct the NFLOCD assessment for Enrollees with identified long term care needs, and MDCH will make final eligibility determinations, unless otherwise directed by the State and CMS.

2.5.3.2.3. The ICO Care Coordinator must collaborate with the applicable PIHP Supports Coordinator or identified behavioral health representative as defined in the contract between the ICO and the PIHP when:

2.5.3.2.3.1. The Enrollee has received services through a PIHP within the last twelve (12) months, or

2.5.3.2.3.2. A new Enrollee requests or is identified as having potential need for BH, I/DD, or SUD services.

2.5.3.2.4. If the Enrollee has need of LTSS, the ICO Care Coordinator will collaborate with the Enrollee's chosen LTSS Supports Coordinator when:

2.5.3.2.4.1. The Enrollee has received LTSS within the last twelve (12) months, or

2.5.3.2.4.2. A new Enrollee requests or is identified as having potential need for LTSS.

2.5.3.3. ICO Care Coordinator Assignments and Change Requests

2.5.3.3.1. The ICO shall allow the Enrollee or his or her authorized representative choice in ICO Care Coordinator.

2.5.3.3.2. The ICO shall ensure every Enrollee has an ICO Care Coordinator with the appropriate experience and qualifications based on the Enrollee's assigned risk level and individual needs (e.g., communication, cognitive, or other barriers).

2.5.3.3.3. The ICO must have a process to ensure that an Enrollee or his or her authorized representative is able to request a change in his or her ICO Care Coordinator at any time including a process for the transition from one ICO Care Coordinator to another.

2.5.3.3.4. The ICO must establish policies for appropriate assignment of ICO Care Coordinators to align with the Enrollee's known or expressed cultural, religious and ethnic preferences by considering the knowledge and experience of the ICO Care Coordinator.

2.5.3.4. ICO Care Coordinator Caseloads

2.5.3.4.1. The ICO must ensure that the ICO Care Coordinator's caseload is reasonable to provide appropriate Care Coordination.

2.5.3.4.2. The ICO Care Coordinator shall maintain contact with Enrollees as frequently as appropriate.

2.5.4. LTSS Supports Coordinator

2.5.4.1. LTSS Supports Coordinator will be offered to all Enrollees who meet Michigan Medicaid NFLOCD standards.

2.5.4.2. The LTSS Supports Coordinator must be either a Michigan:

2.5.4.2.1. Licensed registered nurse;

2.5.4.2.2. Licensed nurse practitioner;

2.5.4.2.3. Licensed physician's assistant;

2.5.4.2.4. Licensed Bachelor's prepared social worker;

2.5.4.2.5. Limited license Master's prepared social worker; or

2.5.4.2.6. Licensed Master's prepared social worker.

2.5.4.3. The LTSS Supports Coordinator must:

2.5.4.3.1. Have knowledge of HCBS;

2.5.4.3.2. Have completed a person-centered planning and person-centered direction training;

2.5.4.3.3. Be culturally competent;

2.5.4.3.4. Be able to provide information regarding the quality ratings and licensure status, if applicable, of available options;

2.5.4.3.5. Be knowledgeable about risk factors and indicators of and resources to respond to abuse and neglect;

2.5.4.3.6. Be familiar with applicable long term care facility licensing requirements and resources such as the long term care ombudsman program; and

2.5.4.3.7. Have experience conducting LTSS needs assessments.

2.5.4.4. LTSS Supports Coordinator Responsibilities:

2.5.4.4.1. The ICO will be responsible to provide, directly or contractually, the following LTSS Supports Coordination services:

2.5.4.4.1.1. Support an on-going Person-Centered Planning Process;

2.5.4.4.1.2. Assist the Enrollee to take a lead role in the Person-Centered Planning Process;

2.5.4.4.1.3. Provide information to the Enrollee and ICT;

2.5.4.4.1.4. Communicate and collaborate with the PIHP when BH, SUD, or I/DD needs are identified in the Level I Assessment;

2.5.4.4.1.5. Participate in the assessment process as needed, including conducting the Level II Assessment specific to the Enrollee's needs;

2.5.4.4.1.6. Participate on the Enrollee's ICT;

2.5.4.4.1.7. Develop, with the Enrollee and the ICT, an IICSP;

2.5.4.4.1.8. Ensure optimal utilization of information and community supports;

2.5.4.4.1.9. Arrange services as identified in the IICSP;

2.5.4.4.1.10. Update the ICBR with current Enrollee status information to manage communication and information flow regarding referrals, transitions, and care delivery;

2.5.4.4.1.11. Monitor service implementation, service outcomes, and the Enrollee's satisfaction;

2.5.4.4.1.12. Collaborate with the ICO Care Coordinator to assist the Enrollee during transitions between care settings, including full consideration of all options; and

2.5.4.4.1.13. Advocate for the Enrollee and support self-advocacy by the Enrollee.

2.5.4.4.2. The ICO Care Coordinator may serve as the LTSS Supports Coordinator and complete the required functions of both roles.

2.5.5. Coordination Tools

2.5.5.1. Care Coordination Platform and Integrated Care Bridge Record (ICBR):

2.5.5.1.1. The ICO will employ a Care Coordination Platform, supported by web-based technology, that allows secure access to information and enables all Enrollees and members of the ICT to use and (where appropriate) update information.

2.5.5.1.2. The ICO will be required to share information with PIHPs, across providers, and between ICOs through its Care Coordination Platform.

2.5.5.1.3. To minimize the duplicate data entry burden on providers that have already invested in certified electronic health records and who have or will soon achieve meaningful use stage one, two, or three compliance, the ICO will also support automated electronic data exchange from providers using the Office of the National Coordinator (ONC) compliant protocols and formats.

2.5.5.1.4. The Care Coordination Platform will support the ICBR.

2.5.5.1.5. The Care Coordination Platform will:

2.5.5.1.5.1. Manage communication and information flow regarding referrals, care transitions, and care delivery;

2.5.5.1.5.2. Facilitate timely and thorough coordination and communication among the ICO, the primary care provider, PIHP and LTSS Supports Coordinators, and other providers; and

2.5.5.1.5.3. Provide prior authorization information for services.

2.5.5.1.6. The approved electronic Care Coordination Platform will generate and maintain an individualized Enrollee record referred to as ICBR including:

2.5.5.1.6.1. Current integrated condition list;

2.5.5.1.6.2. Contact information for the ICO Care Coordinator and ICT members;

2.5.5.1.6.3. Current medications list;

2.5.5.1.6.4. The date of service and the name of the provider for the most recently provided services;

2.5.5.1.6.5. Historical and current utilization and Claims information;

2.5.5.1.6.5.1. Historic Medicaid and Medicare utilization data: MDCH will provide the ICO with access to the CareConnect360 system to view and extract historic utilization data.

2.5.5.1.6.5.2. MDCH will initially provide the ICO with extract files containing historical data for all Enrollees for the previous twenty-four (24) months. Updates thereafter are available on a monthly basis or by the frequency identified by the ICO.

2.5.5.1.6.6. Initial screening, Assessments (Level I and Level II) described in Sections 2.6.1.3 and 2.6.1.4 and Reassessments (section 2.6.1.5);

2.5.5.1.6.7. Service outcomes, including specialty provider reports, lab results, and emergency room visits;

2.5.5.1.6.8. IICSP; and

2.5.5.1.6.9. Notes and correspondence across provider settings.

2.5.5.1.7. The Care Coordination Platform will allow ICO Care Coordinators, Supports Coordinators and providers to post key updates and notify ICT members.

2.5.5.1.8. The ICO will maintain the Care Coordination Platform and address technological issues as they arise.

2.5.5.1.9. The ICO is responsible for initiating an ICBR for the Enrollee and granting access to appropriate ICT members.

2.5.5.1.10. The ICO will provide ICBR in paper format to the Enrollee upon request.

2.5.5.1.11. The ICO will verify the accuracy of the ICBR and amend or correct inaccuracies. Corrections or amendments must be dated and attributed to the person making the change.

2.5.5.1.12. The ICO will have a mechanism to alert ICT members of emergency department use or inpatient admissions using the electronic Care Coordination Platform or other methods such as telephonic notification.

2.5.6. Health Promotion and Wellness Activities

2.5.6.1. The ICO must provide a range of health promotion and wellness informational activities for Enrollees, their family members, and other informal caregivers. The focus and content of this information must be relevant to the specific health status needs and high-risk behavior in the Medicare-Medicaid population. Interpreter services must be available for Enrollees who are not proficient in English. Examples of health promotion and wellness topics include, but are not limited to the following:

2.5.6.1.1. Chronic condition self-management;

2.5.6.1.2. Smoking cessation;

2.5.6.1.3. Nutrition; and,

2.5.6.1.4. Prevention and treatment of alcohol and substance abuse.

2.6. Enrollee Stratification, Assessments, and Individual Integrated Care and Support Plan (IICSP)

2.6.1.1. Enrollee Stratification

2.6.1.1.1. The ICO will develop and implement a strategy that uses a combination of initial screenings, assessments, assessment tools, functional assessments, referrals, administrative claims data, etc. to help prioritize and determine the level of Care Coordination needed by each Enrollee.

2.6.1.1.2. The ICO may also choose to use existing predictive modeling software to support the screening and assessment requirements but will not be required to do so.

2.6.1.1.3. The ICO is required to review program level data through CHAMPS and CareConnect360 or through file exacts provided by MDCH as part of the initial screening process. CareConnect360 contains past Medicare and Medicaid utilization data from the MDCH Data Warehouse.

2.6.1.1.3.1. The ICO must review program level data and utilization data within fifteen (15) calendar days of Enrollment.

2.6.1.1.4. These levels of stratification should be based on:

2.6.1.1.4.1. Enrollee demographics, medical conditions, functional status, care patterns, resource utilization data; and

2.6.1.1.4.2. The Enrollee's risk for long term care institutionalization or avoidable hospitalization.

2.6.1.1.5. Enrollees receiving services in the Habilitation and Supports Waiver or an Enrollee transitioning to the Demonstration from the MI Choice waiver are automatically stratified as high risk.

2.6.1.1.6. The ICO will determine the parameters and definitions for other Enrollees defined as high risk as well as definitions for low or moderate risk Enrollees.

2.6.1.2. Initial Screening

2.6.1.2.1. The purpose of the initial screening is to identify Enrollees with immediate needs in order to prioritize in person Level I Assessments.

2.6.1.2.2. The initial screening is a series of Enrollee reported yes/no questions related to historical and current service usage.

2.6.1.2.3. The initial screening will be conducted via telephone when individuals call the Enrollment Broker to enroll in the Demonstration.

2.6.1.2.4. For those individuals passively enrolled into the ICO, the ICO must make its best efforts to administer the initial screening within fifteen (15) calendar days of Enrollment.

2.6.1.2.4.1. The ICO must document attempts in the ICBR to contact the Enrollee for the purpose of scheduling or conducting the initial screening on different days of the week and at different times during the day, including times outside of standard work hours. If the initial contact is not made within fifteen (15) calendar days of Enrollment, the ICO must continue efforts to contact the Enrollee and document such in the ICBR.

2.6.1.2.4.2. The ICO Care Coordinator may complete the Level I Assessment in lieu of the initial screening if the Level I Assessment is completed within fifteen (15) calendar days of Enrollment.

2.6.1.2.5. The ICO will review the Enrollee's responses to the initial screening questions to identify current utilization of PIHP services, Nursing Facility Care, community-based supports and services and hospital care (inpatient or emergency room treatment).

2.6.1.2.5.1. Results of the initial screening will be sent to the ICO by MDCH in a supplemental file sent with the 834 Enrollment file.

2.6.1.2.6. The ICO must document the Enrollee's responses to the initial screening questions in the ICBR.

2.6.1.3. Level I Assessments

2.6.1.3.1. Each Enrollee shall receive, and be an active participant in, a timely Level I Assessment of medical, behavioral health, psychosocial, and LTSS needs completed by the ICO Care Coordinator, unless one of the following circumstances applies:

2.6.1.3.1.1. An Enrollee may choose to decline an assessment. Should that occur, the ICO will honor the Enrollee's decision and will only contact the Enrollee regarding an assessment if the Enrollee requests one or a new assessment is needed as indicated in 2.6.1.3.11.

2.6.1.3.1.2. In some instances, Enrollees are not reachable through the contact information provided by the State or CMS.

2.6.1.3.1.2.1. To comply with 2.6.1.3.1 and the time requirements in 2.6.1.3.9, the ICO must document its attempts to reach Enrollees and the modes of communication attempted.

2.6.1.3.1.2.2. The ICO shall attempt to reach the Enrollee at least five times within the first 45 days of enrollment. Attempts must be on different days of the week and at different times during the day, including times outside of standard work hours.

2.6.1.3.1.2.3. ICO shall use community resources where possible to identify and engage Enrollees.

2.6.1.3.1.3. The ICO Care Coordinator will identify, through the Level I Assessment, Enrollees who may require institutional level of care.

The ICO will use a validated screening tool which will be reviewed and approved by MDCH as part of Level I Assessment to identify Enrollees with BH, SUD, and I/DD needs.

2.6.1.3.2. The ICO will perform the Level I Assessment using its tool approved by MDCH to assess each Enrollee's current health, welfare, functional needs and risks.

2.6.1.3.2.1. Level I Assessment domains must include, but not be limited to, the following:

2.6.1.3.2.1.1. Individual preferences, strengths, and goals including Self-Determination arrangements;

2.6.1.3.2.1.2. Natural supports, including family and community caregiver capacity and social strengths and needs;

2.6.1.3.2.1.3. Communication needs, including hearing, vision, cultural and linguistic needs and preferences, and Enrollee health literacy;

2.6.1.3.2.1.4. Current services, including those covered by Medicare and Medicaid, community supports, and care transition needs;

2.6.1.3.2.1.5. Medical health risk, status, and history, including but not limited to medications (prescription, over-the-counter, and herbal supplements), frequent falls, and treatment for recurring urinary tract infections;

2.6.1.3.2.1.6. BH and SUD risk status; BH, SUD, and I/DD history and needs, including medications;

2.6.1.3.2.1.7. Nutritional strengths and needs;

2.6.1.3.2.1.8. Activities of daily living and instrumental activities of daily living, including any assistive technology used or needed and immediate environmental or housing needs;

2.6.1.3.2.1.9. Cognitive strengths and needs;

2.6.1.3.2.1.10. LTSS;

2.6.1.3.2.1.11. Quality of life including physical, mental, and psycho-social well-being;

2.6.1.3.2.1.12. Discussion and education related to abuse, neglect, and exploitation; and

2.6.1.3.2.1.13. Advance directive including the choice to execute a directive, its incorporation in the IICSP, and assurance of provider knowledge of the Enrollee's directive.

2.6.1.3.2.2. The ICO may include State-approved domains as appropriate. Additional domains should be included in the ICO's Level I Assessment tool when submitting the tool for approval by MDCH.

2.6.1.3.3. The ICO will coordinate with the PCP to ensure that Enrollees with complex medical needs identified in the Level I Assessment have further follow-up relevant to these needs.

2.6.1.3.4. The Level I Assessment will be completed by the ICO Care Coordinator (see qualifications in section 2.5.3.1) employed or contracted with the ICO who is accountable for providing Care Coordination services. The ICO may delegate through contract with entities or individuals meeting the Care Coordinator qualifications for performance of Initial Screenings, Level I Assessments and LTSS Level II Assessments, as well as Care Coordination functions. The ICO retains responsibility and accountability for utilization management functions, appeals, and approval of services. The Care Coordinator role cannot be delegated through contract or other means to Long Term Supports and Services providers who are otherwise responsible for providing services to Enrollees, such as nursing facilities.

2.6.1.3.4.1. The ICO will include the appropriate PIHP or LTSS Supports Coordinator or nursing facility staff in conducting the Level I Assessment if the Enrollee has been active in the PIHP or LTSS system during the previous twelve (12) months or is currently residing in a nursing facility.

2.6.1.3.4.2. Family members or other individuals may also be included in the Level I Assessment process to the extent desired by the Enrollee.

2.6.1.3.5. The ICO will use the results of the Level I Assessment to confirm the appropriate acuity or risk stratification level for Enrollee Care Coordination assignments.

2.6.1.3.6. The Level I Assessment and the validated screening tool for BH, SUD, I/DD, if applicable, will be used to determine need for a Level II Assessment, referral for PIHP services, or development of the IICSP.

2.6.1.3.6.1. The ICO will make referrals according to the process identified in ICO/PIHP contract to the PIHP/BH system for Enrollees identified as having BH, SUD, and/or I/DD needs.

2.6.1.3.6.2. The PIHP will conduct in person Level II Assessments for Enrollees identified as receiving services from the Habilitation Supports Waiver and/or the Specialty Services and Supports Program.

2.6.1.3.6.3. The PIHP will conduct a telephonic screen using the level of care utilization system (LOCUS) tool to determine:

2.6.1.3.6.3.1. If the Enrollee has mild to moderate needs that can be met through referral for additional services; or

2.6.1.3.6.3.2. If the Enrollee has needs that require the Level II Assessment to be completed.

2.6.1.3.6.4. The PIHP will coordinate service referrals to ICO or PIHP network providers or conduct further assessment as needed.

2.6.1.3.6.4.1. The PIHP will document the results from the telephonic screen and referral in the ICBR.

2.6.1.3.7. The Enrollee will continue to receive any services in any existing care plan prior to the Level I Assessment. The ICO will adhere to all transition requirements for services, as outlined in Section 2.6.4.1.

2.6.1.3.8. Level I Assessments will be documented in the ICBR and results used in the development of the IICSP.

2.6.1.3.9. Timing of Level I Assessments

2.6.1.3.9.1. Level I Assessments will be completed within forty-five (45) calendar days of Enrollment.

2.6.1.3.9.2. Enrollees identified with immediate needs or as having high risk should have Level I Assessments completed earlier than forty-five (45) calendar days from Enrollment, as appropriate.

2.6.1.3.9.2.1. The ICO Care Coordinator is responsible for assuring completion of further assessment for Enrollees with medically complex conditions.

2.6.1.3.10. The ICO Care Coordinator is encouraged to conduct the Level I Assessment in person.

2.6.1.3.10.1. Enrollees identified with immediate needs or as having high risk will have assessments completed in person.

2.6.1.3.11. The ICO must ensure that a Reassessment and an IICSP update are performed:

2.6.1.3.11.1. As warranted by the Enrollee's condition but at least every twelve (12) months after the Level 1 Assessment completion date;

2.6.1.3.11.2. When there is a change in the Enrollee's health status or needs;

2.6.1.3.11.3. Consistent with the parameters described in 2.6.1.3.1;

2.6.1.3.11.4. As requested by the Enrollee, his or her caregiver or authorized representative, or his or her provider; and

2.6.1.3.11.5. Upon any of the following trigger events:

2.6.1.3.11.5.1. A hospital admission;

2.6.1.3.11.5.2. Transition between care settings;

2.6.1.3.11.5.3. Change in functional status;

2.6.1.3.11.5.4. Loss or change in circumstances of a caregiver so that the Enrollee supports or services are affected;

2.6.1.3.11.5.5. Change in diagnosis; and

2.6.1.3.11.5.6. As requested by a member of the ICT who observes a change that requires further investigation.

2.6.1.3.12. The ICO will analyze utilization data of all Enrollees monthly to identify acuity and risk level changes. As acuity and risk levels change, Reassessments will be completed as necessary and IICSP and interventions updated and documented in the ICBR.

2.6.1.3.12.1. The ICO shall identify Enrollees through referrals, transition information, service authorizations, alerts, memos, assessment results, and from families, caregivers, providers, community organizations and ICO personnel.

2.6.1.3.13. The ICO shall notify PCPs of Enrollment of any Enrollee who has not completed a Level I Assessment within the time period set forth above and whom the ICO has been unable to contact. The ICO shall encourage PCPs to conduct outreach to these Enrollees and to schedule visits.

2.6.1.3.14. The ICO shall collaborate with clinics, hospitals, or Urgent Care centers to identify Enrollee contact information for Enrollees the ICO has not been able to contact.

2.6.1.4. Level II Assessment

2.6.1.4.1. The ICO will collaborate with the PIHP to ensure that the Level II Assessment is conducted for Enrollees identified through the telephonic screen as needing referral to the PIHP for Level II Assessment.

2.6.1.4.2. The ICO will ensure that the Level II Assessment is conducted for Enrollees demonstrating LTSS needs identified in the Level I Assessment.

2.6.1.4.2.1. The Michigan Medicaid NFLOCD tool will be conducted, as necessary, to determine eligibility for waiver or Medicaid nursing facility services. The entity completing the tool will record the findings in CHAMPS for MDCH to make final eligibility determinations and authorize appropriate Tier assignment and ICO Capitation Payment.

2.6.1.4.2.1.1. Final eligibility determinations for NFLOC will be completed by MDCH, or by an independent contracted entity, as directed by MDCH and CMS.

2.6.1.4.3. The Level II Assessment tools determined by MDCH include:

2.6.1.4.3.1. interRAI home care assessment system (interRAI HC) for Enrollees needing MI Health Link waiver services;

2.6.1.4.3.2. Supports intensity scale (SIS) for Enrollees with I/DD needs;

2.6.1.4.3.3. Level of care utilization system (LOCUS) for Enrollees with behavioral health needs; and

2.6.1.4.3.4. American Society of Addiction Medicine (ASAM) tool for Enrollees with SUD needs.

2.6.1.4.4. Level II Assessments will be conducted by professionally knowledgeable and trained LTSS Supports Coordinators or PIHP Supports Coordinators or behavioral health case managers, who have experience working with the population.

2.6.1.4.5. Any Level II Assessment that may have been completed prior to Enrollment by the PIHP Supports Coordinator, a trained LTSS Supports Coordinator or a behavioral health case manager may be adopted if it is not past the Reassessment date. The Level II Assessment should be reviewed to determine if it is complete, accurate and appropriate for the Enrollee's current status.

2.6.1.4.6. Level II Assessments will be conducted in person within fifteen (15) calendar days of completion of the Level I Assessment.

2.6.1.4.7. Level II Assessments will be documented in the ICBR and results used in the development of the IICSP.

2.6.1.5. Reassessments

2.6.1.5.1. The ICO is responsible to ensure that an annual Reassessment for each Enrollee (including analysis of medical, LTSS, BH, and I/DD utilization data) is completed within twelve (12) months of the last Level I Assessment.

2.6.1.5.2. If prior to the annual Reassessment, the Enrollee experiences a major change impacting health status, the ICO is required to reassess the Enrollee and review and revise the IICSP with members of the ICT as needed.

2.6.1.5.3. The ICO is responsible to complete a Reassessment as often as desired by the Enrollee and update the IICSP with members of the ICT as needed.

2.6.1.5.4. The ICO is encouraged to conduct Reassessments in person.

2.6.1.5.5. Level II Reassessments will be completed according to the Reassessment timeframe of the assessment tool utilized.

2.6.1.5.6. For Enrollees receiving nursing facility level of care services, the Reassessment must confirm that the Enrollee continues to meet the Michigan Medicaid NFLOCD standards.

2.6.1.5.6.1. If the standards are not met, the ICO will initiate planning for transitioning the Enrollee to more appropriate supports and services.

2.6.1.5.7. Reassessments will be documented in the ICBR and results used in the development of the IICSP.

2.6.2. Individual Integrated Care and Supports Plan (IICSP)

2.6.2.1. The ICO Care Coordinator, the Enrollee, his or her family, caregiver or authorized representative, providers, and other ICT members develop a comprehensive, person-centered, written IICSP for each Enrollee.

2.6.2.2. Every Enrollee must have an IICSP, unless the Enrollee refuses and such refusal is documented in the ICBR.

2.6.2.2.1. If the Enrollee refuses the IICSP, at a minimum the ICO Care Coordinator or Supports Coordinator must provide his or her contact information to the Enrollee and re-visit the refusal at the time of Reassessment or a change of condition.

2.6.2.3. The ICO must complete the initial IICSP within ninety (90) calendar days of Enrollment.

2.6.2.3.1. Existing person-centered service plans or plans of care can be incorporated into the IICSP.

2.6.2.3.1.1. The ICO must review the adopted plan with the Enrollee to determine if revisions are necessary to address the Enrollee's goals and meet the Enrollee's needs

2.6.2.4. The IICSP must be contained in the ICBR and shared with the Enrollee and the ICT.

2.6.2.5. IICSP Monitoring

2.6.2.5.1. The ICO will review the Enrollee's IICSP to ensure the IICSP continues to meet the Enrollee's needs and is updated accordingly.

2.6.2.5.1.1. The ICO must review IICSPs of high-risk Enrollees at least every thirty (30) calendar days.

2.6.2.5.1.2. The ICO must review IICSPs of moderate-risk Enrollees at least every ninety (90) calendar days.

2.6.2.5.1.3. The ICO must review IICSPs of low-risk Enrollees at least every one hundred and eighty (180) calendar days.

2.6.2.6. The ICO must update the Enrollee's IICSP at least annually, and more frequently if conditions warrant, or if an Enrollee requests a change.

2.6.2.7. The IICSP must:

2.6.2.7.1. Focus on supporting the Enrollee to achieve personally defined goals in the most integrated setting;

2.6.2.7.2. Be developed following MDCH principles for person-centered planning;

2.6.2.7.3. Include the Enrollee's preferences for care, services, and supports;

2.6.2.7.4. Include the Enrollee's prioritized list of concerns, goals and objectives, and strengths;

2.6.2.7.5. Include specific providers, supports and services including amount, scope, and duration;

2.6.2.7.6. Include a summary of the Enrollee's health status;

2.6.2.7.7. Include the plan for addressing concerns or goals and measures for achieving the goals;

2.6.2.7.8. Include person(s) responsible for specific interventions, monitoring, and Reassessment; and

2.6.2.7.9. Include the due date for the interventions and Reassessment.

2.6.3. Self-Determination

2.6.3.1. The ICO will offer Enrollees the opportunity to use arrangements that support Self-Determination for LTSS including the personal care benefit and appropriate waiver services.

2.6.3.2. The ICO will establish and submit policies and procedures to MDCH that develop and implement mechanisms for Enrollees to access arrangements that support Self-Determination consistent with MDCH requirements and guidance.

2.6.3.3. These policies and procedures will include provisions to:

2.6.3.3.1. Inform the Enrollee of his or her right to use arrangements that support Self-Determination and document the Enrollee's decisions regarding these arrangements;

2.6.3.3.2. Reflect current statutory, policy and regulatory requirements related to arrangements that support Self-Determination including the authority to control an individual budget (with the assistance of a fiscal intermediary) and the right to employ (hire, manage, and when necessary fire) workers and contract with providers; and

2.6.3.3.3. Make personnel available to help inform, navigate, connect, and refer the Enrollees who are using arrangements that support Self-Determination.

2.6.3.4. Notification of Self-Determination Options

2.6.3.4.1. Enrollees must be informed of the option to self-direct their own services. The ICT must inform Enrollees of the option to self-direct their services when their IICSPs are created or updated.

2.6.3.4.2. Explanations of the Self-Direction Option must:

2.6.3.4.2.1. Make clear that self-direction of services is voluntary and that Enrollees can choose the extent to which they would like to self-direct their services;

2.6.3.4.2.2. Provide the options to select self-directed supports or services; and

2.6.3.4.2.3. Provide an overview of the supports and resources available to assist Enrollees to participate to the extent desired in self-direction.

2.6.4. Continuity of Care

2.6.4.1. Service Transitions

2.6.4.1.1. The ICO must maintain an Enrollee's current providers and amount, scope and duration of services at the time of Enrollment. This includes prescription drugs and providers which are not part of the ICO's network.

2.6.4.1.2. Transition requirements vary based on the service and population, in accordance with the requirements and timelines set forth in Section 2.6.4.1.2 below.

2.6.4.1.2.1. For Enrollees receiving services from the Habilitation Supports Waiver (HSW) and/or the Specialty Services and Supports Program (SSSP) through the PIHP, the following continuity of care requirements apply to ICO services.

Exhibit 1 ICO Transition Requirements for HSW and SSSP Enrollees

Provider Type	ICO Transition Requirement for HSW and SSSP Enrollees
Physician/Other Practitioners	Maintain current provider at the time of Enrollment for one hundred and eighty (180) calendar days. (ICO must honor existing plans of care and prior authorizations (PAs) until the authorization ends or one hundred and eighty (180) calendar days from Enrollment, whichever is sooner)
DME	Must honor PAs when item has not been delivered and must review ongoing PAs for medical necessity
Scheduled Surgeries	Must honor specified provider and PAs for surgeries scheduled within one hundred eighty (180) calendar days of Enrollment
Chemotherapy/ Radiation	Treatment initiated prior to Enrollment must be authorized through the course of treatment with the specified provider
Organ, Bone Marrow, Hematopoietic Stem Cell Transplant	Must honor specified provider, PAs and plans of care
Dialysis Treatment	Maintain current level of service and same provider at the time of Enrollment for one hundred eighty (180) calendar days
Vision and Dental	Must honor PAs when an item has not been delivered
Medicaid Home Health	Maintain current level of service and same provider at the time of Enrollment for one hundred eighty (180) calendar days
State Plan Personal Care	Maintain current provider and level of services at the time of Enrollment for one hundred eighty (180) calendar days. The IICSP must be reviewed and updated and providers secured within one hundred eighty (180) calendar days of Enrollment.

2.6.4.1.2.1.1. Enrollees in the Habilitation Supports Waiver will continue to receive waiver services through the PIHP. Waiver services will not change due to Enrollment in the ICO.

2.6.4.1.2.1.2. The ICO will provide the State Plan Personal Care benefit to Enrollees.

2.6.4.1.2.2. For all other Enrollees, the following continuity of care requirements apply to ICO services:

Exhibit 2 ICO Transition Requirements for all Other Enrollees

Transition Requirements	ICO Transition Requirements for All Other Enrollees
Physician/Other Practitioners	Maintain current provider at the time of Enrollment for ninety (90) calendar days. (ICO must honor existing plans of care and prior authorizations (PAs) until the authorization ends or one hundred eighty (180) calendar days from Enrollment, whichever is sooner)
DME	Must honor PAs when item has not been delivered and must review ongoing PAs for medical necessity
Scheduled Surgeries	Must honor specified provider and PAs for surgeries scheduled within one hundred eighty (180) calendar days of Enrollment
Chemotherapy/ Radiation	Treatment initiated prior to Enrollment must be authorized through the course of treatment with the specified provider
Organ, Bone Marrow, Hematopoietic Stem Cell Transplant	Must honor specified provider, PAs and plans of care
Dialysis Treatment	Maintain current level of service and same provider at the time of Enrollment for one hundred eighty (180) calendar days
Vision and Dental	Must honor PAs when an item has not been delivered
Medicaid Home Health	Maintain current level of service and same provider at the time of Enrollment for ninety (90) calendar days
Medicaid Nursing Facility Services	Enrollee may remain at the facility through contract with the ICO or via single case agreements or on an out-of-network basis for the duration of the Demonstration or until the Enrollee chooses to relocate.
Waiver Services	MI Choice HCBS waiver enrollees: Maintain current providers and level of services at the time of Enrollment for ninety (90) calendar days unless changed during the Person-Centered Planning Process.

Transition Requirements	ICO Transition Requirements for All Other Enrollees
	Not applicable to other Enrollees
State Plan Personal Care	Maintain current provider and level of services at the time of Enrollment for ninety (90) calendar days. The IICSP must be reviewed and updated and providers secured within ninety (90) calendar days of Enrollment. Not applicable for MI Choice HCBS waiver enrollees

2.6.4.1.2.2.1. The ICO will provide the State Plan Personal Care benefit to Enrollees.

2.6.4.1.2.3. During the transition period referenced in 2.6.4.1.2.1 and 2.6.4.1.2.2., change from the existing provider or reductions in the amount, scope and duration of services can only occur in the following circumstances:

2.6.4.1.2.3.1. The Enrollee requests a change;

2.6.4.1.2.3.2. The provider chooses to discontinue providing services to an Enrollee as currently allowed by Medicare or Medicaid; or

2.6.4.1.2.3.3. The ICO, CMS, or MDCH identifies provider performance issues that affect an Enrollee's health and welfare.

2.6.4.1.3. Any reduction, suspension, denial or termination of previously authorized services shall trigger the required notice under 42 C.F.R. §§ 438.404, and 422.568 which articulates the Enrollee's right to file an Appeal (either expedited, if warranted, or standard), the right to have authorized service continue pending the Appeal, and the right to a fair hearing if the plan renders an adverse determination (either in whole or in part) on the Appeal.

2.6.4.2. Drug Transitions

2.6.4.2.1. Part D transition rules and rights will continue as provided for in current law and regulation.

2.6.4.2.2. The ICO must provide an appropriate transition process for Enrollees who are prescribed Part D drugs that are not on its formulary (including drugs that are on the ICO's formulary but require prior authorization or step therapy under the ICO's UM rules). This transition process must be consistent with the requirements at 42 C.F.R. § 423.120(b)(3).

2.6.4.2.3. Except as provided in Appendix A, all prior approvals for non-Part D drugs, therapies, or other services existing in Medicare or Medicaid at the time of Enrollment will be honored for one hundred eighty (180) calendar days after Enrollment and will not be terminated at the end of one hundred eighty (180) calendar days without advance notice to the Enrollee and transition to other services, if needed.

2.6.4.3. Provider Transitions

2.6.4.3.1. During the transition period outlined in 2.6.4.1.2.1 and 2.6.4.1.2.2, the ICO will allow Enrollees access to any provider seen by the Enrollee within the previous twelve (12) months, as indicated in CareConnect360, or reported by the Enrollee or provider, prior to transition, even if the provider is not in the ICO's network.

2.6.4.3.2. During the transition period, the ICO will advise Enrollees and providers if and when they have received care that would not otherwise be covered in-network.

2.6.4.3.3. On an ongoing basis, and as appropriate, the ICO must contact providers who provide services to ICO Enrollees but who are not members of the ICO's network to provide information on becoming in-network providers.

2.6.4.3.4. Out-of-network nursing facilities must be offered Single Case Agreements to continue to care for the Enrollee through the life of the Demonstration if the nursing facility does not participate in the ICO's network and the Enrollee:

2.6.4.3.4.1. Resides in the nursing facility at the time of Enrollment;

2.6.4.3.4.2. Has a family member or spouse that resides in the nursing facility; or

2.6.4.3.4.3. Requires nursing facility care and resides in a retirement community that includes a nursing facility.

2.6.4.4. Out of Network Reimbursement Rules

2.6.4.4.1. If a Enrollee is receiving any item or service that would not otherwise be covered by the ICO at an in-network level after the continuity of care period, the ICO must notify the Enrollee prior to the end of the continuity of care period, according to the requirements at 42 C.F.R. § 438.404 and 42 C.F.R. § 422.568.

2.6.4.4.1.1. The Enrollee shall be entitled to all Appeal rights, including aid pending Appeal, if applicable, as outlined in Section 2.11 of this Contract.

2.6.4.5. Transferring Service Plans and Liabilities

2.6.4.5.1. The ICO must be able to accept and honor established service plans provided on paper or electronically transferred from FFS or prior plans when Enrollees transition with service plans in place, until the IICSP is developed.

2.6.4.5.2. The ICO must be able to ensure timely transfer of an IICSP to another ICO or other plans when an Enrollee is disenrolling from the ICO.

2.6.4.5.3. If a Enrollee is receiving medical care or treatment as an inpatient in an acute care hospital at the time coverage under this Contract is terminated, the ICO shall arrange for the continuity of care or treatment for the current episode of illness until such medical care or treatment has been fully transferred to a Treating Provider who has agreed to assume responsibility for such medical care or treatment for the remainder of that hospital episode and subsequent follow-up care. The ICO must maintain documentation of such transfer of responsibility of medical care or treatment.

2.6.4.5.3.1. For hospital stays that would otherwise be reimbursed under Medicare or the Michigan Medicaid Program on a per diem basis, the ICO shall be liable for payment for any medical care or treatment provided to a Enrollee until the effective date of disenrollment.

2.6.4.5.3.2. For hospital stays that would otherwise be reimbursed under Medicare or the Michigan Medicaid Program on a DRG basis, the ICO shall be liable for payment for any inpatient medical care or treatment provided to a Enrollee where the discharge date is after the effective date of disenrollment.

2.6.4.6. Transitions Prior to the End of the Transition Period

2.6.4.6.1. The ICO may choose to transition the Enrollee to a network specialist or LTSS provider before the end of the transition period only if all the following criteria are met:

2.6.4.6.1.1. The Level I Assessment and Level II Assessments if applicable, are complete;

2.6.4.6.1.2. The IICSP is developed with Enrollee input and includes a transition plan to be updated and agreed to with the new provider, as necessary; and

2.6.4.6.1.3. The Enrollee agrees to the transition and IICSP prior to the expiration of the transition period.

2.7. Provider Network

2.7.1. Network Adequacy

2.7.1.1. The ICO must maintain a Provider Network sufficient to provide all Enrollees with access to the full range of Covered Services, including the appropriate range of preventive, primary care, and specialty services, behavioral health services, other specialty services, and all other services required in 42 C.F.R. §§422.112, 423.120, and 438.206, and under this Contract (see Covered Services in Appendix A), taking into consideration:

2.7.1.1.1. The anticipated number of Enrollees;

2.7.1.1.2. The expected utilization of services, in light of the characteristics and health care needs of the ICOs' Enrollees;

2.7.1.1.3. The number and types (in terms of training, experience, and specialization) of providers required to furnish the Covered Services;

2.7.1.1.4. The number of network providers who are not accepting new patients;

2.7.1.1.5. The geographic location of providers and Enrollees, considering distance, travel time, the means of transportation ordinarily used by Enrollees, and whether the location provides physical access for Enrollees with disabilities;

2.7.1.1.6. The communication needs of Enrollees; and

2.7.1.1.7. The cultural and ethnic diversity and demographic characteristics of Enrollees.

2.7.1.2. The ICO must demonstrate annually that its Provider Network meets the stricter of the following standards:

2.7.1.2.1. For Medicare medical providers and facilities, time, distance and minimum number standards updated annually on the CMS website (http://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/index.html);

2.7.1.2.2. For Medicare pharmacy providers, time, distance and minimum number as required in Appendix D, Article II, Section I and 42 C.F.R. § 423.120; or

2.7.1.2.3. State Medicaid standards shall be utilized for LTSS, as described below, and for other services for which Medicaid is exclusive.

2.7.1.2.4. The ICO must meet the Medicare requirements for any Covered Services for which Medicare requires a more rigorous network adequacy standard than Medicaid (including time, distance, and/or minimum number of providers or facilities).

2.7.1.2.5. Both MDCH and CMS will monitor access to services through survey, utilization, Grievance and Appeals data to assess needs for ICO network corrective actions.

2.7.1.2.6. Minimum LTSS standards for ICOs:

2.7.1.2.6.1. The ICO must have at least two available providers for each provider type with sufficient capacity to accept Enrollees. For services provided in the Enrollee's home, the ICO must assure that the enrollee has choice of providers. For services provided in the community, the ICO must assure that the enrollee has a choice of providers and the enrollee does not travel more than 30 miles or for more than 30 minutes to receive the service. (Travel time is measured during non-peak hours.) If the ICO cannot assure choice within the travel time or distance for each Enrollee, it may make a request of MDCH for a rural exception. LTSS providers are described in Exhibit 3 below:

Exhibit 3 Medicaid and LTSS Provider Types

Adaptive Medical Equipment and Supplies
Adult Day Program
Assistive Technology Devices
Assistive Technology Van Lifts and Tie Downs
Chore Services
Community Transition Services
Environmental Modifications
Expanded Community Living Supports
Eye Examinations
Eye Wear (providers dispensing eyeglasses and contact lenses)
Fiscal Intermediary

Home Delivered Meals
Medical Supplies (incontinence supplies)
Non-Emergency Transportation
Non-medical transportation (waiver service only)
Personal Care Services (non-agency and agency)
Personal Emergency Response System
Dental (Preventive and Restorative)
Preventive Nursing Services (non-agency and agency)
Private Duty Nursing (non-agency and agency)
Respite (non-waiver provided in the home)
Waiver Respite (provided overnight in the home or a licensed setting)
Skilled Nursing Home (beds certified for both Medicare and Medicaid)

2.7.1.2.6.2. The ICO will directly employ or contract with independent care providers of the Enrollee's choice, if the individual meets MDCH qualification requirements, to provide personal care services. Enrollees who currently receive personal care services from an independent care provider may elect to continue to use that provider or select a new provider so long as that provider meets the State qualifications. The ICOs must make best efforts to assist independent care providers providing personal care services to Enrollees to join the Provider Network.

2.7.1.2.6.3. The ICO must comply with standards described within the approved 1915 (b) and 1915(c) waivers.

2.7.1.2.6.4. CMS and MDCH will monitor access to care and the prevalence of needs indicated through Enrollee HRAs, and, based on those findings, may require that the ICO initiates further network expansion over the course of the Demonstration.

2.7.1.2.7. For providers of overlap services that may be subject to either Medicaid or Medicare network requirements, such as home health and durable medical equipment, the stricter of any applicable standards will apply.

2.7.1.3. The ICO must notify the CMT of any significant Provider Network changes immediately, but no later than five (5) business days after becoming aware of an issue, including a change in the ICO's Provider Network that renders the ICO unable to provide one or more covered items and services within the access to care standards set forth in this section, with the goal of providing notice to the CMT at least sixty (60) calendar days prior to the effective date of any such change.

2.7.1.4. Enrollees must be assured choice of all Providers, including the ICO Care Coordinator and others that will participate in their ICT.

2.7.1.5. The ICO ensures that Enrollees have access to the most current and accurate information by updating its online provider directory and search functionality on a timely basis. This information includes provider compliance with the ADA in terms of physical and communications accessibility for Enrollees who are blind or deaf as well as other reasonable accommodations.

2.7.2. Network Provider Requirements

2.7.2.1. Network providers must serve all Enrollees.

2.7.2.2. The ICO must provide or arrange accessible care twenty-four (24) hours per day, seven (7) days per week. The ICO must guarantee that Emergency Services are available twenty four (24) hours per day, seven (7) days per week.

2.7.2.3. All providers' physical sites must be accessible to all Enrollees, as must all providers that deliver services in the Enrollees' locations.

2.7.2.3.1. The ICO and its providers must comply with and apply the United States Supreme Court's *Olmstead* decision which requires that Enrollees be served in the most integrated setting appropriate to their needs. Any appropriate home and community-based service options must be exhausted prior to an Enrollee's admission into an institution. The ICO must have sufficient capacity to provide home and community-based services to meet the needs of Enrollees who choose to receive supports and services in community settings. This includes providing options for community living in places like adult foster care homes, assisted living facilities, homes for the aged, an individual's own home, etc., as desired by the individual, and in compliance with requirements under the approved 1915(c) waiver for Enrollees participating in the 1915(c) waiver.

2.7.2.4. The ICO must offer options for independent facilitators for Person-Centered Planning, peer support specialists, and fiscal intermediaries to facilitate arrangements that support self-determination.

2.7.2.5. The ICO shall ensure that its network providers are responsive to the linguistic, cultural, ethnic, racial, religious, age, gender and other unique needs of any minority, homeless population, Enrollees with disabilities (both congenital and acquired disabilities), or other special population served by the ICO. This responsiveness includes the capacity to communicate with Enrollees in languages other than English, when necessary, as well as those with a vision or hearing impairment.

2.7.2.6. The ICO shall ensure that multilingual network providers and, to the extent that such capacity exists within the ICO's Service Area, all network providers, understand and comply with their obligations under State or federal law to assist Enrollees with skilled medical interpreters and the resources that are available to assist network providers to meet these obligations.

2.7.2.7. The ICO shall ensure that network providers and interpreters/translators are available for those within the ICO's Service Area who are deaf or vision- or hearing-impaired.

2.7.2.8. The ICO shall ensure that its network providers have a strong understanding of disability, recovery, and resilience cultures and LTSS.

2.7.2.9. The ICO shall make best efforts to ensure that minority-owned or controlled agencies and organizations are represented in the Provider Network.

2.7.2.10. Network Provider Enrollment. ICO shall assure that all network providers that provide Medicare Covered Services are enrolled as Medicare

providers in order to submit Claims for reimbursement or otherwise participate in the Medicare program. ICO shall assure that all network providers, including out-of-State network providers that provide Medicaid Covered Services are enrolled in the Michigan Medicaid Program, if such Enrollment is required by MDCH's rules or policy in order to submit Claims for reimbursement or otherwise participate in the Michigan Medicaid program.

2.7.2.11. Providers must ensure that nursing facility beds will be held for the Enrollee for hospital and therapeutic leave days pursuant to the Michigan Medicaid Provider Manual/Nursing Facility Coverages/Special Placements and Agreement.

2.7.2.12. Providers and facilities must be appropriately licensed or certified, as applicable, if required pursuant to the Michigan Public Health Code, 1978 PA 368, as amended, MCL 333.1101-333.25211.

2.7.2.13. The ICO shall ensure that the Provider Network provides female Enrollees with direct access to a women's health specialist, including an obstetrician or gynecologist, within the Provider Network for Covered Services necessary to provide women's routine and preventive health care services. This shall include contracting with, and offering to female Enrollees, women's health specialists as PCPs.

2.7.2.14. At the Enrollee's request, the ICO shall provide for a second opinion from a qualified health care professional within the Provider Network, or arrange for the Enrollee to obtain one outside the Provider Network, at no cost to the Enrollee.

2.7.3. Provider Contracting

2.7.3.1. The ICO must contract directly or subcontract only with qualified or licensed providers who continually meet federal and State requirements, as applicable, and the qualifications contained in Appendix C.

2.7.3.2. The ICO shall not establish selection policies and procedures for providers that discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

2.7.3.3. Paid family caregivers will be permitted in accordance with Michigan's State Plan for Personal Care Services and as permitted under 1915 (c) waiver authority.

2.7.3.4. If the ICO declines to include individuals or groups of providers in its Provider Network, the ICO must give the affected providers written notice of the reason for its decision.

2.7.3.5. Excluded Providers

2.7.3.5.1. The ICO may not contract with, or otherwise pay for any items or services furnished, directed or prescribed by, a provider that has been excluded from participation in federal health care programs by the OIG of the U.S. Department of Health and Human Services under either Section 1128 or Section 1128A of the Social Security Act, and implementing regulations at 42 C.F.R. Part 1001 et. seq., or that has been terminated from participation under Medicare or another state's Medicaid program, except as permitted under 42 C.F.R. §1001.1801 and §1001.1901;

2.7.3.5.2. The ICO shall, at a minimum, check the MDCH health professions website monthly for excluded providers.

2.7.3.5.3. The ICO shall, at a minimum, check the OIG List of Excluded Individuals Entities (LEIE), Medicare Exclusion Database (MED), and the System for Awards Management (SAM) [the successor to the Excluded Parties List System (EPLS)] for its providers at least monthly, before contracting with the provider, and at the time of a provider's credentialing and recredentialing.

2.7.3.5.4. If a provider is terminated or suspended from the MDCH Medicaid Program, Medicare, or another state's Medicaid program or is the subject of a State or federal licensing action, the ICO shall terminate, suspend, or decline a provider from its Provider Network as appropriate.

2.7.3.5.5. Upon notice from MDCH or CMS, the ICO shall not authorize any providers who are terminated or suspended from participation in the Michigan Medicaid Program, Medicare, or from another state's Medicaid program, to treat Enrollees and shall deny payment to such providers for services provided. In addition:

2.7.3.5.5.1. The ICO shall notify CMS and MDCH, via the CMT, when it terminates, suspends, or declines a provider from its Provider Network because of Fraud, integrity, or quality; and

2.7.3.5.5.2. The ICO shall notify CMS and MDCH on a quarterly basis when a provider fails credentialing or re-credentialing because of a program integrity or Adverse Action reason, and shall provide related and relevant information to CMS and MDCH as required by CMS, MDCH, or State or federal laws, rules, or regulations.

2.7.3.6. Primary Care Provider (PCP) Qualifications: For purposes of establishing the Provider Network, a PCP must be one of the following:

2.7.3.6.1. A Physician who is

2.7.3.6.1.1. Licensed by the State of Michigan;

2.7.3.6.1.2. Specialized in family practice, internal medicine, general practice, OB/GYN, or geriatrics; or

2.7.3.6.1.3. A Specialist who performs primary care functions including specialists who provide primary care in FQHCs, rural health clinics, health departments and other similar community clinics; and

2.7.3.6.1.4. In good standing with the Medicare and Medicaid programs.

2.7.3.6.2. An Advanced Practice Nurse Practitioner who is licensed by the State of Michigan; or

2.7.3.6.3. A Physician Assistant who is licensed by the State of Michigan.

2.7.3.6.4. Primary care providers must be available to see patients a minimum of twenty (20) hours per week per practice location, as per state Medicaid policy.

2.7.3.7. Primary Care Provider (PCP) Network

2.7.3.7.1. The ICO shall monitor and annually report to MDCH the number and rate of PCP turnover separately for those PCPs who leave the ICO voluntarily and those PCPs who are terminated by the ICO. If the ICO's annual PCP turnover rate exceeds ten percent (10%), the ICO shall submit an explanation for the turnover rate to MDCH. MDCH may subsequently request a business plan addressing the turnover rate for MDCH review and approval.

2.7.3.7.2. The ICO shall monitor Enrollees' voluntary changes in PCPs to identify Enrollees with multiple and frequent changes in PCPs in order to address opportunities for Enrollee education about the benefits of developing a consistent, long term patient-doctor relationship with one's PCP, and to recommend to the PCP that a screen for the need for referral to the PIHP for behavioral health services may be indicated, including situations where the ICO suspects drug seeking behavior.

2.7.3.7.3. The ICO will submit to MDCH the Provider File in a format required by MDCH on the Thursday before the last Saturday of each month containing all providers contracted with the ICO on the date of submission.

2.7.3.8. Behavioral Health Providers

2.7.3.8.1. In addition to those requirements described above, the ICO shall comply with the requirements of 42 C.F.R. § 438.214 regarding selection, retention and exclusion of behavioral health providers. The ICO shall through a contract with the PIHP have an adequate network of behavioral health, intellectual/developmental disability, and substance use providers to meet the needs of the population, including their community mental health rehabilitative service needs. Examples of these types of providers include, but are not limited to, psychiatrists, clinical psychologists, licensed clinical social workers, outpatient substance use treatment providers, and residential substance use treatment providers for pregnant women, etc.

2.7.3.8.2. Providers of Medicaid covered behavioral health services must have the appropriate licensure and qualifications as outlined in the in the Michigan Public Health Code (MCL 330.1001) et seq. and the Michigan Medicaid Provider Manual.

2.7.3.9. Indian Health Care Providers

2.7.3.9.1. The ICO must demonstrate that it made reasonable efforts to contract with Indian health care providers located within its operating region(s), including Tribal Health Centers (THC) operated by Michigan's federally recognized tribes and Urban Indian Organizations. This is necessary to ensure timely access to services available under the contract for Indian Enrollees who are eligible to receive services from such providers.

2.7.3.9.2. The ICO shall offer Indian Enrollees the option to choose an Indian health care provider as a PCP if the ICO has an Indian PCP in its network that has capacity to provide such services;

2.7.3.9.3. The ICO shall demonstrate that it has sufficient access to Indian health care providers to ensure access to Covered Services for Indian Enrollees;

2.7.3.9.4. The ICO shall pay both network and non-network Indian health care providers who provide Covered Services to Indian Enrollees a negotiated rate which shall be no lower than the MDCH fee for service rate for the same service or, in the absence of a negotiated rate, an amount not less than the amount that the ICO would pay for the Covered Service provided by a non-Indian health care provider;

2.7.3.9.5. The ICO shall make prompt payment to Indian health care providers; and

2.7.3.9.6. The ICO shall pay non-network Indian health care providers that are FQHCs for the provision of services to an Indian Enrollee at a rate equal to the rate that the ICO would pay to a network FQHC that is not an Indian health care provider.

2.7.3.10. Non-Allowed Terms of Provider Contracts

2.7.3.10.1. The ICO shall not require as a condition of participation/contracting with providers in their ICO network to also participate in the ICO's other lines of business (e.g., commercial managed care network). However, this provision would not preclude an ICO from requiring their commercial network providers to participate in their ICO Provider Network.

2.7.3.10.2. The ICO shall not require as a condition of participation/contracting with providers in the network a provider's terms of panel participation with other ICOs.

2.7.3.10.3. The ICO shall not include in its provider contracts any provision that directly or indirectly prohibits, through incentives or other means, limits, or discourages network providers from participating as network or non-network providers in any Provider Network other than the ICO's Provider Network(s).

2.7.3.11. Provider Credentialing, Recredentialing, and Board Certification

2.7.3.11.1. The ICO shall implement written policies and procedures that comply with the requirements of 42 C.F.R. §§422.504(i)(4)(iv) and 438.214(b) regarding the selection, retention and exclusion of providers, credentialing and recredentialing requirements and nondiscrimination, and meet, at a minimum, the requirements below.

2.7.3.11.2. The ICO shall directly, or through subcontracts, credential providers, except as provided in Section 2.8.8, in accordance with National Committee for Quality Assurance (NCQA) credentialing standards as well as applicable State and federal requirements.

2.7.3.11.3. Re-credentialing shall occur every three (3) years (thirty-six (36) months). At re-credentialing and on a continuing basis, the ICO shall verify minimum credentialing requirements and monitor Enrollee Grievance and Appeals, quality of care and quality of service events, and medical record review. The re-credentialing process shall take into consideration various forms of data including, but not limited to, Grievances, results of quality reviews UM information, and Enrollee satisfaction surveys.

2.7.3.11.4. The ICO's standards for licensure and certification shall be included in its participating Provider Network contracts with its network providers which must be secured by current subcontracts or employment contracts.

2.7.3.11.5. The ICO shall ensure that all providers are credentialed prior to becoming network providers and that a site visit is conducted as appropriate for initial credentialing.

2.7.3.11.6. The ICO shall ensure that no credentialed provider engages in any practice with respect to any Enrollee that constitutes unlawful discrimination under any other State or federal law or regulation, including, but not limited to, practices that violate the provisions of 45 C.F.R. Part 80, 45 C.F.R. Part 84, and 45 C.F.R. Part 90;

2.7.3.11.7. The ICO shall obtain disclosures from all network providers and applicants in accordance with 42 C.F.R. 455 Subpart B and 42 C.F.R.§ 1002.3, including but not limited to obtaining such information through Provider Enrollment forms and credentialing and recredentialing packages, and maintain such disclosed information in a manner which can be periodically searched by the ICO for exclusions and provided to MDCH in accordance with this Contract, including this Section, and relevant State and federal laws and regulations; and

2.7.3.11.8. Include the consideration of performance indicators obtained through the quality improvement plan (QIP), UM program, Grievance and Appeals system, and Enrollee satisfaction surveys in the ICO's recredentialing process.

2.7.3.11.9. The ICO shall submit its written policies and procedures annually to MDCH, if amended, and shall demonstrate to MDCH, by reporting annually, that all providers within the ICO's provider and pharmacy network are credentialed according to such policies and procedures. The ICO shall maintain written policies that:

2.7.3.11.9.1. Designate and describe the department(s) and person(s) at the ICO's organization who will be responsible for provider credentialing and re-credentialing;

2.7.3.11.9.2. Document the processes for the credentialing and re-credentialing of licensed physician providers and all other licensed or certified providers who participate in the ICO's Provider Network to perform the services agreed to under this Contract. At a minimum, the scope and structure of the processes shall be consistent with recognized managed care industry standards such as those provided by the National Committee for Quality Assurance (NCQA) and relevant State regulations found at MCL 500.3528

2.7.3.11.10. Board Certification Requirements

2.7.3.11.10.1. The ICO shall maintain a policy with respect to board certification for PCPs and specialty providers participating in the Provider Network.

2.7.4. Provider Payment and Reimbursement

2.7.4.1. The ICO must demonstrate to MDCH, including through submission of reports as may be requested by MDCH, use of Alternative Payment Methodologies (APMs) that will advance the delivery system innovations inherent in this model, incentivize quality care, and improve health outcomes for Enrollees. Notwithstanding the foregoing, nothing herein shall be construed to conflict with the requirements of 42 U.S.C. 1395w-111, Sec. 1860D-11(i).

2.7.4.1.1. Alternat ive Payment Methodologies or methods are defined as, methods of payment that are not solely based on FFS reimbursements; provided that, "alternative payment methodologies" may include, but shall not be limited to, bundled payments, global payments, and shared savings arrangements; provided further, that "alternative payment methodologies" may include FFS payments, which are settled or reconciled with a bundled or global payment.

2.7.4.2. For services in which Medicaid is the traditional primary payer, including behavioral health and substance abuse services, the ICO must establish or assure a Provider Network using the PIHP that meets the requirements identified in the Contract and specify a reimbursement model that is mutually agreed upon and identified via contract with the PIHP.

2.7.4.2.1. For services covered under the traditional Medicaid benefit, the ICO must offer a reimbursement model that is at least the MDCH FFS Medicaid payment level unless an alternative payment arrangement is mutually agreed upon by both the ICO and provider.

2.7.4.2.2. The ICO may include shared savings program for both community based and facility based LTSS providers.

2.7.4.3. For items and services that are part of the traditional Medicare benefit package, the ICO will be required to pay non-contracting providers at least the lesser of the providers' charges or the Medicare FFS rate, regardless of the setting and type of care for authorized out-of-network services.

2.7.4.4. Out of Network Providers. It is understood that in some instances Enrollees will require specialty care not available from a network provider and that the ICO will arrange that such services be provided by a non-network provider. In such event, ICO will negotiate a Single Case Agreement with a non-network provider at the applicable Medicaid or Medicare FFS rate to treat the Enrollee until a qualified network provider is available. The ICO shall make best efforts to have any non-network provider billing for services be enrolled in the Medicare Program or Michigan Medicaid Program, as appropriate and in the same manner as network providers under Section 2.7.1.2, prior to paying a Claim.

2.7.4.4.1. If the ICO's network is unable to provide necessary medical services covered under the Contract to a particular Enrollee, the ICO must adequately and timely cover these services out of network for the Enrollee, for as long as the ICO is unable to provide them. The ICO must ensure that there is no cost to the Enrollee as though the service was provided by an in-network provider for the following services:

2.7.4.4.1.1. Ventilator care in a nursing facility with a Medicaid contract for a Ventilator Dependent Care Unit; and

2.7.4.4.1.2. Ventilator care and dialysis services in a facility with a Medicaid contract for ventilator and dialysis services.

2.7.4.4.2. The ICO shall annually report to MDCH on its use of out-of-network providers to meet Enrollees' necessary medical service needs.

2.7.4.4.3. Reimbursement Rules for Out-of-Network providers are outlined in Section 2.4.1.9.

2.7.4.5. FQHCs Reimbursements

2.7.4.5.1. The ICO shall ensure that its payments to FQHCs for services to Enrollees are no less than the sum of:

2.7.4.5.1.1. The level and amount of payment that the ICO would make for such services if the services had been furnished by an entity providing similar services that was not a FQHC, and

2.7.4.5.1.2. The amount that Michigan Medicaid would have paid in cost sharing if the Enrollee were in FFS.

2.7.4.6. Primary Care Payment Rates

2.7.4.6.1. As directed by MDCH, the ICO shall set payment rates for primary care services provided by eligible providers in accordance with Section 1202 of the ACA and 42 U.S.C. § 1396a(13)(C), and all applicable federal and State laws, regulations, rules, and policies related to the implementation of such requirement. Notwithstanding the generality of the foregoing, the ICO shall, in accordance with 42 C.F.R. § 438.6(c)(5)(vi), for payments for primary care services in calendar year 2014 furnished to Enrollees under 42 C.F.R. Part 447, subpart G:

2.7.4.6.1.1. Make payments to those specified physicians (whether directly or through a capitated arrangement) at least equal to the amounts set forth and required under 42 C.F.R. Part 447, subpart G; and

2.7.4.6.1.2. Provide documentation to the MDCH, sufficient to enable MDCH to ensure that provider payments are made as required by Section 2.7.5.

2.7.4.7. Non-Payment and Reporting of Provider Preventable Conditions

2.7.4.7.1. The ICO agrees to take such action as is necessary in order for MDCH to comply with and implement all federal and State laws, regulations, policy guidance, and Michigan policies and procedures relating to the identification, reporting, and non-payment of Provider Preventable Conditions, as defined in 42 C.F.R. § 447.26 and regulations promulgated thereunder.

2.7.4.7.2. As a condition of payment, the ICO shall develop and implement policies and procedures for the identification, reporting, and non-payment of Provider Preventable Conditions. Such policies and procedures shall be consistent with federal law, including but not limited to 42 C.F.R. §§ 434.6(a)(12), 438.6(f)(2), and 447.26, and guidance and be consistent with MDCH policies, procedures, and guidance on Provider Preventable Conditions.

2.7.4.7.3. The ICO's policies and procedures shall also be consistent with the following:

2.7.4.7.3.1. The ICO shall not pay a provider for a Provider Preventable Condition.

2.7.4.7.3.2. The ICO shall require, as a condition of payment from the ICO, that all providers comply with reporting requirements on Provider Preventable Conditions as described at 42 C.F.R. § 447.26(d) and as may be specified by the ICO and/or MDCH.

2.7.4.7.3.3. The ICO shall not impose any reduction in payment for a Provider Preventable Condition when the condition defined as a Provider Preventable Condition for a particular Enrollee existed prior to the provider's initiation of treatment for that Enrollee.

2.7.4.7.3.4. An ICO may limit reductions in provider payments to the extent that the following apply:

2.7.4.7.3.4.1. The identified Provider Preventable Condition would otherwise result in an increase in payment;

2.7.4.7.3.4.2. The ICO can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the Provider Preventable Condition;

2.7.4.7.3.5. The ICO shall ensure that its non-payment for Provider Preventable Conditions does not prevent Enrollee access to services;

2.7.5. Network Management

2.7.5.1. The ICO shall develop and implement a strategy to manage the Provider Network with a focus on access to services for Enrollees, quality, consistent practice patterns, recovery and resilience, Independent Living Philosophy, Cultural Competence, integration and cost effectiveness. The management strategy shall address all providers. At a minimum, such strategy shall include:

2.7.5.1.1. A system for the ICO and network providers to identify and establish improvement goals and periodic measurements to track network providers' progress toward those improvement goals;

2.7.5.1.2. Conducting on-site visits to network providers for quality management and quality improvement purposes, and for assessing meaningful compliance with ADA requirements; and

2.7.5.1.3. Ensuring that its Provider Network, is adequate to assure access to all Covered Services, and that all providers are appropriately credentialed, maintain current licenses, and have appropriate locations to provide the Covered Services;

2.7.5.2. The ICO shall not limit or prohibit provider-based marketing activities or provider affiliation information addressed by §§ 70.11.1 and 70.11.2 of the Medicare Marketing Guidelines. The ICO shall not prohibit a provider from informing Enrollees of the provider's affiliation or change in affiliation.

2.7.5.3. The ICO shall establish and conduct an ongoing process for enrolling in their Provider Network willing and qualified providers who meet the ICO's requirements and with whom mutually acceptable provider contract terms, including with respect to rates, are reached.

2.7.5.4. The ICO shall maintain a protocol that shall facilitate communication to and from providers and the ICO, and which shall include, but not be limited to, a provider newsletter and periodic provider meetings;

2.7.5.5. Except as otherwise required or authorized by CMS, MDCH, or by operation of law, the ICO shall ensure that providers receive thirty (30) calendar days advance notice in writing of policy and procedure changes, and maintain a process to provide education and training for providers regarding any changes that may be implemented, prior to the policy and procedure changes taking effect; and

2.7.5.6. The ICO shall work in collaboration with providers to actively improve the quality of care provided to Enrollees, consistent with the Quality Improvement Strategic Workplan and all other requirements of this Contract.

2.7.5.7. The ICO shall perform an annual review to assure that the health care professionals under contract with the First Tier, Downstream, and Related Entities are qualified to perform the services covered under this Contract. The ICO must have in place a mechanism for reporting to the appropriate authorities any actions that seriously impact quality of care and which may result in suspension or termination of a provider's license.

2.7.5.8. The ICO shall require its providers to fully comply with federal requirements for disclosure of ownership and control, business transactions, and information for persons convicted of crimes against federal related health care programs, including Medicare, Medicaid, and/or Children's Health Insurance Program, as described in 42 C.F.R. § 455.

2.7.5.9. The ICO shall collect sufficient information from providers to assess compliance with the ADA. As necessary to serve Enrollees, provider locations where Enrollees receive services shall be ADA compliant. In addition, ICO shall include within its network provider locations that are able to accommodate the unique needs of Enrollees.

2.7.5.10. The ICO must have mechanisms in place to ensure compliance with timely access requirements pursuant to 42 C.F.R. § 438.206 and Section 2.8 of this Contract, including monitoring providers regularly to ensure compliance and taking corrective action if there has been a failure to comply.

2.7.6. Provider Education and Training

2.7.6.1. Prior to any Enrollment of Enrollees under this Contract and thereafter, the ICO shall conduct network provider education regarding the ICO's policies and procedures as well as the Demonstration.

2.7.6.2. The ICO must educate its Provider Network about its responsibilities for the integration and coordination of Covered Services;

2.7.6.3. The ICO must inform its Provider Network about its policies and procedures, especially regarding in and out-of-network referrals;

2.7.6.4. The ICO must inform its Provider Network about its service delivery model and Covered Services, flexible benefits, excluded services (carved-out) and, policies, procedures, and any modifications to these items;

2.7.6.5. The ICO must inform its Provider Network about the procedures and timeframes for Enrollee Grievances and Enrollee Appeals, per 42 C.F.R. § 438.414;

2.7.6.6. The ICO must inform its Provider Network about its quality improvement efforts and the providers' role in such a program;

2.7.6.7. The ICO must ensure that all network providers receive proper education and training regarding the Demonstration to comply with this Contract and all applicable federal and State requirements. The ICO shall offer educational and training programs that cover topics or issues including, but not limited to, the following:

2.7.6.7.1. Eligibility standards, eligibility verification, and benefits;

2.7.6.7.2. The role of MDCH (or its authorized agent) regarding Enrollment and disenrollment;

2.7.6.7.3. Special needs of Enrollees that may affect access to and delivery of services, to include, at a minimum, transportation needs;

2.7.6.7.4. ADA compliance, accessibility and accommodations;

2.7.6.7.5. The rights and responsibilities pertaining to

2.7.6.7.5.1. Grievance and Appeals procedures and timelines; and

2.7.6.7.5.2. Procedures for identifying, preventing and reporting Fraud, waste, neglect, abuse, exploitation, and critical incidents;

2.7.6.7.6. References to Medicaid and Medicare manuals, memoranda, and other related documents;

2.7.6.7.7. Payment policies and procedures including information on no balance billing;

2.7.6.7.8. PCP training on identification of and coordination of LTSS and Behavioral Health services;

2.7.6.7.9. Cultural competencies;

2.7.6.7.10. Person-Centered Planning Processes taking into consideration the specific needs of subpopulations of Enrollees;

2.7.6.7.11. Billing instructions which are in compliance with the Demonstration Encounter Data submission requirements; and,

2.7.6.7.12. Marketing practice guidelines and the responsibility of the provider when representing the ICO.

2.7.6.8. The ICO must train or assure training of its medical, behavioral, and LTSS providers on disability literacy, including, but not limited to the following information:

2.7.6.8.1. Various types of chronic conditions prevalent within the target population;

2.7.6.8.2. Awareness of personal prejudices;

2.7.6.8.3. Legal obligations to comply with the ADA requirements;

2.7.6.8.4. Definitions and concepts, such as communication access, medical equipment access, physical access, and access to programs;

2.7.6.8.5. Types of barriers encountered by the target population;

2.7.6.8.6. Training on the Person-Centered Planning Process and Self-Determination, the social model of disability, the Independent Living Philosophy, and the recovery model;

2.7.6.8.7. Use of evidence-based practices and specific levels of quality outcomes; and

2.7.6.8.8. Working with Enrollees with mental health diagnoses, including crisis prevention and treatment.

2.7.6.9. Provider Manual: The Provider Manual shall be a comprehensive online reference tool for the provider and staff regarding, but not limited to, administrative, prior authorization, and referral processes, Claims and Encounter Data submission processes, and plan benefits. The Provider Manual shall also address topics such as clinical practice guidelines, availability and access standards, Care Management programs and Enrollee rights, including Enrollees rights not to be balanced billed. The ICO must include in the Provider Manual a provision explaining that the ICO may not limit a provider's communication with Enrollees as provided in Section 2.7.5.2.

2.7.6.10. Provider and Pharmacy Directory. The ICO shall make its Provider and Pharmacy Directory available to providers via the ICO's web-portal. Upon request, the ICO must be able to provide a paper copy to providers.

2.7.6.11. The ICO shall educate providers through a variety of means including, but not limited to, provider alerts or similar written issuances, about their legal obligations under State and Federal law to communicate with Enrollees and Potential Enrolleeswith limited English proficiency, including the provision of interpreter services, and the resources available to help providers comply with those obligations. All such written communications shall be subject to review at MDCH's and CMS' discretion.

2.7.7. Subcontracting Requirements

2.7.7.1. The ICO remains fully responsible for meeting all of the terms and requirements of the Contract regardless of whether the ICO subcontracts for performance of any Contract responsibility. The ICO shall require each First Tier, Downstream or Related Entity to meet all terms and requirements of the Contract that are applicable to such First Tier, Downstream or Related Entity. No subcontract will operate to relieve the ICO of its legal responsibilities under the Contract.

2.7.7.2. The ICO is responsible for the satisfactory performance and adequate oversight of its First Tier, Downstream and Related Entities. First Tier, Downstream and Related Entities are required to meet the same federal and State financial and program reporting requirements as the ICO. The ICO is required to evaluate any potential First Tier, Downstream or Related Entity prior to delegation, pursuant to 42 C.F.R. § 438.240. Additional information about subcontracting requirements is contained in Appendix C.

2.7.7.3. The ICO must establish contracts and other written agreements between the ICO and First Tier, Downstream and Related Entities for Covered Services not delivered directly by the ICO or its employees;

2.7.7.4. The ICO must require that First Tier, Downstream and Related Entities afford Enrollees the opportunity and assistance with filing a Grievance, Appeal, or State Fair Hearing, and require procedures and timeframes for doing so, as well as the rules for representation at hearing; and that First Tier, Downstream and Related Entities must permit an Enrollee to request continuation of benefits if the Enrollee files an Appeal or a request for a State Fair Hearing within specified timeframes; and the ICO must provide the toll-free numbers to file oral grievances and appeals to First Tier, Downstream and Related Entities;

2.7.7.5. The ICO must subject the First Tier, Downstream and Related Entities' performance to formal review according to a periodic schedule established by the State, consistent with industry standards or State MCO laws and regulations.

2.8. Enrollee Access to Services

2.8.1. General

2.8.1.1. The ICO must authorize, arrange, coordinate and ensure the provision of all Medically Necessary Covered Services for Enrollees, as specified in Section 2.4 and Appendix A, in accordance with the requirements of the Contract. Services shall be available twenty-four (24) hours a day, seven (7) days a week when medically necessary.

2.8.1.2. The ICO must offer adequate choice and availability of primary, specialty, acute care, behavioral health and LTSS providers that meet CMS and MDCH standards as provided for in Section 2.7;

2.8.1.2.1. The ICO shall have a mechanism in place to allow Enrollees to directly access a specialist as appropriate for the Enrollee's condition and identified needs.

2.8.1.3. The ICO must at all times cover the appropriate level of service for all Emergency Services and non-Emergency Services in an appropriate setting;

2.8.1.4. All urgent and symptomatic office visits must be available to Enrollees within twenty-four (24) hours. A symptomatic office visit is an encounter associated with the presentation of medical symptoms or signs, but not requiring immediate attention;

2.8.1.5. Network providers shall offer hours of operation that are no less than the hours of operation offered to individuals who are not Enrollees.

2.8.1.6. The ICO must reasonably accommodate persons and shall ensure that the programs and services are as accessible (including physical and geographic access) to an individual with disabilities as they are to an individual without disabilities. The ICO and its network providers must comply with the American with Disabilities Act (ADA) as outlined in Section 2.8.12.1 of this Contract. The ICO shall have written policies and procedures to assure compliance, including ensuring that physical, communication, and programmatic barriers do not inhibit individuals with disabilities from obtaining all Covered Services from the ICO by:

2.8.1.6.1. Providing flexibility in scheduling to accommodate the needs of the Enrollees;

2.8.1.6.2. Providing interpreters or translators for Enrollees who are Deaf and hard of hearing and those who do not speak English;

2.8.1.6.3. Ensuring that individuals with disabilities are provided with reasonable accommodations to ensure effective communication, including auxiliary aids and services. Reasonable accommodations will depend on the particular needs of the individual and include but are not limited to:

2.8.1.6.3.1. Providing large print (at least 16-point font) versions of all written materials to individuals with visual impairments;

2.8.1.6.3.2. Ensuring that all written materials are available in formats compatible with optical recognition software;

2.8.1.6.3.3. Reading notices and other written materials to individuals upon request;

2.8.1.6.3.4. Assisting individuals in filling out forms over the telephone;

2.8.1.6.3.5. Ensuring effective communication to and from individuals with disabilities through email, telephone, and other electronic means;

2.8.1.6.3.6. Providing TTY/TDD, computer-aided transcription services, telephone handset amplifiers, assistive listening systems, closed caption decoders, videotext displays and qualified interpreters for the Deaf;

2.8.1.6.3.7. Providing Individualized forms of assistance;

2.8.1.6.3.8. Ensuring safe and appropriate physical access to buildings, services and equipment;

2.8.1.6.3.9. Demonstrating compliance with the ADA by conducting an independent survey or site review of facilities for both physical and programmatic accessibility, documenting any deficiencies in compliance and monitoring correction of deficiencies; and

2.8.1.6.3.10. The ICO must identify to MDCH the individual in its organization who is responsible for ADA compliance related to this Demonstration and his/her job title. The ICO must also establish and execute, and annually update a work plan to achieve and maintain ADA compliance.

2.8.1.7. When a PCP or any medical, behavioral health or LTSS provider is terminated from the ICO's plan or leaves the network for any reason, the ICO must make a good faith effort to give written notification of termination of such provider, within fifteen (15) calendar days after receipt or issuance of the termination notice, to each Enrollee who received his or her care from, or was seen on a regular basis by, the terminated PCP or any other medical, behavioral or LTSS provider. For terminations of PCPs, the ICO must also report the termination to MDCH and provide assistance to the Enrollee in selecting a new PCP within fifteen (15) calendar days. For Enrollees who are receiving treatment for a chronic or ongoing medical condition or LTSS, the ICO shall ensure that there is no disruption in services provided to the Enrollee.

2.8.1.8. When the Food and Drug Administration (FDA) determines a drug to be unsafe, the ICO shall remove it from the formulary immediately. The ICO must make a good faith effort to give written notification of removal of this drug from the formulary and the reason for its removal, within five (5) calendar days after the removal, to each Enrollee with a current or previous prescription for the drug. The ICO must also make a good faith effort to call, within three (3) calendar days, each Enrollee with a current or previous prescription for the drug; a good faith effort must involve no fewer than three phone call attempts at different times of day. Phone call attempts shall be documented in the ICBR.

2.8.2. Services Not Subject to Prior Approval

2.8.2.1. The ICO will assure coverage of Emergency Medical Conditions and Urgent Care Services. The ICO must not require prior approval for the following services:

2.8.2.1.1. Any services for Emergency Medical Conditions as defined in 42 C.F.R §§ 422.113(b)(1) and 438.114(a) (which includes emergency behavioral health care);

2.8.2.1.2. Urgent Care sought outside of the Service Area;

2.8.2.1.3. Urgent Care under unusual or extraordinary circumstances provided in the Service Area when the contracted medical provider is unavailable or inaccessible;

2.8.2.1.4. Family planning services;

2.8.2.1.5. Out-of-area renal dialysis services; and

2.8.2.1.6. Prescription drugs as required in Appendix D.

2.8.3. Authorization of Services

2.8.3.1. ICO shall authorize services as in accordance with 42 C.F.R. § 438.210.

2.8.3.2. For the processing of requests for initial and continuing authorizations of Covered Services, the ICO and any First Tier, Downstream, or Related Entities shall:

2.8.3.2.1. Have in place and follow written policies and procedures;

2.8.3.2.2. Have in place procedures to allow Enrollees to initiate requests for provision of services;

2.8.3.2.3. Have in effect mechanisms to ensure the consistent application of review criteria for authorization decisions; and

2.8.3.2.4. Consult with the requesting provider when appropriate.

2.8.3.3. The ICO shall ensure that an ICO representative and a behavioral health provider are available twenty-four (24) hours a day for timely authorization of Medically Necessary Services, including, if necessary, the transfer of the Enrollee who presented to an emergency department with an Emergency Medical Condition that has been Stabilized. The ICO's Medical Necessity guidelines must, at a minimum, be no more restrictive than Medicare standards for acute services and prescription drugs and Medicaid standards for LTSS and community mental health and substance use disorder services.

2.8.3.4. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be made by a health care professional who has appropriate clinical expertise in treating the Enrollee's medical condition, performing the procedure, or providing the treatment. Behavioral health services denials must be rendered by board-certified or board-eligible psychiatrists or by a clinician licensed with the same or similar specialty as the behavioral health services being denied, except in cases of denials of service for psychological testing, which shall be rendered by a qualified psychologist.

2.8.3.5. The ICO shall assure that all behavioral health authorization and UM activities are in compliance with 42 U.S.C. § 1396u-2(b)(8). The ICO must comply with the requirements for demonstrating parity for treatment limitations between mental health and substance use disorder and medical/surgical inpatient, outpatient and pharmacy benefits.

2.8.3.6. The ICO must notify the requesting provider, either orally or in writing, and give the Enrollee written Adverse Action Notice of any decision by the ICO to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice must meet the requirements of 42 C.F.R. § 438.404 and Section 5.1, and must:

2.8.3.6.1. Be produced in a manner, format, and language that can be easily understood;

2.8.3.6.2. Be made available in Prevalent Languages, upon request; and

2.8.3.6.3. Include information, in the most commonly used languages about how to request translation services and Alternative Formats.

2.8.3.7. The ICO must make authorization decisions in the following timeframes and provide notice that meet the timing requirements set forth in 42 C.F.R. §§ 438.404 and 438.210:

2.8.3.7.1. For standard authorization decisions, provide notice as expeditiously as the Enrollee's health condition requires and no later than fourteen (14) calendar days after receipt of the request for service, with a possible extension not to exceed fourteen (14) additional calendar days. Such extension shall only be allowed if:

2.8.3.7.1.1. The Enrollee or the provider requests an extension, or

2.8.3.7.1.2. The ICO can justify (to the satisfaction of the CMT upon request) that:

2.8.3.7.1.2.1. The extension is in the Enrollee's interest; and

2.8.3.7.1.2.2. There is a need for additional information where:

2.8.3.7.1.2.2. 1. There is a reasonable likelihood that receipt of such information would lead to approval of the request, if received; and

2.8.3.7.1.2.2. 2. Such outstanding information is reasonably expected to be received within fourteen (14) calendar days.

2.8.3.7.2. For expedited service authorization decisions, where the provider indicates or the ICO determines that following the standard timeframe in Section 2.8.3.7 could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function, the ICO must make a decision and provide notice as expeditiously as the Enrollee's health condition requires and no later than seventy-two (72) hours after receipt of the request for service, with a possible extension not to exceed fourteen (14) additional calendar days. Such extension shall only be allowed if:

2.8.3.7.2.1. The Enrollee or the provider requests an extension; or

2.8.3.7.2.2. The ICO can justify (to MDCH and/or CMS upon request) that:

2.8.3.7.2.2.1. The extension is in the Enrollee's interest; and

2.8.3.7.2.2.2. There is a need for additional information where:

2.8.3.7.2.2.2. 1. There is a reasonable likelihood that receipt of such information would lead to approval of the request, if received; and

2.8.3.7.2.2.2. 2. Such outstanding information is reasonably expected to be received within fourteen (14) calendar days.

2.8.3.7.3. In accordance with 42 C.F.R. §§ 438.6(h), 438.210, and 422.208, compensation to individuals or entities that conduct UM activities for the ICO must not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary Services to any Enrollee.

2.8.4. Behavioral Health Service Authorization Policies and Procedures

2.8.4.1. The ICO shall delegate to the PIHP BH Service authorizations. The contract between the ICO and the PIHP shall include requirements as outlined in Appendix C and will adhere to the authorization requirements found in Section 2.8.3.

2.8.5. Authorization of LTSS

2.8.5.1. The ICO must develop an authorization process for the LTSS listed in Appendix A.

2.8.5.2. At a minimum, the ICO's authorization of LTSS must comply with MDCH's FFS authorization criteria for those Covered Services. However, the ICO has the discretion to authorize LTSS more broadly in terms of criteria, amount, duration and scope, if the IICSP determines that such authorization would provide sufficient value to the Enrollee's care. Value shall be determined in light of the full range of services included in the IICSP, considering how the services contribute to the health and independent living of the Enrollee in the most integrated and least restrictive setting with reduced reliance on emergency department use, acute inpatient care and institutional LTSS.

2.8.6. Utilization Management

2.8.6.1. The ICO's UM programs shall comply with CMS requirements and timeframes for historically Medicare primary paid services in addition to the requirements for historically Medicaid primary paid services.

2.8.6.2. The ICO must have a written UM program description which includes procedures to evaluate medical necessity, criteria used, information source, and the process used to review and approve or deny the provision of medical and long-term care services. The ICO's UM program must ensure consistent application of review criteria for authorization decisions; and must consult with the requesting provider when appropriate. The program shall demonstrate that Enrollees have equitable access to care across the network and that UM decisions are made in a fair, impartial, and consistent manner that serves the best interests of the Enrollees. The program shall reflect the standards for UM from the most current NCQA standards when applicable. The program must have mechanisms to detect under-utilization and/or over-utilization of care including, but not limited to, provider profiles.

2.8.6.3. If the ICO delegates responsibilities for UM to a First Tier, Downstream or Related Entity, the contract must have a mechanism in place to ensure that these standards are met by the First Tier, Downstream or Related Entity. The UM plan shall be submitted annually to MDCH and upon revision.

2.8.6.4. The ICO shall assume responsibility for all Covered Services authorized by MDCH, CMS or a previous ICO, which are rendered after the Enrollment effective date.

2.8.7. Services for Specific Populations

2.8.7.1. As appropriate, the ICO shall coordinate with social service agencies (e.g., local departments of health and social services) and refer Enrollees to the following programs, to include, but not be limited to:

2.8.7.1.1. Community Mental Health Service Programs (CMHSPs)

2.8.7.1.2. Area Agencies on Aging

2.8.7.1.3. Centers for Independent Living

2.8.7.1.4. Faith based organizations

2.8.7.1.5. Local Department of Human Services

2.8.7.1.6. Local Health Departments

2.8.7.1.7. Non-profit service organizations

2.8.7.1.8. Adult Protective Services

2.8.7.1.9. Long Term Care Ombudsman

2.8.7.1.10. Legal Services.

2.8.7.2. The ICO shall deliver preventive health care services including, but not limited to, cancer screenings and appropriate follow-up treatment to Enrollees, other screenings or services as specified in guidelines set by MDCH or, where there are no MDCH guidelines, in accordance with nationally accepted standards of practice.

2.8.7.3. The ICO shall provide family planning services in accordance with Covered Services outlined in Section 2.4;

2.8.7.4. Through the Care Bridge (see section 2.5.1.6 for details), the ICO shall provide systems and mechanisms designed to make Enrollees' medical history and treatment information available, within applicable legal limitations, at the various sites where the same Enrollee may be seen for care, especially for Enrollees identified as homeless. While establishing a fully integrated delivery system, the ICO shall respect the privacy of Enrollees. The ICO shall comply with Section 5.2 regarding compliance with laws and regulations relating to confidentiality and privacy.

2.8.8. Emergency and Post-stabilization Care Coverage

2.8.8.1. The ICO's Provider Network must ensure access to twenty-four (24) hour Emergency Services for all Enrollees, whether they reside in institutions or in the community. The ICO must cover and pay for any services obtained for Emergency Medical Conditions in accordance with 42 C.F.R. § 438.114(b) and (c) and 42 C.F.R. § 422.113(b) and (c).

2.8.8.2. The ICO shall cover and pay for Emergency Services regardless of whether the provider that furnishes the services has a Contract with the ICO. The ICO shall pay an out-of-network provider of Emergency and Post-Stabilization Care an amount equal to or, if the ICO can negotiate a

lower payment, less than the amount allowed under Medicare's FFS rate, less any payments for indirect costs of medical education and direct costs of graduate medical education. The ICO shall ensure that the Enrollee is not billed for the difference, if any, between such rate and the non-contracted provider's charges.

2.8.8.2.1. Payment shall be made within sixty (60) calendar days after the Claim has been submitted. The ICO must ensure that cost to the Enrollee is no greater than it would be if the services were furnished within the network.

2.8.8.3. The ICO shall:

2.8.8.3.1. Have a process established to notify the PCP or ICT (or the designated covering physician) of an Emergency Condition within one (1) business day after the ICO is notified by the provider. If the ICO is not notified by the provider within ten (10) calendar days of the Enrollee's presentation for Emergency Services, the ICO may not refuse to cover Emergency Services.

2.8.8.3.2. Have a process to notify the PCP or ICT of required Urgent Care within twenty-four (24) hours of the ICO being notified.

2.8.8.3.3. Record summary information about Emergency Medical Conditions and Urgent Care services in the Enrollee ICBR no more than twenty-four (24) hours after the PCP or ICT is notified, and a full report of the services provided within two (2) business days.

2.8.8.4. The ICO shall not deny payment for treatment for an Emergency Medical Condition, pursuant to 42 C.F.R § 438.114 and 42 C.F.R § 422.113.

2.8.8.5. The ICO shall not deny payment for treatment of an Emergency Medical Condition if a representative of the ICO instructed the Enrollee to seek Emergency Services.

2.8.8.5.1. ICO may not deny payment for treatment obtained when a Enrollee had an Emergency Medical Condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 C.F.R § 438.114(a) and 42 C.F.R § 422.113(b) of the definition of Emergency Medical Condition.

2.8.8.6. The ICO shall not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms.

2.8.8.7. The ICO shall require providers to notify the Enrollee's PCP of an Enrollee's screening and treatment, but may not refuse to cover Emergency Services based on their failure to do so.

2.8.8.8. An Enrollee who has an Emergency Medical Condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the Enrollee.

2.8.8.9. The attending emergency physician, or the provider actually treating the Enrollee, is responsible for determining when the Enrollee is sufficiently stabilized for transfer or discharge. That determination is binding on the ICO if:

2.8.8.9.1. Such transfer or discharge order is consistent with generally accepted principles of professional medical practice; and

2.8.8.9.2. Is a Covered Service under the Contract.

2.8.8.10. The ICO shall cover and pay for Post-Stabilization Care Services in accordance with 42 C.F.R. §§ 438.114(e) and 422.113(c).

2.8.8.11. The ICO shall cover Post-Stabilization Care Services provided by provider in any of the following situations:

2.8.8.11.1. The ICO authorized such services;

2.8.8.11.2. Such services were administered to maintain the Enrollee's Stabilized condition within one (1) hour after a request to the ICO for authorization of further Post-Stabilization Care Services; or

2.8.8.11.3. The ICO does not respond to a request to authorize further Post-Stabilization Care Services within one (1) hour, the ICO could not be contacted, or the ICO and the treating Provider cannot reach an agreement concerning the Enrollee's care and a provider is unavailable for a consultation, in which case the treating Provider must be permitted to continue the care of the Enrollee until a provider is reached and either concurs with the treating Provider's plan of care or assumes responsibility for the Enrollee's care.

2.8.9. Emergency Medical Treatment and Labor Act (EMTALA)

2.8.9.1. The ICO and providers shall comply with EMTALA, which, in part, requires:

2.8.9.1.1. Qualified hospital medical personnel to provide appropriate medical screening examinations to any Enrollee who "comes to the emergency department," as defined in 42 C.F.R.§ 489.24(b); and,

2.8.9.1.2. As applicable, to provide Enrollees stabilizing treatment or, if the hospital lacks the capability or capacity to provide stabilizing treatment, appropriate transfers.

2.8.9.1.3. The ICO's contracts with its providers must clearly state the provider's EMTALA obligations and must not create any conflicts with hospital actions required to comply with EMTALA.

2.8.10. Availability of Services

2.8.10.1. Twenty-Four (24) Hour Coverage

2.8.10.1.1. The ICO must provide a twenty-four (24)hour, seven (7) days toll-free system with access to a registered nurse who:

2.8.10.1.1.1. Has immediate access to the Enrollee Medical Record;

2.8.10.1.1.2. Is able to respond to Enrollee questions about health or medical concerns;

2.8.10.1.1.3. Has the experience and knowledge to provide clinical triage;

2.8.10.1.1.4. Is able to provide options other than waiting until business hours or going to the emergency room; and,

2.8.10.1.1.5. Is able to provide access to oral interpretation services available as needed, free-of-charge.

2.8.11. Linguistic Competency

2.8.11.1. The ICO must demonstrate linguistic competency in its dealing, both written and verbal, with Enrollees and must understand that linguistic differences between the provider and the Enrollee cannot be permitted to present barriers to access and quality health care and demonstrate the ability to provide quality health care across a variety of cultures.

2.8.11.2. The ICO must have the capacity to meet the needs of the linguistic groups in its Service Area. The following must be available:

2.8.11.2.1. The provision of care, including twenty-four (24)hour telephone access and scheduling appointments, by providers who are fluent in both English and the language spoken by the Enrollee, or through translation services performed by individuals who are:

2.8.11.2.1.1. Trained to translate in a medical setting;

2.8.11.2.1.2. Fluent in English; and

2.8.11.2.1.3. Fluent in the Enrollee's language;

2.8.11.2.2. Linguistically appropriate pharmacy, specialty, behavioral health, and LTSS providers.

2.8.12. Access for Enrollees with Disabilities

2.8.12.1. The ICO and its providers must comply with the ADA (28 C.F.R. § 35.130) and Section 504 of the Rehabilitation Act of 1973 (Section 504) (29 U.S.C. § 794) and maintain capacity to deliver services in a manner that accommodates the needs of its Enrollees.

2.8.12.2. The ICO and its providers can demonstrate compliance with the ADA by conducting an independent survey or site review of facilities for both physical and programmatic accessibility.

2.8.12.3. Physical and telephone access to services must be made available for individuals with disabilities and fully comply with the ADA.

2.8.12.4. The ICO must reasonably accommodate persons with disabilities and ensure that physical and communication barriers do not inhibit individuals with disabilities from obtaining services from the ICO.

2.8.12.5. The ICO must have policies and procedures in place demonstrating a commitment accommodating physical access and flexible scheduling needs of Enrollees, in compliance with the ADA. This includes the use of TTY/TDD devices for the Deaf and hard of hearing, qualified American Sign Language (ASL) interpreters and alternative cognitively accessible communication for persons with cognitive limitations.

2.9. Enrollee Services

2.9.1. Enrollee Service Representatives (ESRs)

2.9.1.1. The ICO must employ ESRs trained to answer Enrollee inquiries and concerns from Enrollees and Potential Enrollees, consistent with the requirements of 42 C.F.R.§§ 422.111(h) and 423.128(d).

2.9.1.2. ESRs must be trained to answer Enrollee inquiries and concerns from Enrollees and prospective Enrollees;

2.9.1.3. ESRs must be trained in the use of TTY/TDD, Video Relay services, remote interpreting services, how to provide accessible PDF materials, and other Alternative Formats as described in Section 2.8.1.6.3.6;

2.9.1.4. ESRs must be capable of speaking directly with, or arranging for an interpreter to speak with, Enrollees in their primary language, including ASL, or through an alternative language device or telephone translation service;

2.9.1.5. ESRs must inform callers that interpreter services are free.

2.9.1.6. ESRs must be knowledgeable about Michigan Medicaid, Medicare, and the terms of the Contract, including the Covered Services listed in Appendix A;

2.9.1.7. ESRs must be knowledgeable about PIHP services and enrollee service lines including the PIHP twenty-four (24) hour crisis line and transfer or refer callers appropriately;

2.9.1.8. ESRs must be available to Enrollees to discuss and provide assistance with resolving Enrollee Grievances;

2.9.1.9. ESRs must have access to the Enrollee's ICBR and an electronic Provider and Pharmacy Directory.

2.9.1.10. ESRs must make oral interpretation services available free-of-charge to Enrollees in all non-English languages spoken by Enrollees, including ASL;

2.9.1.11. ESRs must maintain the availability of services, such as TTY/TDD services, computer-aided transcription services, telephone handset amplifiers, assistive listening systems, closed caption decoders, videotext displays and qualified interpreters including ASL and other services for Enrollees who are Deaf or hard of hearing;

2.9.1.12. ESRs must demonstrate sensitivity to culture, including disability culture, the Independent Living Philosophy, and Person-Centered Planning;

2.9.1.13. ESRs must provide assistance to Enrollees with cognitive impairments; for example, provide written materials in simple, clear language at or below sixth (6th) grade reading level, and individualized guidance from ESRs to ensure materials are understood;

2.9.1.14. ESRs must provide reasonable accommodations needed to assure effective communication and provide Enrollees with a means to identify their disability to the ICO;

2.9.1.15. ESRs must maintain employment standards and requirements (e.g., education, training, and experience) for Enrollee services department staff and provide a sufficient number of staff to meet defined performance objectives; and

2.9.1.16. The ICO must ensure that ESRs make available to Enrollees and potential Enrollees, upon request, information concerning the following:

2.9.1.16.1. The identity, locations, qualifications, and availability of providers;

2.9.1.16.2. Enrollees' rights and responsibilities;

2.9.1.16.3. The procedures available to an Enrollee and provider(s) to challenge or Appeal the failure of the ICO to provide a Covered Service and to Appeal any Adverse Actions (denials);

2.9.1.16.4. How to access oral interpretation services and written materials in Prevalent Languages and Alternative Formats;

2.9.1.16.5. Information on all Covered Services and other available services or resources (e.g., State agency services) either directly or through referral or authorization including referral to the PIHP for BH, SUD and I/DD services;

2.9.1.16.6. Process by which an Enrollee can access the Demonstration's Ombudsman, the State Long Term Care Ombudsman, the MDCH Enrollee Help Line, MMAP and 1-800-Medicare;

2.9.1.16.7. Information on all ICO Covered Services and other available services or resources (e.g., State agency services) either directly or through referral or authorization;

2.9.1.16.8. How to contact immediate emergency assistance including adult protective services, suicide hotlines and other appropriate emergency services;

2.9.1.16.9. The procedures for an Enrollee to change plans or to Opt Out of the Demonstration; and

2.9.1.16.10. Additional information that may be required by Enrollees and Potential Enrollees to understand the requirements and benefits of the ICO's plan.

2.9.2. Enrollee Service Telephone Responsiveness

2.9.2.1. The ICO must operate a call center during normal business hours and never less than from 8:00 a.m. to 8:00 p.m. (EST), seven (7) days a week, consistent with the required Marketing Guidelines.

2.9.2.1.1. ESRs must be available Monday through Friday, at least from 8:00 a.m. to 8:00 p.m. (EST). The ICO may use alternative call center technologies on Saturdays, Sundays, and Federal holidays.

2.9.2.1.2. ESRs must be appropriately trained and qualified health professionals who, according to HIPAA laws, assess the Enrollee's issues and provide an appropriate course of action (i.e., medical advice, direct the Enrollee to an appropriate care setting, etc.).

2.9.2.1.3. A toll-free TTY/TDD number or State relay service must be provided.

2.9.2.1.4. The ICO must ensure that if care management needs are identified for an Enrollee that the ESR facilitating the Enrollee's issue has access to, and is familiar with, the Enrollee's IICSP. The ICO must ensure that follow-up is timely and appropriate to assure the Enrollee's health and welfare.

2.9.2.1.5. The ICO must provide interpreter service to all non-English speaking and limited English proficient Enrollees.

2.9.2.1.6. The ICO must inform callers that interpreter services are available free of charge.

2.9.2.2. Call Center Performance

2.9.2.2.1. The ICO's ESRs' must answer eighty percent (80%) of all Enrollee telephone calls within thirty (30) seconds or less.

2.9.2.2.2. The ICO must limit average hold time to two (2) minutes, with the average hold time defined as the time spent on hold by the caller following the interactive voice response (IVR) system, touch tone response system, or recorded greeting and before reaching a live person.

2.9.2.2.3. The ICO must limit the disconnect rate of all incoming calls to five percent (5%).

2.9.2.2.4. The ICO must have a process to measure the time from which the telephone is answered to the point at which an Enrollee reaches an ESR capable of responding to the Enrollee's question in a manner that is sensitive to the Enrollee's language and cultural needs.

2.9.2.3. Informational calls to the ICO's call centers that become sales/Enrollment calls at the proactive request of the Potential Enrollee must be transferred to MDCH's Enrollment Broker.

2.9.3. Coverage Determinations and Appeals Call Center Requirements

2.9.3.1. The ICO must operate a toll-free call center with live enrollee service representatives available to respond to providers and Enrollees for information related to requests for coverage under Medicare and Medicaid, and Medicare and Medicaid Appeals (including requests for Medicare and Medicaid exceptions and prior authorizations).

2.9.3.2. The ICO is required to provide immediate access to requests for Medicare and Medicaid covered benefits and services, including Medicare and Medicaid coverage determinations and redeterminations, via its toll-free call centers.

2.9.3.3. The coverage determination and Appeals call centers must operate during normal business hours and never less than from 8:00 a.m. to 8:00 p.m. EST, Monday through Friday.

2.9.3.4. The ICO must accept requests for Medicare and Medicaid coverage, including Medicare and Medicaid coverage determinations /redeterminations, outside of normal business hours, but is not required to have live enrollee service representatives available to accept such requests outside normal business hours.

2.9.3.5. Voicemail may be used outside of normal business hours provided that the message:

2.9.3.5.1. Indicates that the mailbox is secure;

2.9.3.5.2. Lists the information that must be provided so the case can be worked [e.g., provider identification, Enrollee identification, type of request (coverage determination or Appeal), physician support for an exception request, and whether the Enrollee is making an expedited or standard request];

2.9.3.5.3. For coverage determination calls (including exceptions requests), articulates and follows a process for resolution within twenty-four (24) hours of call for expedited requests and seventy-two (72) hours for standard requests; and

2.9.3.5.4. For Appeals calls related to Part D, information articulates the process information needed and provide for a resolution within seventy-two (72) hours for Expedited Appeal requests and seven (7) calendar days for standard Appeal requests.

2.9.3.6. Provider Accessibility and Nurse Advice Line:

2.9.3.6.1. The ICO shall require PCPs and specialty provider Contracts to provide coverage for their respective practices twenty-four (24) hours a day, seven (7) days a week and have a published after hours telephone number; voicemail alone after hours is not acceptable.

2.9.3.6.2. The ICO shall establish a toll-free nurse advice line, available twenty-four (24) hours a day, seven (7) days a week, through which Enrollees may obtain medical guidance and support from a nurse. The ICO shall ensure that the nurses staffing the nurse advice line will be able to obtain physician support and advice by contacting the ICO's medical director or equally-credentialed designee, if needed.

2.9.4. Enrollee Participation on the ICO Advisory Council

2.9.4.1. Each ICO shall establish at least one ICO Advisory Council and a process for that council to provide input to the governing board of the ICO's parent organization and that will provide regular feedback to the ICO's governing board on issues of Demonstration management and Enrollee care.

2.9.4.2. The ICO shall ensure that the ICO Advisory Council:

2.9.4.2.1. Is comprised of Enrollees, family members and other caregivers that reflect the diversity of the Demonstration population, including individuals with disabilities.

2.9.4.2.2. Meets at least quarterly and provide a permanent record of proceedings that are reported to MDCH.

2.9.4.2.3. Composition reflects the diversity of the Demonstration, including a mix of Enrollees, caregivers, and local representation from key community stakeholders such as advocacy organizations, faith-based organizations, and other community-based organizations, with one third of the advisory board composed of Enrollees

2.9.4.3. The ICO must accommodate and support the ICO Advisory Council members by arranging necessary transportation, appropriate

communications, and other measures to ensure and encourage their full participation on the ICO Advisory Council.

2.9.4.4. The ICO shall also include Ombudsman reports in quarterly updates to the ICO Advisory Council and shall participate in all statewide stakeholder and oversight convenings as requested by MDCH and/or CMS.

2.9.4.5. The ICO must have written policies and procedures for ICO Advisory Council elections detailing, at a minimum, the following

2.9.4.5.1. How the members of the ICO Advisory Council will be elected;

2.9.4.5.2. The length of the term for ICO Advisory Council members;

2.9.4.5.3. The process for filling vacancies; and

2.9.4.5.4. Procedures for providing notice to Enrollees.

2.9.4.6. A member of the ICO's parent organization's governing board must participate on the ICO Advisory Council and serve as the ICO Advisory Council's direct liaison to the parent organization's governing body.

2.10. Enrollee Grievance

2.10.1. Grievance Filing

2.10.1.1. Internal Grievance Filing: An Enrollee, or an authorized representative, may file an internal Enrollee Grievance at any time with the ICO or its providers by calling or writing to the ICO or provider. If the internal Enrollee Grievance is filed with a provider, the ICO must require the provider to forward it to the ICO. If remedial action is requested regarding a Medicare issue, the Enrollee must file the Grievance with the ICO or provider no later than ninety (90) calendar days after the event or incident triggering the Grievance.

2.10.1.2. External Grievance Filing: The ICO shall inform Enrollees that they may file an external Grievance through 1-800 Medicare. The ICO must display a link to the electronic Grievance form on the Medicare.gov Internet Web site on the ICO's main Web page per 42 C.F.R. § 422.504(a)(15)(ii). The ICO must inform Enrollees of the email address, postal address or toll-free telephone number where an Enrollee Grievance may be filed.

2.10.1.3. External Grievances filed with the State shall be forwarded to the Contract Management Team and entered into the CMS Health Plan Management System (HPMS) complaints tracking module, which will be accessible to the ICO.

2.10.1.4. Authorized representatives may file Grievances on behalf of Enrollees to the extent allowed under applicable federal or State law.

2.10.1.5. The ICO will coordinate Enrollee grievances for Medicare behavioral health services with the PIHP as outlined in Appendix C.

2.10.2. Grievance Administration

2.10.2.1. Internal (plan level) Grievance

2.10.2.1.1. The ICO must have a formally structured Grievance system, consistent with42 C.F.R. § 431 Subpart E and 42 C.F.R. § 438 Subpart F in place for addressing Enrollee Grievances, including Grievances regarding reasonable accommodations and access to services under the ADA. The ICO must maintain written records of all Grievance activities, and notify CMS and MDCH of all Grievances.

2.10.2.1.2. The ICO must submit its Grievance procedures to MDCH for prior approval. The ICO must submit in writing to the MDCH any request to make changes to grievance procedures. MDCH must review and approve the request prior to implementing any change. Request for changes must allow adequate time for review and approval by MDCH. When the change requires written notice to the Enrollees, the change cannot take effect until such notice is issued.

2.10.2.1.3. The system must meet the following standards:

2.10.2.1.3.1. Timely acknowledgement of receipt of each Enrollee Grievance;

2.10.2.1.3.2. Timely review of each Enrollee Grievance;

2.10.2.1.3.3. Response, electronically, orally or in writing, to each Enrollee Grievance within a reasonable time, but no later than thirty (30) calendar days after the ICO receives the Grievance; and dispose of each Grievance as expeditiously as the Enrollee's health requires, but in no event later than (90) calendar days;

2.10.2.1.3.4. Expedited response, orally or in writing, within twenty-four (24) hours after the ICO receives the Grievance to each Enrollee Grievance whenever ICO extends the Appeals timeframe or ICO refuses to grant a request for an expedited Appeal;

2.10.2.1.3.5. Notice to the Enrollee of the disposition of the Grievance; and

2.10.2.1.3.6. Availability to Enrollees of information about Enrollee Appeals, as described in Subsection 2.11, including reasonable assistance in completing any forms or other procedural steps, which shall include interpreter services and toll-free numbers with TTY/TDD and interpreter capability.

2.10.2.1.3.7. The ICO must ensure that the individuals who make decisions on Grievances (1) were not involved in previous levels of review or decision making and, (2) if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by MDCH, in treating the Enrollee's clinical condition or disease:

2.10.2.1.3.7.1. A Grievance regarding denial of expedited resolution of an Appeal; or

2.10.2.1.3.7.2. A Grievance that involves clinical issues.

2.11. Enrollee Appeals

2.11.1. General Requirements

2.11.1.1. The ICO and First Tier, Downstream and Related Entities shall utilize and all Enrollees may access the existing Part D Appeals Process, as described in Appendix D. Consistent with existing rules, Part D Appeals will be automatically forwarded to the CMS Medicare Independent Review Entity (IRE) if the ICO misses the applicable adjudication timeframe. The CMS IRE is contracted by CMS. The ICO must maintain written records of all Appeal activities, and notify CMS and MDCH of all internal Appeals.

2.11.1.2. The ICO and First Tier, Downstream and Related Entities agrees to be fully compliant with all State and federal laws, regulations, and policies governing the Appeal and State Fair Hearing process, and all statutory and regulatory timelines related thereto. This includes the requirements for both standard and expedited requests. The ICO shall be financially liable for all judgments, penalties, costs and fees related to an Appeal in which the ICO has failed to comply fully with said requirements. The ICO must maintain written records of all Appeal activities, and notify CMS and MDCH of all internal Appeals. The ICO must cooperate with the Michigan Department of Insurance and Financial Services (DIFS) in the implementation of MCL 550.1901-1929 (Patients Right to Independent Review Act or PRIRA) for the Appeal of a Medicaid service.

2.11.1.3. For the purposes of Appeals, the term "entity" means either the ICO or, for appeals dealing with services managed by the PIHP, the PIHP.

2.11.2. Appeals Process Overview

2.11.2.1. Notice of Adverse Action – In accordance with 42 C.F.R. §§ 438.404 and 422.570, the entity must give the Enrollee written notice of any Adverse Action. Such notice shall be provided at least ten (10) calendar days in advance of the date of its action, in accordance with 42 C.F.R. § 438.404. An Enrollee, a provider or authorized representative acting on behalf of an Enrollee and with the Enrollee's written consent may Appeal the entity's decision to deny, terminate, suspend, or reduce services. In accordance with 42 C.F.R. §§ 438.402 and 422.574, an Enrollee, provider or authorized representative acting on behalf of an Enrollee and with the Enrollee's consent may also Appeal the entity's delay in providing or arranging for a Covered Service.

2.11.2.2. The entity's Appeal procedures must:

2.11.2.2.1. Be submitted to the CMT in writing for Prior Approval by CMS and MDCH;

2.11.2.2.2. Provide for resolution with the timeframes specified herein;

2.11.2.2.3. Assure the participation of individuals with authority to require corrective action; and

2.11.2.2.4. Be consistent with 42 CFR § 422.560 et seq. and 42 CFR § 438.400 et seq.

2.11.2.3. The entity must have a committee in place for reviewing Appeals made by Enrollees, a provider or authorized representative acting on the Enrollee's behalf.

2.11.2.4. The entity shall review its Appeal procedures at least annually for the purpose of amending such procedures when necessary.

2.11.2.5. The entity shall amend its procedures only upon receiving prior approval from MDCH.

2.11.2.6. Integrated Notice

2.11.2.6.1. Enrollees will be notified of all applicable Demonstration, Medicare and Medicaid Appeal rights through a single notice specific to the service or item type in question, developed jointly by MDCH and CMS. The form and content of the notice must be prior approved by CMS and MDCH. The entity shall notify the Enrollee of its decision at least twelve (12) calendar days in advance of the effective date of its action. The notice must explain:

2.11.2.6.1.1. The action the entity has taken or intends to take;

2.11.2.6.1.2. The reasons for the action explained in simple and appropriate terms for the Enrollee to understand;

2.11.2.6.1.3. The citation to the regulations supporting such action;

2.11.2.6.1.4. The Enrollee's, provider's or authorized representative's right to file an internal Appeal with the entity and that exhaustion of the entity's internal Appeal processes is a prerequisite to filing an External Appeal to Medicare for a Medicare service or filing an external review (PRIRA) with DIFS for a Medicaid service;

2.11.2.6.1.5. The Enrollee's or authorized representative's right to file an External Appeal with MAHS concurrent to the filing of an internal Appeal with the entity for Medicaid services.

2.11.2.6.1.6. Procedures for exercising Enrollee's rights to Appeal;

2.11.2.6.1.7. The Enrollee's right to request a State Fair Hearing in accordance with federal and state Medicaid law and as described in Section 2.11.4.2 of this Contract, Circumstances under which expedited resolution is available and how to request it;

2.11.2.6.1.8. The Enrollee's right to request an independent review of a Medicaid service with the DIFS in the implementation of PRIRA,MCL 550.1901-1929; and

2.11.2.6.1.9. If applicable, the Enrollee's rights to have benefits continue pending the resolution of the Appeal, and the circumstances under which the Enrollee may be required to pay the costs of these services.

2.11.2.6.2. Written material must use easily understood language and format, be available in Alternative Formats and in an appropriate manner that takes into consideration those with special needs. All Enrollees and Potential Enrollees must be informed that information is available in Alternative Formats and how to access those formats.

2.11.2.6.3. Written notice must be translated for the individuals who speak Prevalent Languages.

2.11.2.6.4. Written notices must include language clarifying that oral interpretation is available for all languages and how to access it.

2.11.2.7. Appeal levels

2.11.2.7.1. Internal Appeals of coverage determinations, or Medicare service denials, reductions and terminations will be made to the entity taking the action.

2.11.2.7.1.1. Subsequent Appeals for traditional Medicare A and B services that are not fully in favor of the Enrollee will be automatically forwarded to the Medicare IRE by the entity.

2.11.2.7.1.2. Enrollees will be able to request a hearing before an Office of Medicare Hearings and Appeals (OMHA) administrative law judge for decisions sustained by the IRE. Further levels of Appeal are also available.

2.11.2.7.2. Internal Appeals for Medicaid service denials will be made to the entity taking the action and/or MAHS. Requests to MAHS may be made in lieu of, prior to, concurrently, or after it is made to the entity taking the action if the request is made within 90 calendar days of the Adverse Action Notice.

2.11.2.7.3. Sustained decisions by the entity resulting in Medicaid service denials will not be auto-forwarded to MAHS, but may be appealed by Enrollees or their authorized representative to MAHS if they have not already done so as long as they are still within ninety (90) calendar days of the Adverse Action Notice.

2.11.2.7.4. The Enrollee also has the right to request an external review with DIFS through the PRIRA MCL 550.1901-1929 on Medicaid service denials by the entity.

2.11.2.7.5. For Appeals for services for which Medicare and Medicaid overlap (including, but not limited to home health, durable medical equipment and skilled therapies, but excluding Part D), Enrollees may file an Appeal through either the Medicaid or Medicare Appeals processes or both. Internal Appeals will be auto-forwarded to the IRE by the entity, and the Enrollee may also file a request for a hearing with MAHS. If an Appeal is filed with both the IRE and MAHS, any determination in favor of the Enrollee will bind the entity and will require payment by the entity for the service or item in question granted in the Enrollee's favor which is closest to the Enrollee's relief requested on Appeal.

2.11.2.7.6. All Appeals must be resolved by the entity as expeditiously as the Enrollee's condition requires, but always within thirty (30) calendar days of request for standard Appeals and within seventy-two (72) hours of request for Expedited Appeals.

2.11.2.7.6.1. This time frame may be extended up to fourteen (14) calendar days if the Enrollee, the authorized representative, the provider or the entity can show that there is a need for additional information and can demonstrate that the delay is in the Enrollee's interest

2.11.2.7.7. MAHS will resolve Appeals as expeditiously as the Enrollee's condition requires, but always within ninety (90) calendar days of the received request.

2.11.2.7.7.1. Timeframes of more than ninety (90) calendar days will only apply when any of the following occurs

2.11.2.7.7.1.1. MAHS requests a policy or legal clarification;

2.11.2.7.7.1.2. An act of nature or unexpected disaster causes a delay;

2.11.2.7.7.1.3. The Enrollee requests a delay, postponement or reschedule of the hearing;

2.11.2.7.7.1.4. The hearing is reconvened; or

2.11.2.7.7.1.5. The hearing record is left open pending additional information.

2.11.2.7.8. Prescription Drugs

2.11.2.7.8.1. Part D Appeals may not be filed with MAHS.

2.11.2.7.8.2. Appeals related to drugs excluded from Part D that are covered by Medicaid must be filed with the entity and/or MAHS.

2.11.2.8. Continuation of Benefits Pending an Appeal and State Fair Hearing

2.11.2.8.1. The entity must provide continuing benefits for all prior approved non-Part D benefits that are terminated or modified pending internal entity Appeals, per timeframes and conditions in 42 C.F.R. § 438.420. This means that such benefits will continue to be provided by providers to Enrollees and that the entity must continue to pay providers for providing such services or benefits pending an internal Appeal.

2.11.2.8.2. For all Appeals filed with MAHS, Covered Services will continue for appeals requested received within twelve (12) calendar days of the date of the Adverse Action Notice or prior to the date of action, consistent with §431.230 and 431.231.

2.11.2.8.2.1. For external reviews filed under PRIRA, Medicaid Covered Services will continue for requests appealed to the entity within twelve (12) calendar days of the date of the Adverse Action Notice. The notice informing the Enrollee of PRIRA rights will include an explanation of the procedure for continuing covered services during a PRIRA external review.

2.11.2.8.2.2. Payments will not be recouped based on the outcome of the Appeal for services covered during pending Appeals.

2.11.2.8.3. If MAHS decides in the Enrollee's favor and reverses the entity's decision, the entity must authorize the service under dispute as expeditiously as the Enrollee's health condition requires but no later than seventy-two (72) hours from the date the entity receives the notice reversing the decision.

2.11.2.8.4. If the entity or the State fair hearings officer reverses a decision to deny authorization of Covered Services, and the Enrollee received the disputed services while the Appeal was pending, the entity must pay for those services in accordance with State rules and policy.

2.11.3. Internal (plan-level) Appeals

2.11.3.1. Internal Appeals for Medicare services must be filed with the entity taking the action (as defined in Section 2.11.1.3). The filing of an internal

Appeal and exhaustion of the entity's internal Appeal process is a prerequisite to pursuing an External Appeal to Medicare.

2.11.3.2. The filing of an internal Appeal and exhaustion of the ICO's internal Appeal process is a prerequisite to filing an External Review to PRIRA.

2.11.3.3. Internal Appeals for Medicaid services can be filed with the entity and MAHS concurrently. The filing of an internal Appeal and exhaustion of the entity's internal Appeal process is not a prerequisite to filing an External Appeal to Medicaid.

2.11.3.4. The Enrollee may file an oral or written Appeal with the entity within sixty (60) calendar days following the date Adverse Action Notice that generates such Appeal consistent with 2.10.2.1.3.6.

2.11.3.5. Standard Appeals

2.11.3.5.1. The ICO's Appeals process must include the following requirements:

2.11.3.5.1.1. Acknowledge receipt of each Appeal.

2.11.3.5.1.2. Ensure that the individuals who make decisions on Appeals (1) were not involved in any previous level of review or decision making and, (2) if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by MDCH and CMS, in treating the Enrollee's clinical condition or disease:

2.11.3.5.1.2.1. An Appeal of a denial that is based on a lack of medical necessity; or

2.11.3.5.1.2.2. An Appeal that involves clinical issues.

2.11.3.5.1.3. Provide that oral inquiries seeking to Appeal an action are treated as Appeals (to establish the earliest possible filing date for the Appeal) and must be confirmed in writing unless the Enrollee, the provider acting on behalf of the Enrollee, or the authorized representative appealing on the Enrollee's behalf requests expedited resolution.

2.11.3.5.1.4. Provide the Enrollee, the provider or the authorized representive a reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing. (The entity must inform the Enrollee, the provider or the authorized representative of the limited time available for this, especially in the case of expedited resolution.)

2.11.3.5.1.5. Provide the Enrollee, the provider, or the authorized representative opportunity, before and during the Appeals process, to examine the Enrollee's case file, including any medical records and any other documents and records considered during the Appeals process.

2.11.3.5.1.6. Consider the Enrollee, authorized representative or estate representative of a deceased Enrollee as parties to the Appeal.

2.11.3.5.2. For Appeals filed with the entity, if the Enrollee does not request an Expedited Appeal pursuant to 42 C.F.R. § 438.410, the entity may require the Enrollee to file a written, signed Appeal following the oral Appeal.

2.11.3.5.3. The entity shall respond in writing to standard Appeals as expeditiously as the Enrollee's health condition requires and shall not exceed thirty (30) calendar days from the initial date of receipt of the Appeal.

2.11.3.5.3.1. The entity may extend this timeframe by up to an additional fourteen (14) calendar days if the Enrollee requests the extension or if the entity provides evidence satisfactory to MDCH that a delay in rendering the decision is in the Enrollee's interest.

2.11.3.5.3.2. For any Appeals decisions not rendered within thirty (30) calendar days where the Enrollee has not requested an extension, the entity shall provide written notice to the Enrollee of the reason for the delay.

2.11.3.6. Expedited Appeals

2.11.3.6.1. The entity shall establish and maintain an expedited review process for Appeals where either the entity or the Enrollee's provider determines that the time expended in a standard resolution could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function. The entity shall ensure that punitive action is neither taken against a provider that requests an expedited resolution nor supports the Enrollee's Appeal. In instances where the Enrollee's request for an Expedited Appeal is denied, the Appeal must be transferred to the timeframe for standard resolution of Appeals and the Enrollee must be given prompt oral notice of the denial (make reasonable efforts) and a written notice within two (2) calendar days.

2.11.3.6.2. The entity shall ensure that the individuals who make decisions on Expedited Appeals (1) were not involved in any previous level of review or decision making and, (2) if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by MDCH and CMS, in treating the Enrollee's clinical condition or disease:

2.11.3.6.2.1. An Expedited Appeal of a denial that is based on a lack of medical necessity; or

2.11.3.6.2.2. An Expedited Appeal that involves clinical issues.

2.11.3.6.3. The entity shall issue decisions for Expedited Appeals as expeditiously as the Enrollee's health condition requires, not to exceed seventy-two (72) hours from the initial receipt of the Appeal.

2.11.3.6.3.1. The entity may extend this timeframe by up to an additional fourteen (14) calendar days if the Enrollee requests the extension or if the entity provides evidence satisfactory to MDCH that a delay in rendering the decision is in the Enrollee's interest.

2.11.3.6.3.2. For any extension not requested by the Enrollee, the entity shall provide written notice to the Enrollee of the reason for the delay. The entity shall make reasonable efforts to provide the Enrollee with prompt verbal notice of any decisions that are not resolved wholly in favor of the Enrollee and shall follow-up within two (2) calendar days with a written notice of action.

2.11.3.6.4. All decisions to Appeal must be in writing and shall include, but not be limited to, the following information:

2.11.3.6.4.1. The decision reached by the entity;

2.11.3.6.4.2. The date of decision;

2.11.3.6.4.3. For Appeals not resolved wholly in favor of the Enrollee;

2.11.3.6.4.3.1. The right to request a State Fair Hearing and how to do so within the initial ninety (90) calendar day from the Adverse Action notice;

2.11.3.6.4.3.2. If the internal Appeal was received within twelve (12) calendar days of the Adverse Action Notice or prior to the date of action, the right to continue to receive benefits while the hearing is pending.

2.11.3.6.4.3.3. For appeals filed with the ICO, the right to request an External Review through PRIRA and how to do so.

2.11.4. External Appeals

2.11.4.1. The CMS Independent Review Entity (IRE)

2.11.4.1.1. If, on internal Appeal, the entity does not decide fully in the Enrollee's favor within the relevant time frame, the entity shall automatically forward the case file regarding Medicare services to the CMS IRE for a new and impartial review. The IRE is contracted by CMS.

2.11.4.1.2. For standard External Appeals, the IRE will send the Enrollee and the entity a letter with its decision within thirty (30) calendar days after it receives the case from the entity, or at the end of up to a fourteen (14) calendar day extension.

2.11.4.1.3. If the IRE decides in the Enrollee's favor and reverses the entity's decision, the entity must authorize the service under dispute as expeditiously as the Enrollee's health condition requires but no later than seventy-two (72) hours from the date the entity receives the notice reversing the decision.

2.11.4.1.4. For expedited External Appeals, the IRE will send the Enrollee and the ICO a letter with its decision within seventy-two (72) hours after it receives the case from the ICO (or at the end of up to a fourteen (14) calendar day extension), a pre-service decision within thirty (30) calendar days.

2.11.4.1.5. If the entity or the Enrollee disagrees with the IRE's decision, further levels of Appeal are available, including a hearing before an Administrative Law Judge, a review by Departmental Appeals Board, and judicial review. The entity must comply with any requests for information or participation from such further Appeal entities.

2.11.4.2. The Medicaid State Fair Hearing Process

2.11.4.2.1. If the entity's internal Appeal decision is not fully in the Enrollee's favor, the Enrollee may Appeal to MAHS for Medicaid-based adverse decisions. Appeals to MAHS will not be automatically forwarded by the entity. Such Appeals must be made in writing and may be made via US Mail, fax transmission, hand-delivery or electronic transmission.

2.11.4.2.2. An Expedited Appeal must be submitted in writing to MAHS pursuant to 42 C.F.R. § 438.410.

2.11.4.2.3. An Enrollee may appoint any authorized representative, including, but not limited to, a guardian, caretaker relative, or provider, to represent the Enrollee throughout the Appeal process. The entity shall provide a form and instructions on how an Enrollee may appoint a representative. The entity shall consider the Enrollee, the Enrollee's authorized representative, or the representative of the Enrollee's estate as parties to the Appeal. The entity shall provide such parties a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The entity shall allow such parties an opportunity, before and during the Appeal process, to examine the Enrollee's case file, including medical records and any other documents and records.

2.11.4.2.4. Appeals to the external Medicaid State Fair Hearing process must be filed within ninety (90) calendar days from the Adverse Action Notice, unless the time period is extended by MDCH upon a finding of "good cause" in accordance with current State Fair Hearing regulations.

2.11.4.2.5. External Appeals to the Medicaid State Fair Hearing process that qualify as Expedited Appeals shall be resolved within seventy-two (72) hours or as expeditiously as the Enrollee's condition requires. The entity may extend this timeframe by up to an additional fourteen (14) calendar days if the Enrollee requests the extension or if the entity provides evidence satisfactory to MDCH that a delay in rendering the decision is in the Enrollee's interest. If the Enrollee requests the extension, the appeal will be changed from an Expedited Appeal to a standard Appeal. For any extension not requested by the Enrollee, the entity shall provide written notice to the Enrollee of the reason for the delay.

2.11.4.2.6. If the Enrollee waits to file the request for fair hearing with MAHS until after receipt of notice of the Internal Appeal decision, the Enrollee must file the request within ninety (90) calendar days from the date of the initial Adverse Action Notice.

2.11.4.2.7. External Appeals to MAHS that do not qualify as expedited shall be resolved or a decision issued within ninety (90) calendar days of the date of filing the ICO Adverse Action if the appeal is filed directly with MAHS.

2.11.5. Hospital Discharge Appeals

2.11.5.1. The ICO must comply with the hospital discharge Appeal requirements at 42 C.F.R. §§ 422.620-422.622.

2.11.5.2. The Enrollee has the right to request a review by a Quality Improvement Organization (QIO) of any hospital discharge notice. The notice includes information on filing the QIO Appeal. The Enrollee must contact the QIO before he/she leaves the hospital but no later than the planned discharge date

2.11.5.3. If the Enrollee asks for immediate review by the QIO, the Enrollee will be entitled to this process instead of the standard Appeals process described above. The ICO must ensure that the Enrollee receives the Detailed Notice of Discharge (CMS-10066). Note: an Enrollee may file an oral or written request for an expedited seventy-two (72) hour ICO Appeal if the Enrollee has missed the deadline for requesting the QIO review.

2.11.5.4. The QIO will make its decision within one (1) business day after it receives the Enrollee's request, medical records, and any other information it needs to make its decision.

2.11.5.5. If the QIO agrees with the ICO's decision, the ICO is not responsible for paying the cost of the hospital stay beginning at noon of the calendar day following the day the QIO notifies the Enrollee of its decision.

2.11.5.6. If the QIO overturns the ICO's decision, the ICO must pay for the remainder of the hospital stay.

2.11.6. Other Discharge Appeals

2.11.6.1. The ICO must comply with the termination of services Appeal requirements for individuals receiving services from a comprehensive outpatient rehabilitation facility, skilled nursing facilities, or home health agency at 42 C.F.R. §§ 422.624 and 422.626.

2.12. Provider Appeals

2.12.1. MDCH Website

2.12.1.1. MDCH will update the web-site addresses of ICOs. This information will make it more convenient for providers (including out-of-network providers) to be aware of and contact respective health plans regarding documentation, prior authorization issues, and provider Appeal processes. The ICO is responsible for maintaining the prior authorization issues, and provider Appeal processes. The ICO is responsible for maintaining the completeness and accuracy of their web-sites regarding this information. The MDCH web-site location is: www.michigan.gov/mdch.

2.12.2. Payment Resolution Process

2.12.2.1. The ICO must develop and maintain an effective provider Appeal process to promptly resolve provider billing disputes. The ICO will cooperate with providers who have exhausted the ICO's Appeal process by entering into arbitration or other alternative dispute resolution process.

2.12.3. Arbitration/Rapid Dispute Resolution

2.12.3.1. The ICO must comply with the provisions of the Hospital Access Agreement for any non-contracted hospital providers. To resolve claim disputes with non-contracted hospital providers, the ICO must follow the Rapid Dispute Resolution Process specified in the Medicaid Provider Manual. This applies solely to disputes with non-contracted hospital providers that have signed the Hospital Access Agreement. Non-contracted hospital providers that have not signed the Hospital Access Agreement and non-hospital providers do not have access to the Rapid Dispute Resolution Process.

2.12.3.2. When a non-hospital provider or hospital provider that has not signed the Hospital Access Agreement requests arbitration, the ICO is required to

participate in a binding arbitration process. Providers must exhaust the ICO's internal provider Appeal process before requesting arbitration.

2.12.3.3. MDCH will provide a list of neutral arbitrators that can be made available to resolve billing disputes. These arbitrators will have the appropriate expertise to analyze medical Claims and supporting documentation available from medical record reviews and determine whether a Claim is complete, appropriately coded, and should or should not be paid. The party found to be liable will be assessed the cost of the arbitrator. If both parties are at fault, the cost of the arbitration will be as determined by the arbiter.

2.13. Quality Improvement Program

2.13.1. Quality Improvement:

2.13.1.1. The ICO shall deliver quality care that enables Enrollees to avoid preventable disease, manage chronic illnesses and disabilities, and maintain or improve health and quality of life. Quality care refers to the following criteria:

2.13.1.1.1. Quality of physical health care, including primary and specialty care;

2.13.1.1.2. Quality of behavioral health care focused on recovery, resiliency and rehabilitation;

2.13.1.1.3. Quality of LTSS;

2.13.1.1.4. Adequate access to and availability of primary care, behavioral health care, pharmacy, specialty health care, and LTSS providers and services;

2.13.1.1.5. Continuity and coordination of care across all care and services settings, including transitions in care;

2.13.1.1.6. Seamless Enrollee and caregiver experience with and access to high quality, coordinated and culturally competent clinical care and services, inclusive of LTSS across the care continuum;

2.13.1.1.7. Best practices with regards to disease and risk screening, assessment and prevention;

2.13.1.1.8. Sufficient and capable organizational structure and staffing;

2.13.1.1.9. Environment and actions that promote quality of life, health, and well-being for Enrollees; and

2.13.1.1.10. Effective UM that generates value for the resources spent by Enrollees, families, and governments.

2.13.1.2. Apply the principles of continuous quality improvement (CQI) to all aspects of the ICO's service delivery system through ongoing analysis, evaluation and systematic enhancements based on:

2.13.1.2.1. Quantitative and qualitative data collection and data-driven decision-making;

2.13.1.2.2. Up-to-date evidence-based practice guidelines and explicit criteria developed by recognized sources or appropriately certified professionals or, where evidence-based practice guidelines do not exist, consensus of professionals in the field;

2.13.1.2.3. Feedback provided by Enrollees and network providers in the design, planning, and implementation of its CQI activities; and

2.13.1.2.4. Issues identified by the ICO, MDCH and/or CMS.

2.13.1.3. Ensure that the quality improvement (QI) requirements of this Contract are applied to the delivery of primary and specialty health care services, behavioral health services, and LTSS.

2.13.2. QI Program Structure

2.13.2.1. The ICO shall structure its QI program for the Demonstration separately from any of its existing Medicaid, or Medicare, or Commercial lines of business. For example, required measures for this Demonstration must be reported for the Demonstration population only. Integrating the Demonstration population into an existing line of business shall not be acceptable.

2.13.2.2. The ICO shall maintain a well-defined QI organizational and program structure that supports the application of the principles of CQI to all aspects of the ICO's service delivery system. The QI program must be communicated in a manner that is accessible and understandable to internal and external individuals and entities, as appropriate. The ICO's QI organizational and program structure shall comply with all applicable provisions of 42 CFR § 438, including Subpart D, Quality Assessment and Performance Improvement 42 CFR § 422, Subpart D, Quality Improvement.

2.13.3. QI Functions and responsibilities:

2.13.3.1.1. The ICO shall establish a set of QI functions and responsibilities that are clearly defined and that are proportionate to, and adequate for, the planned number and types of QI initiatives and for the completion of QI initiatives in a competent and timely manner;

2.13.3.1.2. Ensure that such QI functions and responsibilities are assigned to individuals with the appropriate skill set to oversee and implement an organization-wide, cross-functional commitment to, and application of, CQI to all clinical and non-clinical aspects of the ICO's service delivery system;

2.13.3.1.3. Seek the input of providers and medical professionals representing the composition of the ICO's Provider Network in developing functions and activities;

2.13.3.1.4. Establish internal processes to ensure that the QM activities for primary, specialty, and behavioral health services, and LTSS reflect utilization across the network and include all of the activities in this Section 2.13 of this Contract and, in addition, the following elements:

2.13.3.1.4.1. A process to utilize Healthcare Plan Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Services (CAHPS), the Health Outcomes Survey (HOS) and other measurement results in designing QI activities;

2.13.3.1.4.2. A medical record review process for monitoring Provider Network compliance with policies and procedures, specifications and appropriateness of care consistent with the utilization control requirements of 42 C.F.R. Part 456. Such process shall include the sampling method used which shall be proportionate to utilization by service type. The ICO shall submit its process for medical record reviews and the results of its medical record reviews to MDCH;

2.13.3.1.4.3. A process to measure network providers and Enrollees, at least annually, regarding their satisfaction with the ICO's Demonstration plan. The ICO shall submit a survey plan to MDCH for approval and shall submit the results of the survey to MDCH and CMS;

2.13.3.1.4.4. A process to measure clinical reviewer consistency in applying clinical criteria to UM activities using inter-rater reliability measures;

2.13.3.1.4.5. A process for including Enrollees and their families in Quality Management activities, as evidenced by participation in the ICO Advisory Council; and

2.13.3.1.4.6. In collaboration with and as further directed by MDCH, develop a customized medical record review process to monitor the assessment for and provision of LTSS.

2.13.3.1.5. Have in place a written description of the QI Program that delineates the structure, goals, and objectives of the ICO's QI initiatives. Such description shall accomplish the following:

2.13.3.1.5.1. Address all aspects of health care, including specific references to behavioral health care and LTSS, with respect to monitoring and improvement efforts, and integration with physical health care. Behavioral health and LTSS aspects of the QI program may be included in the QI description or in a separate QI Plan referenced in the QI description;

2.13.3.1.5.2. Address the roles of the designated physician(s), behavioral health clinician(s) and LTSS providers with respect to QI program;

2.13.3.1.5.3. Identify the resources dedicated to the QI program including staff or data sources and analytic programs or IT systems; and

2.13.3.1.5.4. Include organization-wide policies and procedures that document processes through which the ICO ensures clinical quality, access and availability of health care and services, and continuity and coordination of care. Such processes shall include, but not be limited to, Appeals and Grievances and UM.

2.13.3.1.6. Submit to MDCH and CMS an annual QI Work Plan that shall include the following components or other components as directed by MDCH and CMS:

2.13.3.1.6.1. Planned clinical and non-clinical initiatives;

2.13.3.1.6.2. The objectives for planned clinical and non-clinical initiatives;

2.13.3.1.6.3. The short and long term time frames within which each clinical and non-clinical initiative's objectives are to be achieved;

2.13.3.1.6.4. The individual(s) responsible for each clinical and non-clinical initiative;

2.13.3.1.6.5. Any issues identified by the ICO, MDCH, Enrollees, and providers, and how those issues are tracked and resolved over time;

2.13.3.1.6.6. Program review process for formal evaluations that address the impact and effectiveness of clinical and non-clinical initiatives at least annually; and

2.13.3.1.6.7. Process for correcting deficiencies.

2.13.3.1.7. Evaluate the results of QI initiatives at least annually and submit the results of the evaluation to MDCH and CMT. The evaluation of the QI program initiatives shall include, but not be limited to, the results of activities that demonstrate the ICO's assessment of the quality of physical and behavioral health care rendered, the effectiveness of LTSS services, and accomplishments and compliance and/or deficiencies in meeting the previous year's annual QI Work Plan; and

2.13.3.1.8. Maintain sufficient and qualified staff employed by the ICO to manage the QI activities required under the Contract, and establish minimum employment standards and requirements (e.g. education, training, and experience) for employees who will be responsible for QM. QI staff shall include the following individuals:

2.13.3.1.8.1. At least one designated physician with qualifications deemed appropriate by MDCH, who shall be a medical director or associate medical director, at least one designated behavioral health clinician, and a professional with expertise in the assessment and delivery of LTSS with substantial involvement in the QI program;

2.13.3.1.8.2. A qualified individual to serve as the Demonstration QI director who will be directly accountable to the ICO's Michigan chief executive director and, in addition, if the ICO offers multiple products or services in multiple states, will have access to the ICO's executive leadership team. This individual shall be responsible for the following:

2.13.3.1.8.2.1. Overseeing all QI activities related to Enrollees, ensuring compliance with all such activities, and maintaining accountability for the execution of and performance in all such activities;

2.13.3.1.8.2.2. Maintaining an active role in the ICO's overall QI structure; and

2.13.3.1.8.2.3. Ensuring the availability of staff with appropriate expertise in all areas, as necessary for the execution of QI activities including, but not limited to, the following:

2.13.3.1.8.2.3. 1. Physical and behavioral health care;

2.13.3.1.8.2.3. 2. Pharmacy management;

2.13.3.1.8.2.3. 3. Care management;

2.13.3.1.8.2.3. 4. LTSS;

2.13.3.1.8.2.3. 5. Financial;

2.13.3.1.8.2.3. 6. Statistical and analytical;

2.13.3.1.8.2.3. 7. Information systems;

2.13.3.1.8.2.3. 8. Marketing and publications;

2.13.3.1.8.2.3. 9. Enrollment; and

2.13.3.1.8.2.3. 10. Operations management;

2.13.3.1.9. Actively participate in, or assign staff to actively participate in, QI workgroups and other meetings, including any quality management workgroups or activities that may be facilitated by MDCH, or its designee, that may be attended by representatives of MDCH, a MDCH Contractor, the ICO, and other entities, as appropriate; and

2.13.3.1.10. Serve as liaison to, and maintain regular communication with, Michigan QI representatives. Responsibilities shall include, but are not limited to, promptly responding to requests for information and/or data relevant to all QI activities.

2.13.4. QI Activities

2.13.4.1. The ICO shall engage in performance measurement and quality improvement projects designed to achieve, through ongoing measurement and intervention, significant improvements, sustained over time, in clinical care and non-clinical care processes, outcomes, and Enrollee experience. This will include the ability to assess the quality and appropriateness of care furnished to Enrollees with special health care needs.

2.13.4.2. The ICO's QI program must include a health information system to collect, analyze, and report quality performance data as described in 42 C.F.R. §§ 438.242(a), 422.516(a) and 423.514.

2.13.4.3. Performance Measurement

2.13.4.3.1. ICO shall perform and report the quality and utilization measures identified by CMS and MDCH and in accordance with requirements in the MOU between CMS and the State of Michigan on April 3, 2014, Table 7-C (Core Quality Measures under the Demonstration), and as articulated in this Contract. These measures shall include, but are not limited to the following:

2.13.4.3.1.1. All HEDIS, HOS and CAHPS data, as well as all other measures specified in Table 7-C (Core Quality Measures under the Demonstration) of the MOU referenced above. HEDIS, HOS and CAHPS data must be reported consistent with Medicare requirements. All existing Part D metrics will be collected as well. Additional details, including technical specifications, will be provided in annual guidance for the upcoming reporting year.

2.13.4.3.2. The ICO shall not modify the reporting specifications methodology prescribed by CMS and MDCH without first obtaining CMS' and the State's written approval. ICO must obtain an independent validation of its findings by a recognized entity, e.g., NCQA-certified auditor, as approved by CMS and MDCH. CMS and MDCH (or its designee) will perform an independent validation of at least a sample of ICO's findings.

2.13.4.3.3. The ICO shall monitor other performance measures not specifically stated in the Contract that are required by CMS. MDCH will use its best efforts to notify ICO of new CMS requirements.

2.13.4.3.4. The ICO shall collect annual data and contribute to all Demonstration QI-related processes, as directed by MDCH and CMS, as follows:

2.13.4.3.4.1. Collect and submit to MDCH and/or CMS in a timely manner, data for the measures specified in Table 7-c (Core Quality Measures under the Demonstration) and further defined in the Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements and the Michigan-Specific Reporting Requirements; Contribute to all applicable MDCH and CMS data quality assurance processes, which shall include, but not be limited to, responding, in a timely manner, to data quality inadequacies identified by MDCH and rectifying those inadequacies, as directed by MDCH;

2.13.4.3.4.2. Contribute to MDCH and CMS data regarding the individual and aggregate performance of ICOs with respect to the noted measures; and

2.13.4.3.4.3. Contribute to MDCH processes culminating in the publication of any additional technical or other reports by MDCH related to the noted measures; and

2.13.4.3.4.4. Incorporate any statewide performance improvement objectives, established as a result of a statewide performance improvement project or monitoring, into the written plan for its QI program. MDCH will use the results of performance assessments as part of the formula for automatic Enrollment assignments. MDCH will continually monitor the ICO's performance on the performance monitoring standards and make changes as appropriate.

2.13.4.3.5. The ICO shall demonstrate how to utilize results of the measures outlined in Section2.13.4.3.4.1.

2.13.4.4. Enrollee Experience Surveys:

2.13.4.4.1. The ICO shall conduct Enrollee experience survey activities, as directed by MDCH and/or CMS, as follows:

2.13.4.4.1.1. Conduct, as directed by MDCH and CMS, an annual CAHPS survey and supplemental questions as determined by MDCH using an approved CAHPS vendor. The ICO must directly contract with NCQA certified CAHPS vendor and submit the data according to the specifications identified by CMS per Section 2.13.4.3.1.1 and established by NCQA. Annually, the ICO must provide NCQA summary and Enrollee level data to MDCH. The ICO must provide an electronic or hard copy of the final survey analysis report to MDCH upon request;

2.13.4.4.1.2. Conduct, as directed by MDCH, a consumer experience survey for Enrollees utilizing LTSS during the prior calendar year. This shall require that individuals conducting such survey are appropriately and comprehensively trained, culturally competent, and knowledgeable of the population being surveyed;

2.13.4.4.1.3. Conduct, as directed by MDCH, a quality of life survey, adapted for general populations. This survey may be self-administered or administered by a trained interviewer;

2.13.4.4.1.4. Contribute, as directed by MDCH and CMS, to data quality assurance processes, including responding, in a timely manner, to data quality inadequacies identified by MDCH and CMS and rectifying those inadequacies, as directed by MDCH and CMS;

2.13.4.4.1.5. Contribute, as directed by MDCH, to processes culminating in the development of an annual report by MDCH regarding the individual and aggregate performance of ICOs; and

2.13.4.4.1.6. The ICO shall demonstrate best efforts to utilize Enrollee experience survey results in designing QI initiatives.

2.13.5. QI Project Requirements

2.13.5.1.1. The ICO shall implement and adhere to all processes relating to the QI project requirements, as directed by MDCH and CMS, as follows:

2.13.5.1.1.1. During the initial Demonstration year and annually thereafter, ICO will identify applicable representatives to serve on an ICO Advisory Council with MDCH. This committee will determine QI initiatives to begin in Year 1 of the Demonstration and annually thereafter;

2.13.5.1.1.2. In accordance with 42 C.F.R. §438.240 (d) and 42 C.F.R. § 422.152 (d), collect information and data in accordance with QI project requirement specifications for its Enrollees using the format and submission guidelines specified by MDCH and CMS in annual guidance provided for the upcoming contract year;

2.13.5.1.1.3. Implement the QI project requirements, in a culturally competent manner, to achieve objectives as specified by MDCH and CMS;

2.13.5.1.1.4. Conduct an annual effectiveness review of its QI program. The effectiveness review must include analysis of whether there have been improvements in the quality of health care and services for enrollees as a result of quality assessment and improvement activities and interventions carried out by ICO. The analysis should take into consideration trends in service delivery and health outcomes over time and include monitoring of progress on performance goals and objectives. Information on the effectiveness of the ICO's QI program must be provided annually to network providers and to enrollees upon request. Information on the effectiveness of the ICO's QI program must be provided to the CMT annually upon request;

2.13.5.1.1.5. Plan and initiate processes to sustain achievements and continue improvements;

2.13.5.1.1.6. Submit to MDCH and CMS, comprehensive written reports, using the format, submission guidelines and frequency specified by MDCH and CMS. Such reports shall include information regarding progress on QI project requirements, barriers encountered and new knowledge gained. As directed by MDCH and CMS, the ICO shall present this information to MDCH and CMS at the end of the QI requirement project cycle as determined by MDCH and CMS; and

2.13.5.1.1.7. In accordance with 42 C.F.R. §422.152 (c), develop a chronic care improvement program (CCIP) and establish criteria for participation in the program. The CCIP must be relevant to and target the ICO's plan population. Although the ICO has the flexibility to choose the design of their CCIPs, MDCH and CMS may require them to address specific topic areas.

2.13.5.2. CMS-Specified Performance Measurement and Performance Improvement Projects

2.13.5.2.1. The ICO shall conduct additional performance measurement or performance improvement projects if mandated by CMS pursuant to 42 C.F.R. § 438.240(a)(2).

2.13.6. External Quality Review (EQR) Activities

2.13.6.1. The ICO shall take all steps necessary to support the External Quality Review Organization (EQRO) contracted by MDCH and the QIO to conduct EQR activities, in accordance with 42 C.F.R. § 438.358 and 42 C.F.R. § 422.153. ICO shall address the findings of the external review through its QI program. ICO shall develop and implement performance improvement goals, objectives, and activities in response to the EQR findings as part of ICO's QI program. A description of the performance improvement goals, objectives, and activities developed and implemented in response to the EQRO findings will be included in ICO's QI program. MDCH may also require separate submission of an improvement plan specific to the findings of the EQRO. EQR activities shall include, but are not limited to the following:

2.13.6.1.1. Annual validation of performance measures reported to MDCH, as directed or calculated by MDCH;

2.13.6.1.2. Annual validation of quality improvement projects required by MDCH and CMS; and

2.13.6.1.3. At least once every three (3) years, review of compliance with standards mandated by 42 C.F.R. Part 438, Subpart D, 42 C.F.R. Part 422, Subpart D, and 42 C.F.R. Part 423, Subpart D, and at the direction of MDCH, regarding access, structure and operations, and quality of care and services furnished to Enrollees. The ICO shall take all steps necessary to support the EQRO and QIO in conducting EQR activities including, but not limited to:

2.13.6.1.3.1. Designating a qualified individual to serve as project director for each EQR activity who shall, at a minimum perform the following activities:

2.13.6.1.3.1.1. Oversee and be accountable for compliance with all aspects of the EQR activity;

2.13.6.1.3.1.2. Coordinate with staff responsible for aspects of the EQRO activity and ensure that staff respond to requests by the EQRO, QIO, MDCH and CMS staff in a timely manner;

2.13.6.1.3.1.3. Serve as the liaison to the EQRO, QIO, MDCH and CMS and answer questions or coordinate responses to questions from the EQRO, QIO, CMS and MDCH in a timely manner; and

2.13.6.1.3.1.4. Ensure timely access to information systems, data, and other resources, as necessary for the EQRO and/or QIO to perform the EQR activity and as requested by the EQRO, QIO, CMS or MDCH.

2.13.6.1.3.2. Maintaining data and other documentation necessary for completion of EQR activities specified above. The ICO shall maintain such documentation for a minimum of ten (10) years;

2.13.6.1.3.3. Reviewing the EQRO's draft EQR report and offering comments and documentation to support the correction of any factual errors or omissions, in a timely manner, to the EQRO or MDCH;

2.13.6.1.4. Participating in ICO-specific and cross-ICO meetings relating to the EQR process, EQR findings, and/or EQR trainings with the EQRO and MDCH;

2.13.6.1.5. Implementing actions, as directed by MDCH and/or CMS, to address recommendations for QI made by the EQRO or QIO, and sharing outcomes and results of such activities with the EQRO or QIO, MDCH, and CMS in subsequent years; and

2.13.6.1.6. Participating in any other activities deemed necessary by the EQRO and/or QIO and approved by MDCH and CMS.

2.13.7. QI for Utilization Management Activities

2.13.7.1. The ICO shall utilize QI to ensure that it maintains a well-structured UM program that supports the application of fair, impartial and consistent UM determinations.

2.13.7.2. The QI activities for the UM program shall include, at a minimum, the following:

2.13.7.2.1. Written policies with review decision criteria and procedures that conform to managed health care industry standards and processes;

2.13.7.2.2. A formal utilization review committee directed by the ICO's medical director to oversee the utilization review process;

2.13.7.2.3. Sufficient resources to regularly review the effectiveness of the utilization review process and to make changes to the process as needed;

2.13.7.2.4. An annual review and reporting of utilization review activities, and outcomes and interventions from the review; and

2.13.7.2.5. The UM activities of the ICO must be integrated with the ICO's QI program

2.13.7.3. The ICO must establish and use a written prior approval policy and procedure for UM purposes. The ICO may not use such policies and procedures to avoid providing Medically Necessary Services within the coverage established under the Contract. The policy must ensure that the review criteria for authorization decisions are applied consistently and require that the reviewer consult with the requesting provider when appropriate. The policy must also require that UM decisions be made by a health care professional who has appropriate clinical expertise regarding the service under review.

2.13.7.4. The ICO must ensure that compensation to the individuals or First Tier, Downstream, or Related Entity that conduct UM activities is not structured so as to provide incentives for the individual or First Tier,

Downstream, or Related Entity to deny, limit, or discontinue Medically Necessary Services to any Enrollee.

2.13.7.5. The ICO must provide a full-time Quality Improvement and Utilization Director who possess the training and education necessary to meet the requirements for quality improvement and utilization review activities required in the Contract. The Quality Improvement and Utilization Director may be any of the following:

2.13.7.5.1. Michigan licensed physician

2.13.7.5.2. Michigan Licensed registered nurse

2.13.7.5.3. Certified professional in health care quality

2.13.7.5.4. Other licensed clinician as approved by MDCH

2.13.7.5.5. Other professional possessing appropriate credentials as approved by MDCH

2.13.8. Clinical Practice Guidelines

2.13.8.1. The ICO shall adopt, disseminate, and monitor the use of clinical practice guidelines relevant to Enrollees that include the following:

2.13.8.1.1.1. Are based on valid and reliable clinical evidence or a consensus of health care professionals or professionals with expertise in the assessment and delivery of long term services;

2.13.8.1.1.2. Stem from recognized organizations that develop or promulgate evidence-based clinical practice guidelines, or are developed with involvement of board-certified providers from appropriate specialties or professionals with expertise in the assessment and delivery of services;

2.13.8.1.1.3. Do not contradict existing Michigan-promulgated statute and policies or requirements as published by the Departments of Community Health, Human Services, Licensing and Regulatory Authority, Insurance and Financial Services , or other State agencies;

2.13.8.1.1.4. Prior to adoption, have been reviewed by the ICO's medical director, as well as other ICO practitioners and network providers, as appropriate; and

2.13.8.1.1.5. Are reviewed and updated, as appropriate, or at least every two (2) years.

2.13.8.2. Guidelines shall be reviewed and revised, as appropriate, based on changes in national guidelines, changes in valid and reliable clinical evidence, or consensus of health care professionals and providers. For guidelines that have been in effect 2 years or longer, the ICO must document that the guidelines were reviewed with appropriate practitioner involvement, and were updated accordingly;

2.13.8.3. Disseminate, in a timely manner, the clinical guidelines to all new network providers, to all affected providers, upon adoption and revision, and, upon request, to Enrollees and Potential Enrollees. The ICO shall make the clinical and practice guidelines available via the ICO's web site. The ICO shall notify providers of the availability and location of the guidelines, and shall notify providers whenever changes are made. The ICO should submit these guidelines to providers with sufficient explanation and information to enable the providers to meet the established standards;

2.13.8.4. Establish explicit processes for monitoring the consistent application of clinical and practice guidelines across UM decisions and Enrollee education, coverage of services; and

2.13.8.5. Submit to MDCH a listing and description of clinical guidelines adopted, endorsed, disseminated, and utilized by the ICO, upon request.

2.13.9. QI Workgroups

2.13.9.1. As directed by MDCH, the ICO shall actively participate in QI workgroups that are led by MDCH, including any quality management workgroups or activities, attended by representatives of MDCH, ICOs, and other entities, as appropriate, and that are designed to support QI activities and to provide a forum for discussing relevant issues. Participation may involve contributing to QI initiatives identified and/or developed collaboratively by the workgroup.

2.13.9.2. MDCH Directed Performance Incentive Program

2.13.9.2.1. MDCH and CMS will require that the ICO meet specific performance requirements in order to receive payment of withheld amounts over the course of the Contract. These withhold measures are detailed in Section 4.4.4.

2.13.9.2.2. In order to receive any withhold payments, the ICO shall comply with all MDCH and CMS withhold measure requirements while maintaining satisfactory performance on all other Contract requirements.

2.13.9.3. Enrollee Incentives

2.13.9.3.1. The ICO may implement Enrollee incentives, as appropriate, to promote engagement in specific behaviors (e.g., guideline-recommended clinical screenings, PCP visits, and wellness initiatives). The ICO shall do the following:

2.13.9.3.1.1. Take measures to monitor the effectiveness of such Enrollee incentives, and revise incentives as appropriate, with consideration of Enrollee feedback;

2.13.9.3.1.2. Ensure that the nominal value of Enrollee incentives do not exceed fifteen dollars ($15) with a maximum aggregate of $50 per person, per year;

2.13.9.3.1.3. Submit to MDCH, at the direction of MDCH, ad hoc report information relating to planned and implemented Enrollee incentives and assure that all such Enrollee incentives comply with all applicable Medicare-Medicaid marketing guidance, as well as State and federal laws.

2.13.9.4. Behavioral Health Services Outcomes

2.13.9.4.1. The ICO through sub-contract with the PIHP shall require behavioral health providers to measure and collect clinical outcomes data and incorporate that data in treatment data available to the ICO, upon request; and

2.13.9.4.2. The ICO's behavioral health provider through sub-contracts shall require the provider to make available behavioral health clinical assessment and outcomes data for quality management and network management purposes.

2.13.9.5. External Audit/Accreditation Results

2.13.9.5.1. The ICO shall inform MDCH if it is nationally accredited or if it has sought and been denied such accreditation and submit to MDCH, at MDCH's direction, a summary of its accreditation status and the results, if any, in addition to the results of other quality-related external audits, if any.

2.13.9.6. Health Information System

2.13.9.6.1. The ICO shall maintain a health information system or systems consistent with the requirements established in the Contract and that supports all aspects of the QI Program.

2.13.10. Evaluation Activities

2.13.10.1. MDCH, CMS and its designated agent(s) will conduct periodic evaluations of the Demonstration over time from multiple perspectives using both quantitative and qualitative methods.

2.13.10.2. The evaluations will be used for program improvement purposes and to assess the Demonstration's overall impact on various outcomes including, but not limited to, Enrollment and disenrollment patterns, Enrollee access and quality of care experiences, utilization and costs by service type (e.g., inpatient, outpatient, home health, prescription drugs, nursing facility, and MI Health Link 1915 (c) waiver), and program staff and provider experiences.

2.13.10.3. As such, the evaluations will include surveys, site visits, analysis of Claims and Encounter Data, focus groups, key informant interviews, and document reviews. The ICO shall participate in evaluation activities as directed by CMS and/or MDCH and provide information or data upon request.

2.14. Marketing, Outreach, and Enrollee Communications Standards

2.14.1. Requirements, General

2.14.1.1. The ICO is subject to rules governing marketing and Enrollee Communications as specified under Section 1851(h) of the Social Security Act; 42 CFR §422.111, §422.2260 et. seq., §423.120(b) and (c), §423.128, and §423.2260 et seq.; and the Medicare Marketing Guidelines (Chapter 3 of the Medicare Managed Care Manual and Chapter 2 of the Prescription Drug Benefit Manual), with the following additional requirements or clarifications:

2.14.1.1.1. The ICO must refer any Enrollees who inquire about MI HealthLink eligibility or Enrollment to the MDCH Enrollment broker, or the MMAP, although the ICO may provide Enrollees and Potential Enrollees with factual information about the ICO's plan and its benefits prior to referring a request regarding eligibility or Enrollment to the MDCH authorized agent;

2.14.1.1.2. The ICO must make available to CMS and MDCH, upon request, current schedules of all educational events conducted by the ICO to provide information to Enrollees or Potential Enrollees;

2.14.1.1.3. The ICO must distribute all materials to its entire Service Area as referenced in Appendix H; and must convene all educational and marketing/sales events at sites within the ICO's Service Area that are physically accessible to all Enrollees or Potential Enrollees, including persons with disabilities and persons using public transportation.

2.14.1.1.4. The ICO may not offer financial or other incentives, including private insurance, to induce Enrollees or Potential Enrollees to enroll with the ICO or to refer a friend, neighbor, or other person to enroll with the ICO;

2.14.1.1.5. The ICO will not be allowed to market directly to Potential Enrollees on a one-on-one basis but may provide responses to Enrollee -initiated requests for information and/or Enrollment;

2.14.1.1.6. The ICO may participate in group marketing events and provide general audience materials (such as general circulation brochures, and media and billboard advertisements);

2.14.1.1.7. The ICO must refer all Potential Enrollees to the State or its vendor for Enrollment;

2.14.1.1.8. The ICO may not directly or indirectly conduct door-to-door, telephone, or other unsolicited contacts;

2.14.1.1.9. The ICO may not use any Marketing, Outreach, or Enrollee Communications materials that contain any assertion or statement (whether written or oral) that:

2.14.1.1.9.1. The Enrollee or Potential Enrollee must enroll with the ICO in order to obtain benefits or in order not to lose benefits; and

2.14.1.1.9.2. The ICO is endorsed by CMS, Medicare, Medicaid, the federal government, MDCH or similar entity.

2.14.1.1.10. Annually, the ICO shall present its marketing plan to MDCH for review and approval.

2.14.2. Requirements for Materials

2.14.2.1. The ICO's Marketing, Outreach, and Enrollee Communications materials must be:

2.14.2.1.1. Made available in Alternative Formats, upon request and as needed to ensure effective communication for individuals who are blind or have impaired vision;

2.14.2.1.2. Provided in a manner, format and language that may be easily understood by persons with limited English proficiency, or for those with developmental disabilities or cognitive impairments;

2.14.2.1.3. Translated into Prevalent Languages for all materials, as specified in the Medicare-Medicaid Marketing Guidelines and annual guidance to the ICO on specific translation requirements for its Service Area;

2.14.2.1.3.1. Prevalent Languages are those that meet the more stringent of either: (1) Medicare's 5 percent threshold for language translation; or (2) MDCH's Prevalent Language requirements.

2.14.2.1.4. Mailed with a multi-language insert that indicates that the Enrollee can access free interpreter services to answer any questions about the plan. This message shall be written in the languages required in the Medicare Marketing Guidelines provisions on the multi-language insert and any additional languages that meet the more stringent of either: (1) Medicare's five percent (5%) threshold for language translation; or (2) MDCH's Prevalent Language requirements.

2.14.2.1.5. Distributed to the ICO's entire Service Area as specified in Appendix G of this Contract.

2.14.3. Requirements for the Submission, Review, and Approval of Materials

2.14.3.1. The ICO must receive prior approval of all marketing and Enrollee Communications materials in categories of materials that CMS and MDCH require to be prospectively reviewed. ICO materials may be designated as eligible for the File & Use process, as described in 42 C.F.R. §422.2262(b) and §423.2262(b), and will therefore be exempt from prospective review and approval by both CMS and MDCH. CMS and MDCH may agree to defer to one or the other party for review of certain types of marketing and Enrollee Communications, as agreed in advance by both parties. The ICO must submit all materials that are consistent with the definition of marketing materials at 42 C.F.R. § 422.2260, whether prospectively reviewed or not, via the CMS HPMS Marketing Module.

2.14.3.2. CMS and MDCH may conduct additional types of review of ICO Marketing, Outreach, and Enrollee Communications activities, including, but not limited to:

2.14.3.2.1. Review of on-site marketing facilities, products, and activities during regularly scheduled Contract compliance monitoring visits.

2.14.3.2.2. Random review of actual Marketing, Outreach, and Enrollee Communications pieces as they are used in the marketplace.

2.14.3.2.3. "For cause" review of materials and activities when complaints are made by any source, and CMS or MDCH determine it is appropriate to investigate.

2.14.3.2.4. "Secret shopper" activities where CMS or MDCH request ICO materials, such as Enrollment packets.

2.14.3.3. Beginning of Marketing, Outreach and Enrollee Communications Activity

2.14.3.3.1. The ICO may not begin Marketing, Outreach, and Enrollee Communications activities to new Enrollees more than ninety (90) calendar days prior to the effective date of Enrollment for the Contract year.

2.14.3.3.2. In addition, for the first year of the Demonstration, the ICO may not begin marketing activity until the ICO has entered into this Contract, passed the joint CMS-Michigan Readiness Review, and is connected to CMS Enrollment and payment systems such that the ICO is able to receive payment and Enrollments.

2.14.4. Requirements for Dissemination of Materials

2.14.4.1. Consistent with the timelines specified in the Medicare-Medicaid marketing guidance, the ICO must provide Enrollees with the following materials which, with the exception of the materials specified in Section 2.14.4.1.3 and Section 2.14.4.1.4 below, must also be provided annually thereafter:

2.14.4.1.1. An Evidence of Coverage (EOC)/Enrollee Handbook document that is consistent with the requirements at 42 C.F.R. §§438.10, 422.11, and 423.128; includes information about all Covered Services, as outlined below, and that uses the model document developed by CMS and MDCH.

2.14.4.1.1.1. Enrollee rights (see Appendix B);

2.14.4.1.1.2. An explanation of the Enrollee Medical Record and the process by which clinical information, including diagnostic and medication information, will be available to key caregivers;

2.14.4.1.1.3. How to obtain a copy of the Enrollee's Enrollee Medical Record;

2.14.4.1.1.4. How to obtain access to specialty, behavioral health, pharmacy and LTSS providers;

2.14.4.1.1.5. The Enrollee's requirement to select a PCP and how to change PCP;

2.14.4.1.1.6. How to obtain services and prescription drugs for Emergency Medical Conditions and Urgent Care in and out of the Provider Network and in and out of the Service Area; including:

2.14.4.1.1.6.1. What constitutes an Emergency Medical Condition, Emergency Services, Urgent Care and Post-Stabilization Care Services, with reference to the definitions is 42 C.F.R. §438.114(a) and 42 C.F.R. §422.113;

2.14.4.1.1.6.2. The fact that prior authorization is not required for Emergency Services;

2.14.4.1.1.6.3. The process and procedures for obtaining Emergency Services, including the use of the 911 telephone system or its local equivalent;

2.14.4.1.1.6.4. The locations of any emergency settings and other locations at which providers and hospitals furnish Emergency Services and Post-Stabilization Care Services covered under the Contract;

2.14.4.1.1.6.5. That the Enrollee has a right to use any hospital or other setting for emergency care; and

2.14.4.1.1.6.6. The Post-Stabilization Care Services rules at 42 C.F.R. §422.113(c).

2.14.4.1.1.7. Information about advance directives (at a minimum those required in 42 C.F.R. §§ 489.102 and 422.128), including:

2.14.4.1.1.7.1. Enrollee rights under the law of the State of Michigan;

2.14.4.1.1.7.2. The ICO's policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience;

2.14.4.1.1.7.3. That complaints concerning noncompliance with the advance directive requirements may be filed with MDCH;

2.14.4.1.1.7.4. Designating a health care proxy, and other mechanisms for ensuring that future medical decisions are made according to the desire of the Enrollee; and

2.14.4.1.1.7.5. The ICO must update materials to reflect any changes in State law as soon as possible, but no later than ninety (90) calendar days after the effective date of change.

2.14.4.1.1.8. How to obtain assistance from ESRs;

2.14.4.1.1.9. How to file Grievances and internal and External Appeals, including;

2.14.4.1.1.9.1. Grievance, Appeal and State Fair Hearing procedures and timeframes;

2.14.4.1.1.9.2. Toll free numbers that the Enrollee can use to file a Grievance or an Appeal by phone for expedited External Appeals only (only Expedited Appeals may be received telephonically for External Appeals through the State Fair Hearing Process);

2.14.4.1.1.9.3. That when requested by the Enrollee, benefits will continue at the plan level for all benefits, and if the Enrollee files an Appeal or a request for State Fair Hearing within the timeframes specified for filing;

2.14.4.1.1.9.4. How the Enrollee can identify who the Enrollee wants to receive Adverse Action Notices;

2.14.4.1.1.9.5. How to obtain assistance with the Appeals processes through the ESR and other assistance mechanisms as MDCH or CMS may identify, including an Ombudsman;

2.14.4.1.1.10. The extent to which, and how Enrollees may obtain benefits, including family planning services, from out-of-network providers;

2.14.4.1.1.11. How and where to access any benefits that are available under the Michigan Medicaid State plan or applicable waivers but are not covered under the Contract;

2.14.4.1.1.12. How to change providers; and

2.14.4.1.1.13. How to disenroll voluntarily.

2.14.4.1.1.14. Notice of privacy practices;

2.14.4.1.1.15. Eligibility requirements for Demonstration Enrollment;

2.14.4.1.1.16. Self-referral services;

2.14.4.1.1.17. Explanation that the ICO identification (ID) card replaces the Medicare and Medicaid cards and that Enrollees should keep their original Medicare and Medicaid cards;

2.14.4.1.1.18. The right to change plans;

2.14.4.1.1.19. Non-discrimination requirements;

2.14.4.1.1.20. How to contact the Department of Community Health with concerns about the ICO;

2.14.4.1.1.21. The structure and operation of any physician incentive plans the ICO may have in place;

2.14.4.1.1.22. The structure and operation of the ICO;

2.14.4.1.1.23. How to access the ICO Provider and Pharmacy Directory; and

2.14.4.1.1.24. The name of the ICO's parent company and any doing business as name that may be used; toll-free Enrollee services and care management and nurse advice twenty-four (24) hour service lines; and any other content required by State or federal regulation.

2.14.4.1.2. A Summary of Benefits (SB) that contains a concise description of the important aspects of enrolling in the ICO's plan, as well as the benefits offered under the ICO's plan, including any cost sharing, applicable conditions and limitations, and any other conditions associated with receipt or use of benefits, and is consistent with the model document developed by CMS and MDCH.

2.14.4.1.2.1. The SB should provide sufficient detail to ensure that Enrollees understand the benefits to which they are entitled.

2.14.4.1.2.2. For new Enrollees, the SB is required only for individuals enrolled through Passive Enrollment.

2.14.4.1.2.3. The SB must contain language that instructs Enrollees how and where to obtain services for BH, SUD, and I/DD through the PIHP.

2.14.4.1.2.4. The ICO will use a Demonstration-specific SB.

2.14.4.1.2.5. For current Enrollees, the SB must be sent with the Annual Notice of Change (ANOC) as described in the Medicare-Medicaid marketing guidance.

2.14.4.1.3. A combined Provider and Pharmacy Directory that is consistent with the requirements in Section 2.8.

2.14.4.1.4. A single ID card for accessing all Covered Services under the plan that uses the model document developed by CMS and MDCH;

2.14.4.1.5. A comprehensive, integrated formulary that includes prescription drugs and over-the-counter products required to be covered by Medicare Part D and MDCH's outpatient prescription drug benefit and that uses the model document developed by CMS and MDCH.

2.14.4.1.6. The procedures for an Enrollee to change ICOs or to Opt Out of the Demonstration.

2.14.4.1.7. The ICO must provide the following materials to current Enrollees on an ongoing basis:

2.14.4.1.7.1. An ANOC that summarizes all major changes to the ICO's covered benefits from one Contract year to the next, and that uses the model document developed by CMS and the MDCH.

2.14.4.1.7.2. A combined Provider and Pharmacy Directory as frequently as specified in Section 2.14.5; and as needed to replace old versions or upon a Enrollee's request

2.14.4.1.8. The ICO must provide all Medicare Part D required notices, with the exception of the late Enrollment penalty notices and the creditable coverage notices required under Chapter 4 of the Prescription Drug Benefit Manual, and the late LIS Rider required under Chapter 13 of the Prescription Drug Benefit Manual.

2.14.4.1.9. Consistent with the requirement at 42 C.F.R. §423.120(b)(5), the ICO must provide Enrollees with at least sixty (60) calendar day advance notice regarding changes to the comprehensive, integrated formulary.

2.14.4.1.10. The ICO must ensure that all information provided to Enrollees and Potential Enrollees (and families when appropriate) is provided in a manner and format that is easily understood and that is:

2.14.4.1.10.1. Made available in large print (at least 16 point font) to Enrollees as an Alternative Format, upon request;

2.14.4.1.10.2. For vital materials, available in any languages that meet the more stringent of either: (1) Medicare's five percent (5%) threshold for language translation; or (2) MDCH's Prevalent Language requirements, as provided for in the Medicare-Medicaid marketing guidance.

2.14.4.1.10.3. Written with cultural sensitivity and at or below a sixth (6th) grade reading level; and

2.14.4.1.10.4. Available in Alternative Formats, according to the needs of Enrollees and Potential Enrollees, including Braille, oral interpretation services in non-English languages, as specified in Section 2.14.2.1.1. of this Contract; audiotape; ASL video clips, and other alternative media, as requested.

2.14.5. Requirements for the Provider and Pharmacy Network Directory

2.14.5.1. Maintenance and Distribution: The ICO must:

2.14.5.1.1. Maintain a combined Provider and Pharmacy Network Directory that uses the model document developed by CMS and MDCH;

2.14.5.1.2. Provide either a copy or information about how to access a copy, as specified in the Medicare-Medicaid marketing guidance, to all new Enrollees at the time of Enrollment and, upon request, to both new and continuing Enrollees;

2.14.5.1.3. Provide a copy or information about how to access a copy, as specified in the Medicare-Medicaid marketing guidance, to continuing Enrollees at least every three (3) years after the time of Enrollment, unless there is a significant change to the network, in which case the ICO must send a special mailing of an updated directory or information about the network change and how to access a copy, as specified in the Medicare-Medicaid marketing guidance immediately;

2.14.5.1.4. Ensure an up-to-date copy is available on the ICO's website, consistent with the requirements at 42 C.F.R. §§ 422.111(h) and 423.128(d);

2.14.5.1.5. Consistent with 42 C.F.R. § 422.111(e), make a good faith effort to provide written notice of termination of a contracted provider or pharmacy at least thirty (30) calendar days before the termination effective date to all Enrollees who regularly use the provider or pharmacy's services; if a contract termination involves a PCP, all Enrollees who are patients of that PCP must be notified; and

2.14.5.1.6. Include written and oral offers of such Provider and Pharmacy Directory in its outreach and orientation sessions for new Enrollees.

2.14.5.2. Content of Provider and Pharmacy Directory

2.14.5.2.1. The Provider and Pharmacy Directory must include, at a minimum, the following information for all providers/pharmacies in the ICO's Provider/Pharmacy Network:

2.14.5.2.1.1. The names, addresses, and telephone numbers of all current network providers and pharmacies.

2.14.5.2.1.2. Network providers with areas of special experience, skills and training, including providers with expertise in treating:

2.14.5.2.1.2.1. Persons with physical disabilities, chronic illness, HIV/AIDS, and/or persons with serious mental illness;

2.14.5.2.1.2.2. Individuals who are homeless;

2.14.5.2.1.2.3. Individuals who are Deaf, hard-of-hearing, blind and/or visually impaired;

2.14.5.2.1.2.4. Persons with co-occurring disorders; and

2.14.5.2.1.2.5. Other specialties.

2.14.5.2.1.3. Office hours for each network provider, including the names of any network provider sites open after 5:00 p.m. (Eastern Time) weekdays and on weekends;

2.14.5.2.1.4. The cultural and linguistic capabilities of network providers, including languages spoken by the network provider or by skilled medical interpreter at the network provider's site;

2.14.5.2.1.5. Network provider licensing information;

2.14.5.2.1.6. Whether the network provider is accessible for people with physical disabilities, including its office, exam room(s) and equipment;

2.14.5.2.1.7. Whether the provider is accepting new patients;

2.14.5.2.1.8. Whether the network provider access by public transportation;

2.14.5.2.1.9. Languages other than English spoken by providers or by skilled medical interpreters at the provider's site, including ASL, and whether translation services are available;

2.14.5.2.1.10. For behavioral health providers, qualifications and licensing information, and special experience, skills, and training (i.e., trauma, child welfare, substance use);

2.14.5.2.1.11. For pharmacies, instructions for the Enrollee to contact the ICO's toll-free Enrollee services telephone line (as described in Section 2.9) for assistance in finding a convenient pharmacy; and

2.14.5.2.1.12. A description of the roles of the ICT and the process by which Enrollees select and change PCPs.

2.15. Financial Requirements

2.15.1. Financial Viability

2.15.1.1. Consistent with Section 1903 (m) of the Social Security Act, and regulations found at 42 C.F.R. § 422.402, and 42 C.F.R. § 438.116, the ICO shall meet all State and federal financial soundness requirements. These may include:

2.15.1.1.1. The ICO must provide assurances that its provision against the risk of insolvency is adequate to ensure that its Enrollees will not be liable for the entity's debts, if the entity becomes insolvent.

2.15.1.1.2. The ICO must produce adequate documentation satisfying the State that it has met its Solvency requirements.

2.15.1.1.2.1. The ICO must comply with all HMO statutory requirements for fiscal soundness and MDCH will evaluate the ICO's financial soundness based upon the thresholds established in Appendix I of the Contract.

2.15.1.1.3. The ICO must also maintain reserves to remain solvent for a forty-five (45) calendar day period, and provide satisfactory evidence to the State of such reserves.

2.15.2. The ICO will be required to meet Solvency requirements as specified in MDCH procurement, including rules developed by the DIFS.

2.15.2.1. The DIFS is responsible for the licensing and monitoring of the financial Solvency of Health Insuring Corporations (HICs).

2.15.2.2. The ICO is required to have a certificate of authority to operate as a HMO in accordance with MCL 500.3505.

2.15.3. Other Financial Requirements

2.15.3.1. The ICO must cover continuation of services to Enrollees for duration of period for which payment has been made, as well as for inpatient admissions up until discharge.

2.16. Data Submissions, Reporting Requirements, and Survey

2.16.1. General Requirements for Data

2.16.1.1. The ICO must provide and require its First Tier, Downstream and Related Entities to provide:

2.16.1.1.1. All information CMS and MDCH require under the Contract related to the performance of the ICO's responsibilities, including non-medical information for the purposes of research and evaluation;

2.16.1.1.2. Any information CMS and MDCH require to comply with all applicable federal or State laws and regulations; and

2.16.1.1.3. Any information CMS or MDCH require for external rapid cycle evaluation including program expenditures, service utilization rates, rebalancing from institutional to community settings, Enrollee satisfaction, Enrollee Grievances and Appeals and Enrollment/disenrollment rates.

2.16.2. General Reporting Requirements

2.16.2.1. The ICO must:

2.16.2.1.1. Submit to MDCH applicable MDCH reporting requirements in compliance with this Contract;

2.16.2.1.2. Submit to CMS applicable Medicare and any Medicaid reporting requirements in compliance with 42 C.F.R. §§ 422.516, § 423.514 and § 438 et seq.

2.16.2.1.3. Submit to CMS all applicable ICO reporting requirements;

2.16.2.1.4. Submit to CMS and MDCH all required reports and data in accordance with the specifications, templates and time frames described in this Contract;

2.16.2.1.5. Report HEDIS, HOS, and CAHPS data, as well as measures related to Long Term Supports and Services. HEDIS, HOS, and CAHPS measures will be reported consistent with Medicare requirements for HEDIS, plus additional Medicaid measures required by MDCH. All existing Part D metrics will be collected as well. Such measures shall include a combined set of core measures that the ICO must report to CMS and MDCH;

2.16.2.1.5.1. The ICO must contract with an NCQA certified HEDIS vendor and undergo a full audit of its HEDIS reporting process.

2.16.2.1.5.2. The ICO must directly contract with a NCQA certified CAHPS vendor and submit the data according to the specifications established by NCQA.

2.16.2.1.6. Upon request, submit to CMS and MDCH any internal reports that the ICO uses for internal management. Such reports shall include, but not be limited to, internal reports that analyze the medical/loss ratio, financial stability, or other areas where standard compliance reports indicate a problem in performance;

2.16.2.1.7. Pursuant to 42 C.F.R. § 438.6(f)(2)(ii), comply with any reporting requirements on Provider Preventable Conditions in the form and frequency as may be specified by MDCH; and

2.16.2.1.8. Provide to CMS and MDCH, in a form and format approved by CMS and MDCH and in accordance with the timeframes established by CMS and MDCH, all reports, data or other information CMS and MDCH determine are necessary for compliance with provisions of the Affordable Care Act of 2010, Subtitle F, Medicaid Prescription Drug Coverage, and applicable implementing regulations and interpretive guidance.

2.16.2.1.9. Submit at the request of CMS or MDCH additional ad hoc or periodic reports or analyses of data related to the Contract.

2.16.3. Information Management and Information Systems

2.16.3.1. General: the ICO shall:

2.16.3.1.1. Maintain information systems (Systems) that will enable the ICO to meet all of MDCH's requirements as outlined in this Contract. The ICO's Systems shall be able to support current MDCH requirements, and any future IT architecture or program changes. Such requirements include, but are not limited to, the following MDCH standards:

2.16.3.1.1.1. The MDCH Unified Process Methodology User Guide;

2.16.3.1.1.2. The User Experience and Style Guide Version 2.0;

2.16.3.1.1.3. Information Technology Architecture Version 2.0; and

2.16.3.1.1.4. Enterprise Web Accessibility Standards 2.0.

2.16.3.1.2. Ensure a secure, HIPAA-compliant exchange of Enrollee information between the ICO and MDCH and any other entity deemed appropriate by MDCH. Such files shall be transmitted to MDCH through secure FTP, HTS, or a similar secure data exchange as determined by MDCH;

2.16.3.1.3. Develop and maintain a website that is accurate and up-to-date, and that is designed in a way that enables Enrollees and providers to quickly and easily locate all relevant information. If directed by MDCH, establish appropriate links on the ICO's website that direct users back to the MDCH website portal;

2.16.3.1.4. The ICO shall cooperate with MDCH in its efforts to verify the accuracy of all ICO data submissions to MDCH; and

2.16.3.1.5. Actively participate in any MDCH Systems Workgroup, as directed by MDCH. The MDCH Systems Workgroup shall meet in the location and on a schedule determined by MDCH.

2.16.3.2. Design Requirements

2.16.3.2.1. The ICO shall comply with MDCH requirements, policies, and standards in the design and maintenance of its Systems in order to successfully meet the requirements of this Contract.

2.16.3.2.2. The ICO's Systems shall interface with MDCH Legacy MMIS system, MDCH's MMIS system, the MDCH Virtual Gateway, and other MDCH IT architecture.

2.16.3.2.3. The ICO shall have adequate resources to support the MMIS interfaces. The ICO shall demonstrate the capability to successfully send and receive interface files. Interface files, which include, but are not limited to:

2.16.3.2.3.1. Inbound Interfaces;

2.16.3.2.3.2. Daily Inbound Demographic Change File;

2.16.3.2.3.3. HIPAA 834 History Request File;

2.16.3.2.3.4. Inbound Co-pay Data File (daily);

2.16.3.2.3.5. Monthly ICO Provider and Pharmacy Directory;

2.16.3.2.3.6. Outbound Interfaces;

2.16.3.2.3.7. HIPAA 834 Outbound Daily File;

2.16.3.2.3.8. HIPAA 834 Outbound Full File;

2.16.3.2.3.9. HIPAA 834 History Response;

2.16.3.2.3.10. FFS Wrap Services;

2.16.3.2.3.11. HIPAA 820; and

2.16.3.2.3.12. TPL Carrier Codes File.

2.16.3.2.4. The ICO shall conform to HIPAA compliant standards for data management and information exchange.

2.16.3.2.5. The ICO shall demonstrate controls to maintain information integrity.

2.16.3.2.6. The ICO shall maintain appropriate internal processes to determine the validity and completeness of data submitted to MDCH.

2.16.4. Accepting and Processing Assessment Data

2.16.4.1. System Access Management and Information Accessibility Requirements

2.16.4.1.1. The ICO shall make all Systems and system information available to authorized CMS, MDCH and other agency staff as determined by CMS or MDCH to evaluate the quality and effectiveness of the ICO's data and Systems.

2.16.4.1.2. The ICO is prohibited from sharing or publishing CMS or MDCH data and information without prior written consent from CMS or MDCH.

2.16.4.2. System Availability and Performance Requirements

2.16.4.2.1. The ICO shall ensure that its Enrollee and provider web portal functions and phone-based functions are available to Enrollees and providers twenty-four (24) hours a day, seven (7) days a week.

2.16.4.2.2. The ICO shall draft an alternative plan that describes access to Enrollee and provider information in the event of system failure. Such plan shall be contained in the ICO's continuity of operations plan (COOP) and shall be updated annually and submitted to MDCH upon request. In the event of System failure or unavailability, the ICO shall notify CMT upon discovery and implement the COOP immediately.

2.16.4.2.3. The ICO shall preserve the integrity of Enrollee-sensitive data that resides in both a live and archived environment.

2.17. Encounter Reporting

2.17.1. Requirements

2.17.1.1. The ICO must meet any diagnosis and/or encounter reporting requirements that are in place for Medicare Advantage plans and Medicaid managed care organizations, as may be updated from time to time.

2.17.1.2. Furthermore, the ICO's Systems shall generate and transmit Encounter Data files according to additional specifications as may be provided by CMS or MDCH and updated from time to time.

2.17.1.3. CMS and MDCH will provide technical assistance to the ICO for developing the capacity to meet encounter reporting requirements.

2.17.1.4. The ICO shall:

2.17.1.4.1. Collect and maintain one hundred percent (100%) Encounter Data for all Covered Services provided to Enrollees, including from any sub-capitated sources (First Tier, Downstream and Related Entities). Such data must be able to be linked to MDCH eligibility data;

2.17.1.4.2. Participate in site visits and other reviews and assessments by CMS and MDCH, or its designee, for the purpose of evaluating the ICO's collection and maintenance of Encounter Data;

2.17.1.4.3. Upon request by CMS, MDCH, or their designee, provide medical records of Enrollees and a report from administrative databases of the Encounter Data of such Enrollees in order to conduct validation assessments. Such validation assessments may be conducted annually;

2.17.1.4.4. Produce Encounter Data according to the specifications, format, and mode of transfer reasonably established by CMS, MDCH, or their designee, in consultation with the ICO. Such Encounter Data shall include elements and level of detail determined necessary by CMS and MDCH. As directed by CMS and MDCH, such Encounter Data shall also include the National Provider Identifier (NPI) of the ordering and referring physicians and professionals and any National Drug Code (NDC);

2.17.1.4.4.1. 5010 837 HIPAA format for all non-pharmacy Claims

2.17.1.4.4.2. Post Adjudicated NCPDP v 4.2 format for all pharmacy Claims

2.17.1.4.5. Submit complete, timely, reasonable and accurate Encounter Data to CMS no less than monthly and in the form and manner specified by MDCH and CMS. CMS will forward Encounter Data directly to MDCH;

2.17.1.4.6. Submit Encounter Data that meets minimum standards for completeness and accuracy as defined by CMS and MDCH. The ICO must also correct and resubmit denied encounters as necessary;

2.17.1.4.7. Report as a voided Claim in the monthly Encounter Data submission any Claims that the ICO pays, and then later determines should not have paid.

2.17.1.4.8. If CMS, MDCH, or the ICO, determines at any time that the ICO's Encounter Data is not complete and accurate, the ICO shall:

2.17.1.4.8.1. Notify CMS and MDCH, prior to Encounter Data submission, that the data is not complete or accurate, and provide an action plan and timeline for resolution;

2.17.1.4.8.2. Submit for CMS and MDCH approval, within a time frame established by CMS and MDCH, which shall in no event exceed thirty (30) calendar days from the day the ICO identifies or is notified that it is not in compliance with the Encounter Data requirements, a corrective action plan to implement improvements or enhancements to bring the accuracy and/or completeness to an acceptable level;

2.17.1.4.8.3. Implement the CMS and MDCH-approved corrective action plan within a time frame approved by CMS and MDCH, which shall in no event exceed thirty (30) calendar days from the date that the ICO submits the corrective action plan to CMS and MDCH for approval; and

2.17.1.4.8.4. Participate in a validation study to be performed by CMS, MDCH, and/or their designee, following the end of a twelve-month period after the implementation of the corrective action plan to assess whether the Encounter Data is complete and accurate. The ICO may be financially liable for such validation study.

Section 3. CMS and MDCH Responsibilities

3.1. Contract Management

3.1.1. Administration

3.1.1.1. CMS and MDCH will designate a CMT that will include at least one (1) representative from CMS, and at least one (1) representative from MDCH authorized and empowered to represent CMS and MDCH about all aspects of the Contract. Generally, the CMS part of the team will include the State Lead from the Medicare Medicaid Coordination Office (MMCO), Regional Office lead from the Consortium for Medicaid and Children's Health Operations (CMCHO), and an Account Manager from the Consortium for Health Plan Operations (CMHPO). The precise makeup will include individuals who are knowledgeable about the full range of supports and services utilized by the target population, particularly LTSS. The CMS representatives and MDCH representatives will act as liaisons between the ICO and CMS and MDCH for the duration of the Contract. The CMT will:

3.1.1.1.1. Monitor compliance with the terms of the Contract including issuance of joint notices of non-compliance/enforcement.

3.1.1.1.2. Coordinate periodic audits and surveys of the ICO;

3.1.1.1.3. Receive and respond to complaints;

3.1.1.1.4. Conduct regular meetings with the ICO;

3.1.1.1.5. Coordinate requests for assistance from the ICO and assign CMS and MDCH staff with appropriate expertise to provide technical assistance to the ICO;

3.1.1.1.6. Make best efforts to resolve any issues applicable to the Contract identified by the ICO, CMS or MDCH;

3.1.1.1.7. Inform the ICO of any discretionary action by CMS or MDCH under the provisions of the Contract;

3.1.1.1.8. Coordinate review of marketing materials and procedures;

3.1.1.1.9. Coordinate review of Grievance and Appeals data and procedures;

3.1.1.1.10. Review reports from and responses to the Ombudsman; and

3.1.1.1.11. Reviewing direct stakeholder input on both plan-specific and systematic performance.

3.1.1.2. CMS and MDCH will review, approve, and monitor the ICO's outreach and orientation materials and procedures;

3.1.1.3. CMS and MDCH will review, approve, and monitor the ICO's Grievance and Appeals procedures;

3.1.1.4. CMS and MDCH will apply one or more of the sanctions provided in Section 5.3.14, including termination of the Contract in accordance with Section 5.5, if CMS and MDCH determine that the ICO is in violation of any of the terms of the Contract stated herein**;**

3.1.1.5. CMS and MDCH will conduct site visits as determined necessary by CMS and MDCH to verify the accuracy of reported data;

3.1.1.6. CMS and MDCH will coordinate the ICO's external quality reviews conducted by the EQRO;

3.1.1.7. Both CMS and MDCH shall retain discretion to take immediate action where the health, safety or welfare of any Enrollee is imperiled or where significant financial risk is indicated. In such situations, CMS and MDCH shall notify a member of the CMT no more than twenty-four (24) hours from the date of such action, and the CMT will undertake subsequent action and coordination.

3.1.1.8. Oversight of the ICO and providers will be at least as rigorous as existing procedures for Medicare Advantage, Part D, and MDCH's Medicaid 1915(c) waiver and managed care programs.

3.1.2. Performance Evaluation

3.1.2.1. CMS and MDCH will, at their discretion:

3.1.2.1.1. Evaluate, through inspection or other means, the ICO's compliance with the terms of this Contract, including but not limited to the reporting requirements in Sections 2.16 and 2.17, and the quality, appropriateness, and timeliness of services performed by the ICO and its Provider Network. CMS and MDCH will provide the ICO with the written results of these evaluations;

3.1.2.1.2. Conduct periodic audits of the ICO, including, but not limited to an annual independent external review and an annual site visit;

3.1.2.1.3. Conduct annual Enrollee surveys and provide the ICO with written results of such surveys; and

3.1.2.1.4. Meet with the ICO at least semi-annually to assess the ICO's performance**.**

3.2. Enrollment and Disenrollment Systems

3.2.1. CMS and MDCH

3.2.1.1. Will maintain systems to provide Enrollment and disenrollment, information to the ICO; and continuous verification of eligibility status.

3.2.2. MDCH Enrollment Broker

3.2.2.1. MDCH or its designee shall assign a staff person(s) who shall have responsibility to:

3.2.2.1.1. Develop generic materials to assist Potential Enrollees in choosing whether to enroll in the Demonstration. Said materials shall present the ICO's Demonstration Plan in an unbiased manner to Potential Enrollees eligible to enroll in the ICO. MDCH may collaborate with the ICO in developing ICO-specific materials;

3.2.2.1.2. Present the ICO in an unbiased manner to Potential Enrollees or those Enrollees seeking to transfer from one ICO to another. Such presentation(s) shall ensure that Potential Enrollees are informed prior to Enrollment or transfer of the following:

3.2.2.1.2.1. The rights and responsibilities of participation in the Demonstration;

3.2.2.1.2.2. The nature of the ICO's care delivery system, including, but not limited to the Provider Network; the assessment processes, and the ICT;

3.2.2.1.2.3. Orientation and other Enrollee services made available by the ICO;

3.2.2.1.3. Enrollment, disenrollment, and process transfer requests of Enrollees in the ICO, including completion of MDCH Enrollment and disenrollment forms;

3.2.2.1.4. Ensure that Enrollees are informed at the time of Enrollment or transfer of their right to terminate their Enrollment voluntarily at any time, unless otherwise provided by federal law or waiver;

3.2.2.1.5. Be knowledgeable about the ICO's policies, services, and procedures; and

3.2.2.1.6. At its discretion, develop and implement processes and standards to measure and improve the performance of the MDCH Enrollment Broker. MDCH and CMS shall monitor the performance of the MDCH Enrollment Broker.

Section 4. Payment and Financial Provisions

4.1. General Financial Provisions

4.1.1. Capitation Payments

4.1.1.1. CMS and MDCH will each make monthly Capitation Payment to the ICO, in accordance with the rates of payment and payment provisions set forth herein and subject to all applicable federal and State laws, regulations, rules, billing instructions, and bulletins, as amended.

4.1.1.2. The ICO will receive three (3) monthly payments for each Enrollee:

4.1.1.2.1. One amount from CMS reflecting coverage of Medicare Parts A/B services (Medicare Parts A/B Component);

4.1.1.2.2. One amount from CMS reflecting coverage Medicare Part D services (Medicare Part D Component); and

4.1.1.2.3. One amount from MDCH reflecting coverage of Medicaid services (Medicaid Component).

4.1.1.3. The Medicare Parts A/B payment will be risk adjusted using the Medicare Advantage CMS-HCC Model. The Medicare Part D payment will be risk adjusted using the Part D RxHCC Model. The Medicaid Component will utilize the rate cell methodology described in Section 4.2.

4.1.1.4. CMS and MDCH will provide the ICO with a rate report on an annual basis for the upcoming calendar year.

4.1.2. Demonstration Year Dates

4.1.2.1. Capitation Payment updates will take place on January 1st of each calendar year or more frequently, as described in this section; however, savings percentages and quality withhold percentages (see Sections 4.2.3 and 4.4.4) will be applied based on Demonstration Years, as follows:

4.1.2.1.1. Demonstration Year 1: January 1, 2015-December 31, 2015

4.1.2.1.2. Demonstration Year 2: January 1, 2016-December 31, 2016

4.1.2.1.3. Demonstration Year 3: January 1, 2017-December 31, 2017

4.2. Capitated Rate Structure

4.2.1. Medicaid Component of the Capitation Payment

4.2.1.1. MDCH shall pay the ICO a monthly capitation amount (the Medicaid Component) based on the rate cell of the Enrollee, a sum equal to the

product of the approved Capitation Payment and the number of Enrollees in that category as of the first day of that month.

4.2.1.2. The largest component of the Medicaid baseline costs will be based on Michigan FFS costs, using for the first Demonstration Year Michigan FFS Claims for State Fiscal Years 2011, 2012 and the first nine months of 2013. Completion factors are calculated and applied to the baseline data, in order to include expenditures for services that were incurred but not reported in the available data. The data are then adjusted for known policy and program changes that will be in effect during the contract period to the extent such policy and program changes would be occurring in the absence of the Demonstration. Further adjustments are made to SFY 2013 data to reflect a complete year of experience. The completed and adjusted data are trended forward to the midpoint of the contract period and used to develop Capitation Payments. All steps in this process are subject to CMS review.

4.2.1.3. For the portion of individuals expected to transition into Tier 2 population, the Medicaid baseline costs will be established using the 1915(c) capitation rates in effect in absence of the Demonstration under the MIChoice program plus costs that are provided to the MIChoice Enrollees and paid on a FFS basis

4.2.1.4. For the portion of individuals expected to transition from the State's 1915(b) Medicaid capitated program (referred to as Duals Lite) to the Demonstration, the Medicaid baseline costs will incorporate the 1915(b) capitation rates that would be in effect in absence of the Demonstration along with the additional costs for Duals Lite Enrollees that are paid on a FFS basis.

4.2.1.5. Updates to the capitation rates component of the rate for Demonstration Years 2 and 3 will use updated information consistent with data utilized in the development of rates for Demonstration year 1 with savings percentages applied.

4.2.1.6. The State and its actuaries will continue to update the baseline cost for this Demonstration to reflect changes and/or adjustments that are made to the 1915(b) capitation rates outside of the Demonstration. Except for these updates and those based on more recent historical data, updates to the Medicaid baseline will not be allowable unless CMS determines the update would result in a substantial change to the baseline necessary to calculate accurate payment rates for the Demonstration.

4.2.1.7. The Capitation Payments are based on the rate cell structure. Any and all costs incurred by the ICO in excess of the Capitation Payment will be borne in full by the ICO, except as described in Section 4.3.1.

4.2.1.8. No less than annually, MDCH will monitor ICOs for unanticipated increase in the number of Enrollees meeting the NFLOC standard. If the findings show increased numbers of LOC approvals compared to the assumptions used to create the rate cells, MDCH will prospectively adjust rate cell payment levels or make other changes to the rate structure, subject to CMS approval, to achieve budget neutrality relative to baseline costs.

4.2.1.9. All NFLOCD are subject to audit by MDCH, CMS, or their authorized representatives

4.2.1.10. For Nursing Facility services covered under the traditional Medicaid benefit, the ICO shall reimburse monthly, at a minimum, nursing facilities equivalent to their Medicaid FFS rate, including the Quality Assurance Supplement (QAS), as established by the Long Term Care Reimbursement and Rate Setting Section of MDCH, unless otherwise agreed to by the nursing facility and ICO through an alternative arrangement. Any such alternative arrangement must be approved by MDCH.

Exhibit 4 Medicaid Rate Cell Categories

Rating Category / Rate Cell	Description
Tier 1	• Enrollees who on the first day of the month, (1) meet the nursing facility level of care as determined by the Michigan Nursing Facility Level of Care Determination (NFLOCD) tool, and (2) occupy a nursing facility bed certified for both Medicare and Medicaid. • Rates may vary by age. • Rates will vary for the four contracting regions. • Separate rates will be paid for publicly owned and privately owned nursing facilities
Tier 2	• Enrollees who on the first day of the month, (1) meet the nursing facility level of care as determined by the Michigan Nursing Facility Level of Care Determination (NFLOCD) tool, (2) live in any setting other than that referenced in Tier 1, and (3) are enrolled in the ICO 1915(c) waiver. • Rates may vary by age. • Rates will vary for the four contracting regions
Tier 3	• Enrollees who do not meet the criteria for Tier 1 or Tier 2 on the first day of the month. • Rates may vary by age. • Rates will vary for the four contracting regions

4.2.2. Medicare Component of the Capitation Payment

4.2.2.1. Medicare will pay the ICO a monthly capitation amount for the Medicare Parts A/B services (the Medicare A/B Component), risk adjusted using the

Medicare Advantage CMS-HCC Model and the CMS-HCC ESRD Model, except as specified in Section 4.2.4. Medicare will also pay the ICO a monthly capitation amount for Medicare Part D services, risk adjusted using the Part D RxHCC Model (the Medicare Part D Component).

4.2.2.2. Medicare A/B Component

4.2.2.2.1. The Medicare baseline spending for Parts A/B services are a blend of the Medicare Advantage projected payment rates and the Medicare FFS standardized county rates for each year, weighted by the proportion of the target population that will be transitioning from each program into the Demonstration. The Medicare Advantage baseline spending will include costs that would have occurred absent the Demonstration, such as quality bonus payments for applicable Medicare Advantage plans. The FFS county rates will generally reflect amounts published with the April Medicare Advantage Final Rate Announcement, although CMS may adjust the Medicare FFS standardized county rates as necessary to calculate accurate payment rates for the Demonstration. To the extent that the published FFS county rates do not conform with current law in effect for Medicare during an applicable payment month, and to the extent that such nonconformance would have a significant fiscal impact on the Demonstration, CMS will update the baseline (and therefore the corresponding payment rate) to calculate and apply an accurate payment rate for such month. Such update may take place retroactively, as needed.

4.2.2.2.2. Separate baselines will exist for Enrollees meeting the Medicare ESRD criteria. For Enrollees with ESRD in the dialysis or transplant status phases, the Medicare Parts A/B baseline will be the ESRD dialysis State rate. For Enrollees in the functioning graft status phase, the Medicare Parts A/B baseline will be the Medicare Advantage 3-star county rate (benchmark) for the applicable county.

4.2.2.2.3. Both baseline spending and payment rates under the Demonstration for Medicare Parts A/B services will be calculated as per member per month (PMPM) standardized amounts for each county participating in the Demonstration for each year. Enrollee risk scores will be applied to the standardized rates at the time of payment.

4.2.2.2.4. The Medicare A/B Component will be updated annually consistent with annual FFS estimates and Medicare Advantage rates released each year with the annual rate announcement.

4.2.2.3. Medicare Part D

4.2.2.3.1. The Medicare Part D baseline for the Part D Direct Subsidy will be set at the Part D national average monthly bid amount (NAMBA) for the calendar year. CMS will estimate an average monthly prospective payment amount for the low income cost-sharing subsidy and federal reinsurance amounts; these payments will be reconciled after the end of each payment year in the same manner as for all Part D sponsors.

4.2.2.3.2. The monthly Medicare Part D Component for an Enrollee can be calculated by multiplying the Part D NAMBA by the RxHCC risk score assigned to the individual, and then adding to this estimated average monthly prospective payment amount for the low income cost-sharing subsidy and federal reinsurance amounts.

4.2.3. Aggregate Savings Percentages

4.2.3.1. Aggregate savings percentages will be applied equally, as follows, to the baseline spending amounts for the Medicare Parts A/B Component and the Medicaid Component of the capitated rate, provided that such savings percentages may be adjusted in accordance with Section 4.2.3.3 or 4.2.3.4.

4.2.3.1.1. Demonstration Year 1: 1%

4.2.3.1.2. Demonstration Year 2: 2%

4.2.3.1.3. Demonstration Year 3: 4%

4.2.3.2. Rate updates will take place on January 1st of each calendar year, however savings percentages will be calculated and applied based on Demonstration Years.

4.2.3.3. Savings percentages will not be applied to the Part D Component of the rate. CMS will monitor Part D costs closely on an ongoing basis. Any material change in Part D costs relative to the baseline may be factored into future year savings percentages.

4.2.3.4. In the event that at least one-third of ICOs experience losses in Demonstration Year 1 exceeding three percent (3%) of revenue, prior to any risk sharing adjustment, the savings percentage for Demonstration Year 3 will be reduced to three percent (3%). CMS and the State will make such a determination at least four (4) months prior to the start of Demonstration Year 3.

4.2.4. Risk Adjustment Methodology

4.2.4.1. Medicare Parts A/B: The Medicare Parts A/B Component will be risk adjusted based on the risk profile of each Enrollee. Except as specified below, the existing Medicare Advantage CMS-HCC and CMS-HCC ESRD risk adjustment methodology will be used for the Demonstration.

4.2.4.1.1. In calendar year 2015, CMS will calculate and apply a coding intensity adjustment reflective of all Demonstration Enrollees. This will apply the prevailing Medicare Advantage coding intensity adjustment proportional to the anticipated proportion of Demonstration Enrollees in 2015 with Medicare Advantage experience in 2014, prior to the Demonstration.

4.2.4.1.2. In calendar year 2016, CMS will apply an appropriate coding intensity adjustment reflective of all Demonstration Enrollees; this will apply the prevailing Medicare Advantage coding intensity adjustment proportional to the anticipated proportion of Demonstration Enrollees in CY 2016 with prior Medicare Advantage experience and/or Demonstration experience based on the Demonstration's Enrollment phase-in as of September 30, 2015. (This may result in application of the full Medicare Advantage coding intensity adjustment for 2016.)

4.2.4.1.3. After calendar year 2016, CMS will apply the prevailing Medicare Advantage coding intensity adjustment to all Demonstration Enrollees.

4.2.4.1.4. The coding intensity adjustment factor will not be applied during the Demonstration to risk scores for Enrollees with an ESRD status of dialysis or transplant, consistent with Medicare Advantage policy.

4.2.4.2. Medicare Part D: The Medicare Part D NAMBA will be risk adjusted in accordance with existing Part D RxHCC methodology. The estimated average monthly prospective payment amount for the low income cost-sharing subsidy and federal reinsurance amounts will not be risk adjusted.

4.2.4.3. Medicaid: The Medicaid component will employ rating categories described in Section 4.2.1.

4.3. Risk Mitigation Approaches

4.3.1. Risk Corridor

4.3.1.1. Risk corridors will be established for Demonstration Year 1.

4.3.1.2. Risk corridors will not be applied for Demonstration Years 2 or 3.

4.3.1.3. The Demonstration will utilize a tiered ICO-level symmetrical risk corridor to include all Medicare A/B and Medicaid eligible costs.

4.3.1.4. The risk corridors will be reconciled after application of any risk adjustment methodologies (e.g., CMS-HCC).

4.3.1.5. Risk corridors will be reconciled as if all ICOs had received the full quality withhold payment.

4.3.1.6. Process for collecting cost information

4.3.1.6.1. CMS and MDCH will evaluate Encounter Data, cost data, and ICO financial reports to determine ICO incurred costs of services and Care Coordination/management. By June 1, 2016, the ICO will submit a certified financial statement as developed by MDCH which will be used in cost validation for the risk corridor. Final settlements will be made by September 1, 2016.

4.3.1.6.2. Risk corridor share: The Medicare and Medicaid contributions to risk corridor payments or recoupments will be in proportion to their contributions to the capitated rates, not including Part D, with the maximum Medicare payment/recoupment equaling two percent (2%) of the risk-adjusted Medicare baseline.

4.3.1.6.3. All remaining payments or recoveries once Medicare has reached its maximum shall be treated as Medicaid expenditures eligible for FMAP. Risk corridors will consider both service and care management costs.

4.3.1.6.4. Risk corridor tiers: CMS and MDCH will use the bands as described in Exhibit 5 to address potential ICO gains/losses in Demonstration Year.

Exhibit 5 Risk Corridor Tiers

Percentage of Loss or Gain	ICO Share	Medicare Share	MDCH Share
≤ 3%	100%	0%	0%
>3% and ≤ 9%	50%	Percentage based on Medicare share of combined Capitation Payments, excluding Part D, with the maximum Medicare payment/recoupment equaling 2% of the risk-adjusted	Percentage based on Medicaid share of combined Capitation Payments, excluding Part D, subject to FMAP

		Medicare Capitation Payment	
>9%	100%	0%	0%

4.3.2. Medical loss ratio (MLR)

4.3.2.1. Beginning Demonstration Year 2, each ICO will be required each year to meet a Minimum Medical Loss Ratio (MMLR) threshold which regulates the minimum amount (as a percentage of the gross joint Medicare and Medicaid payments after final risk adjustment) that must be used for expenses either directly related to Covered Services or those which are related to the care of and quality improvement for Enrollees.

4.3.2.2. The ICO has a target medical loss ratio of eighty-five percent (85%).

4.3.2.3. If the MLR calculated as set forth below is less than the target MLR, the ICO shall refund to MDCH and CMS an amount equal to the percentage of premium equal to 1 minus Actual MLR divided by the Target MLR. MDCH and CMS shall calculate a MLR for Enrollees under this Contract for each coverage year, and shall provide to the ICO the amount to be refunded, if any, to MDCH and CMS respectively. Any refunded amounts will be distributed back to the Medicaid and Medicare programs, with the amount to each payer based on the proportion between the Medicare and Medicaid Components. At the option of CMS and MDCH, separately, any amount to be refunded may be recovered either by requiring the ICO to make a payment or by an offset to future capitation or quality withhold payments. The MLR calculation shall be determined as set forth below; however, MDCH and CMS may adopt NAIC reporting standards and protocols after giving written notice to the ICO.

4.3.2.4. MLR will be based on the 42 C.F.R. §§ 422.2400 et seq and 423.2400 et seq except that the numerator in the MLR calculation will include:

4.3.2.4.1. All Covered Services required in the Demonstration under Section 2.4 and Appendix A;

4.3.2.4.2. Any services purchased in lieu of more costly Covered Services and consistent with the objectives of the Demonstration; and

4.3.2.4.3. Care Coordination Expense. That portion of the personnel costs for ICO Care Coordinators whose primary duty is direct Enrollee contact that is attributable to this Contract shall be included as a benefit expense. The portion of the personnel costs for ICO's medical director that is attributable to this Contract shall be included as a benefit expense.

4.3.2.5. The revenue used in the MLR calculation will consist of the Capitation Payments, as adjusted pursuant to Section 4.2.4, due from MDCH and CMS for services provided during the coverage year. Revenue will include amounts withheld pursuant to Section 4.4.4, regardless of whether the ICO actually receives the amount in Section 4.4.4.

4.3.2.6. Data Submission. The ICO shall submit to MDCH and CMS, in the form and manner prescribed by MDCH and CMS, the necessary data to calculate and verify the MLR after the end of the coverage year.

4.3.2.7. Medical Loss Ratio Calculation. Within ninety (90) calendar days following the six (6) month Claims run-out period following the coverage year, MDCH and CMS shall calculate the MLR by dividing the benefit expense by the revenue. The MLR shall be expressed as a percentage rounded to the second decimal point. The ICO shall have sixty (60) calendar days to review the MLR calculation. Each party shall have the right to review all data and methodologies used to calculate the MLR.

4.3.2.8. Coverage Year. The coverage year shall be the calendar year. The MLR calculation shall be prepared using all data available from the coverage year, including incurred but not paid and six (6) months of run-out for benefit expense (excluding sub-capitation paid during the run-out months).

4.4. Payment Terms

4.4.1. Timing of Capitation Payments

4.4.1.1. CMS and MDCH will each make monthly Capitation Payments to the ICO. If an individual is enrolled with the ICO on the first day of a month, the ICO has the responsibility of providing Covered Services to that Enrollee for that month, even if the Enrollee moves to another locality. Any and all costs incurred by the ICO in excess of the Capitation Payment will be borne in full by the ICO, except as described in Section 4.3.1 and in the application of rules related to Medicare Part D. The ICO shall accept MDCH electronic transfer of funds to receive Capitation Payments.

4.4.1.2. The Medicare Parts A/B Component will be the product of the Enrollee's CMS-HCC risk score multiplied by the relevant standard county payment rate (or the ESRD dialysis State rate by the HCC ESRD risk score, as applicable). The Medicare Part D Component will be the product of the Enrollee's RxHCC risk score multiplied by the Part D NAMBA, with the addition of the estimated average monthly prospective payment.

4.4.1.3. The Medicaid Component for each rate cell will be the product of the number of Enrollees in each category multiplied by the payment rate for that rate cell.

4.4.1.4. Enrollee contribution to care amounts (Patient Pay Amounts (PPA) for Enrollees on a traditional Medicaid nursing home stay) will be deducted from the Medicaid Component of the monthly Capitation Payment amount, in accordance with Section 4.2.1.

4.4.1.5. Enrollments

4.4.1.5.1. CMS will make monthly PMPM Capitation Payment to the ICO. The PMPM Capitation Payment for a particular month will reflect payment for the Enrollees with effective Enrollment into the ICO as of the first day of that month.

4.4.1.5.2. MDCH will make monthly PMPM Capitation Payments to the ICO prospectively for the current month's Enrollment (e.g., payment for June Enrollment will occur in June). The PMPM Capitation Payment for a particular month will reflect payment for the Enrollees with effective Enrollment into the ICO as of the first day of the current month.

4.4.1.6. Disenrollments

4.4.1.6.1. The final PMPM Capitation Payment made by CMS and MDCH to the ICO for each Enrollee will be for the month: a) in which the disenrollment was submitted, b) the Enrollee loses eligibility, or c) the Enrollee dies (see Section 2.3.7).

4.4.2. Enrollee Contribution to Care Amounts

4.4.2.1. When an Enrollee's income exceeds an allowable amount, he or she must contribute toward the cost of Medicaid nursing home care to maintain Medicaid eligibility. This contribution, known as the PPA, is required for Enrollees residing in a nursing facility. The PPA is required to be calculated for every individual receiving Nursing Facility Care, although not every eligible individual will end up having to pay each month. The PPA is calculated by the local Michigan Department of Human Services.

4.4.2.2. MDCH will provide information to the ICO that identifies Enrollees who are required to pay a PPA and the amount of the obligation as part of the monthly transition report. The Medicaid Component of MDCH Capitation Payments to the ICO for Enrollees who are required to pay a PPA will be net of the monthly PPA. It is the responsibility of the nursing facility provider to collect the PPA from Enrollees, and the ICO shall reduce reimbursements to nursing facility providers equal to the PPA amount each month. PPA may be prorated for stays less than a full month. Proration is based on the facility's Medicaid daily rate charged to the Enrollee per day until the PPA is exhausted.

4.4.3. Modifications to Capitation Payments

4.4.3.1. CMS and MDCH will jointly notify the ICO in advance and in writing as soon as practicable, but in no event less than thirty (30) calendar days prior to processing the change to the Capitation Payment, of any proposed changes to the Capitation Payments, and the ICO shall accept such changes as payment in full as described in Section 4.7. Any mid-year rate changes would be articulated in a rate report.

4.4.3.2. Rates will be updated using a similar process for each calendar year. Subject to Section 4.4.3.3 below, changes to the Medicare and Medicaid baselines (and therefore to the corresponding payment rate) outside of the annual Medicare Advantage and Part D rate announcement and annual Medicaid rate update will be made only if and when CMS and MDCH jointly determine the change is necessary to calculate accurate payment rates for the Demonstration. Such changes may be based on the following factors: shifts in Enrollment assumptions; major changes or discrepancies in federal law and/or State policy used in the development of baseline estimates; and changes to coding intensity.

4.4.3.3. For changes solely affecting the Medicare program baseline, CMS will consult with MDCH prior to making any adjustment, but MDCH concurrence will not be required. CMS will update baselines by amounts necessary to best effectuate accurate payment rates for each month, as identified by the independent CMS Office of the Actuary.

4.4.3.4. Subject to Section 4.4.3.3 above, if other statutory changes enacted after the annual baseline determination and rate development process are jointly determined by CMS and MDCH to have a material change in baseline estimates for any given payment year, baseline estimates and corresponding standardized payment rates shall be updated outside of the annual rate development process.

4.4.3.5. CMS and/or MDCH will make changes to baseline estimates within thirty (30) calendar days of identification of the need for such changes, and changes will be applied, if necessary on a retrospective basis, to effectuate accurate payment rates for each month.

4.4.3.6. Changes to the savings percentages will be made if and when CMS and MDCH jointly determine that changes in Part D spending have resulted in materially higher or lower savings that need to be recouped through higher or lower savings percentages applied to the Medicare A/B baselines.

4.4.3.7. Any material changes in the Medicaid State plan, including pertaining to Covered Services, payment schedules and related methodologies, shall be reflected in corresponding Capitation Payment adjustments. The ICO will not be required to implement such changes without advance notice and corresponding adjustment in the Capitation Payment. In addition, to the extent other Medicaid costs are incurred absent the Demonstration, such costs shall be reflected in corresponding Capitation Payment adjustments.

4.4.3.8. In Demonstration Years 2 and 3, CMS and the MDCH will review the rates and payment parameters if two (2) or more ICOs show MLRs below ninety percent (90%) over all regions in which those ICOs participate, or in the event that two (2) or more ICOs show annual losses exceeding five percent (5%) over all regions in which those ICOs participate.

4.4.4. Quality Withhold Policy

4.4.4.1. Under the Demonstration, both CMS and MDCH will withhold a percentage of their respective components of the Capitation Payment, with the exception of Part D Component amounts. The withheld amounts will be repaid subject to the ICO's performance consistent with established quality thresholds, which includes PIHP responsibilities identified in the Contract between the ICO and PIHP, consistent with established quality thresholds.

4.4.4.2. CMS and MDCH will evaluate the ICO's performance according to the specified metrics required in order to earn back the quality withhold for a given year.

4.4.4.3. All ICO subcontracts with PIHPs must include provisions that reward the PIHP when the ICO achieves the withheld amounts. This may be accomplished by applying the same percentage withhold to the payments from ICOs to PIHPs, subject to the same withhold criteria. MDCH will phase-in a separate quality withhold process specific to PIHP performance following the first year of the Demonstration. The PIHP process will be based on established quality thresholds and be repaid subject to PIHP performance in the Demonstration. Any separate PIHP withhold will be defined in the contract between MDCH and the PIHPs.

4.4.4.4. CMS and MDCH will evaluate ICO performance according to the specified metrics required in order to earn back the quality withhold for a given year. CMS and MDCH will share information as needed to determine whether quality requirements have been met and calculate final payments to each ICO from each payer.

4.4.4.5. Whether or not each ICO has met the quality requirements in a given year will be made public, as will relevant quality results of ICOs in Demonstration Years 2 and 3.

4.4.4.6. Additional details regarding the quality withholds, including more detailed specifications, required thresholds and other information regarding the methodology will be made available in future technical guidance.

4.4.4.7. Withhold Measures in Demonstration Year 1

4.4.4.7.1. Exhibit 6 below identifies the withhold measures for Demonstration Year 1. Together, these will be utilized as the basis for a one percent (1%) withhold.

4.4.4.7.2. The ICO will be evaluated to determine whether it has met required quality withhold requirements at the end of Calendar Year 2015. The determination will be based solely on those measures that can appropriately be calculated based on the actual Enrollment volume during CY 2015.

Exhibit 6 Quality Withhold Measures for Demonstration Year 1

Domain	Measure	Source	CMS Core Withhold Measure	Michigan Withhold Measure

Domain	Measure	Source	CMS Core Withhold Measure	Michigan Withhold Measure
Encounter Data	Encounter Data submitted accurately and completely in compliance with Contract requirements.	CMS/State defined process measure	X	
Assessments	Percent of Enrollees with initial assessments completed within ninety (90) calendar days.	CMS/State defined process measure	X	X
Governance board	Establishment of Enrollee advisory board or inclusion of Enrollees on governance board consistent with Contract requirements.	CMS/State defined process measure	X	
Care Transition Record Transmitted to Health Care Professional	Percent of Demonstration Enrollees discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or to the health care professional designated for follow-up care within twenty-four (24) hours of discharge.	AMA-PCPI		X
Care for Older Adults - Medication Review	Percent of ICO Enrollees whose doctor or clinical pharmacist has reviewed a list of everything they take (prescription and non-prescription drugs, vitamins, herbal remedies, other supplements) at least once a year.	NCQA/HEDIS		X
Documentation of care goals	Percent of Enrollees with documented discussions of care goals.	CMS/State defined process measure		X

4.4.4.8. Withhold Measures in Demonstration Years 2 and 3

4.4.4.8.1. The quality withhold will increase to two percent (2%) in Demonstration Year 2 and three percent (3%) in Demonstration Year 3.

4.4.4.8.2. Payment will be based on performance on the quality withhold measures listed in Exhibit 7 below.

Exhibit 7 Quality Withhold Measures for Demonstration Years 2 and 3

Domain	Measure	Source	CMS Core Withhold Measure	Michigan Withhold Measure
Customer Service	Percent of best possible score the plan earned on how easy it is to get information and help when needed. • In the last six (6) months, how often did your health plan's customer service give you the information or help you needed? • • In the last six (6) months, how often did your health plan's customer service treat you with courtesy and respect? • In the last six (6) months, how often were the forms for your health plan easy to fill out?	AHRQ/CAHPS	X	
Getting Appointments and Care Quickly	Percent of best possible score the plan earned on how quickly Enrollees get appointments and care a. In the last six (6) months, when you needed care right away, how often did you get care as soon as you thought you needed? • b. In the last six (6) months, not counting the times when you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you	AHRQ/CAHPS	X	

Domain	Measure	Source	CMS Core Withhold Measure	Michigan Withhold Measure
	needed?			
Plan all-cause readmissions	Percent of Enrollees discharged from a hospital stay who were readmitted to a hospital within thirty (30) days, either from the same condition as their recent hospital stay or for a different reason.	NCQA/HEDIS	X	
Annual flu vaccine	Percent of Enrollees who got a vaccine (flu shot) prior to flu season.	AHRQ/CAHPS	X	
Follow-up after hospitalization for mental illness	Percentage of discharges for Enrollees 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner.	NCQA/HEDIS	X	X
Screening for clinical depression and follow-up care	Percentage of patients ages twenty-one (21) years and older screened for clinical depression using a standardized tool and follow-up plan documented.	CMS	X	X
Reducing the risk of falling	Percent of Enrollees with a problem falling, walking or balancing who discussed it with their doctor and got treatment for it during the year.	NCQA/HEDIS HOS	X	
Controlling blood pressure	Percentage of Enrollees 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year.	NCQA/HEDIS	X	X

Domain	Measure	Source	CMS Core Withhold Measure	Michigan Withhold Measure
Part D medication adherence for oral diabetes medications	Percent of Enrollees with a prescription for oral diabetes medication who fill their prescription often enough to cover eighty percent (80%) or more of the time they are supposed to be taking the medication.	CMS	X	X
Care Transition Record Transmitted to Health Care Professional	Percent of Enrollees discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or to the health care professional designated for follow-up care within twenty-four (24) hours of discharge.	AMA-PCPI		X
Medication Review – All Populations	Percent of Enrollees whose doctor or clinical pharmacist has reviewed a list of everything they take (prescription and non-prescription drugs, vitamins, herbal remedies, other supplements) at least once a year.	State-defined (HEDIS-like)		X
Documentation of care goals	Percent of Enrollees with documented discussions of care goals.	CMS/State defined process measure		X
Urinary Tract Infection	Percent of Enrollees (specified population) with urinary tract infections.	CMS/State defined process measure		X

4.4.5. American Recovery and Reinvestment Act of 2009

4.4.5.1. All payments to the ICO are conditioned on compliance with the provisions below and all other applicable provisions of the American Recovery and Reinvestment Act of 2009.

4.4.6. Suspension of Payments

4.4.6.1. MDCH may suspend payments to the ICO in accordance with 42 C.F.R. § 455.23, *et seq*. and MCL 400.111a et seq. as determined necessary or appropriate by MDCH.

4.5. Transitions between Rating Categories and Risk Score Changes

4.5.1. Rating Category Changes

4.5.1.1. The Medicaid Component of the Capitation Payments will be updated following a change in an Enrollee's status relative to the rate cells in Section 4.2.1. On a monthly basis, as part of Capitation Payment processing, the rating category of each Enrollee will be verified.

4.5.1.2. Up to three (3) months following the transition of a Tier 2 or Tier 3 Enrollee into a nursing facility, payment will be based on the Tier 2 or Tier 3 rate.

4.5.1.3. A transition case rate will be paid after the transition of a Tier 1 Enrollee into a community setting. In order for the transition to qualify for the case rate, the ICO must have been paid three (3) consecutive Tier 1 Capitation Payments for the Enrollee. The ICO must provide community transitional services for the Enrollee in order to receive the case rate.

4.5.1.4. The payment will be based on the level of care of the Enrollee as of 1st of each month. Enrollees who move between rate tiers will have their level of care adjusted accordingly in CHAMPS to ensure the appropriate rate tier is paid to the ICO. Changes between levels of care will be effective as of 1st of each month.

4.5.2. Medicare Risk Score Changes

4.5.2.1. Medicare CMS-HCC, HCC-ESRD, and RxHCC risk scores will be updated consistent with prevailing Medicare Advantage regulations and processes.

4.6. Reconciliation

4.6.1. General

4.6.1.1. CMS and MDCH will implement a process to reconcile Enrollment and Capitation Payments for the ICO that will take into consideration the following circumstances:

4.6.1.1.1. Transitions between rate cells;

4.6.1.1.2. Retroactive changes in eligibility, rate cells, or Enrollee PPAs;

4.6.1.1.3. Changes in CMS-HCC and RxHCC risk scores; and,

4.6.1.1.4. Changes through new Enrollment, disenrollment, or death.

4.6.1.2. The reconciliation may identify underpayments or overpayments to the ICO.

4.6.2. Medicaid Capitation Reconciliation

4.6.2.1. Retroactive adjustments to Enrollment and payment shall be forwarded to the ICO as soon as possible upon receipt of updated or corrected information. The ICO shall cover retroactive adjustments to Enrollment without regard to timelines of the adjustment. The ICO shall assure correct payment to providers as a result of Enrollment updates and corrections. MDCH shall assure correct payment to the ICO for any retroactive Enrollment adjustments.

4.6.3. Medicare Capitation Reconciliation

4.6.3.1. Medicare capitation reconciliation will comply with prevailing Medicare Advantage and Part D regulations and processes.

4.6.4. Audits/Monitoring

4.6.4.1. CMS and MDCH will conduct periodic audits to validate rate cell assignments or other coding. Audits may be conducted by a peer review organization or other entity assigned this responsibility by CMS and MDCH.

4.7. Payment in Full

4.7.1. General

4.7.1.1. The ICO must accept as payment in full for all Covered Services the Capitation Payment(s) and the terms and conditions of payment set forth herein, except as provided in Appendix A Section A.3.

4.7.1.2. Notwithstanding any contractual provision or legal right to the contrary, the three parties to this Contract (CMS, MDCH and the ICO), for this Demonstration agree there shall be no redress against either of the other two parties, or their actuarial contractors, over the actuarial soundness of the Capitation Payments.

4.7.1.3. By signing this Contract, the ICO accepts that the Capitation Payment(s) offered is reasonable; that operating within this Capitation Payment(s) is the sole responsibility of the ICO; and that while data is made available by the Federal Government to the ICO, any entity participating in the

Demonstration must rely on its own resources to project likely experience under the Demonstration.

Section 5. Additional Terms and Conditions

5.1. Administration

5.1.1. Notification of Administrative Changes

5.1.1.1. The ICO must notify CMS and MDCH through HPMS of all changes affecting the key functions for the delivery of care, the administration of its program, or its performance of Contract requirements. The ICO must notify CMS and MDCH in HPMS no later than thirty (30) calendar days prior to any significant change to the manner in which services are rendered to Enrollees, including but not limited to reprocurement or termination of a First Tier, Downstream and Related Entity pursuant to Appendix C. The ICO must notify CMS and MDCH in HPMS of all other changes no later than five (5) business days prior to the effective date of such change.

5.1.2. Assignment

5.1.2.1. The ICO may not assign or transfer any right or interest in this Contract to any successor entity or other entity without the prior written consent of CMS and MDCH, which may be withheld for any reason or for no reason at all.

5.1.3. Independent ICOs

5.1.3.1. The ICO, its employees, First Tier, Downstream and Related Entities, and any other of its agents in the performance of this Contract, shall act in an independent capacity and not as officers or employees of the federal government, MDCH, or its authorized agents.

5.1.3.2. The ICO must ensure it evaluates the prospective First Tier, Downstream and Related Entities' abilities to perform activities to be delegated.

5.1.4. Subrogation

5.1.4.1. Subject to CMS and MDCH lien and third-party recovery rights, the ICO must:

5.1.4.1.1. Be subrogated and succeed to any right of recovery of a Enrollee against any person or organization, for any services, supplies, or both provided under this Contract up to the amount of the benefits provided hereunder;

5.1.4.1.2. Require that the Enrollee pay to the ICO all such amounts recovered by suit, settlement, or otherwise from any third person or his or her insurer to the extent of the benefits provided hereunder, up to the value of the benefits provided hereunder. The ICO may ask the Enrollee to:

5.1.4.1.2.1. Take such action, furnish such information and assistance, and execute such instruments as the ICO may require to facilitate enforcement of its rights hereunder, and take no action prejudicing the rights and interest of the ICO hereunder; and

5.1.4.1.2.2. Notify the ICO hereunder and authorize the ICO to make such investigations and take such action as the ICO may deem appropriate to protect its rights hereunder whether or not such notice is given.

5.1.5. Prohibited Affiliations

5.1.5.1. In accordance with 42 USC §1396 u-2(d)(1), the ICO shall not knowingly have an employment, consulting, or other agreement for the provision of items and services that are significant and material to the ICO's obligations under this Contract with any person, or affiliate of such person, who is excluded, under federal law or regulation, from certain procurement and non-procurement activities. Further, no such person may have beneficial ownership of more than 5 percent of the ICO's equity or be permitted to serve as a director, officer, or partner of the ICO.

5.1.6. Disclosure Requirements

5.1.6.1. The ICO must disclose to CMS and MDCH information on ownership and control, business transactions, and persons convicted of crimes in accordance with 42 C.F.R. Part 455, Subpart B. The ICO must obtain federally required disclosures from all network providers and applicants in accordance with 42 C.F.R. 455 Subpart B and 42 C.F.R. § 1002.3, and as specified by MDCH, including but not limited to obtaining such information through provider Enrollment forms and credentialing and recredentialing packages. The ICO must maintain such disclosed information in a manner which can be periodically searched by the ICO for exclusions and provided to MDCH and CMS in accordance with this Contract and relevant State and federal laws and regulations.

5.1.7. Physician Incentive Plans

5.1.7.1. The ICO may, in its discretion, operate a physician incentive plan only if:

5.1.7.1.1. No single physician is put at financial risk for the costs of treating a Enrollee that are outside the physician's direct control;

5.1.7.1.2. No specific payment is made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically appropriate services furnished to an individual Enrollee; and

5.1.7.1.3. The applicable stop/loss protection, Enrollee survey, and disclosure requirements of 42 C.F.R. Part 417 are met.

5.1.7.2. The ICO and its First Tier, Downstream and Related Entities must comply with all applicable requirements governing physician incentive plans, including but not limited to such requirements appearing at 42 C.F.R. Parts 417, 422, 434, 438.6(h), and 1003. The ICO must submit all information required to be disclosed to CMS and MDCH in the manner and format specified by CMS and MDCH which, subject to Federal approval, must be consistent with the format required by CMS for Medicare contracts.

5.1.7.3. The ICO shall be liable for any and all loss of federal financial participation (FFP) incurred by MDCH that results from the ICO's or its First Tier, Downstream and Related Entities failure to comply with the requirements governing physician incentive plans at 42 C.F.R. Parts 417, 422, 434, 428.6(h) and 1003; however, the ICO shall not be liable for any loss of FFP under this provision that exceeds the total FFP reduction attributable to Enrollees in the ICO's plan, and the ICO shall not be liable if it can demonstrate, to the satisfaction of CMS and MDCH, that it has made a good faith effort to comply with the cited requirements.

5.1.8. Physician Identifier

5.1.8.1. The ICO must require each physician providing Covered Services to Enrollees under this Contract to have a unique identifier in accordance with the system established under 42 U.S.C. § 1320d-2(b). The ICO must provide such unique identifier to CMS and MDCH for each of its PCPs in the format and time-frame established by CMS and MDCH in consultation with the ICO.

5.1.9. Timely Provider Payments

5.1.9.1. The ICO must make timely payments to its providers. The ICO must include a prompt payment provision in its contracts with providers and suppliers, the terms of which are developed and agreed to by both the ICO and the relevant provider. The ICO must ensure that ninety percent (90%) of payment Claims, which can be processed without obtaining additional

information from the physician or from a third party (a "Clean Claim"), from physicians who are in individual or group practice will be paid within ninety (90) calendar days of the date of receipt of the Claim. Claims from LTSS providers will be paid within 30 (thirty) calendar days of the date of receipt of the "clean claim." The ICO and its providers may by mutual agreement, in writing, establish an alternative payment schedule.

5.1.9.2. The ICO must make timely payments to all providers for covered services rendered to Enrollees as required by MCL 400.111i and in compliance with any established MDCH performance standards. The ICO is not responsible for any payments owed to providers for services rendered prior to a Potential Enrollee's Enrollment with the ICO's plan. Payment for services provided during a period of retroactive eligibility will be the responsibility of MDCH.

5.1.9.3. The ICO is responsible for annual IRS form 1099, Reporting of Provider Earnings, and must make all collected data available to MDCH and, upon request, to CMS.

5.1.9.4. Total Payment: The ICO or its providers may not require any co-payments or other cost-sharing arrangements. The ICO providers must not bill Enrollees for the difference between the provider's charge and the ICO's payment for Covered Services. The ICO's providers must not seek nor accept additional or supplemental payment from the Enrollee, his or her family, or representative, in addition to the amount paid by the ICO even when the Enrollee signed an agreement to do so. These provisions also apply to out-of-network providers.

5.1.10. Protection of Enrollee-Provider Communications

5.1.10.1. In accordance with 42 USC §1396 u-2(b)(3), the ICO shall not prohibit or otherwise restrict a provider or clinical First Tier, Downstream, or Related Entity of the ICO from advising a Enrollee about the health status of the Enrollee or medical care or treatment options for the Enrollee's condition or disease; information the Enrollee needs in order to decide among all relevant treatment options; risk, benefits and consequences of treatment or non-treatment; and/or the Enrollee's rights to participate in decisions about his or her health care, including the right to refuse treatment and to express preferences about future treatment decisions, regardless of whether benefits for such care or treatment are provided under the Contract, if the provider or clinical First Tier, Downstream, or Related Entity is acting within the lawful scope of practice.

5.1.11. Protecting Enrollee from Liability for Payment

5.1.11.1. The ICO must:

5.1.11.1.1. In accordance with 42 C.F.R. § 438.106, not hold a Enrollee liable for:

5.1.11.1.1.1. Debts of the ICO, in the event of the ICO's insolvency;

5.1.11.1.1.2. Covered Services provided to the Enrollee in the event that the ICO fails to receive payment from CMS or MDCH for such services; or

5.1.11.1.1.3. Payments to a clinical First Tier, Downstream and Related Entity in excess of the amount that would be owed by the Enrollee if the ICO had directly provided the services;

5.1.11.1.2. Not charge Enrollees coinsurance, co-payments, deductibles, financial penalties, or any other amount in full or part, for any service provided under this Contract, except as otherwise provided in Appendix A;

5.1.11.1.3. Not deny any service provided under this Contract to a Enrollee for failure or inability to pay any applicable charge;

5.1.11.1.4. Not deny any service provided under this Contract to a Enrollee who, prior to becoming eligible for the Demonstration, incurred a bill that has not been paid; and

5.1.11.1.5. Ensure Provider Network compliance with all Enrollee payment restrictions, including balance billing restrictions, and develop and implement a plan to identify and revoke or provide other specified remedies for any member of the ICO's Provider Network that does not comply with such provisions.

5.1.12. Moral or Religious Objections

5.1.12.1. The ICO is not required to provide, reimburse for, or provide coverage of, a counseling or referral service that would otherwise be required if the ICO objects to the service on moral or religious grounds. If the ICO elects not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds, it must furnish information about the services it does not cover as follows:

5.1.12.1.1. To MDCH;

5.1.12.1.2. With its application for a Contract;

5.1.12.1.3. Whenever it adopts the policy during the term of the Contract; and

5.1.12.1.4. The information provided must be:

5.1.12.1.4.1. Consistent with the provisions of 42 C.F.R. § 438.10

5.1.12.1.4.2. Provided to Potential Enrollees before and during Enrollment; and

5.1.12.1.4.3. Provided to Enrollees within ninety (90) calendar days after adopting the policy with respect to any particular service

5.1.13. Third Party Liability Comprehensive Health Coverage

5.1.13.1. General Requirements

5.1.13.1.1. Enrollees, determined by MDCH as having comprehensive health coverage other than Medicare or Medicaid, will be assigned to the FFS program, effective the first day of the month following the month in which the coverage was verified. Enrollees will not be retroactively disenrolled due to comprehensive health coverage. Until disenrollment occurs, the ICO is responsible for coordinating all benefits covered under this Contract.

5.1.13.1.2. Under Section 1902 (a)(25) of the Social Security Act (42 U.S.C. §1396 a (a)(25)), MDCH is required to take all reasonable measures to identify legally liable third parties and pursue verified resources. In cases in which the Enrollee was not identified for exclusion prior to Enrollment in the ICO, the ICO shall take responsibility for identifying and pursuing comprehensive health coverage. Any moneys recovered by third parties shall be retained by the ICO and identified monthly to MDCH and CMS. The ICO shall notify MDCH and CMS on a monthly basis of any Enrollees identified during that past month who were discovered to have comprehensive health coverage.

5.1.13.2. Governing Law

5.1.13.2.1. For claims between CMS and the State of Michigan: this Contract is governed by, and must be construed, according the laws of the State of Michigan and federal law, as applicable.

5.1.13.2.2. For all claims by or against an ICO: this Contract is governed by, and must be construed, and enforced according to the laws of the State of Michigan, without regard to any Michigan choice of law principles, to the extent not pre-empted by federal law. Any dispute arising from this Contract must be resolved in the Michigan Court of Claims. The ICO expressly consents to personal jurisdiction in Michigan and venue in Ingham County, Michigan, and irrevocably waives any objections to this venue. The ICO agrees to appoint an agent in the State of Michigan to receive service of process.

5.2. Confidentiality

5.2.1. Statutory Requirements

5.2.1.1. The ICO understands and agrees that CMS and MDCH may require specific written assurances and further agreements regarding the security and privacy of PHI that are deemed necessary to implement and comply with standards under HIPAA as implemented in 45 C.F.R., Parts 160 and 164. The ICO represents that it currently has in place policies and procedures that will adequately safeguard any confidential personal data obtained or created in the course of fulfilling its obligations under this Contract in accordance with applicable State and federal laws. The ICO is required to design, develop, or operate a system of records on individuals, to accomplish an agency function subject to the Privacy Act of 1974, Public Law 93-579, December 31, 1974 (5 U.S.C.552a) and applicable agency regulations. Violation of the Act may involve the imposition of criminal penalties.

5.2.2. Non-Disclosure of Confidential Information.

5.2.2.1. The parties acknowledge that each party may be exposed to or acquire communication or data of the other party that is confidential, privileged communication not intended to be disclosed to third parties. The provisions of this Section survive the termination of this Contract.

5.2.2.2. The ICO must inform each of its employees having any involvement with personal data or other Confidential Information, whether with regard to design, development, operation, or maintenance of the laws and regulations relating to confidentiality.

5.2.2.3. For purposes of this Contract, in all cases and for all matters, State Data, as defined in Section 5.2.7.1 is deemed to be Confidential Information.

5.2.2.4. Obligation of Confidentiality.

5.2.2.4.1. The parties agree to hold all Confidential Information in strict confidence and not to copy, reproduce, sell, transfer, or otherwise dispose of, give or disclose such Confidential Information to third parties other than employees, agents, or First Tier, Downstream or Related Entities of a party who have a need to know in connection with this Contract or to use such Confidential Information for any purposes whatsoever other than the performance of this Contract. The parties agree to advise and require their respective employees, agents, and First Tier, Downstream, and Related Entities of their obligations to keep all Confidential Information confidential. Disclosure to a First Tier, Downstream, or Related Entity is permissible where:

5.2.2.4.1.1. Use of a First Tier, Downstream, or Related Entity is authorized under this Contract;

5.2.2.4.1.2. The disclosure is necessary or otherwise naturally occurs in connection with work that is within the First Tier's, Downstream's or Related Entity's responsibilities; and

5.2.2.4.1.3. The ICO obligates the First Tier, Downstream, or Related Entity in a written contract to maintain the State's Confidential Information in confidence.

5.2.2.4.2. At the State's request, any employee of the ICO or any First Tier, Downstream, or Related Entity may be required to execute a separate agreement to be bound by the provisions of this Section.

5.2.2.5. Cooperation to Prevent Disclosure of Confidential Information.

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

5.2.2.6. Remedies for Breach of Obligation of Confidentiality.

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

5.2.2.7. Surrender of Confidential Information upon Termination.

5.2.2.7.1. Upon termination of this Contract, in whole or in part, each party must, within five (5) calendar days from the date of termination, return to the other parties any and all Confidential Information received from the other parties, or created or received by a party on behalf of the other parties, which are in such party's possession, custody, or control; provided, however, that the ICO must return State data to the State following the timeframe and procedure described further in this Contract. Should the ICO or the State determine that the return of any non-State data Confidential Information is not feasible, such party must destroy the non-State data Confidential Information and must certify the same in writing within five (5) calendar days from the date of termination to the other parties.

5.2.3. Data Security

5.2.3.1. The ICO must take reasonable steps to ensure the physical security of personal data or other Confidential Information under its control, including, but not limited to: fire protection; protection against smoke and water damage; alarm systems; locked files, guards, or other devices reasonably expected to prevent loss or unauthorized removal of manually held data; passwords, access logs, badges, or other methods reasonably expected to prevent loss or unauthorized access to electronically or mechanically held data by ensuring limited terminal access; limited access to input documents and output documents; and design provisions to limit use of Enrollee names.

5.2.3.2. The ICO must put all appropriate administrative, technical, and physical safeguards in place before the start date to protect the privacy and security of PHI in accordance with 45 C.F.R. §164.530(c).

5.2.3.3. The ICO must meet the security standards, requirements, and implementation specifications as set forth in 45 C.F.R. Part 164, Subpart C, the HIPAA Security Rule.

5.2.3.4. The ICO must follow the National Institute for Standards and Technology (NIST) Guidelines for the Risk Management Framework (RMF) to establish an information security program in accordance with the Federal Information Security Management Act (FISMA).

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

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

5.2.3.7. Audit Findings. The ICO must implement any required safeguards as identified by the State or by any audit of the ICO's data privacy and information security program.

5.2.3.8. State's Right to Termination for Deficiencies. The State and CMS reserve the right, at its sole election, to immediately terminate this Contract without limitation and without liability if the State or CMS determines that the ICO fails or has failed to meet its obligations under this Section.

5.2.4. Return of Personal Data and Confidential Information

5.2.4.1. The ICO must return any and all personal data, with the exception of medical records, furnished pursuant to this Contract promptly at the request of CMS or MDCH in whatever form it is maintained by the ICO.

5.2.4.2. Upon the termination or completion of this Contract, the ICO shall not use any such data or any material derived from the data for any purpose, and, where so instructed by CMS or MDCH will destroy such data or material.

5.2.5. Destruction of Personal Data

5.2.5.1. For any PHI received regarding an Potential Enrollee referred to the ICO by MDCH but who does not enroll in ICO's plan, the ICO must destroy the PHI in accordance with standards set forth in NIST Special Publication 800-88, Guidelines for Media Sanitizations, and all applicable State and federal privacy and security laws including HIPAA and its related

implementing regulations, at 45 C.F.R. Parts 160, 162, and 164, as may be amended from time to time.

5.2.5.2. The ICO shall also adhere to standards described in OMB Circular No. A-130, Appendix III-Security of Federal Automated Information Systems and NIST Federal Information Processing Standard 200 entitled "Minimum Security Requirements for Federal Information and Information Systems" while in possession of all PHI.

5.2.6. Research Data

5.2.6.1. The ICO must seek and obtain prior written authorization from CMS and MDCH for the use of any data pertaining to this Contract for research or any other purposes not directly related to the ICO's performance under this Contract.

5.2.7. State Data.

5.2.7.1. Ownership. The State's data ("State data," which will be treated by the ICO as Confidential Information) includes: (a) the State's data collected, used, processed, stored, or generated as the result of the Contract activities; (b) personally identifiable information ("PII") collected, used, processed, stored, or generated as the result of the Contract activities, including, without limitation, any information that identifies an Enrollee, such as an Enrollee's social security number or other government-issued identification number, date of birth, address, telephone number, biometric data, mother's maiden name, email address, credit card information, or an individual's name in combination with any other of the elements here listed; and, (c) PHI collected, used, processed, stored, or generated as the result of the Contract activities, which is defined under HIPAA and its related rules and regulations. State data is and will remain the sole and exclusive property of the State and all right, title, and interest in the same is reserved by the State. This Section survives the termination of this Contract.

5.2.7.2. ICO Use of State Data. ICO is provided a limited license to State Data for the sole and exclusive purpose of providing the Contract activities, including a license to collect, process, store, generate, and display State data only to the extent necessary in the provision of the Contract Activities. The ICO must: (a) keep and maintain State Data in strict confidence, using such degree of care as is appropriate and consistent with its obligations as further described in this Contract and applicable law to avoid unauthorized access, use, disclosure, or loss; (b) use and disclose State data solely and exclusively for the purpose of providing the Contract activities, such use and disclosure being in accordance with this Contract, any applicable statement of work, and applicable law; and (c) not use, sell, rent, transfer, distribute, or otherwise disclose or make available State data

for the ICO's own purposes or for the benefit of anyone other than the State without the State's prior written consent. This Section survives the termination of this Contract.

5.2.7.3. Extraction of State Data. The ICO must, within one (1) business day of the State's request, provide the State, without charge and without any conditions or contingencies whatsoever (including but not limited to the payment of any fees due to the ICO), an extract of the State data in the format specified by the State.

5.2.7.4. Backup and Recovery of State Data. The ICO is responsible for maintaining a backup of State Data and for an orderly and timely recovery of such data. The ICO must maintain a contemporaneous backup of State data that can be recovered within two (2) hours at any point in time. Loss of Data. In the event of any act, error or omission, negligence, misconduct, or breach that compromises or is suspected to compromise the security, confidentiality, or integrity of State data or the physical, technical, administrative, or organizational safeguards put in place by the ICO that relate to the protection of the security, confidentiality, or integrity of State data, the ICO must, as applicable: (a) notify the State as soon as practicable but no later than twenty-four (24) hours of becoming aware of such occurrence; (b) cooperate with the State in investigating the occurrence, including making available all relevant records, logs, files, data reporting, and other materials required to comply with applicable law or as otherwise required by the State; (c) in the case of PII or PHI, at the State's sole election, (i) notify the affected individuals who comprise the PII or PHI as soon as practicable but no later than is required to comply with applicable law, or, in the absence of any legally required notification period, within five (5) calendar days of the occurrence; or (ii) reimburse the State for any costs in notifying the affected individuals; (d) in the case of PII, provide third-party credit and identity monitoring services to each of the affected individuals who comprise the PII for the period required to comply with applicable law, or, in the absence of any legally required monitoring services, for no less than twenty-four (24) months following the date of notification to such individuals; (e) perform or take any other actions required to comply with applicable law as a result of the occurrence; (f) without limiting the ICO's obligations of indemnification as further described in this Contract, indemnify, defend, and hold harmless the State for any and all claims, including reasonable attorneys' fees, costs, and expenses incidental thereto, which may be suffered by, accrued against, charged to, or recoverable from the State in connection with the occurrence; (g) be responsible for recreating lost State Data in the manner and on the schedule set by the State without charge to the State; and, (h) provide to the State a detailed plan within ten (10) calendar days of the occurrence describing the measures the ICO will undertake to prevent a future occurrence. Notification to affected individuals, as described above, must comply with applicable law, be written in plain language, and

contain, at a minimum: name and contact information of the ICO's representative; a description of the nature of the loss; a list of the types of data involved; the known or approximate date of the loss; how such loss may affect the affected individual; what steps the ICO has taken to protect the affected individual; what steps the affected individual can take to protect himself or herself; contact information for major credit card reporting agencies; and, information regarding the credit and identity monitoring services to be provided by the ICO. This Section survives the termination of this Contract.

5.3. General Terms and Conditions

5.3.1. Applicable Law

5.3.1.1. The term "applicable law," as used in this Contract, means, without limitation, all federal and State law, and the regulations, policies, procedures, and instructions of CMS and MDCH all as existing now or during the term of this Contract. All applicable law is hereby incorporated into this Contract by reference.

5.3.2. Sovereign Immunity

5.3.2.1. Nothing in this Contract will be construed to be a waiver by the State of Michigan or CMS of its rights under the doctrine of sovereign immunity and the Eleventh Amendment to the United States Constitution.

5.3.3. Advance Directives

5.3.3.1. Nothing in this Contract shall be interpreted to require an Enrollee to execute an Advance Directive or agree to orders regarding the provision of life-sustaining treatment as a condition of receipt of services under the Medicare or Medicaid program.

5.3.4. Loss of Licensure

5.3.4.1. If, at any time during the term of this Contract, the ICO or any of its First Tier, Downstream or Related Entities incurs loss of licensure at any of the ICO's facilities or loss of necessary Federal or State approvals, the ICO must report such loss to CMS and MDCH. Such loss may be grounds for termination of this Contract under the provisions of Section 5.5.

5.3.5. Indemnification

5.3.5.1. Federal indemnification

5.3.5.1.1. The ICO shall indemnify and hold harmless CMS, the federal government, and their agencies, officers, employees, agents and volunteers from and against any and all liability, loss, damage, costs, or expenses which CMS may sustain, incur, or be required to pay, arising out of or in connection with any negligent action as inaction, or willful misconduct of the ICO, any person employed by the ICO, or any of its First Tier, Downstream, or Related Entities as provided that the ICO is notified of any claims within a reasonable amount of time from which CMS becomes aware of the claim.

5.3.5.2. State indemnification

5.3.5.2.1. The ICO must defend, indemnify and hold the State, its departments, divisions, agencies, offices, commissions, officers, and employees harmless, without limitation, from and against any and all actions, claims, losses, liabilities, damages, costs, attorney fees, and expenses (including those required to establish the right to indemnification), arising out of or relating to: (a) any breach by The ICO (or any of The ICO's employees, agents, First Tier, Downstream, or Related Entities, or by anyone else for whose acts any of them may be liable) of any of the promises, agreements, representations, warranties, or insurance requirements contained in this Contract; (b) any infringement, misappropriation, or other violation of any intellectual property right or other right of any third party; (c) any bodily injury, death, or damage to real or tangible personal property occurring wholly or in part due to action or inaction by the ICO (or any of the ICO's employees, agents, First Tier, Downstream, or Related Entities, or by anyone else for whose acts any of them may be liable); and (d) any acts or omissions of the ICO (or any of the ICO's employees, agents, First Tier, Downstream, or Related Entities, or by anyone else for whose acts any of them may be liable).

5.3.5.2.2. The State will notify the ICO in writing if indemnification is sought; however, failure to do so will not relieve the ICO, except to the extent that is materially prejudiced. The ICO must, to the satisfaction of the State, demonstrate its financial ability to carry out these obligations.

5.3.5.2.3. The State is entitled to: (i) regular updates on proceeding status; (ii) participate in the defense of the proceeding; (iii) employ its own counsel; and to (iv) retain control of the defense if the State deems necessary. The ICO will not, without the State's written consent (not to be unreasonably withheld), settle, compromise, or consent to the entry of any judgment in or otherwise seek to terminate any claim, action, or proceeding. To the extent that any State employee, official, or law may be involved or challenged, the State may, at its own expense, control the defense of that portion of the claim.

5.3.5.2.4. 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. An attorney designated to represent the State may not do so until approved by the Michigan Attorney General and appointed as a Special Assistant Attorney General.

5.3.6. Prohibition against Discrimination

5.3.6.1. In accordance with 42 U.S.C. §1396 u-2(b)(7), the ICO shall not discriminate with respect to participation, reimbursement, or indemnification of any provider in the ICO's Provider Network who is acting within the scope of the provider's license or certification under applicable federal or State law, solely on the basis of such license or certification. This section does not prohibit the ICO from including providers in its Provider Network to the extent necessary to meet the needs of the ICO's Enrollees or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the ICO.

5.3.6.2. The ICO shall abide by all Federal and State laws, regulations, and orders that prohibit discrimination because of race, color, religion, sex, national origin, ancestry, age, physical or mental disability, including, but not limited to, the Federal Civil Rights Act of 1964, the Americans with Disabilities Act of 1990, the Federal Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972 (regarding education programs and activities), the Age Discrimination Act of 1975, "Elliott-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." The ICO further agrees to take affirmative action to ensure that no unlawful discrimination is committed in any manner including, but not limited to, the delivery of services under this Contract.

5.3.6.3. The ICO will not discriminate against Potential Enrollees, Prospective Enrollees, or Enrollees on the basis of health status or need for health services.

5.3.6.4. The ICO will provide each provider or group of providers whom it declines to include in its network written notice of the reason for its decision.

5.3.6.5. Nothing in Section 5.3.6.4 above may be construed to require the ICO to contract with providers beyond the number necessary to meet the needs of its Enrollees; preclude the ICO from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or preclude the ICO from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to Enrollees.

5.3.6.6. If a Complaint or claim against the ICO is presented to MDCH for handling discrimination complaints, the ICO must cooperate with in the investigation and disposition of such Complaint or claim.

5.3.7. Anti-Boycott Covenant

5.3.7.1. During the time this Contract is in effect, neither the ICO nor any affiliated company, as hereafter defined, must participate in or cooperate with an international boycott, as defined in Section 999(b)(3) and (4) of the Internal Revenue Code of 1954, as amended. Without limiting such other rights as it may have, CMS and MDCH will be entitled to rescind this Contract in the event of noncompliance with this Section.

5.3.7.2. As used herein, an affiliated company is any business entity directly or indirectly owning at least 51% of the ownership interests of the ICO.

5.3.8. Information Sharing

5.3.8.1. During the course of an Enrollee's Enrollment or upon transfer or termination of Enrollment, whether voluntary or involuntary, and subject to all applicable Federal and State laws, the ICO must arrange for the transfer, at no cost to CMS, MDCH, or the Enrollee, of medical information regarding such Enrollee to any subsequent provider of medical services to such Enrollee, as may be requested by the Enrollee or such provider or directed by CMS and MDCH, the Enrollee, regulatory agencies of the State of Michigan, or the United States Government. With respect to Enrollees who are in the custody of the State, the ICO must provide, upon reasonable request of the State agency with custody of the Enrollee, a copy of said Enrollee's medical records in a timely manner.

5.3.9. Other Contracts

5.3.9.1. Nothing contained in this Contract must be construed to prevent the ICO from operating other comprehensive health care plans or providing health care services to persons other than those covered hereunder; provided, however, that the ICO must provide CMS and MDCH with a complete list

of such plans and services, upon request. CMS and MDCH will exercise discretion in disclosing information that the ICO may consider proprietary, except as required by law. Nothing in this Contract may be construed to prevent CMS or MDCH from contracting with other comprehensive health care plans, or any other provider, in the same Service Area.

5.3.10. Counterparts

5.3.10.1. This Contract may be executed simultaneously in two or more counterparts, each of which will be deemed an original and all of which together will constitute one and the same instrument.

5.3.11. Entire Contract

5.3.11.1. This Contract constitutes the entire agreement of the parties with respect to the subject matter hereof, including all Attachments and Appendices hereto, and supersedes all prior agreements, representations, negotiations, and undertakings not set forth or incorporated herein. The terms of this Contract will prevail notwithstanding any variances with the terms and conditions of any verbal communication subsequently occurring.

5.3.12. No Third-Party Rights or Enforcement

5.3.12.1. No person not executing this Contract is entitled to enforce this Contract against a party hereto regarding such party's obligations under this Contract.

5.3.13. Corrective Action Plan

5.3.13.1. If, at any time, CMS and MDCH reasonably determines that the ICO is deficient in the performance of its obligations under the Contract, CMS and MDCH may require the ICO to develop and submit a corrective action plan that is designed to correct such deficiency. CMS and MDCH will approve, disapprove, or require modifications to the corrective action plan based on their reasonable judgment as to whether the corrective action plan will correct the deficiency. The ICO must promptly and diligently implement the corrective action plan as approved by CMS and MDCH. Failure to implement the corrective action plan may subject the ICO to termination of the Contract by CMS and MDCH or other intermediate sanctions as described in Section.

5.3.14. Intermediate Sanctions and Civil Monetary Penalties

5.3.14.1. In addition to termination under Section 5.5, CMS and MDCH may, impose any or all of the sanctions in Subsection 5.3.17 upon any of the events below; provided, however, that CMS and MDCH will only impose those sanctions they determine to be reasonable and appropriate for the specific violations identified.

5.3.14.2. Sanctions may be imposed in accordance with regulations that are current at the time of the sanction.

5.3.14.3. Sanctions may be imposed in accordance with this section if the ICO:

5.3.14.3.1. Fails substantially to provide Covered Services required to be provided under this Contract to Enrollees;

5.3.14.3.2. Imposes charges on Enrollees in excess of any permitted under this Contract;

5.3.14.3.3. Discriminates among Enrollees or individuals eligible to enroll on the basis of health status or need for health care services, race, color or national origin, and will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin;

5.3.14.3.4. Misrepresents or falsifies information provided to CMS, MDCH and its authorized representatives, Enrollees, prospective Enrollees, or its Provider Network;

5.3.14.3.5. Fails to comply with requirements regarding physician incentive plans (see Section 5.1.7);

5.3.14.3.6. Fails to comply with federal or State statutory or regulatory requirements related to this Contract;

5.3.14.3.7. Violates restrictions or other requirements regarding marketing;

5.3.14.3.8. Fails to comply with quality management requirements consistent with Section 2.14;

5.3.14.3.9. Fails to comply with any corrective action plan required by CMS and MDCH;

5.3.14.3.10. Fails to comply with financial Solvency requirements;

5.3.14.3.11. Fails to comply with reporting requirements; or

5.3.14.3.12. Fails to comply with any other requirements of this Contract.

5.3.14.4. Such sanctions may include:

5.3.14.4.1. Intermediate sanctions consistent with 42 C.F.R. § 438.702;

5.3.14.4.2. Financial penalties consistent with 42 C.F.R. § 438.704;

5.3.14.4.3. The appointment of temporary management to oversee the operation of the ICO in those circumstances set forth in 42 U.S.C. §1396 u-2(e)(2)(B);

5.3.14.4.4. Suspension of Enrollment (including assignment of Enrollees);

5.3.14.4.5. Suspension of payment to the ICO;

5.3.14.4.6. Disenrollment of Enrollees;

5.3.14.4.7. Suspension of marketing; and

5.3.14.4.8. Denial of payment as set forth in 42 C.F.R. § 438.730.

5.3.14.5. If CMS or MDCH have identified a deficiency in the performance of a First Tier, Downstream or Related Entity and the ICO has not successfully implemented an approved corrective action plan in accordance with Section 5.3.13, CMS and MDCH may:

5.3.14.5.1. Require the ICO to subcontract with a different First Tier, Downstream or Related Entity deemed satisfactory by CMS and MDCH; or

5.3.14.5.2. Require the ICO to change the manner or method in which the ICO ensures the performance of such contractual responsibility.

5.3.14.6. Before imposing any intermediate sanctions, MDCH and/or CMS, may, at their discretion, give the ICO a one-time thirty (30) days written notice and opportunity to cure the basis for the sanctions. The notice will explain the basis and nature of the sanction(s); that the curative action must be completed within the thirty (30) day timeframe; and other due process protections that MDCH and CMS elect to provider.

5.3.15. Additional Administrative Procedures

5.3.15.1. CMS and MDCH may, from time to time, issue program memoranda clarifying, elaborating upon, explaining, or otherwise relating to Contract administration and other management matters. The ICO must comply with all such program memoranda as may be issued from time to time.

5.3.16. Effect of Invalidity of Clauses

5.3.16.1. If any clause or provision of this Contract is officially declared to be in conflict with any federal or State law or regulation, that clause or provision will be null and void and any such invalidity will not affect the validity of the remainder of this Contract.

5.3.17. Conflict of Interest

5.3.17.1. Neither the ICO nor any First Tier, Downstream or Related Entity may, for the duration of the Contract, have any interest that will conflict, as determined by CMS and MDCH with the performance of services under the Contract, or that may be otherwise anticompetitive. Without limiting the generality of the foregoing, CMS and MDCH require that neither the ICO nor any First Tier, Downstream, or Related Entity has any financial, legal, contractual or other business interest in any entity performing ICO Enrollment functions for MDCH. The ICO further certifies that it will comply with Section 1932(d) of the Social Security Act.

5.3.18. Insurance for ICO's Employees

5.3.18.1. The ICO must agree to maintain at the ICO's expense all insurance required by law for its employees, including worker's compensation and unemployment compensation, and must provide CMS and MDCH with certification of same upon request. The ICO, and its professional personnel providing services to Enrollees, must obtain and maintain appropriate professional liability insurance coverage. The ICO must, at the request of CMS or MDCH, provide certification of professional liability insurance coverage.

5.3.19. Waiver

5.3.19.1. The ICO, CMS, or MDCH shall not be deemed to have waived any of its rights hereunder unless such waiver is in writing and signed by a duly authorized representative. No delay or omission on the part of the ICO, CMS, or MDCH in exercising any right shall operate as a waiver of such right or any other right. A waiver on any occasion shall not be construed as a bar to or waiver of any right or remedy on any future occasion. The acceptance or approval by CMS and MDCH of any materials including but not limited to, those materials submitted in relation to this Contract, does not constitute waiver of any requirements of this Contract.

5.3.20. Section Headings

5.3.20.1. The headings of the sections of this Contract are for convenience only and will not affect the construction hereof.

5.4. Record Retention, Inspection, and Audits

5.4.1. General

5.4.1.1. The ICO must maintain books, records, documents, and other evidence of administrative, medical, and accounting procedures and practices for ten years from the end of the final Contract period or completion of audit, whichever is later.

5.4.1.2. The ICO must make the records maintained by the ICO and its Provider Network, as required by CMS and MDCH and other regulatory agencies, available to CMS and MDCH and its agents, designees or ICOs or any other authorized representatives of the State of Michigan or the United States Government, or their designees or ICOs, at such times, places, and in such manner as such entities may reasonably request for the purposes of financial or medical audits, inspections, and examinations, provided that such activities are conducted during the normal business hours of the ICO.

5.4.1.3. The ICO further agrees that the Secretary of the U.S. Department of Health and Human Services or his or her designee, the Governor or his or her designee, Comptroller General or his or her designee, and the State Auditor or his or her designee have the right at reasonable times and upon reasonable notice to examine the books, records, and other compilations of data of the ICO and its First Tier, Downstream and Related Entities that pertain to: the ability of the ICO to bear the risk of potential financial losses; services performed; or determinations of amounts payable.

5.4.1.4. The ICO must make available, for the purposes of record maintenance requirements, its premises, physical facilities and equipment, records relating to its Enrollees, and any additional relevant information that CMS or MDCH may require, in a manner that meets CMS and MDCH's record maintenance requirements.

5.4.1.5. The ICO must comply with the right of the U.S. Department of Health and Human Services, the Comptroller General, and their designees to inspect, evaluate, and audit records through ten years from the final date of the Contract period or the completion of audit, whichever is later, in accordance with Federal and State requirements.

5.5. Termination of Contract

5.5.1. General

5.5.1.1. In the event the ICO materially fails to meet its obligations under this Contract or has otherwise violated the laws, regulations, or rules that govern the Medicare or Michigan Medicaid programs, CMS or MDCH may take any or all action under this Contract, law, or equity, including but not limited to immediate termination of this Contract. CMS or MDCH may terminate the Contract in accordance with regulations that are current at the time of the termination.

5.5.2. Termination without Prior Notice

5.5.2.1. Without limiting the above, if CMS and MDCH determine that participation of the ICO in the Medicare or Michigan Medicaid program or in the Demonstration, may threaten or endanger the health, safety, or welfare of Enrollees or compromise the integrity of the Medicare or

Michigan Medicaid program, CMS or MDCH, without prior notice, may immediately terminate this Contract, suspend the ICO from participation, withhold any future payments to the ICO, or take any or all other actions under this Contract, law, or equity. Such action may precede Potential Enrollee Enrollment into any ICO, and shall be taken upon a finding by CMS or MDCH that the ICO has not achieved and demonstrated a state of readiness that will allow for the safe and efficient provision of Medicare-Medicaid services to Enrollees.

5.5.2.2. United States law will apply to resolve any Claim of breach of this Contract.

5.5.2.3. Federal law applies to any claim of breach or termination of this Contract arising out of federal rules, regulations, requirements, and programs. State law applies to resolution of any claim of breach or termination of this Contract arising out of State rules, regulations, requirements and programs.

5.5.3. Termination with Prior Notice

5.5.3.1. CMS or MDCH may terminate this Contract without cause upon no less than one hundred and eighty (180) calendar days prior written notice to the other party specifying the termination date, unless applicable law requires otherwise. Per Section 5.7, plans may choose to non-renew prior to the end of each term pursuant to 42 C.F.R. 422.506(a), except in Demonstration Year 1, in which the ICO may choose to non-renew the Contract as of December 31, 2015 provided the ICO gives notice before August 1, 2015, and may terminate the Contract by mutual consent of CMS and MDCH at any time pursuant to 42 C.F.R. § 422.508. In considering requests for termination under 42 C.F.R. § 422.508, CMS and MDCH consider, among other factors, financial performance and stability in granting consent for termination. Any written communications or oral scripts developed to implement the requirements of 42 C.F.R. § 422.506(a) must be submitted to and approved by CMS and MDCH prior to their use.

5.5.3.2. Pursuant to 42 C.F.R. §§ 422.506(a)(4) and 422.508(c), CMS considers ICO termination of this Contract with prior notice as described in Section 5.5.3 and non-renewal of this Contract as described in Section 5.7 to be circumstances warranting special consideration, and will not prohibit the ICO from applying for new Medicare Advantage contracts or Service Area expansions for a period of two (2) years due to termination.

5.5.4. Termination pursuant to Social Security Act § 1115A(b)(3)(B).

5.5.5. Termination for Cause

5.5.5.1. Any party may terminate this Agreement upon ninety (90) calendar day notice due to a material breach of a provision of this Contract unless CMS or MDCH determines that a delay in termination would pose an imminent and serious risk to the health of the individuals enrolled with the ICO or the ICO experiences financial difficulties so severe that its ability make necessary health services available is impaired to the point of posing an imminent and serious risk to the health of its Enrollees, whereby CMS or MDCH may expedite the termination.

5.5.5.2. Pre-termination Procedures: Before terminating a contract under 42 C.F.R. §422.510 and §438.708, the ICO may request a pre-termination hearing or develop and implement a corrective action plan. CMS or MDCH must:

5.5.5.2.1. Give the ICO written notice of its intent to terminate, the reason for termination, and a reasonable opportunity of at least thirty (30) calendar days to develop and implement a corrective action plan to correct the deficiencies; and/or

5.5.5.2.2. Notify the ICO of its Appeal rights as provided in 42 C.F.R. §422 Subpart N and §438.710.

5.5.5.3. The ICO must pay all reasonable costs incurred by the State in terminating this Contract for cause, including administrative costs, attorneys' fees, court costs, transition costs, and any costs the State incurs to procure the Contract activities from other sources.

5.5.6. Termination due to a Change in Law

5.5.6.1. In addition, CMS or MDCH may terminate this Contract upon thirty (30) calendar day notice due to a material change in law, or with less or no notice if required by law.

5.5.7. Continued Obligations of the Parties

5.5.7.1. In the event of termination, expiration, or non-renewal of this Contract, or if the ICO otherwise withdraws from the Medicare or Michigan Medicaid programs, the ICO shall continue to have the obligations imposed by this Contract or applicable law. These include, without limitation, the obligations to continue to provide Covered Services to each Enrollee at the time of such termination or withdrawal until the Enrollee has been disenrolled from the ICO's plan; provided, however, that CMS and MDCH will exercise best efforts to complete all disenrollment activities within six (6) months from the date of termination or withdrawal.

5.5.7.2. In the event that this Contract is terminated, expires, or is not renewed for any reason:

5.5.7.2.1. If CMS or MDCH, or both, elect to terminate or not renew the Contract, CMS and MDCH will be responsible for notifying all Enrollees covered under this Contract of the date of termination and the process by which those Enrollees will continue to receive care. If the ICO elects to terminate or not renew the Contract, the ICO will be responsible for notifying all Enrollees and the general public, in accordance with federal and State requirements;

5.5.7.2.2. The ICO must promptly return to CMS and MDCH all payments advanced to the ICO for Enrollees after the effective date of their disenrollment; and

5.5.7.2.3. The ICO must supply to CMS and MDCH all information necessary for the payment of any outstanding Claims determined by CMS and MDCH to be due to the ICO, and any such Claims will be paid in accordance with the terms of this Contract.

5.6. Order of Precedence

5.6.1. Order of Precedence Rules

5.6.1.1. The following documents are incorporated into and made a part of this Contract, including all appendices:

5.6.1.1.1. Capitated Financial Alignment Application, a document issued by CMS and MDCH subject to modification each program year

5.6.1.1.2. Memorandum of Understanding, a document between CMS and MDCH Regarding a Federal-State Partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Enrollees (April 3, 2014);

5.6.1.1.3. The Michigan Department of Technology, Management and Budget issued a request for proposal (RFP) on July 26, 2013 for bidders interested in participating in Michigan's Demonstration. RFP #0071141113B0000292 – Demonstration Program to Integrate Care for Persons Eligible for Medicare and Medicaid

5.6.1.1.4. The ICO's response to RFP #0071141113B0000292.

5.6.1.1.5. Any State or federal Requirements or Instructions released to Medicare-Medicaid Plans. Examples include the annual rate report, Medicare-Medicaid Marketing Guidance, Enrollment Guidance, and Reporting Requirements.

5.6.1.2. In the event of any conflict among the documents that are a part of this Contract, including all appendices, the order of priority to interpret the Contract shall be as follows:

5.6.1.2.1. The Contract terms and conditions, including all appendices;

5.6.1.2.2. Capitated Financial Alignment Application;

5.6.1.2.3. The Memorandum of Understanding between CMS and Michigan;

5.6.1.2.4. The Michigan Department of Technology, Management and Budget issued a request for proposal (RFP) on July 26, 2013 for bidders interested in participating in Michigan's Demonstration. RFP #0071141113B0000292 – Demonstration Program to Integrate Care for Persons Eligible for Medicare and Medicaid

5.6.1.2.5. The ICO's response to RFP #0071141113B0000292

5.6.1.2.6. Any special Any State or Federal Requirements or Instructions released to Medicare-Medicaid Plans. Examples include the annual rate report, Medicare-Medicaid Marketing Guidance, and Enrollment Guidance.

5.6.1.3. In the event of any conflict between this Contract and the MOU, the Contract shall prevail.

5.7. Contract Term

5.7.1. Contract Effective Date

5.7.1.1. This Contract shall be in effect starting on the date on which all Parties have signed the Contract and shall be effective, unless otherwise terminated, through December 31, 2015. The Contract shall be renewed in one-year terms through December 31, 2017, so long as the ICO has not provided CMS and the Department with a notice of intention not to renew, pursuant to 42 C.F.R. 422.506 or Section 5.5, above.

5.7.1.2. At the discretion of CMS and MDCH upon notice to the Parties, this Contract may be terminated, or the effectuation of the Contract Operational Start Date may be delayed, if Michigan has not received all necessary approvals from CMS or MDCH, as provided in Section 2.2.1.3 of this Contract, if the ICO is determined not to be ready to participate in the Demonstration.

5.7.1.3. MDCH may not expend Federal funds for, or award Federal funds to, the ICO until MDCH has received all necessary approvals from CMS. MDCH may not make payments to ICO by using Federal funds, or draw Federal

Medical Assistance Payment (FMAP) funds, for any services provided, or costs incurred, by the ICO prior to the later of the approval date for any necessary State Plan and waiver authority, the Readiness Review approval, or the Contract Operational Start Date.

5.8. Amendments

5.8.1. Amendment Process

5.8.1.1. The parties agree to negotiate in good faith to cure any omissions, ambiguities, or manifest errors herein.

5.8.1.2. By mutual agreement, the parties may amend this Contract where such amendment does not violate federal or State statutory, regulatory, or waiver provisions, provided that such amendment is in writing, signed by authorized representatives of both parties, and attached hereto.

5.9. Written Notices

5.9.1. Contacts

5.9.1.1. Notices to the parties as to any matter hereunder will be sufficient if given in writing and sent by certified mail, postage prepaid, or delivered in hand to the contacts in this Section. Copies may be delivered to the designated entities by email at the discretion of the sender.

5.9.1.2. CMS:

To	Centers for Medicare and Medicaid Services Medicare-Medicaid Coordination Office 7500 Security Boulevard, S3-13-23 Baltimore, MD 21244

5.9.1.3. The State of Michigan:

To	Susan Yontz, Director Integrated Care Division Medical Services Administration MDCH PO Box 30479 Lansing, MI 48909-7979 yontzs@michigan.gov
Copies to:	Stephen Fitton, Medicaid Director Medical Services Administration MDCH PO Box 30479 Lansing, MI 48909-7979

	fittons@michigan.gov Matthew Rick, Director Office of Legal Affairs and FOIA Bureau of Legal and Policy Affairs MDCH Capitol View Building, 7th Floor 201 Townsend Street Lansing, MI 48913 rickm@michigan.gov

5.9.1.4. The ICO (Meridian Health Plan of Michigan, Inc.):

To	Jon B. Cotton, President 777 Woodward Avenue Suite 600 Detroit, MI 48226 jon.cotton@mhplan.com
Copies to:	General Counsel 777 Woodward Avenue Suite 600 Detroit, MI 48226 michael.stines@mhplan.com

Section 6. Signatures

In Witness Whereof, CMS, The State of Michigan, and Meridian Health Plan of Michigan, Inc. (the ICO) have caused this Agreement to be executed by their respective authorized officers:

Jon B. Cotton, President	Date
Meridian Health Plan of Michigan, Inc.	

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In Witness Whereof, CMS, the State of Michigan, and Meridian Health Plan of Michigan, Inc. (the ICO) have caused this Agreement to be executed by their respective authorized officers:

Jeff Brownlee, Chief Procurement Officer	Date
Michigan Department of Technology, Management and Budget	

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In Witness Whereof, CMS, the State of Michigan, and Meridian Health Plan of Michigan, Inc. (the ICO) have caused this Agreement to be executed by their respective authorized officers:

Steve Fitton, Medicaid Director, Medical Services Administration	Date

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In Witness Whereof, CMS, the State of Michigan, and Meridian Health Plan of Michigan, Inc. (the ICO) have caused this Agreement to be executed by their respective authorized officers:

Verlon Johnson Associate Regional Administrator Centers for Medicare & Medicaid Services United States Department of Health and Human Services	Date
Kathryn Coleman Acting Director Medicare Drug & Health Plan Contract Administration Group Centers for Medicare & Medicaid Services United States Department of Health and Human Services	Date

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APPENDIX A. Covered Services

A.1 Medical Necessity: The ICO shall provide services to Enrollees as follows:

A.1.1 Authorize, arrange, coordinate, and provide to Enrollees all Medically Necessary Covered Services as specified in Section 2.4, in accordance with the requirements of the Contract.

A.1.2 Provide all Covered Services that are Medically Necessary, including but not limited to, those Covered Services that:

A.1.2.1 Prevent, diagnose, or treat health impairments;

A.1.2.2 Attain, maintain, or regain functional capacity.

A.1.3 Not arbitrarily deny or reduce the amount, duration, or scope of a required Covered Service solely because of diagnosis, type of illness, or condition of the Enrollee.

A.1.4 Not deny authorization for a Covered Service that the Enrollee or the provider demonstrates is Medically Necessary.

A.1.5 The ICO may place appropriate limits on a Covered Service on the basis of Medical Necessity, or for the purpose of utilization management, provided that the furnished services can reasonably be expected to achieve their purpose. The ICO's Medical Necessity guidelines must, at a minimum, be:

A.1.5.1 Developed with input from practicing physicians in the ICO's Service Area;

A.1.5.2 Developed in accordance with standards adopted by national accreditation organizations;

A.1.5.3 Developed in accordance with the definition of Medical Necessity in Section 1;

A.1.5.4 Updated at least annually or as new treatments, applications and technologies are adopted as generally accepted professional medical practice;

A.1.5.5 Evidence-based, if practicable; and,

A.1.5.6 Applied in a manner that considers the individual health care needs of the Enrollee.

A.1.6 The ICO's Medical Necessity guidelines, program specifications and service components for Behavioral Health services must, at a minimum, be submitted to MDCH annually for approval no later than 30 calendar days prior to the

start of a new contract Year, and no later than 30 calendar days prior to any change.

A.1.7 The ICO must offer to Enrollees any additional non-medical programs and services available to a majority of the ICO's commercial population, if any, on the same terms and conditions on which those programs and services are offered to the commercial population, unless otherwise agreed upon in writing by MDCH and the ICO, such as health club discounts, diet workshops and health seminars. The ICO's Capitation Payment shall not include the costs of such programs and services.

A.1.8 Offer and provide to all Enrollees any and all non-medical programs and services specific to Enrollees for which the ICO has received MDCH approval.

A.2 Covered Services: The ICO agrees to provide Enrollees access to the following Covered Services:

A.2.1 All services provided under Michigan State Plan Services, excluding those services otherwise excluded or limited in A.4 or A.5 of this Appendix.

A.2.2 All services provided under Medicare Part A

A.2.3 All services provided under Medicare Part B

A.2.4 All services provided under Medicare Part D

A.2.5 Demonstration specific-benefits, including Palliative Care

A.2.6 Pharmacy products that are covered by MDCH and may not be covered under Medicare Part D, including:

A.2.7 Over-the-counter (OTC) drugs are included in Michigan's MPPL available on the web at: https://michigan.fhsc.com/Providers/DrugInfo.asp

A.2.8 Barbiturates for indications not covered by Part D (butalbital, mephobarbital, phenobarbital secobarbital);

A.2.9 "Miscellaneous" drugs for indications that may not be covered by Part D (dronabinol, megestrol, oxandrolone, somatropin); and

A.2.10 Prescription vitamins and minerals.

A.2.11 The ICO is encouraged to offer a broader drug formulary than minimum requirements.

A.3 Cost-sharing for Covered Services

A.3.1 Except as described in Section 4.4.2 above, cost-sharing of any kind is not permitted in this Demonstration.

A.3.2 Cost sharing for Part D drugs.

A.3.2.1 Co-pays charged by the ICO for Part D drugs must not exceed the applicable amounts for brand and generic drugs established yearly by CMS under the Part D Low Income Subsidy.

A.3.2.2 The ICO may establish lower cost-sharing for prescription drugs than the maximum allowed.

A.3.3 Cost sharing for Medicaid Services.

A.3.3.1 For Medicaid services beyond the pharmacy cost sharing described here, the ICO will not charge cost sharing to Enrollees above levels established under the State Plan.

A.3.3.2 The ICO is free to waive Medicaid cost sharing.

A.3.3.3 For Enrolleeswho are residents of NFs, the ICO may require the Enrollee to contribute to the cost of NF care that amount listed for the Enrollee on the Department's patient credit file, which will be transmitted monthly to the Demonstration Plan.

A.4 Limitations on Covered Services. The following services and benefits shall be limited as Covered Services:

A.4.1 Termination of pregnancy may be provided only as allowed by applicable State and federal law and regulation (42 C.F.R. Part 441, Subpart E).

A.4.2 Sterilization services may be provided only as allowed by State and federal law (see 42 C.F.R. Part 441, Subpart F).

A.5 Excluded Services

A.5.1 Elective abortions and related services

A.5.2 Elective cosmetic surgery

A.5.3 Services for treatment of infertility

A.5.4 Hospice benefits

A.5.5 Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies

A.5.6 Acupuncture

A.5.7 Naturopath services (the use of natural or alternative treatments)

A.5.8 Experimental medical and surgical treatments, items, and drugs, unless covered by Medicare or under a Medicare-approved clinical research study or the ICO

A.6 Waiver Services and Supplemental Benefits

Table A.1: Planned ICO Waiver Services

Waiver Service	Service Definition
Adaptive Medical Equipment and Supplies	The plan covers devices, controls, or appliances that enable an increase in ability to perform activities of daily living or to perceive, control, or communicate with the environment in which one lives. Services might include: ▪ shower chairs/benches ▪ lift chairs ▪ raised toilet seats ▪ reachers ▪ jar openers ▪ transfer seats ▪ bath lifts/room lifts ▪ swivel discs ▪ bath aids such as long handle scrubbers ▪ telephone aids ▪ automated/telephone or watches that assist with medication reminders ▪ button hooks or zipper pulls ▪ modified eating utensils ▪ modified oral hygiene aids ▪ modified grooming tools ▪ heating pads ▪ sharps containers ▪ exercise items and other therapy items ▪ voice output blood pressure monitor ▪ nutritional supplements such as Ensure
Adult Day Program	The plan covers structured day activities at a program of direct care and supervision. This service: ▪ provides personal attention

Waiver Service	Service Definition
	▪ promotes social, physical and emotional well-being
Assistive Technology	The plan covers technology items used to increase, maintain, or improve functioning and promote independence. Some examples of services include: ▪ van lifts ▪ hand controls ▪ computerized voice system ▪ communication boards ▪ voice activated door locks ▪ power door mechanisms ▪ specialized alarm or intercom ▪ assistive dialing device
Chore Services	The plan covers services needed to maintain the Enrollee's home in a clean, sanitary, and safe environment. Examples of services include: ▪ heavy household chores (washing floors, windows, and walls) ▪ tacking loose rugs and tiles ▪ moving heavy items of furniture ▪ mowing, raking, and cleaning hazardous debris such as fallen branches and trees The plan may cover materials and disposable supplies used to complete chore tasks.
Expanded Community Living Supports	(1) To get this service, the Enrollee MUST have a need for prompting, cueing, observing, guiding, teaching, and/or reminding to help complete activities of daily living (ADLs) like eating, bathing, dressing, toileting, other personal hygiene, etc. (2) If the Enrollee has a need for them, he or she can also get assistance with instrumental activities of daily living (IADLs) like laundry, meal preparation, transportation, help with finances, help with medication, shopping, attending medical appointments, other household tasks. This may also include prompting, cueing, guiding, teaching, observing, reminding and/or other support to complete IADLs.
Community Transition Services	The plan will pay for non-reoccurring expenses for

Waiver Service	Service Definition
	transition from a nursing home to another residence where Enrollees are responsible for their own living arrangement. Must have a 6 month continuous stay in the nursing home to receive this service. Covered services may include: ▪ housing or security deposits ▪ utility hook-ups and deposits (excludes television and internet) ▪ furniture (limited) ▪ appliances (limited) ▪ moving expenses (excludes diversion or recreational devices) ▪ cleaning including pest eradication, allergen control, and over-all cleaning This service does not include ongoing monthly rental or mortgage expense, regular utility charges, or items that are intended for purely diversional or recreational purposes.
Environmental Modifications	The plan covers modifications to a home. The modifications must be designed to ensure health, safety and welfare or make the Enrollee more independent in the home. Modifications may include: ▪ installing ramps and grab bars ▪ widening of doorways ▪ modifying bathroom facilities ▪ installing specialized electric systems that are necessary to accommodate medical equipment and supplies
Home Delivered Meals	The plan covers prepared meals brought to the home.
Non-Medical Transportation	The plan covers transportation services to enable an Enrollee to gain access to waiver and other community services, activities, and resources.
Personal Emergency Response System	This includes an electronic in home device that secures help in an emergency. This may also include a portable "help" button to allow for mobility. The system is connected to a phone and programmed to signal a response center once a "help" button is activated.
Preventive Nursing Services	The plan covers nursing services provided by a registered nurse (RN) or licensed practical nurse (LPN). The

Waiver Service	Service Definition
	Enrollee must require observation and evaluation of skin integrity, blood sugar levels, prescribed range of motion exercises, or physical status to qualify. The Enrollee may receive other nursing services during the nurse visit to the home. These services are not provided on a continuous basis.
Private Duty Nursing	The plan covers skilled nursing services on an individual and continuous basis, up to a maximum of 16 hours per day, to meet health needs directly related to a physical disability. PDN includes the provision of nursing assessment, treatment and observation provided by licensed nurse, consistent with physician's orders and in accordance with the IICSP. Certain medical criteria must be met to qualify for this service.
Respite	Respite care services are intended to be for a short-term, intermittent basis to relieve family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid care. Relief needs of hourly or shift staff workers should be accommodated by staffing substitutions, plan adjustments, or location changes and not by respite care. **Respite is not intended to be provided on a continuous, long-term basis where it is a part of daily services that would enable an unpaid caregiver to work elsewhere full time.**

Table A.2: Supplemental Benefits

Supplemental Benefits	Service Definition
Adaptive Medical Equipment and Supplies	The plan covers devices, controls, or appliances that enable an increase in ability to perform activities of daily living or to perceive, control, or communicate with the environment in which one lives. Services might include:

Supplemental Benefits	Service Definition
	▪ shower chairs/benches ▪ lift chairs ▪ raised toilet seats ▪ reachers ▪ jar openers ▪ transfer seats ▪ bath lifts/room lifts ▪ swivel discs ▪ bath aids such as long handle scrubbers ▪ telephone aids ▪ automated/telephone or watches that assist with medication reminders ▪ button hooks or zipper pulls ▪ modified eating utensils ▪ modified oral hygiene aids ▪ modified grooming tools ▪ heating pads ▪ sharps containers ▪ exercise items and other therapy items ▪ voice output blood pressure monitor ▪ nutritional supplements such as Ensure.
Community Transition Services	The plan will pay for non-reoccurring expenses for transition from a nursing home to another residence where Enrollees are responsible for their own living arrangement. Must have a 6 month continuous stay in the nursing home to receive this service. Covered services may include: ▪ housing or security deposits ▪ utility hook-ups and deposits (excludes television and internet) ▪ furniture (limited) ▪ appliances (limited) ▪ moving expenses (excludes diversion or recreational devices) ▪ cleaning including pest eradication, allergen control, and over-all cleaning This service does not include ongoing monthly rental or

Supplemental Benefits	Service Definition
	mortgage expense, regular utility charges, or items that are intended for purely diversional or recreational purposes.
Personal Emergency Response System	This includes an electronic in home device that secures help in an emergency. This may also include a portable "help" button to allow for mobility. The system is connected to a phone and programmed to signal a response center once a "help" button is activated.
Respite	Respite care services may be received on a short-term, intermittent basis to relieve family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid care. Respite is limited to 14 overnight stays per 365 days. ICOs may cover additional days outside the rates as a flexible benefit. Relief needs of hourly or shift staff workers should be accommodated by staffing substitutions, plan adjustments, or location changes and not by respite care. **Respite is not intended to be provided on a continuous, long-term basis where it is a part of daily services that would enable an unpaid caregiver to work elsewhere full time.**

APPENDIX B. Enrollee Rights

B.1 The ICO must have written policies regarding the Enrollee rights specified in this appendix, as well as written policies specifying how information about these rights will be disseminated to Enrollees. Enrollees must be notified of these rights and protections at least annually, and in a manner that takes in to consideration cultural considerations, Functional Status and language needs. Enrollee rights include, but are not limited to, those rights and protections provided by 42 C.F.R. § 438.100, 42 C.F.R. §422 Subpart C, and the Michigan Memorandum of Understanding (MOU).

B.2 Specifically, Enrollees must be guaranteed:

B.2.1 The right to be treated with dignity and respect.

B.2.2 The right to be afforded privacy and confidentiality in all aspects of care and for all health care information, unless otherwise required by law.

B.2.3 The right to be provided a copy of his or her medical records, upon request, and to request corrections or amendments to these records, as specified in 45 C.F.R. part 164.

B.2.4 The right not to be discriminated against based on race, ethnicity, national origin, religion, sex, age, sexual orientation, medical or Claims history, mental or physical disability, genetic information, or source of payment.

B.2.5 The right to have all plan options, rules, and benefits fully explained, including through use of a qualified interpreter if needed.

B.2.6 Access to an adequate network of primary and specialty providers who are capable of meeting the Enrollee's needs with respect to physical access, and communication and scheduling needs, and are subject to ongoing assessment of clinical quality including required reporting.

B.2.7 The right to choose a plan and provider at any time, including a plan outside of the Demonstration, and have that choice be effective the first calendar day of the following month.

B.2.8 The right to have a voice in the governance and operation of the integrated system, provider or health plan, as detailed in this Contract.

B.2.9 The right to participate in all aspects of care, including the right to refuse treatment, and to exercise all rights of Appeal.

B.2.10 Enrollees have a responsibility to be fully involved in maintaining their health and making decisions about their health care, including the right to refuse treatment if desired, and must be appropriately informed and supported to this end. Specifically, Enrollees must:

B.2.10.1 Receive a Health Risk Assessment upon Enrollment in a plan and to participate in the development and implementation of the Individual Integrated Care and Supports Plan. The assessment must include considerations of social, functional, medical, behavioral, wellness and prevention domains, an evaluation of the Enrollee's goals, preferences, strengths and weaknesses, and a plan for managing and coordination Enrollee's care. Enrollees, or authorized representative, also have the right to request a Reassessment by the Integrated Care Team and be fully involved in any such Reassessment.

B.2.10.2 Receive complete and accurate information on his or her health and functional status by the Integrated Care Team.

B.2.10.3 Be provided information on all program services and health care options, including available treatment options and alternatives, presented in a culturally appropriate manner, taking in to consideration the Enrollee's condition and ability to understand. An Enrollee who is unable to participate fully in treatment decisions has the right to designate a representative. This includes the right to have translation services available to make information appropriately accessible. Information must be available:

B.2.10.3.1 Before Enrollment

B.2.10.3.2 At Enrollment

B.2.10.3.3 At the time an Enrollee's needs necessitate the disclosure and delivery of such information in order to allow the Enrollee to make an informed choice

B.2.10.4 Be encouraged to involve caregivers or family members in treatment discussions and decisions.

B.2.10.5 Have advance directives explained and to establish them, if the Enrollee so desires, in accordance with 42 C.F.R. §§489.100 and 489.102.

B.2.10.6 Receive reasonable advance notice, in writing, of any transfer to another treatment setting and the justification for the transfer.

B.2.10.7 Be afforded the opportunity file an Appeal if services are denied that he or she thinks are medically indicated, and to be able to ultimately take that Appeal to an independent external system of review.

B.2.10.8 The right to receive medical and non-medical care from a team that meets the Enrollee's needs, in a manner that is sensitive to the

Enrollee's language and culture, and in an appropriate care setting, including the home and community.

B.2.10.9 The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

B.2.10.10 Each Enrollee is free to exercise his or her rights and that the exercise of those rights does not adversely affect the way the ICO and its providers or the State Agency treat the Enrollee.

B.2.10.11 The right to receive timely information about plan changes. This includes the right to request and obtain the information listed in the orientation materials at least once per year, and the right to receive notice of any significant change in the information provided in the orientation materials at least 30 calendar days prior to the intended effective date of the change. See 438.10.

B.2.10.12 The right to be protected from liability for payment of any fees that are the obligation of the ICO.

B.2.10.13 The right not to be charged any cost sharing for any Demonstration services.

APPENDIX C. Relationship With First Tier, Downstream, And Related Entities

C.1 ICO shall ensure that any contracts or agreements with First Tier, Downstream and Related Entities performing functions on ICO's behalf related to the operation of the Medicare-Medicaid Plan are in compliance with 42 C.F.R. §§422.504, 423.505, 438.6(l), and 438.230(b)(1).

C.2 ICO shall specifically ensure:

C.2.1 HHS, the Comptroller General, MDCH or their designees have the right to audit, evaluate, and inspect and books, contracts, computer or other electronic systems, including medical records and documentation of the First Tier, Downstream and Related Entities; and

C.2.2 HHS's, the Comptroller General's, MDCH's or their designees right to inspect, evaluate, and audit any pertinent information for any particular contract period for ten years from the final date of the contract period or from the date of completion of any audit, whichever is later.

C.3 ICO shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities contain the following:

C.3.1 Enrollee protections that include prohibiting First Tier, Downstream and Related Entities from holding an Enrollee liable for payment of any fees that are the obligation of the ICO;

C.3.2 Language that any services or other activity performed by a First Tier, Downstream and Related Entities is in accordance with the ICO's contractual obligations to CMS and MDCH;

C.3.3 Language that specifies the delegated activities and reporting requirements;

C.3.4 Language that provides for revocation of the delegation activities and reporting requirements or specifies other remedies in instances where CMS, MDCH or the ICO determine that such parties have not performed satisfactorily;

C.3.5 Language that specifies the performance of the parties is monitored by the ICO on an ongoing basis and the ICO may impose corrective action as necessary;

C.3.6 Language that specifies the First Tier, Downstream and Related Entities agree to safeguard Enrollee Privacy and confidentiality of Enrollee health records; and

C.3.7 Language that specifies the First Tier, Downstream and Related Entities must comply with all Federal and State laws, regulations and CMS instructions.

C.4 ICO shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities that are for credentialing of medical providers contains the following language:

C.4.1 The credentials of medical professionals affiliated with the party or parties will be either reviewed by the ICO; or

C.4.2 The credentialing process will be reviewed and approved by the ICO and the ICO must audit the credentialing process on an ongoing basis.

C.5 ICO shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities that delegate the selection of providers must include language that the ICO retains the right to approve, suspend, or terminate any such arrangement.

C.6 ICO shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities shall state that neither the ICO nor the provider has the right to terminate the contract without cause and shall require the provider to provide at least 60 calendar day notice to the ICO and assist with transitioning Enrollees to new providers, including sharing the Enrollee's medical record and other relevant Enrollee information as directed by the ICO or Enrollee.

C.7 ICO shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities shall state that the ICO shall provide a written statement to a provider of the reason or reasons for termination with cause.

C.8 ICO shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities for medical providers include additional provisions. Such contracts or arrangements must contain the following:

C.8.1 Language that the ICO is obligated to pay contracted medical providers under the terms of the contract between the ICO and the medical provider. The contract must contain a prompt payment provision, the terms of which are developed and agreed to by both the ICO and the relevant medical provider;

C.8.2 Language that services are provided in a culturally competent manner to all Enrollees, including those with limited English proficiency or reading skills, and diverse culturally and ethnic backgrounds;

C.8.3 Language that medical providers abide by all Federal and State laws and regulations regarding confidentiality and disclosure of medical records, or other health and Enrollment information;

C.8.4 Language that medical providers ensure that medical information is released in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas;

C.8.5 Language that medical providers maintain the Enrollee Medical Record and information in an accurate and timely manner;

C.8.6 Language that medical providers ensure timely access by Enrollees to the records and information that pertain to them; and

C.8.7 Language that Enrollees will not be held liable for Medicare Part A and B cost sharing. Specifically, Medicare Parts A and B services must be provided at zero cost-sharing to Enrollees.

C.8.8 Language that clearly state the medical providers EMTALA obligations and must not create any conflicts with hospital actions required to comply with EMTALA.

C.8.9 Language prohibiting providers, including, but not limited to PCPs, from closing or otherwise limiting their acceptance of Enrollees as patients unless the same limitations apply to all commercially insured Enrollees.

C.8.10 Language that prohibits the ICO from refusing to contract or pay an otherwise eligible health care provider for the provision of Covered Services solely because such provider has in good faith:

C.8.10.1 Communicated with or advocated on behalf of one or more of his or her prospective, current or former patients regarding the provisions, terms or requirements of the ICO's health benefit plans as they relate to the needs of such provider's patients; or

C.8.10.2 Communicated with one or more of his or her prospective, current or former patients with respect to the method by which such provider is compensated by the ICO for services provided to the patient.

C.8.11 Language that states the provider is not required to indemnify the ICO for any expenses and liabilities, including, without limitation, judgments, settlements, attorneys' fees, court costs and any associated charges, incurred in connection with any Claim or action brought against the ICO based on the ICO's management decisions, utilization review provisions or other policies, guidelines or actions.

C.8.12 Language that states the ICO shall require providers to comply with the ICO's requirements for utilization review, quality management and improvement, credentialing and the delivery of preventive health services.

C.8.13 Language that states the ICO shall notify providers in writing of modifications in payments, modifications in Covered Services or modifications in the ICO's procedures, documents or requirements, including those associated with utilization review, quality management and improvement, credentialing and preventive health services, that have a substantial impact on the rights or responsibilities of the providers, and the effective date of the modifications. The notice shall be provided 30 calendar days before the effective date of such modification unless such other date for notice is mutually agreed upon

between the ICO and the provider or unless such change is mandated by CMS or MDCH without 30 calendar days prior notice.

C.8.14 Language that states that providers shall not bill patients for charges for Covered Services other than pharmacy co-payments, if applicable.

C.8.15 Language that states that No payment shall be made by the ICO to a provider for a Provider Preventable Condition; and

C.8.16 As a condition of payment, the provider shall comply with the reporting requirements as set forth in 42 C.F.R. § 447.26(d) and as may be specified by the ICO. The provider shall comply with such reporting requirements to the extent the provider directly furnishes services.

C.8.17 Language that requires PCPs and specialty provider contracts to provide coverage for their respective practices twenty-four (24) hours a day, seven (7) days a week and have a published after hours telephone number; voicemail alone after hours is not acceptable.

C.9 ICO shall ensure that contracts or arrangements with First Tier, Downstream and Related Entities for medical providers do not include incentive plans that include a specific payment to a provider as an inducement to deny, reduce, delay, or limit specific, Medical Necessary Services and;

C.9.1 The provider shall not profit from provision of Covered Services that are not Medically Necessary or medically appropriate.

C.9.2 The ICO shall not profit from denial or withholding of Covered Services that are Medically Necessary or medically appropriate.

C.10 ICO shall ensure that contracts or arrangements with First Tier, Downstream and Related Entities for PIHPs include additional provisions. Such contracts or arrangements must contain the following:

C.10.1 Language that requires the ICO and PIHP develop policies and procedures that specify joint coordination and management of care for Enrollees with BH, SUD, and/or I/DD needs.

C.10.2 Language that requires the PIHP to provide specified Medicare BH services.

C.10.2.1 Language that specifies that The PIHP will authorize Medicare covered inpatient psychiatric hospital admissions and outpatient therapy services.

C.10.3 Language that specifies the PIHP will contract directly with the State for the delivery of covered Medicaid BH services.

C.10.4 Language that specifies that the PIHP BH, SUD, I/DD inpatient and outpatient services that require prior authorization as outlined in Medicaid policy.

C.10.5 Language that requires the PIHP to conduct all BH, SUD, I/DD authorization and UM in compliance with 42 USC § 1396u-2(b)(8).

C.10.6 Language that requires the PIHP to maintain BH Services authorization policies and procedures, which shall, at a minimum contain the following requirements:

C.10.6.1 If prior authorization is required for any Behavioral Health Inpatient Services admission for acute care, assure the availability of such prior authorization twenty-four (24) hours a day, seven (7) days a week; access to a reviewer and response to a request for authorization is within established timeliness standards aligned with the level of urgency of the request, ensuring the safety of a Enrollee at all times;

C.10.6.2 A plan and a system in place to direct Enrollees to the most integrated setting and least restrictive environment and the least intensive yet the most clinically appropriate service to safely and adequately treat the Enrollee;

C.10.6.3 A process to render an authorization and communicate the authorized length of stay to the Enrollee, facility, and attending physician for all behavioral health emergency inpatient admissions verbally within thirty (30) minutes, and within two (2) hours for non-emergency inpatient authorization and in writing within twenty-four (24) hours of admission;

C.10.6.4 Processes to ensure safe placement for Enrollees who require Behavioral Health Inpatient Services when no inpatient beds are available, including methods and places of care to be utilized while Enrollee is awaiting an inpatient bed and to avoid delay of onset of treatment to minimize risk to Enrollee;

C.10.6.5 The PIHP shall monitor Medical Necessity for the clinical need for continued stay, and progress toward and achievement of Behavioral Health Inpatient Services treatment goals and objectives;

C.10.6.6 Provide for verification and authorization of all adjustments to Behavioral Health Inpatient Services treatment plans based on updated clinical reports of Enrollee's status and response to existing treatment plan;

C.10.6.7 Processes to ensure that treatment and discharge needs are addressed at the time of initial authorization and concurrent review, and that treatment planning includes coordination with the PCP and other service providers as appropriate;

C.10.7 Language that requires the PIHP to maintain Behavioral Health Outpatient Services policies and procedures, which shall include, but are not limited to, the following:

C.10.7.1 Policies and procedures to authorize Behavioral Health Outpatient Services for initial and ongoing requests for outpatient care;

C.10.7.2 Policies and procedures to authorize Behavioral Health Outpatient Services based upon Behavioral Health Clinical Criteria, based on current research, relevant quality standards and evidence-based models of care; and,

C.10.7.3 Review and update annually its Behavioral Health Outpatient Services policies and procedures.

C.10.8 Language that requires the PIHP to report on UM activities for BH services.

C.10.9 Language that ensures the contract includes a provision for the policies and procedures for referrals from the ICO to the PIHP based on identification of BH needs using an MDCH approved validated screening tool. The policy shall include:

C.10.9.1 Scoring criteria for the screening tool;

C.10.9.2 The referral process for additional assessment and/or behavioral health services;

C.10.9.3 Standards for follow-up and communication with the Enrollee; and

C.10.9.4 Standards for follow-up and communication with the ICT

C.10.10 Language that requires the ICO and PIHP to use the Level II Assessments, including the use of the LOCUS, SIS and ASAM as appropriate, for the determination of medical necessity for BH services.

C.10.11 Language requiring the ICO and PIHP to develop and submit to MDCH for approval, referral and authorization policies for BH and potentially overlapping services.

C.10.12 Language that requires the ICO and PIHP to identify PIHP Coordinators as the responsible party for ensuring the coordination of care of all Medicaid BH services with other services outlined in Enrollees' IICSPs.

C.10.13 Language that requires the PIHP to Review and update annually, at a minimum, the behavioral health clinical criteria and other clinical protocols that the ICO may develop and utilize in its clinical case reviews and care management activities. Submit any modifications to MDCH annually for review and approval. In its review and update process, the ICO shall consult with clinical experts either within its own clinical and medical staff or medical consultants outside of the ICO's organization, who are familiar with standards and practices of mental health and substance use treatment in Michigan. ICO shall ensure that clinical criteria are based on current research, relevant quality standards and evidence-based models of care.

C.10.14 Language that requires the ICO to share a portion of quality withhold amounts when the ICO achieves quality withhold thresholds.

C.10.15 Language that requires the ICO and PIHP to identify shared quality improvement measurement requirements and develop and implement related processes sharing results and undertaking correction and QI activities.

C.10.16 Language that requires the ICO Care Coordinator to collaborate, as applicable, with the PIHP Supports Coordinator and the regional PIHP when:

C.10.16.1 The Enrollee has received services through a PIHP within the last twelve (12) months; or

C.10.16.2 An Enrollee requests or is identified as having potential need for BH, I/DD, or SUD services.

C.10.17 Language that requires for the mutual communication between the ICO and the PIHP to assure that all rights of Appeal under the Demonstration are met within the required timeframes.

C.10.17.1 Language that requires the ICO and the PIHP report grievances related to BH, SUD and/or I/DD to one another in a timely manner;

C.10.17.2 Language that requires the PIHP to track and resolve grievances or if appropriate, direct the grievances to the coverage decision and/or Appeals processes;

C.10.17.3 Language that requires the PIHP to use the integrated notices and forms specific to the Demonstration; and

C.10.17.4 Language that requires the ICO and PIHP to use an internal review process for situations where the ICO or the PIHP are not in agreement about a service authorization.

C.10.18 Language that requires the ICO to delegate to the PIHP specified Medicare BH service payments at a sub-capitated rate that are sufficient to support

service cost and management functions. For the first 12 months of service, the ICOs and PIHPs are permitted to negotiate fee-for-service arrangements.

C.10.19 Language that requires the PIHP to maintain a BH crisis line. The ICO must have the ability to provide call transfers to the BH crisis line.

C.11 Nothing in this section shall be construed to prohibit contracts that contain incentive plans that involve general payments such as Capitation Payments or shared risk agreements that are made with respect to physicians or physician groups or which are made with respect to groups of Enrollees if such agreements, which impose risk on such physicians or physician groups for the costs of medical care, services and equipment provided or authorized by another physician or health care provider, comply with paragraph C.12, below.

C.12 The ICO shall ensure that contracts or arrangements with First Tier, Downstream and Related Entities for medical providers includes language that prohibits the ICO from imposing a financial risk on medical providers for the costs of medical care, services or equipment provided or authorized by another Physician or health care provider such contract includes specific provisions with respect to the following:

C.12.1 Stop-loss protection;

C.12.2 Minimum patient population size for the Physician or Physician group; and

C.12.3 Identification of the health care services for which the Physician or Physician group is at risk.

C.13 The ICO shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities for laboratory testing sites providing services include an additional provision that such laboratory testing sites must have either a Clinical Laboratory Improvement Amendment (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number.

C.14 Nothing in this section shall be construed to restrict or limit the rights of the ICO to include as providers religious non-medical providers or to utilize medically based eligibility standards or criteria in deciding provider status for religious non-medical providers.

APPENDIX D. Part D Addendum

ADDENDUM TO CAPITATED FINANCIAL ALIGNMENT CONTRACT PURSUANT TO SECTIONS 1860D-1 THROUGH 1860D-43 OF THE SOCIAL SECURITY ACT FOR THE OPERATION OF A VOLUNTARY MEDICARE PRESCRIPTION DRUG PLAN

The Centers for Medicare & Medicaid Services (hereinafter referred to as "CMS"), Michigan, acting by and through the Michigan Department of Community Health (MDCH), and the Michigan Department of Technology, Management and Budget (DTMB), and Meridian Health Plan of Michigan, Inc, a Medicare-Medicaid managed care organization (hereinafter referred to as ICO) agree to amend the contract H0480 governing ICO's operation of a Medicare-Medicaid Plan described in § 1851(a)(2)(A) of the Social Security Act (hereinafter referred to as "the Act") to include this addendum under which ICO shall operate a Voluntary Medicare Prescription Drug Plan pursuant to §§1860D-1 through 1860D-43 (with the exception of §§1860D-22(a) and 1860D-31) of the Act.

ARTICLE I
VOLUNTARY MEDICARE PRESCRIPTION DRUG PLAN

A. ICO agrees to operate one or more Medicare Voluntary Prescription Drug Plans as described in its application and related materials submitted to CMS for Medicare approval, including but not limited to all the attestations contained therein and all supplemental guidance, and in compliance with the provisions of this addendum, which incorporates in its entirety the *2013 Capitated Financial Alignment Application*, released on March 29, 2012 (hereinafter collectively referred to as "the addendum"). ICO also agrees to operate in accordance with the regulations at 42 C.F.R. Part 423 (with the exception of Subparts Q, R, and S), §§1860D-1 through 1860D-43 (with the exception of §§1860D-22(a) and 1860D-31) of the Act, and the applicable solicitation identified above, as well as all other applicable Federal statutes, regulations, and policies. This addendum is deemed to incorporate any changes that are required by statute to be implemented during the term of this Contract and any regulations or policies implementing or interpreting such statutory or regulatory provisions.

B. CMS agrees to perform its obligations to ICO consistent with the regulations at 42 C.F.R. Part423 (with the exception of Subparts Q, R, and S), §§1860D-1 through 1860D-43 (with the exception of §§1860D-22(a) and 1860D-31) of the Act, and the applicable solicitation, as well as all other applicable Federal statutes, regulations, and policies.

C. CMS agrees that it will not implement, other than at the beginning of a calendar year, regulations under 42 C.F.R. Part 423 that impose new, significant regulatory requirements on ICO. This provision does not apply to new requirements mandated by statute.

D. This addendum is in no way intended to supersede or modify 42 C.F.R., Parts 417, 422 423, 431 or 438. Failure to reference a regulatory requirement in this addendum does not affect the applicability of such requirements to ICO, MDCH, and CMS.

ARTICLE II
FUNCTIONS TO BE PERFORMED BY ICO

A. ENROLLMENT

ICO agrees to enroll in its Medicare-Medicaid plan only Potential Enrollees as they are defined in 42 C.F.R. §423.30(a) and who have met the Demonstration requirements and have elected to or have been passively enrolled in ICO's Capitated Financial Alignment benefit.

A. PRESCRIPTION DRUG BENEFIT

1. ICO agrees to provide the required prescription drug coverage as defined under 42 C.F.R. §423.100 and, to the extent applicable, supplemental benefits as defined in 42 C.F.R. §423.100 and in accordance with Subpart C of 42 C.F.R. Part 423. ICO also agrees to

provide Part D benefits as described in ICO's Part D plan benefit package(s) approved each year by CMS (and in the Attestation of Benefit Plan and Price, attached hereto).

2. ICO agrees to maintain administrative and management capabilities sufficient for the organization to organize, implement, and control the financial, marketing, benefit administration, and quality assurance activities related to the delivery of Part D services as required by 42 C.F.R. §423.505(b)(25).

B. DISSEMINATION OF PLAN INFORMATION

1. ICO agrees to provide the information required in 42 C.F.R. §423.48.

2. ICO acknowledges that CMS releases to the public summary reconciled Part D Payment data after the reconciliation of Part D Payments for the contract year as provided in 42 C.F.R. §423.505(o).

3. ICO certifies that all materials it submits to CMS under the File and Use Certification authority described in the Medicare Marketing Guidelines are accurate, truthful, not misleading, and consistent with CMS marketing guidelines.

C. QUALITY ASSURANCE/UTILIZATION MANAGEMENT

1. ICO agrees to operate quality assurance, drug utilization management, and medication therapy management programs, and to support electronic prescribing in accordance with Subpart D of 42 C.F.R. Part 423.

2. ICO agrees to address complaints received by CMS against the ICO as required in 42 C.F.R. §423.505(b)(22) by:

   (a) Addressing and resolving complaints in the CMS complaint tracking system; and

   (b) Displaying a link to the electronic complaint form on the Medicare.gov Internet Web site on the Part D plan's main Web page.

D. APPEALS AND GRIEVANCES

ICO agrees to comply with all requirements in Subpart M of 42 C.F.R. Part 423 governing coverage determinations, Grievances and Appeals, and formulary exceptions and the relevant provisions of Subpart U governing reopenings. ICO acknowledges that these requirements are separate and distinct from the Appeals and Grievances requirements applicable to ICO through the operation of its Medicare Parts A and B and Medicaid benefits.

E. PAYMENT TO ICO

ICO and CMS and MDCH agree that payment paid for Part D services under the addendum will be governed by the rules in Subpart G of 42 C.F.R. Part 423.

F. PLAN BENEFIT SUBMISSION AND REVIEW

If ICO intends to participate in the Part D program for the next program year, ICO agrees to submit the next year's Part D plan benefit package including all required information on benefits and cost-sharing, by the applicable due date, as provided in Subpart F of 42 C.F.R. Part 423 so that CMS, MDCH and ICO may conduct negotiations regarding the terms and conditions of the proposed benefit plan renewal. ICO acknowledges that failure to submit a timely plan benefit package under this section may affect the ICO's ability to offer a plan, pursuant to the provisions of 42 C.F.R. §422.4(c).

G. COORDINATION WITH OTHER PRESCRIPTION DRUG COVERAGE

1. ICO agrees to comply with the coordination requirements with State Pharmacy Assistance Programs (SPAPs) and plans that provide other prescription drug coverage as described in Subpart J of 42 C.F.R. Part 423.

2. ICO agrees to comply with Medicare Secondary Payer procedures as stated in 42 C.F.R. §423.462.

H. SERVICE AREA AND PHARMACY ACCESS

1. ICO agrees to provide Part D benefits in the Service Area for which it has been approved by CMS and MDCH (as defined in Appendix G) to offer Medicare Parts A and B benefits and Medicaid benefits utilizing a pharmacy network and formulary approved by CMS and MDCH that meet the requirements of 42 C.F.R. §423.120.

2. ICO agrees to provide Part D benefits through out-of-network pharmacies according to 42 C.F.R. §423.124.

3. ICO agrees to provide benefits by means of point-of-service systems to adjudicate prescription drug Claims in a timely and efficient manner in compliance with CMS standards, except when necessary to provide access in underserved areas, I/T/U pharmacies (as defined in 42 C.F.R. §423.100), and long-term care pharmacies (as defined in 42 C.F.R. §423.100) according to 42 C.F.R. §423.505(b)(17).

4. ICO agrees to contract with any pharmacy that meets ICO's reasonable and relevant standard terms and conditions according to 42 C.F.R. §423.505(b)(18).

I. EFFECTIVE COMPLIANCE PROGRAM/PROGRAM INTEGRITY

ICO agrees that it will develop and implement an effective compliance program that applies to its Part D-related operations, consistent with 42 C.F.R. §423.504(b)(4)(vi).

J. LOW-INCOME SUBSIDY

ICO agrees that it will participate in the administration of subsidies for low-income subsidy eligible individuals according to Subpart P of 42 C.F.R. Part 423.

ICO agrees to afford its Enrollees protection from liability for payment of fees that are the obligation of ICO in accordance with 42 C.F.R. §423.505(g).

L. Relationship with first tier, downstream, and related Entities

1. ICO agrees that it maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of this addendum.

2. ICO shall ensure that any contracts or agreements with First Tier, Downstream and Related Entities performing functions on ICO's behalf related to the operation of the Part D benefit are in compliance with 42 C.F.R. §423.505(i).

M. Certification of Data That Determine Payment

1. ICO must provide certifications in accordance with 42 C.F.R. §423.505(k).

N. ICO REIMBURSEMENT TO PHARMACIES

1. If ICO uses a standard for reimbursement of pharmacies based on the cost of a drug, ICO will update such standard not less frequently than once every 7 days, beginning with an initial update on January 1 of each year, to accurately reflect the market price of the drug.

2. ICO will issue, mail, or otherwise transmit payment with respect to all Claims submitted by pharmacies (other than pharmacies that dispense drugs by mail order only, or are located in, or contract with, a long-term care facility) within 14 calendar days of receipt of an electronically submitted Claim or within 30 calendar days of receipt of a Claim submitted otherwise.

3. ICO must ensure that a pharmacy located in, or having a contract with, a long-term care facility will have not less than 30 calendar days (but not more than 90 calendar days) to submit Claims to ICO for reimbursement.

ARTICLE III
RECORD RETENTION AND REPORTING REQUIREMENTS

A. Record Maintenance and access

ICO agrees to maintain records and provide access in accordance with 42 C.F.R. §§ 423.505 (b)(10) and 423.505(i)(2).

B. GENERAL REPORTING REQUIREMENTS

ICO agrees to submit information to CMS according to 42 C.F.R. §§423.505(f) and 423.514, and the "Final Medicare Part D Reporting Requirements," a document issued by CMS and MDCH subject to modification each program year.

C. CMS and Michigan License For Use of ICO Formulary

ICO agrees to submit to CMS and MDCH the ICO's formulary information, including any changes to its formularies, and hereby grants to the Government, and any person or entity who might receive the formulary from the Government, a non-exclusive license to use all or any portion of the formulary for any purpose related to the administration of the Part D program, including without limitation publicly distributing, displaying, publishing or reconfiguration of the information in any medium, including www.medicare.gov, and by any electronic, print or other means of distribution.

ARTICLE IV
HIPAA PROVISIONS

A. ICO agrees to comply with the confidentiality and Enrollee Medical Record accuracy requirements specified in 42 C.F.R. §423.136.

B. ICO agrees to enter into a business associate agreement with the entity with which CMS has contracted to track Medicare beneficiaries' true out-of-pocket costs.

C. ICO agrees to enter into a business associate agreement with the State of Michigan.

ARTICLE V
ADDENDUM TERM AND RENEWAL

A. Term of ADDENDUM

1. This addendum is effective from the date of CMS' authorized representative's signature through December 31, 2014 This addendum shall be renewable for successive one-year periods thereafter according to 42 C.F.R. §423.506.

B. Qualification to renew ADDENDUM

1. In accordance with 42 C.F.R. §423.507, ICO will be determined qualified to renew this addendum annually only if—

   (a) ICO has not provided CMS or MDCH with a notice of intention not to renew in accordance with Article VII of this addendum, and

   (b) CMS or MDCH has not provided ICO with a notice of intention not to renew.

2. Although ICO may be determined qualified to renew its addendum under this Article, if ICO, CMS, MDCH and MDCH cannot reach agreement on the Part D plan benefit package under Subpart F of 42 C.F.R. Part 423, no renewal takes place, and the failure to reach agreement is not subject to the Appeals provisions in Subpart N of 42 C.F.R. Parts 422 or 423. (Refer to Article X for consequences of non-renewal on the Capitated Financial Alignment contract.)

ARTICLE VI
NONRENEWAL OF ADDENDUM

A. Nonrenewal by ICO

ICO may non-renew this addendum in accordance with 42 C.F.R. 423.507(a).

B. NONRENEWAL BY CMS

CMS may non-renew this addendum under the rules of 42 C.F.R. 423.507(b). (Refer to Article X for consequences of non-renewal on the Capitated Financial Alignment contract.)

ARTICLE VII
MODIFICATION OR TERMINATION OF ADDENDUM BY MUTUAL CONSENT

This addendum may be modified or terminated at any time by written mutual consent in accordance with 42 C.F.R. 423.508. (Refer to Article X for consequences of non-renewal on the Capitated Financial Alignment contract.)

ARTICLE VIII
TERMINATION OF ADDENDUM BY CMS

CMS may terminate this addendum in accordance with 42 C.F.R. 423.509. (Refer to Article X for consequences of non-renewal on the Capitated Financial Alignment contract.)

ARTICLE IX
TERMINATION OF ADDENDUM BY ICO

A. ICO may terminate this addendum only in accordance with 42 C.F.R. 423.510.

B. If the addendum is terminated under Section A of this Article, ICO must ensure the timely transfer of any data or files. (Refer to Article X for consequences of non-renewal on the Capitated Financial Alignment contract.)

ARTICLE X
RELATIONSHIP BETWEEN ADDENDUM AND CAPITATED FINANCIAL ALIGNMENT CONTRACT

A. ICO acknowledges that, if it is a Capitated Financial Alignment ICO, the termination or nonrenewal of this addendum by any party may require CMS to terminate or non-renew the ICO's Capitated Financial Alignment contract in the event that such non-renewal or

termination prevents ICO from meeting the requirements of 42 C.F.R. §422.4(c), in which case the ICO must provide the notices specified in this Contract, as well as the notices specified under Subpart K of 42 C.F.R. Part 422.

B. The termination of this addendum by any party shall not, by itself, relieve the parties from their obligations under the Capitated Financial Alignment contract to which this document is an addendum.

C. In the event that the ICO's Capitated Financial Alignment contract is terminated or nonrenewed by any party, the provisions of this addendum shall also terminate. In such an event, ICO, MDCH and CMS shall provide notice to Enrollees and the public as described in this Contract as well as 42 C.F.R. Part 422, Subpart K or 42 C.F.R. Part 417, Subpart K, as applicable.

ARTICLE XI
INTERMEDIATE SANCTIONS

Consistent with Subpart O of 42 C.F.R. Part 423, ICO shall be subject to sanctions and civil money penalties.

ARTICLE XII
SEVERABILITY

Severability of the addendum shall be in accordance with 42 C.F.R. §423.504(e).

ARTICLE XIII
MISCELLANEOUS

A. DEFINITIONS

Terms not otherwise defined in this addendum shall have the meaning given such terms at 42 C.F.R. Part 423 or, as applicable, 42 C.F.R. Parts 417, 422, 431 or Part 438.

B. ALTERATION TO ORIGINAL ADDENDUM TERMS

ICO agrees that it has not altered in any way the terms of the ICO addendum presented for signature by CMS. ICO agrees that any alterations to the original text ICO may make to this addendum shall not be binding on the parties.

C. ADDITIONAL CONTRACT TERMS

ICO agrees to include in this addendum other terms and conditions in accordance with 42 C.F.R. §423.505(j).

D. CMS AND MDCH APPROVAL TO BEGIN MARKETING AND ENROLLMENT ACTIVITIES

ICO agrees that it must complete CMS operational requirements related to its Part D benefit prior to receiving CMS and MDCH's approval to begin ICO marketing activities relating to its Part D benefit. Such activities include, but are not limited to, establishing and successfully testing connectivity with CMS and MDCH systems to process Enrollment applications (or contracting with an entity qualified to perform such functions on ICO's behalf) and successfully demonstrating the capability to submit accurate and timely price comparison data. To establish and successfully test connectivity, ICO must, 1) establish and test physical connectivity to the CMS data center, 2) acquire user identifications and passwords, 3) receive, store, and maintain data necessary to send and receive transactions to and from CMS, and 4) check and receive transaction status information.

E. Pursuant to §13112 of the American Recovery and Reinvestment Act of 2009 (ARRA), ICO agrees that as it implements, acquires, or upgrades its health information technology systems, it shall utilize, where available, health information technology systems and products that meet standards and implementation specifications adopted under § 3004 of the Public Health Service Act, as amended by §13101 of the ARRA.

F. ICO agrees to maintain a fiscally sound operation by at least maintaining a positive net worth (total assets exceed total liabilities) as required in 42 C.F.R. §423.505(b)(23).

APPENDIX E. Model File & Use Certification Form

Pursuant to the contract between the Centers for Medicare & Medicaid Services (CMS), the State of Michigan, acting by and through the Michigan Department of Community Health (MDCH) and the Michigan Department of Technology and Budget (DTMB), and Meridian Health Plan of Michigan, Inc., hereafter referred to as the ICO, governing the operations of the following health plan: Meridian Health Plan of Michigan, Inc, H0480 the ICO hereby certifies that all qualified materials for the Demonstration is accurate, truthful and not misleading. Organizations using File & Use Certification agree to retract and revise any materials (without cost to the government) that are determined by CMS or the State of Michigan to be misleading or inaccurate or that do not follow established Medicare Marketing Guidelines, Regulations, and sub-regulatory guidance. In addition, organizations may be held accountable for any Beneficiary financial loss as a result of mistakes in marketing materials or for misleading information that results in uninformed decision by a Beneficiary to elect the plan. Compliance criteria include, without limitation, the requirements in 42 CFR §422.2260 – §422.2276 and 42 CFR §422.111 for the ICO and the Medicare Marketing Guidelines.

I agree that CMS or the State of Michigan may inspect any and all information including those held at the premises of the ICO to ensure compliance with these requirements. I further agree to notify CMS and the State of Michigan immediately if I become aware of any circumstances that indicate noncompliance with the requirements described above.

APPENDIX F. Medicare Mark License Agreement

THIS AGREEMENT is made and entered into on September 25, 2014

by and between

THE CENTERS FOR MEDICARE & MEDICAID SERVICES (hereinafter "Licensor"),

with offices located at 7500 Security Blvd., Baltimore, MD 21244

and

Meridian Health Plan of Michigan, Inc. (hereinafter "Licensee"),

with offices located at

777 Woodward Avenue, Suite 600, Detroit, MI 48226.

CMS Contract ID: H0480

WITNESSETH

WHEREAS, Licensor is the owner of the Medicare Prescription Drug Benefit program, a program authorized under Title XVIII, Part D of the Social Security Act (Part D), Mark (the "Mark").

WHEREAS, Licensee desires to use the Mark on Part D marketing materials (including the identification card) beginning December 1, 2014

WHEREAS, both parties, in consideration of the premises and promises contained herein and other good and valuable consideration which the parties agree is sufficient, and each intending to be legally bound thereby, the parties agree as follows:

1. Subject to the terms and conditions of this Agreement, Licensor hereby grants to Licensee a non-exclusive right to use the Mark in their Part D marketing materials.

2. Licensee acknowledges Licensor's exclusive right, title, and interest in and to the Mark and will not, at any time, do or cause to be done any act or thing contesting or in any way impairing or tending to impair any part of such right, title, and interest. Licensee acknowledges that the sole right granted under this Agreement with respect to the Mark is for the purposes described herein, and for no other purpose whatsoever.

3. Licensor retains the right to use the Mark in the manner or style it has done so prior to this Agreement and in any other lawful manner.

4. This Agreement and any rights hereunder are not assignable by Licensee and any attempt at assignment by Licensee shall be null and void.

5. Licensor, or its authorized representative, has the right, at all reasonable times, to inspect any material on which the Mark is to be used, in order that Licensor may satisfy itself that the material on which the Mark appears meets with the standards, specifications, and instructions submitted or approved by Licensor. Licensee shall use the Mark without modification and in accordance with the Mark usage policies described within the Medicare Marketing Guidelines. Licensee shall not take any action inconsistent with the Licensor's ownership of the Mark, and any goodwill accruing from use of such Mark shall automatically vest in Licensor.

6. This agreement shall be effective on the date of signature by the Licensee's authorized representative through December 31, 2015, concurrent with the execution of the Part D addendum to the Contract. This Agreement may be terminated by either party upon written notice at any time. Licensee agrees, upon written notice from Licensor, to discontinue any use of the Mark immediately. Starting December 31, 2015, this agreement shall be renewable for successive one-year periods running concurrently with the term of the Licensee's Part D contract. This agreement shall terminate, without written notice, upon the effective date of termination or non-renewal of the Licensee's Part D contract (or Part D addendum to a Capitated Financial Alignment Demonstration contract).

7. Licensee shall indemnify, defend and hold harmless Licensor from and against all liability, demands, Claims, suits, losses, damages, infringement of proprietary rights, causes of action, fines, or judgments (including costs, attorneys' and witnesses' fees, and expenses incident thereto), arising out of Licensee's use of the Mark.

8. Licensor will not be liable to Licensee for indirect, special, punitive, or consequential damages (or any loss of revenue, profits, or data) arising in connection with this Agreement even if Licensor has been advised of the possibility of such damages.

9. This Agreement is the entire agreement between the parties with respect to the subject matter hereto.

10. Federal law shall govern this Agreement.

APPENDIX G. Data Use Attestation

The ICO shall restrict its use and disclosure of Medicare data obtained from CMS and the State of Michigan information systems (listed in Attachment A) to those purposes directly related to the administration of the Medicare/Medicaid managed care and/or outpatient prescription drug benefits for which it has contracted with the CMS and the State of Michigan to administer. The ICO shall only maintain data obtained from CMS and the State of Michigan information systems that are needed to administer the Medicare/Medicaid managed care and/or outpatient prescription drug benefits that it has contracted with CMS and the State of Michigan to administer. The ICO (or its First Tier, Downstream or other Related Entities) may not re-use or provide other entities access to the CMS information system, or data obtained from the system or the State of Michigan, to support any line of business other than the Medicare/Medicaid managed care and/or outpatient prescription drug benefit for which the ICO contracted with CMS and the State of Michigan.

The ICO further attests that it shall limit the use of information it obtains from its Enrollees to those purposes directly related to the administration of such plan. The ICO acknowledges two exceptions to this limitation. First, the ICO may provide its Enrollees information about non-health related services after obtaining consent from the Enrollees. Second, the ICO may provide information about health-related services without obtaining prior Enrollee consent, as long as the ICO affords the Enrollee an opportunity to elect not to receive such information.

CMS may terminate the ICO's access to the CMS data systems immediately upon determining that the ICO has used its access to a data system, data obtained from such systems, or data supplied by its Enrollees beyond the scope for which CMS and the State of Michigan have authorized under this agreement. A termination of this data use agreement may result in CMS or the State of Michigan terminating the ICO's Medicare-Medicaid contract(s) on the basis that it is no longer qualified as an ICO. This agreement shall remain in effect as long as the ICO remains an ICO sponsor. This agreement excludes any public use files or other publicly available reports or files that CMS or the State of Michigan make available to the general public on their websites.

Attachment A

The following list contains a representative (but not comprehensive) list of CMS information systems to which the Data Use Attestation applies. CMS will update the list periodically as necessary to reflect changes in the agency's information systems

- Automated Plan Payment System (APPS)
- Common Medicare Environment (CME)
- Common Working File (CWF)
- Coordination of Benefits Contractor (COBC)
- Drug Data Processing System (DDPS)
- Electronic Correspondence Referral System (ECRS)
- Enrollment Database (EDB)
- Financial Accounting and Control System (FACS)
- Front End Risk Adjustment System (FERAS)

- Health Plan Management System (HPMS), including Complaints Tracking and all other modules
- HI Master Record (HIMR)
- Individuals Authorized Access to CMS Computer Services (IACS)
- Integrated User Interface (IUI)
- Medicare Advantage Prescription Drug System (MARx)
- Medicare Appeals System (MAS)
- Medicare Beneficiary Database (MBD)
- Payment Reconciliation System (PRS)
- Premium Withholding System (PWS)
- Prescription Drug Event Front End System (PDFS)
- Retiree Drug System (RDS)
- Risk Adjustments Processing Systems (RAPS)

APPENDIX H. Service Area

The Service Area outlined below is contingent upon the ICO meeting all Readiness Review requirements in each Region. CMS and MDCH reserve the right to amend this Appendix to revise the Service Area based on final Readiness Review results or subsequent determinations made by CMS and MDCH. The Service Area consists of the following Regions:

Region 4

Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, and Van Buren

APPENDIX I. Financial Monitoring Standards

Reporting Period	Monitoring Indicator	Threshold	MDCH Action	ICO Action
Quarterly Financial	Working Capital	Below minimum	DCH written notification	Submit written business plan within 30 calendar days of MDCH notification that describes actions including timeframe to restore compliance
Quarterly Financial	Net Worth	Negative Net Worth	DCH written notification Freeze auto assigned Enrollees.	Submit written business plan within 30 calendar days of MDCH notification that describes actions including timeframe to restore compliance.
Quarterly Financial	Medical Loss Ratio	83%	DCH written notification Freeze auto assigned enrollees.	Submit written business plan within 30 calendar days of MDCH notification that describes actions including timeframe to restore compliance.
Annual Financial Statement	Risk Based Capital	150-200% RBC	MDCH written notification. Limit enrollment or freeze auto assigned enrollees.	Submit written business plan within 30 calendar days of MDCH notification that describes actions including timeframe to restore compliance.
Annual Financial Statement	Risk Based Capital	100-149% RBC	MDCH written notification including request for monthly financial statements. Freeze all enrollments.	Submit written business plan (if not previously submitted) within 30 calendar days of MDCH notification that describes actions including timeframe to restore compliance.
Annual Financial Statement	Risk Based Capital	Less than 100% RBC	Freeze all enrollments. Terminate contract.	Develop transition plan.

APPENDIX J. State of Michigan Liability Insurance Requirements for ICO and First Tier Entities, Downstream Entities and Related Entities

ICO Liability Insurance

For the purpose of this Section, "State" includes its departments, divisions, agencies, offices, commissions, officers, employees, and agents.

(a) The ICO must provide proof that it has obtained the minimum levels of insurance coverage indicated or required by law, whichever is greater. The insurance must protect the State from claims that may arise out of, or result from, or are alleged to arise out of, or result from, the ICO's or a First Tier Entity's, Downstream Entity's, or Related Entity's performance, including any person directly or indirectly employed by the ICO or a First Tier Entity, Downstream Entity, Related Entity, or any person for whose acts the ICO or a First Tier Entity, Downstream Entity, Related Entity may be liable.

(b) The ICO waives all rights against the State for the recovery of damages that are covered by the insurance policies the ICO is required to maintain under this Section. The ICO's failure to obtain and maintain the required insurance will not limit this waiver.

(c) All insurance coverage provided relative to this Contract is primary and non-contributing to any comparable liability insurance (including self-insurance) carried by the State.

(d) The State, in its sole discretion, may approve the use of a fully-funded self-insurance program in place of any specified insurance identified in this Section.

(e) Unless the State approves otherwise, any insurer must have an A.M. Best rating of "A" or better and a financial size of VII or better, or if those ratings are not available, a comparable rating from an insurance rating agency approved by the State. All policies of insurance must be issued by companies that have been approved to do business in the State.

(f) Where specific coverage limits are listed in this Section, they represent the minimum acceptable limits. If the ICO's policy contains higher limits, the State is entitled to coverage to the extent of the higher limits.

(g) The ICO must maintain all required insurance coverage throughout the term of this Contract and any extensions. However, in the case of claims-made Commercial General Liability policies, the ICO must secure tail coverage for at least three years following the termination of this Contract.

(h) The ICO must provide, within five business Days, written notice to the Director of DTMB-Procurement if any policy required under this section is cancelled. The notice must include the applicable Contract or Purchase Order number.

(i) The minimum limits of coverage specified are not intended, and may not be construed, to limit any liability or indemnity of the ICO to any indemnified party or other persons.

(j) The ICO is responsible for the payment of all deductibles.

(k) If the ICO fails to pay any premium for a required insurance policy, or if any insurer cancels or significantly reduces any required insurance without the State's approval, the State may, after giving the ICO at least 30 Days' 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 ICO, or require the ICO to pay that cost upon demand.

(l) 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 Michigan Attorney General.

(m) The ICO is required to pay for and provide the type and amount of insurance checked ☑ below:

☑ (i) Commercial General Liability

Minimal Limits:

$2,000,000.00 General Aggregate Limit other than Products/Completed Operations;

$2,000,000.00 Products/Completed Operations Aggregate Limit;

$1,000,000.00 Personal & Advertising Injury Limit; and

$1,000,000.00 Each Occurrence Limit.

Deductible maximum:

$50,000.00 Each Occurrence

Additional Requirements:

The ICO 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 ICO also agrees to provide evidence that the insurance policy contains a waiver of subrogation by the insurance company.

☑ (ii) Umbrella or Excess Liability

$10,000,000.00 General Aggregate

Additional Requirements:

Umbrella or Excess Liability limits must at least apply to the insurance required in (i), General Commercial Liability. The ICO must list the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees, and agents as additional insureds on the certificate. The ICO also agrees to provide evidence that insurance policies contain a waiver of subrogation by the insurance company.

☑ (iii) Motor Vehicle

Minimal Limits:

If a motor vehicle is used in relation to the ICO's performance, the ICO must have vehicle liability insurance on the motor vehicle for bodily injury and property damage as required by law.

☑ (iv) Hired and Non-Owned Motor Vehicle

Minimal Limits:

$1,000,000.00 Per Accident

Additional Requirements:

The ICO 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 ICO also agrees to provide evidence that insurance policies contain a waiver of subrogation by the insurance company.

☑ (v) Workers' Compensation Insurance

Minimal Limits:

The ICO must provide Workers' Compensation coverage according to applicable laws governing work activities in the state of the ICO's domicile. If the applicable coverage is provided by a self-insurer, the ICO must provide proof of an approved self-insured authority by the jurisdiction of domicile.

For employees working outside of the state of the ICO's domicile, the ICO must provide certificates of insurance proving mandated coverage levels for the jurisdictions where the employees' activities occur.

Additional Requirements:

The ICO must provide the applicable certificates of insurance and a list of states where the coverage is applicable. ICO must provide proof that the Workers' Compensation insurance policies contain a waiver of subrogation by the insurance company, except where such a provision is prohibited or limited by the laws of the jurisdiction in which the work is to be performed.

☑ (vi) Employers Liability

Minimal Limits:

$100,000.00 Each Incident;

$100,000.00 Each Employee by Disease

$500,000.00 Aggregate Disease

Additional Requirements:

The ICO must list the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees, and agents as additional insureds on the certificate.

☑ (vii) Employee Fidelity (Crime)

Minimal Limits:

$1,000,000.00 Employee Theft Per Loss

Deductible Maximum:

$50,000.00 Per Loss

Additional Requirements:

Insurance must cover Forgery and Alteration, Theft of Money and Securities, Robbery and Safe Burglary, Computer Fraud, Funds Transfer Fraud, Money Order and Counterfeit Currency.

The ICO must list the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees, and agents as Loss Payees on the certificate.

☑ (viii) Professional Liability (Errors and Omissions)

Minimal Limits:

$3,000,000.00 Each Occurrence

$3,000,000.00 Annual Aggregate

Deductible Maximum:

$50,000.00 Per Loss

☐ (ix) Medical Malpractice

Minimal Limits:

(Small Provider)$200,000.00 Each Occurrence

$600,000.00 Annual Aggregate

(Large Provider)$1,000,000.00 Each Occurrence

$3,000,000.00 Annual Aggregate

Deductible Maximum:

$5,000 Each Occurrence

☑ (x) Cyber Liability

Minimal Limits:

$1,000,000.00 Each Occurrence

$1,000,000.00 Annual Aggregate

Additional Requirements:

Insurance should cover (a)unauthorized acquisition, access, use, physical taking, identity theft, mysterious disappearance, release, distribution or disclosures of personal and corporate information; (b) Transmitting or receiving malicious code via the insured's computer system; (c) Denial of service attacks or the inability to access websites or computer systems.

The ICO must list the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees, and agents as additional insureds on the certificate.

☐ (xi) Property Insurance

Property Insurance covering any loss or damage to the State-owned office space used by ICO for any reason under this Contract, and the State-owned equipment, software and other contents of the office space, including without limitation, those contents used by ICO 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 ICO. The State must be endorsed on the policy as a loss payee as its interests appear.

First Tier Entity, Downstream Entity and Related Entity Insurance Coverage

Except where the State has approved a subcontract with other insurance provisions, the ICO must require any First Tier Entity, Downstream Entity and Related Entity to purchase and maintain the insurance coverage required in the ICO Liability Insurance section. Alternatively, the ICO may include a First Tier Entity, Downstream Entity and Related Entity under the ICO's insurance on the coverage required in that Section. The failure of a First Tier Entity, Downstream Entity and Related Entity to comply with insurance requirements does not limit the ICO's liability or responsibility.

Category I: Health Benefit Managers and Type A Transportation First Tier Entities, Downstream Entities and Related Entities are required to pay for and provide the type and amount of insurance specified below:

☑ (i) Commercial General Liability

Minimal Limits:

$2,000,000.00 General Aggregate Limit other than Products/Completed Operations;

$2,000,000.00 Products/Completed Operations Aggregate Limit;

$1,000,000.00 Personal & Advertising Injury Limit; and

$1,000,000.00 Each Occurrence Limit.

Deductible maximum:

$50,000.00 Each Occurrence

Additional Requirements:

The ICO 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 ICO also agrees to provide evidence that the insurance policy contains a waiver of subrogation by the insurance company.

☑ (ii) Umbrella or Excess Liability

$5,000,000.00 General Aggregate

Additional Requirements:

Umbrella or Excess Liability limits must at least apply to the insurance required in (i), General Commercial Liability. The ICO must list the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees, and agents as additional insureds on the certificate. The ICO also agrees to provide evidence that insurance policies contain a waiver of subrogation by the insurance company.

☑ (iii) Motor Vehicle

Minimal Limits:

If a motor vehicle is used in relation to the ICO's performance, the ICO must have vehicle liability insurance on the motor vehicle for bodily injury and property damage as required by law.

☐ (iv) Hired and Non-Owned Motor Vehicle

Minimal Limits:

$1,000,000.00 Per Accident

Additional Requirements:

The ICO 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 ICO also agrees to provide evidence that insurance policies contain a waiver of subrogation by the insurance company.

☑ (v) Workers' Compensation Insurance

Minimal Limits:

The ICO must provide Workers' Compensation coverage according to applicable laws governing work activities in the state of the ICO's domicile. If the applicable coverage is provided by a self-insurer, the ICO must provide proof of an approved self-insured authority by the jurisdiction of domicile.

For employees working outside of the state of the ICO's domicile, the ICO must provide certificates of insurance proving mandated coverage levels for the jurisdictions where the employees' activities occur.

Additional Requirements:

The ICO must provide the applicable certificates of insurance and a list of states where the coverage is applicable. ICO must provide proof that the Workers' Compensation insurance policies contain a waiver of subrogation by the insurance company, except where such a provision is prohibited or limited by the laws of the jurisdiction in which the work is to be performed.

☑ (vi) Employers Liability

Minimal Limits:

$100,000.00 Each Incident;

$100,000.00 Each Employee by Disease

$500,000.00 Aggregate Disease

Additional Requirements:

The ICO must list the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees, and agents as additional insureds on the certificate.

☑ (vii) Employee Fidelity (Crime)

Minimal Limits:

$1,000,000.00 Employee Theft Per Loss

Deductible Maximum:

$50,000.00 Per Loss

Additional Requirements:

Insurance must cover Forgery and Alteration, Theft of Money and Securities, Robbery and Safe Burglary, Computer Fraud, Funds Transfer Fraud, Money Order and Counterfeit Currency.

The ICO must list the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees, and agents as Loss Payees on the certificate.

☑ (viii) Professional Liability (Errors and Omissions)

Minimal Limits:

$3,000,000.00 Each Occurrence

$3,000,000.00 Annual Aggregate

Deductible Maximum:

$50,000.00 Per Loss

☐ (ix) Medical Malpractice

Minimal Limits:

(Small Provider)$200,000.00 Each Occurrence

$600,000.00 Annual Aggregate

(Large Provider)$1,000,000.00 Each Occurrence

$3,000,000.00 Annual Aggregate

Deductible Maximum:

$5,000 Each Occurrence

☑ (x) Cyber Liability

Minimal Limits:

$1,000,000.00 Each Occurrence

$1,000,000.00 Annual Aggregate

Additional Requirements:

Insurance should cover (a)unauthorized acquisition, access, use, physical taking, identity theft, mysterious disappearance, release, distribution or disclosures of personal and corporate information; (b) Transmitting or receiving malicious code via the insured's computer system; (c) Denial of service attacks or the inability to access websites or computer systems.

The ICO must list the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees, and agents as additional insureds on the certificate.

☐ (xi) Property Insurance

Property Insurance covering any loss or damage to the State-owned office space used by ICO for any reason under this Contract, and the State-owned equipment, software and other contents of the office space, including without limitation, those contents used by ICO 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 ICO. The State must be endorsed on the policy as a loss payee as its interests appear.

Category II, Type A – Administrative First Tier Entities, Downstream Entities and Related Entities dealing with payment decisions are required to pay for and provide the type and amount of insurance listed below:

☑ (i) Commercial General Liability

Minimal Limits:

$2,000,000.00 General Aggregate Limit other than Products/Completed Operations;

$2,000,000.00 Products/Completed Operations Aggregate Limit;

$1,000,000.00 Personal & Advertising Injury Limit; and

$1,000,000.00 Each Occurrence Limit.

Deductible maximum:

$50,000.00 Each Occurrence

Additional Requirements:

The ICO 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 ICO also agrees to provide evidence that the insurance policy contains a waiver of subrogation by the insurance company.

☐ (ii) Umbrella or Excess Liability

$10,000,000.00 General Aggregate

Additional Requirements:

Umbrella or Excess Liability limits must at least apply to the insurance required in (i), General Commercial Liability. The ICO must list the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees, and agents as additional insureds on the certificate. The ICO also agrees to provide evidence that insurance policies contain a waiver of subrogation by the insurance company.

☑ (iii) Motor Vehicle

Minimal Limits:

If a motor vehicle is used in relation to the ICO's performance, the ICO must have vehicle liability insurance on the motor vehicle for bodily injury and property damage as required by law.

☐ (iv) Hired and Non-Owned Motor Vehicle

Minimal Limits:

$1,000,000.00 Per Accident

Additional Requirements:

The ICO 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 ICO also agrees to provide evidence that insurance policies contain a waiver of subrogation by the insurance company.

☑ (v) Workers' Compensation Insurance

Minimal Limits:

The ICO must provide Workers' Compensation coverage according to applicable laws governing work activities in the state of the ICO's domicile. If the applicable coverage is provided by a self-insurer, the ICO must provide proof of an approved self-insured authority by the jurisdiction of domicile.

For employees working outside of the state of the ICO's domicile, the ICO must provide certificates of insurance proving mandated coverage levels for the jurisdictions where the employees' activities occur.

Additional Requirements:

The ICO must provide the applicable certificates of insurance and a list of states where the coverage is applicable. ICO must provide proof that the Workers' Compensation insurance policies contain a waiver of subrogation by the insurance company, except where such a provision is prohibited or limited by the laws of the jurisdiction in which the work is to be performed.

☑ (vi) Employers Liability

Minimal Limits:

$100,000.00 Each Incident;

$100,000.00 Each Employee by Disease

$500,000.00 Aggregate Disease

Additional Requirements:

The ICO must list the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees, and agents as additional insureds on the certificate.

☑ (vii) Employee Fidelity (Crime)

Minimal Limits:

$1,000,000.00 Employee Theft Per Loss

Deductible Maximum:

$50,000.00 Per Loss

Additional Requirements:

Insurance must cover Forgery and Alteration, Theft of Money and Securities, Robbery and Safe Burglary, Computer Fraud, Funds Transfer Fraud, Money Order and Counterfeit Currency.

The ICO must list the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees, and agents as Loss Payees on the certificate.

☑ (viii) Professional Liability (Errors and Omissions)

Minimal Limits:

$3,000,000.00 Each Occurrence

$3,000,000.00 Annual Aggregate

Deductible Maximum:

$50,000.00 Per Loss

☐ (ix) Medical Malpractice

Minimal Limits:

(Small Provider)$200,000.00 Each Occurrence

$600,000.00 Annual Aggregate

(Large Provider)$1,000,000.00 Each Occurrence

$3,000,000.00 Annual Aggregate

Deductible Maximum:

$5,000 Each Occurrence

☑ (x) Cyber Liability

Minimal Limits:

$1,000,000.00 Each Occurrence

$1,000,000.00 Annual Aggregate

Additional Requirements:

Insurance should cover (a)unauthorized acquisition, access, use, physical taking, identity theft, mysterious disappearance, release, distribution or disclosures of personal and corporate information; (b) Transmitting or receiving malicious code via the insured's computer system; (c) Denial of service attacks or the inability to access websites or computer systems.

The ICO must list the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees, and agents as additional insureds on the certificate.

☐ (xi) Property Insurance

Property Insurance covering any loss or damage to the State-owned office space used by ICO for any reason under this Contract, and the State-owned equipment, software and other contents of the office space, including without limitation, those contents used by ICO 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 ICO. The State must be endorsed on the policy as a loss payee as its interests appear.

Category II, Type B – Administrative First Tier Entities, Downstream Entities and Related Entities dealing with medical decisions are required to pay for and provide the type and amount of insurance listed below:

☐ (i) Commercial General Liability

Minimal Limits:

$2,000,000.00 General Aggregate Limit other than Products/Completed Operations;

$2,000,000.00 Products/Completed Operations Aggregate Limit;

$1,000,000.00 Personal & Advertising Injury Limit; and

$1,000,000.00 Each Occurrence Limit.

Deductible maximum:

$50,000.00 Each Occurrence

Additional Requirements:

The ICO 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 ICO also agrees to provide evidence that the insurance policy contains a waiver of subrogation by the insurance company.

☐ (ii) Umbrella or Excess Liability

$10,000,000.00 General Aggregate

Additional Requirements:

Umbrella or Excess Liability limits must at least apply to the insurance required in (i), General Commercial Liability. The ICO must list the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees, and agents as additional insureds on the certificate. The ICO also agrees to provide evidence that insurance policies contain a waiver of subrogation by the insurance company.

☑ (iii) Motor Vehicle

Minimal Limits:

If a motor vehicle is used in relation to the ICO's performance, the ICO must have vehicle liability insurance on the motor vehicle for bodily injury and property damage as required by law.

☐ (iv) Hired and Non-Owned Motor Vehicle

Minimal Limits:

$1,000,000.00 Per Accident

Additional Requirements:

The ICO 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 ICO also agrees to provide evidence that insurance policies contain a waiver of subrogation by the insurance company.

☑ (v) Workers' Compensation Insurance

Minimal Limits:

The ICO must provide Workers' Compensation coverage according to applicable laws governing work activities in the state of the ICO's domicile. If the applicable coverage is provided by a self-insurer, the ICO must provide proof of an approved self-insured authority by the jurisdiction of domicile.

For employees working outside of the state of the ICO's domicile, the ICO must provide certificates of insurance proving mandated coverage levels for the jurisdictions where the employees' activities occur.

Additional Requirements:

The ICO must provide the applicable certificates of insurance and a list of states where the coverage is applicable. ICO must provide proof that the Workers' Compensation insurance policies contain a waiver of subrogation by the insurance company, except where such a provision is prohibited or limited by the laws of the jurisdiction in which the work is to be performed.

☑ (vi) Employers Liability

Minimal Limits:

$100,000.00 Each Incident;

$100,000.00 Each Employee by Disease

$500,000.00 Aggregate Disease

Additional Requirements:

The ICO must list the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees, and agents as additional insureds on the certificate.

☐ (vii) Employee Fidelity (Crime)

Minimal Limits:

$1,000,000.00 Employee Theft Per Loss

Deductible Maximum:

$50,000.00 Per Loss

Additional Requirements:

Insurance must cover Forgery and Alteration, Theft of Money and Securities, Robbery and Safe Burglary, Computer Fraud, Funds Transfer Fraud, Money Order and Counterfeit Currency.

The ICO must list the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees, and agents as Loss Payees on the certificate.

☑ (viii) Professional Liability (Errors and Omissions)

Minimal Limits:

$3,000,000.00 Each Occurrence

$3,000,000.00 Annual Aggregate

Deductible Maximum:

$50,000.00 Per Loss

☐ (ix) Medical Malpractice

Minimal Limits:

(Small Provider)$200,000.00 Each Occurrence

$600,000.00 Annual Aggregate

(Large Provider)$1,000,000.00 Each Occurrence

$3,000,000.00 Annual Aggregate

Deductible Maximum:

$5,000 Each Occurrence

☐ (x) Cyber Liability

Minimal Limits:

$1,000,000.00 Each Occurrence

$1,000,000.00 Annual Aggregate

Additional Requirements:

Insurance should cover (a)unauthorized acquisition, access, use, physical taking, identity theft, mysterious disappearance, release, distribution or disclosures of personal and corporate information; (b) Transmitting or receiving malicious code via the insured's computer system; (c) Denial of service attacks or the inability to access websites or computer systems.

The ICO must list the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees, and agents as additional insureds on the certificate.

☐ (xi) Property Insurance

Property Insurance covering any loss or damage to the State-owned office space used by ICO for any reason under this Contract, and the State-owned equipment, software and other contents of the office space, including without limitation, those contents used by ICO 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 ICO. The State must be endorsed on the policy as a loss payee as its interests appear.

Type B Transportation Provider must verify that individuals providing the transportation have secured appropriate insurance coverage as required by law. The subcontract between the ICO and Type B Transportation Provider should require these Providers to obtain a letter of understanding with the individual providing the transportation that attests that the individual has appropriate insurance coverage.

Certificates of Insurance

Before the Contract is signed, and not less than 20 Days before the insurance expiration date every year thereafter, the ICO must provide evidence that the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees, and agents are listed as additional insureds as required. The ICO must provide DTMB-Procurement with all applicable certificates of insurance verifying insurance coverage or providing, if approved, satisfactory evidence of self-insurance as required in ICO Liability Insurance section. Each certificate must be on the standard "Accord" form or equivalent and MUST IDENTIFY THE APPLICABLE CONTRACT OR PURCHASE ORDER NUMBER.